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SOCIAL WORK IN THE PSYCHIATRIC UNIT OF A GENERAL HOSPITAL.

AN ANALYSIS OF FUNCTION.

BY

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B.A. (SOCIAL WORK).

A DISSERTATION PRESENTED TO
THE DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
IN FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF ARTS
OF
THE UNIVERSITY OF THE WITWATERSRAND,
JOHANNESBURG.

DECEMBER, 1964.

ACKNOWLEDGEMENTS.

When one sets out on a long journey, many mile-stones make up the way, and without each one the journey cannot be completed. To all those people who have formed the mile-stones of my journey, I feel deeply indebted; I should like them to know that they have contributed to my work, and made it possible.

Yet there are some whom I particularly wish to thank, and if, unintentionally, I omit others, I must ask to be forgiven, for so many people have been so kind that it is impossible to record all by name.

First, my thanks go to my two supervisors, who have given unstintingly to me of their time and wisdom. To Professor L.A. Hurst, Head of the Department of Psychological Medicine, University of the Witwatersrand, I wish to express my deep appreciation, not only for the patience and willing help which he has given me in the preparation of this work, but also for the privilege of working under him for three years. This period of supervision by him has formed the culmination of a dynamic and intensive learning experience with a wise and kindly teacher.

Dr. T.R. Seawright, Supervisor of Field Work in the Department of Sociology and Social Work of the University, has provided guidance to me from the time of my earliest gropings in social work. To this thesis, as always, she has brought knowledge and clear thinking, warmth and helpfulness. With a "dead-line" looming ever closer on the horizon, both she and Professor Hurst

have/.....

have facilitated the completion of this work wherever possible.

Then there are those other people whom I know less well, yet who have helped along the way. Thus, the statistical aspects of the project have been carried out under the guidance and direction of Professor J.E. Kerrich, of the Department of Statistics, and Mr. H. Lever, of the Department of Sociology and Social Work. They helped untiringly both with the major and minor problems which arose in this field.

Mr. H.E. Augustyn, of the Office of the Commissioner for Mental Health, Pretoria, has been more than kind in the way in which he not only has obtained for me obscure and important literature, but also has given of his own time and energy in assisting me with various data which I have needed. Dr. M. Minde, Medical Officer of the Department of Social Welfare and Pensions, Pretoria, and Mr. T.J. Stander, Director of the South African National Council for Mental Health, Johannesburg, provided valuable information on the history and development of mental health services in South Africa.

Turning closer to home, again, there are, among my colleagues, several whom I should like to thank. In particular among them is Mrs. A.B. Orsmond, now Psychiatric Social Worker, Johannesburg General Hospital. Throughout the long period during which I have been working on this project, she has helped not only in many major but also in many minor ways, always with an unflagging warmth and helpfulness. Miss J. Dettman,

Psychiatric/.....

Psychiatric Social Worker, Tara Hospital, Johannesburg, provided guidance whenever approached, in spite of the many calls on her time. From my "team-mates" in the wards of the Unit came co-operation and understanding, and every effort to facilitate my research, as well as, over the years, a sense of pioneering and working together to promote a new and good service.

To those whom we tried to help, and especially the anonymous patients of this study, without whom it could have had no base, my thanks must also go.

In the preparation of this text, many people have helped. Mrs. G. Cowling deciphered and typed a very trying manuscript, and assisted, in part, with the final draft. Mrs. F. Kruss, and the Staff and Students of the Rosebank Commercial College, Johannesburg, have typed, carefully and tirelessly, and under great pressure of time, a considerable portion of the remainder of the script, while Mrs. G. van Reenen has ably, cheerfully, and willingly completed the balance, in a remarkably short time. To all, sincere thanks are due.

Monies for payment of expenses came from the G.A. Denny Scholarship, granted to me by the University of the Witwatersrand. Without this scholarship, the completion of my research as well as its production would have been made vastly more difficult. I thank the University authorities, and especially Mrs. A. Pelser, who arranged the details of payment, for this help.

Perhaps/.....

Perhaps because it is most difficult to thank the members of my family, I have left them till last. They have patiently accepted the fact of this thesis, and, in spite of an impending separation, possibly of some years, the time which it has taken from our being together. My love and thanks go out to them all.

Among them, however, are three people whom I want, particularly, to thank. The first are my mother and father. Their high ideals have been a source of inspiration to me always, and this thesis is the outcome of their teachings. As always, their idealism has been accompanied by much practical assistance, and their help and support, especially in the final preparation of this text, have been unstintingly and willingly given.

To my husband, Jack, I cannot even begin to say thank you. He has lived and breathed this thesis from the moment of its inception; shared in its good and bad moments; read through its every word, not once but many times; and spurred me on to completion of what has at times seemed an impossible task. His support and help have been endless and unlimited.

This thesis is for him.

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INTRODUCTION.

HISTORICAL DATA.

The cries of witch-hunters and demon-killers, which in past ages so frequently hounded out the mentally ill, have subsided, for the most part, in our twentieth century world. Though awe and terror may perpetuate them in some cultures, and ignorance, in others, surrounds the mentally sick person with a cloak of secrecy or fear, society no longer drives out its tormented and demented, but, rather, protects and cares for them.

While much has changed, however, these harsh ways are in reality not so far distant from our own times, and when the history of mental disease and its treatment is traced, one finds that, as recently as the middle of the eighteenth century,[1] mentally ill patients in America were being chastised for their illness - beaten, locked up, and chained to walls. Such policy, however, had largely disappeared in Britain prior to this time, and the almshouse system of caring for the indigent mentally ill had taken its place. Under this system, so-called lunatics were herded into almshouses, under appalling conditions, with the poor and deformed of all types. No special provision was made for them, in fact, until 1547, when the Bethlehem Hospital in London (later to become known as Bedlem, infamous for inhuman treatment of the insane), after a chequered

history/....

1. Friedlander, W.A., Introduction to Social Welfare, Prentice-Hall, Inc., Englewood Cliffs, N.J., U.S.A., 1955; pp. 86 and 90.

history as a priory caring, among others, for the mentally ill, was handed over to the City of London by King Henry VIII as a "Hospital for Lunatics."[2] With the exception of an earlier asylum established in Grenada, Spain, this was the first hospital of its kind in Europe,[3] and no similar hospital was established in the New World until 1773, when the Eastern State Hospital at Williamsberg, Virginia, was founded.[4]

Thereafter, care of the mentally ill continued to be cruel and savage, custodial in nature, and treatment primitive or unheard of. The first advance in this state of affairs was precipitated by Philippe Pinel in 1793, when he ordered patients at the Bicêtre and at the Salpétrière Hospitals in Paris to be unchained.[5] This action had ramifications in Europe, Britain and America, and was the first major step towards humane handling of the insane. However, one man could not revolutionize, overnight, an iniquitous system of years, and further change was slow in coming.

Gradually, in Britain, it did come about, however, and by the end of the nineteenth century a few mental hospitals in England had opened their doors to men of religion, and to women visitors who brought comforts and light work to the less severely ill. Due to the efforts

of/....

2. Encyclopedia Britannica, Vol. 3, 1911; p. 622.
3. Ibid., loc. cit.
4. Encyclopedia Britannica, Vol. 12, 1955; p. 389; and Friedlander, W.A., op. cit., p. 90.
5. Encyclopedia Britannica, Vol. 12, 1955; p. 389.

of one of these clergymen, the Mental After-Care Association, originally known as "The After-Care Association for the Female and Friendless Convalescent on Leaving Asylums for the Insane," was established in 1877,[6] with the specific purpose of promoting public interest in the care of the insane.[7]

While events in Britain were leading up to this achievement, matters in America were progressing less satisfactorily. Dorothea Dix, for all her pioneering vigour, was twice thwarted in pressing a bill relating to mental hospitals through the American Congress in 1854, and although the Conference of Charities and Corrections in New York was aware, by 1870, of the need for providing facilities for the indigent insane,[8] it was not until 1890 that the New York State Care Act officially provided for the removal of the insane from almshouses, and for state support of the insane.[9] Shortly thereafter, the New York State Charities Aid Association developed a Committee on the Insane, whose purpose was "to inaugarate and maintain a system of after-care for convalescents leaving a mental hospital."[10]

This after-care emphasis became the principal one in services to the mentally ill in the next decade, and during the first years of the twentieth century social workers were introduced, for this purpose, in treatment

centres/....

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6. Timms, N., Psychiatric Social Work in Great Britain, Routledge and Kegan Paul, London, 1964; p. 14.
7. Hunnybun, N.: "Psychiatric Social Work," in Morris, C. (Ed.), Social Casework in Great Britain, Faber and Faber, Ltd., London, 1950; p. 102.
   This author gives the data of establishment of this society as 1879.
8. Rockmore, M.J.: "Social Work Rsponsibility in Mental Illness," Social Work (N.Yk.), Vol. 5, No. 3, July 1960; p. 70.
9. Ibid., loc.cit.
10. Ibid., loc.cit.

centres for the mentally ill in both England and America. In the latter, the year 1905 marked the arrival of the first social workers at the Neurological Clinics of the Massachusetts General Hospital, Boston, and the Bellevue Hospital and Cornell Clinic, New York City.[11] The following year, the New York Committee on the Insane demonstrated its policy of after-care by introducing a social worker to the Manhattan State Hospital for this purpose, and subsidizing her services.[12] In 1911, the State took over this programme, adding to the above function of the social worker that of preparing families for the return of the discharged patients.[13]

The need for psychiatrically trained workers in mental hospitals was soon felt, however, and in 1914 Miss Mary C. Jarrett launched an apprentice-ship training programme at the Boston Psychopathic Hospital.[14] Four years later, this obvious need, made more urgent by the after-effects of World War I, led to the introduction by Miss Jarrett of a specialized course in psychiatric social work at the Smith College School of Social Work. Thus, some twenty years after the beginning of

professional/....

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11. O'Keefe, D.E.: "Psychiatric Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960, N.A.S.W., N.Yk., 1960; p. 451. (Other writers quote 1906, not 1905, as the year in which the first social worker was appointed to this field). *
    * For list of journal and other bibliographical abbreviations used in this text see page
12. Rockmore, M.J., op. cit., loc. cit.
13. Ibid., loc. cit.
14. Parad, H.J.: "The Smith College School for Social Work in Perspective," Smith Coll. Stud. in Social Work. Vol. XXX, No. 2, Feb. 1960; p. 175.

professional education for social work in America, the first psychiatric training courses began.[15]

Where, previously, Britain had led the United States in developments in the field of mental illness, in specialized[16] training of social workers for this field she was several years behind, and the first training programme of this kind, while also beginning "in the field," did so only in 1929, at the London Child Guidance Clinic and Training Centre in Islington.[17] In the same year, the first theoretical training course for psychiatric social workers was established at the London School of Economics.[18a,b] However, the first such workers in Britain were actually trained in the two years before, in America.[19]

While an account of these events may give the impression that they were easily accomplished, they were, in fact, accompanied by long and hard pioneering efforts. Perhaps the earliest and most vigorous impetus to this

progress/....

15. Rockmore, M.J., op. cit., loc. cit. The First World War lent impetus to this movement, as did the Second, in later years.
16. The term "specialized" is used here without discussion of the wider issue of the generic and specific in social work. Attention is given to this matter in Chapter XIII, pp. 418, foll. and in the interim the history given will be regarded as the history of a specialization. Where the social worker is referred to as the psychiatric social worker, the term will be related not to her training as such, but to her functioning as such at the time.
17. Hunnybun, N., op. cit., p. 104.
18a. Ibid., p. 105, and Timms, N., op. cit., p. 21.
b. History of the Mental Health Movement has been restricted to a brief account relating to adults, and has omitted full mention of the Child Guidance Movement, as this was not considered completely relevant to the present study. Similarly, the specific history of the development of services for the mentally retarded has been omitted, though development of these services and those described frequently went hand in hand.
19. Timms, N., op. cit., pp. 19 and 20.

progress was given years earlier by Clifford Beers. Incarcerated in a mental hospital in the United States, in the early 1900's, for treatment of his own mental illness, he was shocked at conditions still existing in such institutions, and, shortly after his release, published, in 1908, "A Mind that Found Itself" - the story of his experiences while in hospital.[20] This book aroused widespread public interest, and led directly to Beers' work in founding the National Committee for Mental Hygiene in 1909.[21] The aim of this Committee was the conservation of mental health, and its influence soon became so great that it was felt throughout the Western World. So, like a vast underwater eruption, its impact reached the farthest corners, and had washed up, by 1912, on the shores of South Africa.[22]

Until Union, two years before, South Africa had had no co-ordinated mental health services. The provinces, or colonies, as they were then termed, had each had their own laws relating to mental illness, and had each provided such facilities as they saw fit for the detention and treatment of the insane.[23] Although cases of mental illness are reported in the Cape Colony as early as the time of Van Riebeeck,[24]

no/....

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20. Stroup, H.H., "Social Work - An Introduction to the Field," American Book Co., N.Yk. et al, 1953; pp. 267 - 268.
21. Ibid., loc. cit.
22. Stander, Mr. T.J., Director, South African National Council for Mental Health, personal communication, August 1964.
23. Minde, Dr. M., Medical Officer, Department of Social Welfare and Pensions, Pretoria, personal communication, August 1964.
24. Minde, M., "Mental Health Services in South Africa, 1652 - 1952," Unpublished M.D. thesis, University of the Witwatersrand, Johannesburg, June 1953; pp. 20, foll.

no particular facilities for these patients were in existence. Rather, they were placed in the wards of the ordinary hospitals, and, sometimes, in special wards attached to these hospitals.[25] The first specific provision for these patients was made in the Cape Colony in March, 1846, when a group of mental patients, together with chronic sick and lepers, were transferred from the Somerset Hospital in Cape Town to Robben Island.[26] Prior to the arrival of these patients from the mainland, the Island had been used for such varying purposes as a whaling station, a convalescent hospital for soldiers invalided from India, and a military penal settlement.[27] No additions or alterations were made to the buildings and outhouses, although they were unsuitable for medical purposes, and the staff (consisting of a Surgeon Superintendent, Chaplain, Clerk and Storekeeper, Lunatic Keeper and his wife, Assistant Lunatic Keeper and his wife, plus ward attendants and artisans - 19 in all)[28] were hard put to care in any adequate way for the patients. Although this was the first special provision made for mental patients in South Africa, the wards at the Robben Island Settlement formed only a section, although a large one, of the total settlement, and the first mental hospital per se was that established in Grahamstown, in 1875.[29]

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25. Minde, Dr. M., personal communication, August 1964.
26. (First) Report of the Commissioner of Mentally Disordered and Defective Persons for the Union of South Africa, Government Printers, Cape Town, 1920; p. 17.
27. Ibid., loc. cit.
28. Ibid., p. 18.
29. Minde, Dr. M., personal communication, August 1964.

Called the Grahamstown Asylum, it had one doctor in charge,[30] and also was not built specifically as a hospital, but had been the old military barracks of the town. The name "Fort England" thus attached to the hospital for many years. The hospital next established in the Cape Colony was that at Port Alfred, in 1888,[31] followed by Valkenberg, in Cape Town, in 1890,[32] while in 1894 one was opened at Fort Beaufort.[33]

Developments in Natal followed the same trends as those in the Cape, and in the early days of the Colony mentally ill patients were also treated in the public hospitals, these being in Durban and Pietermaritzburg. The policy of separating the mentally disturbed from others, while introduced in the Cape in 1846, was first introduced in Natal only in 1868, when most of these patients were removed to what later became the Central Gaol in Pietermaritzburg,[34] and until 1875, most patients, with the exception of a few "idiots, epileptics and paralytics," who were kept at the hospitals, were held at the prison.[35] In that year, however, a temporary asylum was established in the gaol,[36] and patients kept there under lay supervision until 1880, when a new asylum was built which, in 1882, was put into the charge of a resident medical

practitioner/....

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30. Idem. This doctor was not a psychiatrist, and the first practising psychiatrist in South Africa is thought to have been a Dr. M. Moll, ± 1916, in Johannesburg. (Information also from Dr. Minde).
31. (First) Report of the Commissioner of Mentally Disordered and Defective Persons, etc., p. 22.
32. Ibid., p. 19.
33. Ibid., p. 23.
34. Ibid., p. 25.
35. Ibid., loc. cit.
36. Minde, M., op. cit., p. 67.

practitioner.[37]

The two Northern Republics, having been opened up later than the coastal Colonies, were also later in establishing treatment facilities for the mentally ill. Thus, it was only in 1875 that the Volksraad[38] of the Orange Free State began to consider the problems created by lack of facilities for care of the mentally ill, and resolved to bring all the insane together for custody into one central area.[39] This led to the establishment of a temporary hospital in Bloemfontein in 1876, to accommodate all those who previously had been kept in gaols or huts in the outlying towns.[40] Accommodation soon was over-crowded, and in 1883 the first building of the permanent hospital was erected.[41] Only nine years later, in 1892, the Pretoria Asylum was opened,[42] and a part-time medical officer appointed to care for the patients. He was replaced in 1896 by a full-time resident physician.[43]

By the time of Union, in 1910, the only provisions for the mentally ill in South Africa, were these eight

mental/....

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37. (First) Report of the Commissioner of Mentally Disordered and Defective Persons, etc., p. 25.
38. Parliament of the Republic.
39. (First) Report of the Commissioner of Mentally Disordered and Defective Persons, etc., p. 24.
40. Ibid., loc. cit.
41. Minde, M., op. cit., p. 118.
42. (First) Report of the Commissioner of Mentally Disordered and Defective Persons, etc., p. 25.
43. Minde, M., op. cit., p. 94.

mental hospitals, five being in the Cape, and one each in the other three provinces, and having between them a total population of 3,624 patients of all races.[44] Accommodation in all these institutions was poor, and overcrowding the order of the day. Although the Minister of the Interior at this stage was made responsible for all mental hospitals and their inmates,[45] the laws in relation to the mentally ill for each province of the Union remained separate. However, it soon became apparent that "a consolidating law to secure uniformity of procedure, facilitate transfer of patients from one institution to another and to bring the various laws into line with modern legislation regarding the care and treatment of the mentally afflicted"[46] was necessary.

Into this situation, then, came the news of developments in the United States and elsewhere, following on the work of Clifford Beers. While the Union Government concentrated on accommodation problems

and/....

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44. (First) Report of the Commissioner of Mentally Disordered and Defective Persons, etc., p. 1. No census figures are available for the country in that year, but those for the following year (1911) show the total population of all races then to have been 5,972,757. (Bureau of Census and Statistics, Pretoria: Union Statistics for Fifty Years, 1910 - 1960, Government Printer, Pretoria, 1960; p. a-3.). It should be remembered that the proportionately very small number of persons in mental institutions does not necessarily reflect the total number ill in the population.
45. The Mental Health Services were transferred to the Department of Health only in 1943 (Minde, Dr. M., personal communication, August 1964).
46. (First) Report of the Commissioner of Mentally Disordered and Defective Persons, etc., p. 1.

and the introduction of uniformity into the laws relating to the mentally disturbed, public concern began to manifest itself over the facilities available for these people, and, more especially, for the mentally sub-normal. The Child Life Protection Society of Cape Town was instrumental, in 1912, in promoting interest in this latter subject by an exhibition in the city.[47] This led to the setting up of a Committee, in June 1913, with the specific aim in view of forming a National Society for the Care of the Feebleminded, to deal with this problem and community attitudes towards it.[48] The Committee then decided to extend its activities to cover services to all mentally disturbed people, and in July 1914 held its first annual meeting in Cape Town, under the chairmanship of the Chief Justice, Sir James Rose-Innes.[49] An important resolution taken at this meeting emphasized the drawing up of a unified Act to control the mentally ill in the whole country, and to provide adequate institutional accommodation for the mentally defective.

In the same year, the Government passed a short Act permitting the transfer of patients between mental hospitals in the different provinces.[50] This alleviated slightly the overcrowded conditions prevailing in such hospitals, but did little else, and it was only in 1916 that a Mental Disorders Act finally

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47. Minde, M., op. cit., pp. 210 - 211.
48. Ibid., p. 212.
49. Ibid., p. 214.
50. (First)Report of the Commissioner of Mentally Disturbed and Defective Persons, etc. p. 2.

was promulgated for the Union.[51] Dr. J.T. Dunstan, largely responsible for the passing of the Act, became the first Commissioner for Mental Health,[52] and, through representations to the Government, obtained a promise of financial assistance to the Cape Town Society when it became a national organization.[53] This occurred in 1920, largely due to the efforts of the Cape Town and Johannesburg Societies (the latter founded in 1919), and the first annual meeting of the National Council for Mental Hygiene and for the Care of the Feebleminded was held in Johannesburg in 1922.[54]

With the beginning of this Society and its local branches, and Government interest in mental health, began the main development of mental health facilities in South Africa. Institutions for the feebleminded were established, such as Adam's Farm and the Alexandra Institution in the Cape, and by 1925 Court psychiatrists attended at the Juvenile Courts in Cape Town and Johannesburg. By 1927, special classes for backward children were established in the Transvaal, Natal, and the Cape, and in the same year the first Child Guidance Clinic in the country was opened in Bloemfontein, with a second following shortly afterwards in Pretoria, in 1928.[55]

In the same decade, professional training for social workers was started in South Africa, with the

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51. For details of this Act, No. 38 of 1916, and Amendments (1944 et al), see Appendix B, page 442
52. Then known as the Commissioner of Mentally Disordered and Defective Persons.
53. Minde, M., op. cit., p. 215.
54. Ibid., loc. cit.
55. Ibid., pp. 216 - 218, passim.

introduction of a degree of Bachelor of Arts in Social Work and a Diploma course in Social Work at the University of Pretoria, in 1929.[56] It was not until the following year that the first students registered for the Diploma course, however, and only in 1931 did three students register for the Degree course.[57] By 1937, degree or diploma courses were offered by all five of the Universities in the country - Cape Town,

Pretoria/....

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56. Batson, E., "Report on Training for Social Work in the Universities of the Union," Roneod pamphlet, University of Cape Town, 1938. p. 2. There is considerable controversy around this date, and whether in fact this course was a "true" social work one. Thus, while Batson gives it as such, Laubscher (Mr. A.J., Assistant Registrar, University of Pretoria) states that it was only in 1931 that, under the name of "Applied Sociology", a professional course in social work was introduced. Prior to this, sociologically oriented but non-professional courses had been in existence. Brummer (Dr. F., Under-Secretary for Social Welfare and Pensions, Pretoria) states, on the other hand, that the first Department of Social Work was established at Stellenbosch University in 1932, and offered both Degree and Diploma courses in social work. Again, Auret (Mr. A.J., Social Welfare Department, Johannesburg), who has been engaged in research on this subject, finds that the first organized course to which a social work certificate was attached was one given by the University of Cape Town in 1924. Whether this was a degree or diploma course, or a general course, with special subjects, is uncertain. He then quotes Pretoria as being the next university to introduce training - giving Batson's date of 1929 for this - in the form of both a Degree and a Diploma course, which, although termed "Applied Sociology", were both professional social work courses. (This is in agreement with Batson's comments, and, with the exception of the dates, also with those by Laubscher). He states that Stellenbosch followed with the introduction of social work training courses (Degree and Diploma) in 1932.

57. Batson, E., op. cit., p. 8. It may be this date which was responsible for Laubscher's statement that the course began only in 1931.

Pretoria, South Africa, Stellenbosch, and the University of the Witwatersrand,[58] - and by this year twenty-six degrees or diplomas in social science, social studies, or social work had been granted to students.[59] These workers gradually supplemented and replaced the volunteers and untrained workers who were being employed in the mental health field.[60]

By the beginning of the fifties, a complex web of psychiatric services had been established in South Africa, including in its strands numerous private or voluntary organizations (many initiated by what had become the South African National Council for Mental Health), as well as ten mental hospitals[61] and three

institutions/....

58. Batson, E., op. cit., p. 2.
59. Ibid., p. 9.
60. During the early years of social work in this country, experience or interest in a field was more important than training, and it was only in 1955, when the Government Department of Social Welfare began to subsidize salaries of social workers, that training became essential. (Stander, Mr. T.J., Director, South African National Council for Mental Health, personal communication, August 1964).
61. The newest hospital at that time was Sterkfontein Hospital, in Krugersdorp, opened in 1943. (Secretary, Sterkfontein Hospital, personal communication, August 1964). The newest today is the Stikland Hospital, Bellville, Cape, opened in 1961. (Augustyn, Mr. H.E., Office of the Commissioner for Mental Health, Pretoria, personal communication, August 1964). By then, the term "mental" hospital had been dropped, in keeping with the changing philosophy of the times, and all these hospitals are today no longer termed such. There is also a new institution for the Coloured mentally defective in the Cape, viz., the Westlake Institution, established in 1962. This thus brings the total of such treatment centres in 1964 to eleven hospitals and four institutions for the mentally defective. (Annual Report of the Commissioner for Mental Health, Government Printer, Pretoria, 1962, p. 7; and information from Mr. H.E. Augustyn as above). Patients using these services are both European and non-European.

institutions for the mentally defective. The Provincial Administration of the Transvaal had opened up Tara Hospital, as a branch of the Johannesburg General Hospital, in 1946, as a hospital for the care of patients suffering from psychoneurotic and early mental disease,[62] and free psychiatric clinics were being held by the local Mental Health Societies. Social workers had taken their places in these clinics,[63] in the Child Guidance Clinics of the community, at Tara Hospital,[64] and in many other

spheres/....

62. Moross, H.: "The Treatment of the Psychoneuroses and Minor Mental Illness : Present Facilities and World Trends," S.A.M.J., Vol. 33, No. 13, 28th March, 1959: p. 270. This hospital became autonomous in 1953. (Moross, H.: "The Development of Community Resources for Mental Health Care," S.A.M.J., Vol. 38, No. 19, 13th June, 1964: p. 417.

63. In 1960, Mental Health Societies existed in Johannesburg, Cape Town, Pretoria, Durban, Pietermaritzburg, Bloemfontein, East London, Kimberley, Port Elizabeth, Springs, Welkom, and Potchefstroom. (Official Year Book of the Union of South Africa, No. 30, Government Printer, Pretoria, 1960: p. 146.) Forty-three social workers were employed in such clinics in 1964. (Stander, Mr. T.J., Director, South African National Council for Mental Health, personal communication, August 1964.) Of the social workers employed in mental health services in this country, less than a handful have had specialized training in psychiatric social work. Generically trained workers are employed in such services and the most recent development of such posts has been in the mental hospitals of the country, where the first was established, in April, 1964, at Weskoppies Hospital, Pretoria, and the second two at Sterkfontein at the same time. At each hospital one post was filled by July 1964. (Wintkler, Mr. A.T., Department of Social Welfare and Pensions, Pretoria, personal communication, August 1964.) Where such were among the first social services to the mentally ill overseas, in South Africa the position has been reversed, and, until this year, patients in these hospitals were assisted by social workers from the local mental health societies.

64. There are two social work posts at this hospital at present.

spheres, and a new approach to mental illness had begun. Hospitals were well-equipped and clean, and emphasis was beginning to be placed on the patient and his treatment in the community, rather than in isolated places, and with social ostracism.

One of the most progressive trends in treatment of the patient in recent years has been that which has led to the establishment of psychiatric in-patient units in general hospitals, where previously there had been only out-patient services. While this might at first appear to be a swing full circle back to the days of yesteryear, it is in fact not so. For where, before, the mentally ill were placed in the public hospitals for want of other facilities, today specialized provision is made for these patients in such hospitals, and the philosophy of treatment and practice is to keep the patient as much within the community as possible, and to fashion community facilities to meet his needs.

The concept of such treatment facilities was first transformed into reality in America in 1902,[65] but by 1920 there were only 32 of these units, increasing to 176 in 1945, and reaching 548 by 1956.[66] However, by that year it was still only 11% of the

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65. As the Mosher Memorial Pavilion of the Albany Medical Centre Hospital, according to Donohue, W.V., and Holt, W.L., in "A Psychiatric Service in an All-Purpose General Hospital," Diseases of the Nervous System, Vol. 24, No. 9, Sept. 1963, pp. 562 and 566.

66. Schulberg, H.C.: "Psychiatric Units in General Hospitals : Boon or Bane?" Amer. Jnl. Psychiat., Vol. 120, No. 1, July 1963; p. 30.

general hospitals in the country which had such units.[67] In 1950, these units employed 94 social workers.[68] Similar developments in Britain were, again, somewhat slower, and by 1960 there were only 82 such units, with a modal size of 24 beds, in the United Kingdom, although it was anticipated that 168 units, each holding about twice that number of patients, would be in existence by 1975.[69]

The two units of this nature in South Africa are those at the Groote Schuur Hospital in Cape Town and at the General Hospital in Johannesburg. While all provincial general hospitals in the larger centres hold psychiatric out-patient clinics, it is only these two hospitals which have progressed recently and rapidly into the sphere of in-patient treatment for psychiatric patients. Groote Schuur Hospital which was opened only in 1938, in that year allotted 16 beds, scattered throughout the hospital, to the Department of Neuro-Psychiatry.[70] Ten years later, these beds were reallocated to form a self-contained unit,[71] but until 1951 this unit had only part-time staff treating its patients, and only in that year was a full-time head of the Department of Neuro-Psychiatry appointed.[72] However,

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67. Ibid., loc. cit.
68. Perry, S.: "Implications from the Viewpoint of Psychiatric Social Workers in General Hospitals," Discussion of a paper by Berkman, T.D., on "Research Study and Professional Education for Psychiatric Social Workers," in Jnl. of Psych. Social Work, Vol. XXI, 1952; p. 106.
69. Little, J. Crawford: "A Rational Plan for Integration of Psychiatric Services to an Urban Community," Lancet, Vol. II for 1963, No. 7318, 30th Nov., 1963: p. 1159.
70. Minde, M., op. cit. p. 329.
71. Ibid., p. 330.
72. Ibid., loc. cit.

cases admitted were primarily neurological ones,[73] and it was only in 1957 that a full-time psychiatrist was introduced to the staff.[74] Individual and group psychotherapy are carried out in this unit, with patients suffering from all except certifiable illnesses, and in 1959 it extended its activities to cover specialized treatment of alcoholic patients at the Park Road Hospital, Cape Town,[75] where provision is made for in-patient, day-patient, and follow-up care,[76] while two social workers are employed full-time in the department - one at the main hospital and one at Park Road.[77] It is only during the past few years, however, that the department has changed from one treating mainly neurological illnesses, to one in which the emphasis is predominantly psychiatric,[78] and thus, although the unit started earlier in time than the one in Johannesburg, it is perhaps correct to say that, as modern, dynamic units, both started in the same decade, and at about the same time.

For the unit at the Johannesburg General Hospital was started early in 1959, with the establishment of Chair of Psychological Medicine at the University of

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73. Hurst, Professor L.A., Department of Psychological Medicine, University of the Witwatersrand, Johannesburg, personal communication, August 1964.
74. Walton, H.: "Psychiatric Services in General Hospitals," S.A.M.J., Vol. 33, No. 13, 28th March, 1959, p. 272.
75. Now known as the William Slater Hospital for Alcoholics. Information from: "Report on the William Slater Hospital for Alcoholics, Cape Town, covering the year ended 31.12.63." Mimeographed, Department of Psychiatry, Groote Schuur Hospital and University of Cape Town, 1964; p. 1
76. Walton, H., op. cit., loc.cit.
77. Gerber, Miss B., Social Worker, Groote Schuur Hospital, Cape Town, personal communication, 1963.
78. Hurst, Professor L.A., personal communication, August 1964.

the Witwatersrand in January of that year.[79] While starting with less,[80] it today has two wards and caters not only for its 32 in-patients, but also provides psychiatric coverage for the entire hospital, having added to its staff, since the early days, one senior psychiatrist, three psychiatric registrars, and various paramedical staff members. Among these latter is a social worker, whose services in the unit have increased both in quantity and nature since its inception, moving with and in the growing and living unit as it pushes forward in the fight against mental illness, and the effort to keep the patient functioning in society as effectively as possible.

With these and other developments in her territories, South Africa is now, within the span of a century of years and less, able to trace the development of her mental health services from a dark and uninformed beginning to an enlightened maturity in which willing workers in the psychiatric and public health services are striving for a future in which a mentally healthy society provides adequate community services, in a climate of understanding, and without stigma for those who continue to suffer from psychiatric disability.

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79. Hurst, Professor L.A., personal communication, August 1964.
80. See Chapter I, pages 3 foll., for history of this unit.

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C H A P T E R I.

AIM AND BACKGROUND OF THE STUDY.

When a service develops rapidly, it becomes necessary, after a while, to pause; to see what the service has become, what it is doing, how it is doing it, and whether it is fulfilling its original purpose. It becomes necessary, in other words, to know what we are doing in order to clarify what we can do.[1]

The psychiatric unit at the Johannesburg General Hospital is typical of a service which has, in the space of a few years, developed a wide range of facilities for its patients, and one of these, as was briefly mentioned, is the offering of social work help to them. Exactly what the nature of such assistance is at this hospital has not previously been determined and the writer, having played this role of social worker to the unit for the past three years, seemed to be in a favourable position to attempt its definition. Thus the aim of the present study is to clarify the newly-established position and functions of the social worker in the Psychiatric In-patient Unit of the Johannesburg General Hospital. This will be done by analysis of case records of patients seen by her after their admission to the two wards of the unit, and an attempt will be made to define, from the information obtained in this manner, what exactly she does, and where the quality and type of service rendered could be altered

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1. Bartlett, H.M.: "Ways of Analyzing Social Work Practice," The Social Welfare Forum, Proceedings of the National Conference on Social Welfare, 1960: Columbia University Press, N.Yk., 1960, p. 197.

or improved. No hypothesis has been drawn up for testing, and the study is, rather, an effort to delineate realistically what is actually done: it is a fact-finding attempt at definition of function, based on records of function, and not an attempt to prove or disprove any preconceived suppositions. For, where much has been written on the subject of what should be in social work practice, little has been written on what is done.[2,3] This study is an attempt to show the latter; it does not attempt to evaluate this practice in terms of the success or failure of the social worker's activities with patients and others, but simply to present it as it is carried out in this specific unit.

The scope of the study encompasses primarily the day-to-day activities of the social worker with both patients and staff members. While the greater part of the dissertation will relate to this aspect of the work carried on, mention will be made in the latter part of the study to those functions which are regarded by Berkman as "facilitating" services to the patient,[4] namely, teaching, supervision, recording, and community relations. Also, some attention will be paid to issues, as they arise, which are of special or controversial interest in the field.

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2. Gordon, W.E., and Bartlett, H.M.: "Generalizations in Medical Social Work : Preliminary Findings," Social Work (N.Yk.), Vol. 4, No. 3, July, 1959, p. 75.
3. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961, p. 99.
4. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953, p. 84.

In a study of this kind, however, the part cannot be comprehended without an understanding of the whole. Thus, for an understanding of social work as carried out in the unit, it is necessary first to have an understanding of the complexities, organization, and structure of the unit as it has developed in the short period of its existence.

When a psychiatric unit is introduced into a general hospital, its formation and establishment require more than the introduction of a programme and the appearance of appropriate staff members. It is necessary that the general medical staff, nursing staff, and other hospital personnel understand, identify with, and accept such a service. Thus when, with the establishment of a Chair of Psychological Medicine at the University of the Witwatersrand in January, 1959,[5] it was decided to introduce an in-patient psychiatric unit at the teaching hospital of the University, i.e., at the Johannesburg General Hospital, much interpretation and education of staff had to be done.

At this time, there was an active out-patient department, but no psychiatric in-patient facilities

existed/....

5. Professor L.A. Hurst was appointed to this Chair, and much of what follows is a tribute to his untiring and inspired efforts in establishing the unit at the Johannesburg General Hospital. I thank him for the information which he has given me about the earlier years of the unit, which information I have drawn on heavily.

existed in the hospital,[6] although a full-time consultant psychiatrist was on the staff. This post had been established in November, 1950,[7a,b] but did not bring with it any special psychiatric "beds", and served mainly to ensure that psychiatric consultation was available in the hospital at all times. Thus, although psychiatry was a familiar element in the hospital, and out-patient clinics had been held there since about 1932,[8] the attitudes regarding it were varied, and, particularly on the part of the general nursing staff, much resistance had to be overcome.[9]

Conferences were initiated with the medical superintendent of the hospital,[10] and twelve medical beds were soon converted to psychiatric ones in one of the wards.[11] A senior houseman was appointed in

February/....

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6. In 1932, some nine beds were assigned, by the Sister-in-Charge of the Casualty Department of the hospital, for the care of psychiatric patients. (Minde, M., op. cit., p. 324). However, these beds served only to provide shelter for the night for these patients, who were mainly alcoholics, and were operated on an unofficial basis. The beds were closed some fifteen years ago, at approximately the time that Alcoholics Anonymous started in Johannesburg, and have no connection with the present service. (Information from Sister Maxwell - originally responsible for the service - through Sister J. Nezar, Sister-in-Charge of the present unit, August 1964).

7a. Cowie, Mr. J., Staff Office, Johannesburg General Hospital, personal communication, August 1964.

b. Previously, part-time psychiatrists had been in attendance at the hospital, starting with Dr. Alice Cox in 1929, and Dr. R. Geerling in 1931. (Minde, M., op. cit., p. 323), but even this innovation occurred as much as 39 years after the opening of the hospital (1890).

8. Information obtained through the Superintendent's Office, Johannesburg General Hospital, August 1964.

9. Lynch, Dr. T.E., Psychiatrist, personal communication, August 1964.

10. The Late Dr. K.F. Mills.

11. Nezar, Sister J., personal communication, August 1964. The ward partly converted was Ward 28, at that time a medical one.

February, 1959,[12] to assist in caring for the patients thus accommodated, he being the most junior member of the three psychiatrists then in attendance in the ward, the other two being the professor and the full-time psychiatrist.

However, as stated, the provision of the service did not automatically lead to its acceptance, and a vigorous programme to provide this was instituted. Among other things, conferences were held to orientate the nursing staff towards an understanding of the philosophy of "open-door" treatment of the mentally ill and an attempt made to help them appreciate the fact that patients are not prisoners in such a unit. One of the hospital matrons joined the group, and discussions were held on policy, on the incorrectness of physical methods of restraint, and on treatment methods. One of the problems about which concern was expressed was that of the patient who ran away, and much time had to be devoted to explaining that patients treated in such a ward were not certified patients, and thus had a right to run away, and that such action should not be regarded with agitation, but as equivalent to the refusal of hospital treatment by other patients.[13] Rapidly, by discussion and example, with ups and downs, the service began to find a place in the hospital, and to fulfil its dual function of serving the patient population of the hospital (coping with those patients

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12. Cowie, Mr. J., personal communication, August 1964.
13. Hurst, Professor L.A., personal communication, August 1964.

who developed psychiatric disturbances, presumably of a transient nature, while in hospital, and could not be managed among the "ordinary" patients), and dealing with psychiatric patients appearing in the Casualty and Out-Patient Departments.[14] Finally, by July, 1960, the whole ward, after the remaining medical patients had been moved out, was converted to a psychiatric one, containing 32 beds - 16 male and 16 female.[15] In November of the same year, the ward was split up, for administrative reasons, and the male patients moved to a separate part of the hospital. The physical format of the unit was thus changed, and the beds re-allocated to give 17 male and 15 female beds.[16] The unit has remained so since, and is physically an integral part of the hospital, not being separated from other wards in any intended way, though being in two somewhat outlying wings of the hospital.[17]

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14. Idem.
15. Nezar, Sister J., personal communication, August 1964.
16. This change in allocation of beds was due only to availability of space. Of the 15 female beds, 10 were in the main ward, 4 in a side ward, and one in a single ward. Although solitary confinement is never implemented, this latter ward is useful for separating difficult cases from the rest of the patients, and can also be used for "special" patients. No such facility exists in the male ward, where all 17 beds are in one long ward. Further, "extra" beds are often put up in the wards, and it was at one time not unusual to find as many as 3 - 6 up in each ward. Although a maximum per ward for such beds has now been laid down, 32 remains only the basic number of beds available.
17. A new wing is at present being planned for the hospital, and when this is completed the psychiatric wards will be moved into what is presently the main block of the hospital. Bed capacity will remain approximately the same. (Professor L.A. Hurst, personal communication, August 1964).

In these earlier days, the unit had, also, the services of an occupational therapist, and questions arose as to where her services could best be made use of - in the wards, or in the Occupational Therapy Department. After discussion, it appeared that patients would benefit more from such therapy away from the wards, in a central department, as this would facilitate their mixing socially with other patients.[18] A part-time clinical psychologist attended during this time, and the services of the Social Welfare Department were offered, but the worker assigned to the wards worked, in addition, in many other wards, and could give only a certain amount of time to the psychiatric patients. Nursing staff, always so vital to such a service, were assigned to the unit during their training, none having special psychiatric training, and the average number of nurses per ward was five, including the sister and any other trained staff members.[19] In addition, there were two hospital helps attached to the wards. Specialized services, such as physiotherapy, were requested as needed,[20] and all the facilities of the hospital were available to patients. Those staff members specifically attached to the unit attended the weekly professorial ward round, which was open to interested medical practitioners in the community, and which thus concomitantly brought added understanding of, and prestige to, the unit.

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18. Hurst, Professor L.A., personal communication, August 1964.
19. Nezar, Sister J., personal communication, August 1964.
20. At one time, a physiotherapist was regularly involved in "gym" activities for the men.

With the departure of the houseman in the middle of 1960,[21] however, certain problems arose. The full-time psychiatrist had to assume his duties, and while a compromise was made in that the medical housemen cared for the general medical needs of the patients,[22] the potential advantage this offered of giving these doctors a psychiatric orientation was outweighed by the profusion of work which ensued, and by the disorganization resulting from this system. However, in October, 1960, posts for three registrars were approved.[23a,b.]

With the establishment of these posts, impetus seemed to be given to the more intensive involvement of various other professions in the unit, and in December of that year the present writer was appointed to the staff of the Social Welfare Department, and seconded to the psychiatric unit. In spite of the fact that she also carried responsibility for patients in other wards, the greater part of her energy was directed towards the patients in the psychiatric unit. One month later, an occupational therapist was appointed to do duty only in the psychiatric wards,[24] and when the clinical

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21. Nezar, Sister J., personal communication, August 1964.
22. Idem.
23a. Cowie, Mr. J., Staff Office, personal communication, August 1964.
b. These three posts had originally been suggested as: 1 Specialist, 1 Senior Medical Officer, 1 Senior Houseman. However, it seemed that registrar's posts would be of more use, and attract more people, as the hospital is a teaching one, and these posts are training ones, for specialization. (Professor L.A. Hurst, personal communication, August 1964).
24. Austoker, Miss B., Occupational Therapist to the unit, personal communication, August 1964.

psychologist[25] began working in a full-time capacity in February 1961, at the same time as the three registrars were appointed, filling the posts approved in October, 1960, the unit was well on its way to successful functioning. Only two changes in staffing of the unit occurred thereafter,[26] the first concerning the social worker, who, towards the end of 1961, was assigned in a full-time capacity to the psychiatric unit, and the second being the arrival in January, 1963, of a senior psychiatrist, who filled a post transferred from Tara Hospital to the General.[27] The first of these changes was perhaps the final indication of the unit's integration into the hospital, for it showed an acceptance of it from all those concerned with policy-making and allocation of workers, from the most senior to the most junior administrators and heads of departments, while the workers in the various departments were beginning to understand, from watching and from talking with those working in the unit, a new approach to mental illness.

Within the unit, too, various developments had taken place, following the arrival of the three registrars. In addition to the professorial ward round, which had

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25. Lambert, Mrs. L.M.C., Clinical Psychologist to the unit, personal communication, September 1964. This post had been motivated for at inception of the unit.
26. Although the medical posts have remained the same, there have been several changes in those holding them; the "ancillary" staff remained constant until December, 1963, when the present worker resigned from her position as Social Worker to the unit.
27. The Professor of Psychological Medicine has authority in both hospitals, and is empowered to make such arrangements.

developed into an intensive case conference attended by both professionals and students, a general staff meeting was instituted, and here each patient in the ward was discussed weekly. As the staff members came to know each other professionally and personally, a team spirit, having in it elements of a pioneering and enthusiastic nature, began to grow, and each member of this team began to develop for him- or herself a dynamic and changing role. The intangible element of "atmosphere"[28] had been established, and work could proceed.

The patients served by the unit were drawn from the so-called catchment area for the hospital as a whole; thus they were drawn from the White population of Johannesburg and its surrounds.[29] Referrals came from medical practitioners in the community, from social welfare agencies outside the hospital, from doctors in the out-patients department, and from Casualty, where patients arrived themselves for help. The whole gamut of mental illnesses was seen, though not all patients were admitted, and some were kept only in transit to mental hospitals. But the numbers attended could not be regulated; illness is urgent, and those who came had simply to be seen.

Methods/....

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28. Schulberg, H.C.: "Psychiatric Units in General Hospitals : Boon or Bane?" Jnl. Psychiat., Vol. 120, No. 1, July 1963; p. 33.
29. This selectivity occurs because the hospital caters for European patients only, though it has a non-European branch. Here, as well as at Coronation Hospital, psychiatric out-patient clinics are held regularly. But the real counterpart of the Johannesburg General Hospital is Baragwanath, a vast ± 2,200 bed hospital, having in-patient treatment facilities for psychiatric patients. Plans for the extension of these are at present under consideration. (Hurst, Professor, L.A., personal communication, October 1964).

Methods of treatment employed in the unit covered all except insulin coma therapy. Thus psychotherapy was accompanied not only by chemotherapy, or the administration of drugs, but also by electro-convulsive therapy, narco-analysis, and hypnosis. Psychological tests, histories obtained by the social worker, and observations made by the occupational therapist all contributed to diagnosis and hence to the decision about type of treatment to be employed.

Not only were in-patients dealt with by the staff, but a day-patient service instituted. Defined by Harris[30] as a "....(service) in which patients spend a substantial portion of their working time under a therapeutic régime and from which they return to their own home or hostel to sleep at night," such a facility was not really provided for within the hospital structure, and patients were classified within the out-patient system while attending. Because of the lack of facilities for such patients, numbers fluctuated and no more than six patients were taken at any one time,[31] while treatment for those accepted was of a follow-up nature, rather than in place of in-patient treatment - the purpose, so often, of a day-patient department.[32]

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30. Harris, A.: "Day Hospitals and Night Hospitals in Psychiatry," quoted in Farndale, J., The Day Hospital Movement in Great Britain, Pergamon Press, London, 1961; p. 1.
31. Austoker, Miss B., personal communication, August 1964.
32. The adding of the new block to the hospital within the next decade will provide "proper" day-patient accommodation for 18 patients (Salmon, Dr. M. Deputy Superintendent, Johannesburg General Hospital, personal communication, August 1964). It is hoped that a substantial proportion of these will be for psychiatric patients.

In addition, a "night" hospital system was introduced for selected patients who were almost ready to leave hospital. By this means, such patients were enabled to return to employment for some days (or even weeks) before discharge, working from the ward, and returning there at night. This proved a successful way of supporting patients through their first tentative interactions with the community, and keeping them under medical supervision the while.[33]

However, the unit served other patients besides those within its wards, and one of the facilities which its staff provided was that of consultation to the medical and surgical professorial units. This involved ward rounds in these two sets of wards, and, although part-time consultation was provided to the other such wards by "outside" psychiatrists, full-time, emergency coverage for these came from the psychiatrists of the unit, which was by this time known throughout the hospital, with a resigned affection, as "Ward 28." Where, before, psychiatric patients were admitted to medical wards under the care of the doctors of those wards, and with only psychiatric consultation, such patients admitted to these wards in later times, because of lack of beds in the psychiatric wards, were under the direct care of the unit, and referred to as

"outlying"/....

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33. A system of allowing patients to leave the ward, at the psychiatrist's discretion, in order to see other staff members, to seek employment and accommodation, or to attend to their affairs, was introduced, as was a system of allowing patients home on weekend "leave" in order to see how they coped. This was at first met with concern by the hospital authorities, but later accepted as a valid part of treatment.

"outlying" cases. The unit might thus have more than 32 cases under its care at any one time. Further, where patients were felt to need medical as much as psychiatric care,[34] the decision as to where they should remain became an individual one between the doctors concerned, and such patients could remain in the appropriate ward, still fully under psychiatric care, rather than with only psychiatric consultation. This had been another field in which staff attitudes had had to be influenced.

Not only did the service offered by the unit increase in this sphere, but it did so also in many others. One of the most outstanding developments made was the establishment of a regular Casualty service. Starting in the earliest days of the unit, the full-time psychiatrist had consulted with medical officers in the Casualty Department, when requested to do so, on patients seen by them. Sitting in the main part of the department - a large and busy one - he had interviewed patients and arranged for their admission or referral elsewhere. As the need for such a service began to be manifested by the increasingly greater use made of it, these consultations became more regular, and by the end of 1962, a routine Casualty consultation "clinic" was being held by the psychiatrists from 10.30 a.m. to 1 p.m. every morning; a dressing room had been set aside for interviews, in order to give patient and psychiatrist

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34. E.g., a depressed coronary patient.

some privacy; and an average of 8 - 10 patients were being seen daily each morning,[35] while additional patients were seen in the afternoons when necessary, but not routinely.

Acting as a kind of "sorting station" for patients, this Casualty service proved a very worthwhile one. Through it, patients were channelled to the correct treatment centres, and those not likely to benefit from treatment in the hospital referred elsewhere. Thus an almost selective admitting of patients began, for often acutely ill or senile patients seen in Casualty were referred directly to a mental hospital; alcoholics and drug addicts sent to the Rand Aid Association Clinics[36] for admission to their specialized centres for treatment of such patients; or patients not ill enough for admission referred straight through to the out-patients department. The service thus, in addition to dealing effectively with patients' problems, began to be effective in keeping the numbers of patients within control, and ensured that those patients most likely to benefit from short-term, intensive treatment would be would be admitted for this purpose, while also serving to cut down administrative work connected with unsuitable admissions. As well, where patients were clearly in need of more immediate treatment than would

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35. Hurst, Professor E.A., personal communication, August 1964.

36. This Association is a private, state-subsidized, welfare organization and runs, inter alia, out-patient clinics and two in-patient treatment centres for alcoholics and drug addicts. Northlea, the centre for men, has a special section, Wedge Farm, for chronic patients of this kind. Mount Collins is the sister institution and caters for women. It does not have a separate "chronic" section.

result from referral to an already overcrowded out-patients department, such patients could be seen in Casualty until the crisis situation was somewhat settled. A similar type of service was given to patients awaiting admission to the wards: they could be seen daily and supported until room in the wards was available.

But this service was not offered in place of an out-patient service by the unit. Such a service was in existence, in fact, many years before the inception of the in-patient unit, starting originally in about 1932.[37] and Tara Hospital, from its inception in 1946, had started to send its medical staff members to the General to hold out-patient clinics.[38] It continued to do so after it became autonomous in 1953. It was felt, however, that this service should now, as far as possible, be run by the psychiatric unit within the hospital, but staffing facilities and patient loads prevented the service from being taken over completely. However, of those clinics still attended by Tara staff and private practitioners in 1963, 9 of the total 34 were run by the medical staff of the "home" hospital.[39] A new service was introduced here, too, in that one of these clinics was devoted to treatment of nursing staff, and this was extended to cover treatment of emotionally disturbed nurses admitted to the staff ward.

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37. Information obtained through the Superintendent's Office, Johannesburg General Hospital, August 1964.
38. Moross, Dr. H., Superintendent, Tara Hospital, personal communication, August 1964.
39. Data from roneod list issued by Department of Psychiatry, July 1964. Of the 34 clinics, one was a group therapy session, 6 were diagnostic clinics at which only new patients were seen, 10 were psychotherapy clinics, and 17 were follow-up and other clinics.

In these ways, then, the psychiatric unit had, by January, 1963, become a well-organized and effective one, offering in-patient, out-patient and Casualty facilities, While problems of its acceptance by the rest of the hospital still occurred from time to time, these were usually amicably resolved, and the unit accepted as an integral part of the intensive and comprehensive system of patient care offered by the hospital.

Into what part of this complex web of psychiatric services did the social worker fit? In order to understand the development of her role, she must be seen as functioning in a secondary or host agency. In other words, the focus of the hospital, and of the psychiatric unit in the hospital, is not on the provision of social work services, but, rather, on the provision of medical services.[40] This means that the social worker has to orient herself to the complexities of the hospital, and must understand its organization. She must focus on the social work aspects of the "problems of central concern" and of the "services characteristic" of the hospital setting.[41] But while she may often be willing and anxious to do this latter, the service within which she is working may not be ready to accept her, or its members may feel threatened by her.[42] She must thus

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40. In a primary setting, in contrast, emphasis is on the social work service, and the agency is a social work one, such as a child welfare society, a "poor relief" agency, or a mental health society.
41. Bartlett, H.M., Analyzing Social Work Practice by Fields, N.A.S.W., N.Yk., 1961; p. 46.
42. Klein, A.F.: "Social Work in Non-Social Work Settings," Social Work (N.Yk.), Vol. 4, No. 4, Oct. 1959; pp. 93 to 94.

be able to communicate with these persons and make them feel her interest in and understanding of their professions, as well as her respect for their various disciplines, She, in turn, must clearly understand her own function, be competent in carrying it out, and confident of its value. She must be able to demonstrate it to her team-mates, but be sufficiently secure emotionally not to lose herself in this task, thus losing her central focus of service to the patient.[43] In interpreting her function to those with whom she collaborates, however, she should be concerned with core rather than peripheral functions,[44] and should not be possessive about the social content of the other professions, though not allowing her functions to be taken over by these others. Above all, she must not, in an effort to be accepted, allow herself to be used as a facilitating service "to make the wheels go around" in the hospital or to supplement the activities of other professions;[45] she must, rather, maintain her identity and focus as a social worker, while adapting to the field in which she finds herself. Even with a willingness to change and with great skill in all the above, it may be extremely difficult for the social worker to become integrated into the setting if her personality is incompatible with the setting, or if resistance to her is universal. Usually, however, with time, skill and patience, and, importantly, a host agency at least somewhat receptive to her, she is able to become not

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43. Ibid., p. 93.
44. Ibid., loc. cit.
45. Bartlett, H.M., op. cit., p. 45.

only an acceptable, but an essential, part of the service.

Where she meets no resistance in a host agency, and where a compatibility of all team members seems to exist from the start, however, her integration into the service is usually easier. Thus, in the pioneering spirit of the psychiatric unit here being described, these problems did not arise: differences in personalities and in skills soon were seen in perspective, and roles for each member of the team began to evolve. In the beginning, the social worker was viewed mainly as someone who dealt with financial and material problems. Gradually, however, her contribution to diagnosis and treatment came to be seen, and finally her potential value in all stages of treatment, including rehabilitation, and in relation to both patient and family, was comprehended by her colleagues, and, as she became able to devote more time to her duties in the psychiatric unit, so she became a more integral member of it.

However, while six psychiatrists functioned in the unit and carried the various services outlined above, only one social worker was available to the unit. Thus it was not possible for her to give help to all patients seen by this greater proportion of doctors, and her services were limited primarily to the in-patients of the unit. "Outlying" patients were seen by the social workers allocated to the wards in which these patients were being treated, and referred to the psychiatric social worker only under special circumstances, but on their transfer to the psychiatric wards were transferred

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also to her case-load. Those Casualty- and out-patients seen by the psychiatrists were referred to the social worker "on call" for the day, and thus to the psychiatric social worker on such days, but to other workers at other times. Again, however, many of these were admitted to the psychiatric wards and hence automatically came under the care of the psychiatric social worker, or were already known to her through previous admission to the wards. Further, she attended one diagnostic clinic in the out-patients department, and gave social work help to those patients who attended this. "Day" and "night" patients, being part of the internal unit, were seen by her regularly, and follow-up work for the two wards done by her.

The case-load thus still consisted of considerably more than the thirty-two patients at any one time in the ward, but in-patients formed a large proportion of it, and so it was decided, when this research project was first considered, that these patients would form the basis of the study, and that a description of the role and function of the social worker in such a unit would be based on their social work records. It was hoped that an analysis of such records would yield a full and comprehensive picture of social work function in a unit which has become, dynamically and in a short time, a vital part of the Johannesburg General Hospital.

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C H A P T E R II.

PROBLEMS OF METHODOLOGY.

When it had been decided that the major part of this study would be concerned with analyzing case records, a research method had to be drawn up for doing this. But first various important problems had to be faced, the most fundamental ones being whether such records could be used for analysis, and, if they could, how to analyze them; in other words, whether their content was "researchable." And if these problems could be resolved, what type of research would result.

The question of use of case records was investigated first, as these were to be the basis of the study. If they could not be used, the whole nature of the study would have to be changed.

The records which were to be used were all "practice" records, and had not been written up for research purposes. Briefly, the recording system used in the Social Welfare Department of the Johannesburg Hospital involves the use of a face sheet, and then process or summarized recording, depending on the preference of the individual worker. Correspondence, reports and other material are placed, in chronological order, in the back of the file, behind the record, and all are filed together according to a departmental numbering system. Index cards are listed alphabetically, by name of patient, with file numbers appearing on them, and referral to these is necessary before a file can be obtained from the cabinet. A problem which arose in

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connection with the use of these records was that this system of filing was introduced in the third month of the research project; however, the system of recording remained entirely the same, and only the format of the record and method of filing altered. Previously, records had not been kept in files, but attached to a firm face sheet, which had been filed alphabetically, by patient's name.[1] It was felt that this in no way influenced content or availability of the record, and was purely an administrative change, and thus records from both groups could be used.

The face sheet contains, in addition to date of referral, information relating to the patient's name, address, age, marital status, diagnosis, religion, occupation, family composition, financial position, and registration (or lack of this) with central register,[2a,b] together with the agencies to which the patient is known. These items would form the constants of the research, while the remaining two, viz., problems for which referred, and source of referral, might be interesting variables. The question of individual differences between workers in writing up the body of the record would not come into play, as it was decided that only cases dealt with by the researcher would be analysed, and thus the manner of recording would be constant.

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1. The term "patient" instead of the usual "client" will be used throughout the text - except where the latter term is used in direct quotations from other workers - as this seems more appropriate to a hospital setting.

2a. This is organized by the Government Social Welfare Department, and contains records of clients seen at other agencies in the City, thus preventing duplication of assistance.

b. See Appendix A , page 241 , for copy of face sheet in use at the time of the study.

However, all the above did not solve the problem of whether practice records could be used for research purposes, and various other questions had still to be settled. Eleanor Gay sees the main problem of using such records as being that it is often difficult to find data in the records which are both complete and relevant to a research study,[3] and claims that even face sheets may not provide enough data for a specific research study.[4] On the other hand, the use of such standardized forms tends to standardize data, though it does not eliminate the possibilities of failure to complete the form, or of incorrect completion.[5] While this is a very real difficulty, it was not a major stumbling-block in the present study, as, where data were missing on the face sheet of the case record, they could always be obtained from the clinical files of patients, as the writer had easy access to these, and such information is always noted in these. Furthermore, the use of clinical files provides a source of verification of the data.

The face sheet thus presented no difficulties for the research project, but the validity of using the main body of the record had to be determined. Although Hamilton states that "the purposes of keeping social case records..... are usually formulated as practice, administration, teaching, and research," she adds that "the dominant consideration..... is that of practice, that is, of service to clients."[6]

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3. Gay, E.: "Collecting Data by Case Recording," Social Work (N.Yk.), Vol. 3, No. 1, Jan. 1958; p. 76.
4. Ibid., p. 77.
5. Hochwald, H.L., "The Use of Case Records in Research," Social Casework, Vol. XXXIII, No. 2, Feb. 1952; p. 73.
6. Hamilton, G., Principles of Social Case Recording, Columbia University Press, N.Yk., 1946; p. 4.

She continues with the comment that "records should be written to suit the case, not the case geared to a theoretical pattern."[7] Research records, in contrast, should be primarily concerned with certain categories and facts, and so have a different orientation. This difference in the purpose of the record[8] leads to most difficulty, as information which is pertinent to research may not be so to practice, and hence excluded from the record, which is not kept as a research instrument, but as a tool of practice, with its contents related to the needs of the patient, rather than of the research. However, after consideration of the above, it was felt that the main aim of this study was to analyse practice, and that practice-oriented records would reflect practice, i.e. what was being investigated.

The problem which arose next was that of adequacy of material in the records;[9] some records contained mainly summaries, some process records, and some both. Because they were practice records, they were often written under pressure, and hence some information might have been lost. As regards the first point, it seemed that, as all the records used would be those of one writer, the tendency for her to regard similar things as important, and as important in a record, would result in their being recorded, whether the method of recording was brief or long. While this could be regarded as leading to subjectivity in the records, it did give consistency

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7. Ibid., p. 5.
8. Finestone, S.: "Some Requirements for Agency-Based Research," Social Casework, Vol. XLIV, No. 3, March, 1963; p. 135.
9. Hochwald, H.L., op. cit., p. 72.

to the material contained in them, and it seemed likely that the subjectivity would relate to interpretation of functions, rather than to the actual functions performed. The latter being the focus of interest, subjectivity thus arising did not appear a deterrent to using the records. Whether sufficient information was contained in the records could be ascertained only once the study was under way, and bias created by discarding those of no use only then determined. It was felt that the fact that records were written under pressure of time would, again, throw light upon records as a part of practice, and so fit in with the general aims of the project.

The memory factor is always an important one in recording of any kind, and particularly in recording of interviews in which only a few notes are taken, and when the full writing up of the interview does not follow immediately after it. Selectivity therefore occurs a priori in what is recorded, not only through forgetting, but also through bias and unconscious attitudes in the worker.[10] This, in addition to the question of pressure, led the writer to believe that records of fairly recent cases should be used. The reason for this was that the worker, although she may not have noted down completely all aspects of a case, retains many of them in her memory, and thus there would be a likelihood that, in the event of any information being missing from the record, she would be more likely to recall this information in relation to recent rather than far-distant cases,[11] and

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10. Shyne, A.W.: "Evaluation of Results in Social Work," Social Work, (N.Yk.), Vol. 8, No. 4, Oct. 1963; p. 29.
11. Parten, M., Surveys, Polls and Samples : Practical Procedures, Harper and Bros., N.Yk., 1950; p. 179.

would then be able to make additional notes in the record which could be included in an analysis. However, current records could not be utilized, for the removal of these would have interfered too greatly with daily activities of the department, and, further, the more complete the cases, the more complete, it appeared, the analysis would be; further, current cases, by virtue of their currency, would not have been complete at the time of beginning the study, though some might have been closed by the end of it. A six-month period was therefore chosen, beginning twelve months and ending six months before analysis was started, during which cases were to be selected. This was based on the findings, reported by Nisselson and Woolsey, that memory holds reasonably accurately for a period of one year.[12]

The last question which arose was whether the recorded data were what they seemed to be,[13] that is, whether they corresponded to reality. This was a difficult point to validate. As far as the researcher was able to judge, she had recorded accurately the interaction of the interview, events which had taken place and what she had actually done. It was impossible to approach patients to ask whether what was recorded was true, and no third party had been involved in the interplay between worker and patient. It was therefore resolved that internal consistency of the record would be

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12. Nisselson, H., and Woolsey, T.D.: "Some Problems of the Household: Interview Design for the National Health Survey," Jnl. of the Amer. Statistical Assocn., Vol. 54, Nos. 285 - 288; p. 83.
13. Shyne, A.W.: "Use of Available Material," in Polansky, N. (Ed.), Social Work Research, University of Chicago Press, Chicago, Illinois, 1960; p. 113.

watched, and the record, and memory of the worker, closely scrutinized before any items were analysed.[14]

After careful thinking through of the above problems, it appeared that case records did not have to be relinquished as the basis of the study. Further, there were two important points in favour of their use. First, because the records had been kept for practice and not research purposes, bias resulting from seeking for information needed in the research, and omitting non-research-oriented data, did not occur. Secondly, as has been stressed throughout this discussion, in a practice-oriented project, any source of data which reflects practice is valuable. Records doing precisely this, and being themselves part of practice, would appear to form a sound basis for such research. It was therefore decided that the use of case records in the study would be acceptable.

With this decision reached, attention had next to be paid to the question of how such records would be analysed. It appeared, by this time, that the records were "researchable," but how they were to be analysed and internally classified with a view to eliciting the services rendered by the social worker was still to be decided. A survey of the literature revealed no studies of exactly this kind, but did reveal comments by Bartlett, on two separate occasions, one of these being to the effect that "no generally accepted system for problem

classification/....

14. In the research method, in addition, an outside person was brought in to check analysis. See later, Chapter IV, pages 80, foll.

classification in social work ..... is at present available," though "much attention is currently being directed to this basic gap."[15] In an article published the previous year, she had written that "studies of the social work practitioner in the act of rendering service are relatively rare" and that there were "no research methodologies readily applicable, or tested in, such study of social work practice."[16] Berkman, in 1953, had already stated that no "systematic, overall study of the responsibilities carried by the social worker in his day-to-day job in the psychiatric hospital and in the psychiatric clinic" had ever been made.[17]

Those studies which were found by the writer and thought similar to the present one were examined for classification systems, beginning with the work of Berkman, which was considered particularly relevant by virtue of its direct interest in psychiatric social workers, and its declared objectives of finding out where they were, who they were, and what they were doing.[18] The latter aspect of the study, especially that part concerned with workers in hospitals, was that apparently most closely related to the present project. A schedule was drawn up by Berkman, et al, and posted to all social workers known to be employed in psychiatric settings, irrespective of their age and qualifications.

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15. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p. 143. Problems must be defined before service necessary can be decided upon.
16. Bartlett, H.M.: "Ways of Analyzing Social Work Practice," in The Social Welfare Forum, 1960, Columbia University Press, N.Y., 1960: p. 198.
17. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1963; p. 29.
18. Ibid., p. 3.

Each was asked to complete the schedule, questions in it being broad and related to help rendered at specific stages of treatment. The schedule covered: social casework services rendered to patients before admission, during reception or orientation to the hospital, during psychiatric diagnosis and treatment, with relatives and others, and relating to after-care, family care, and discharge. A final section asked, "What methods do you use to co-ordinate your efforts with that of others on the professional staff?"[19] While this schedule rendered extremely interesting information and results, these were based on workers' broad analyses of what they did, founded not on breaking down case records, but on general practice in the field. The schedule used was thus not applicable to the analysis of case records, although it supplied a factual outline of services rendered.

A study by Domanski, et al,[20] attempted to investigate the reliability and utility of a scheme formulated by Florence Hollis for the classification of treatment procedures used in social casework. Consisting of nine major and sixty-two sub-categories, the scheme relates specifically to interaction, during treatment, between client and worker, but does not cover activities of the worker in relation to anyone except the client. Although these workers concluded, after rating case records, that the scheme was generally

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19. Ibid., passim and p. 130 (schedule).
20. Domanski, T.P., Johns, M.M., and Manly, A.G.: "An Investigation of a Scheme for the Classification of Casework Treatment Activities," Abstract of thesis in Smith Coll. Stud. in Social Work, Vol. 31, No. 1, Oct. 1960; pp. 71-73.

reliable, and although its specific use was in analyzing case records, it was not considered by the present writer to cover sufficiently certain aspects of work known to be carried out in the hospital setting. Thus the fuller description of the study, and the work of Hollis, were not followed up further. For the same reason, and because of the perhaps different orientation of such work, a study on child guidance work, carried out by Timms and also involving the use of a case record analysis, was able to provide only a background to the present study.[21]

Irvine[22] quotes a survey carried out in Britain, in 1954, when psychiatric social workers in fifteen mental hospitals collaborated in an effort to determine the proportion of their time taken up by various activities. This, again, was something slightly different to the purpose of the present study.

The first article which seemed to follow the same sort of outline as that which the present researcher anticipated for her project was that by Marion A. Tennant, entitled "Psychiatric Social Work in a Private Mental Hospital."[23] After explaining briefly the functioning of the hospital (a private mental one run at Yale University, not a public general one) and the position of the social worker in its hierarchy, she

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21. Timms, N., Psychiatric Social Work in Great Britain (1939 - 1962), Routledge and Kegan Paul, London, 1964; pp. 101 - 108.
22. Irvine, E.E.: "Psychosis in Parents : Mental Illness as a Problem for the Family," British Jnl. of Psych. Social Work, Vol. VI, No. 1, 1961; p. 21.
23. Tennant, M.A.: "Psychiatric Social Work in a Private Mental Hospital," Jnl. of Psych. Social Work, Vol. XXIII, No. 4, June 1954; pp. 234 - 241. This study is also mentioned by Timms, N., op. cit., pp. 115 - 116.

proceeded to discuss fully services offered to families of patients, and superficially those offered to patients. Although this did not cover help to patients adequately, the points discussed were similar to those which the worker judged would be covered in the present study, and also similar to the work which was to be assessed with families. While providing guide-lines for the study, the article did not present any formal method of case record analysis.

An investigation which provided further direction for the present one was that by Goldman,[24] in which an attempt was made, after determining various items relating to types of patients served and reasons for service being given, to assess the types of help given by social workers to long-term patients in general hospitals. This article provided valuable guidance in the presentation of the study.

So, too, did three further works, all by Bartlett. The first, "Some Aspects of Social Casework in a Medical Setting,"[25] was an account of the theory and functions of medical social work in hospitals, based, importantly, on case records submitted to the Functions Committee of the American Association of Medical Social Workers by workers practising in the field. In her preface to the sixth printing of this monograph, Miss

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24. Goldman, F.: "What are Social Workers in General Hospitals doing for Long-Term Patients?" Social Work (N.Yk.), Vol. 5, No. 4, Oct. 1960; pp. 68-77.
25. Bartlett, H.M., Some Aspects of Social Casework in A Medical Setting, Amer. Assocn. of Medical Social Workers, N.Yk., 1940, and N.A.S.W., N.Yk., 1958; passim.

Bartlett points out its importance to social work with the words: "The principles defined and the directions of thinking suggested in this earlier study of medical social work represent a beginning in a type of analysis essential for the further growth of the profession."[26] However, the analysis again proved not sufficiently specific for the present inquiry, and attention was turned to a slim booklet entitled "Analyzing Social Work Practice by Fields."[27] Providing a sound theoretical background to social work practice, it introduced a far larger volume on "Social Work Practice in the Health Field."[28] However, while this work offers "an orderly framework within which any social worker can view his practice,"[29] the theoretical concepts on which this work is based were too broad for the present study. Thus, while her last volume covered excellently the practice of social work in the total health field,[30] it did so in a way not entirely utilizable in this study.

So once more a blank had been drawn in searching for material which analyzed function of the social worker from case records. This was not a total blank, however,

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26. Ibid., Preface to Sixth Printing, 1958, p. viii.
27. Bartlett, H.M., Analysing Social Work Practice by Fields, N.A.S.W., N.Yk., 1961; passim.
28. Bartlett, H.M., Social Work Practice in the Health Field, op. cit. (footnote 15); passim.
29. Bartlett, H.M.: "Ways of Analyzing Social Work Practice," op. cit. (footnote 16); p. 202.
30. Miss Bertlett considers that the "health field" covers all forms of the social institutions of medicine and public health, with the addition of a few smaller groups. (Social Work Practice in the Health Field, pp. 31 and 32). She sees it as a broad concept, not narrowed down to specialties.

as valuable background data had been obtained, but an almost complete one in that the absence of the specific system of classification required to elicit the functions of the social worker from the records necessitated the drawing up of such a system by the writer.[31] By means of this system, certain qualitative material could be extracted.

One method, then, of classifying this research would be to term it "operational," as differentiated from "basic," research.[32] The latter, according to Greenwood, seeks abstract and general knowledge and "deals with the core of social work, viz., its principles of practice and its value assumptions," while operational research consists of descriptive statistical studies, studies to develop planning information, and studies to obtain information for administrative purposes.[33] This is, then, practice-oriented research, and covers research studying the social worker in the act of rendering service.

The study would also fall into the category which Kahn calls diagnostic or descriptive.[34] The aim in this kind of research is not theory development, but "a

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31. It seems at this stage logical to discuss the drawing up and application of this classification system, but in fact it fits more appropriately into the context of method of the study, and so will be dealt with in the following chapter.
32. Greenwood, E.: "Social Work Research : A Decade of Reappraisal," Soc. Serv. Rev., Sept. 1957, as discussed by Macdonald, M.E., in "Research in Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960, N.A.S.W., N.Yk., 1960; p. 508.
33. Ibid., loc. cit.
34. Kahn, A.J.: "The Design of Research," in Polansky, N. (Ed.), Social Work Research, N.A.S.W. by University of Chicago Press, Chicago, Illinois, 1960; pages 52 - 53.

descriptive view, which may be qualitative or quantitative - or both - of a situation, agency, program, or client group."[35] Such a research method can include cross-tabulations and a detailed breakdown of data as a contribution to precision and concreteness[36] and is in harmony with the material of this study, which is of such a nature that purely statistical analysis would detract from its value by losing many of the finer points, while pure case history presentation would not elicit those quantifications which are possible. The material of the study is well-suited to such an approach, while the aims of description and assessment of the social worker's role, as put forward in Chapter I, can be accomplished by its use.

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35. Ibid., p. 53.
36. Ibid., p. 54.

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C H A P T E R III.

BEGINNING METHODS OF THE STUDY.

Consideration of the questions in the previous chapter by no means covered all the problems with which the researcher anticipated she would be faced, but did establish the fact that she was able to enter the field, and that research could be conducted in it. The next step was to design the research method, and deal with associated problems as they arose.

A. POPULATION AND SAMPLING PROCEDURES.

1. The population from which the sample for the study was drawn was defined as being all male and female patients admitted, at any time during the existence of the unit, as in-patients to the two psychiatric wards of the Johannesburg General Hospital.[1] The first step in sampling was carried out by time,[2] i.e., the sample was defined by selecting patients admitted to the two wards for the six-month period 1st March, 1963, to 31st August, 1963. This sampling method was based in no way on the characteristics of the group, and was directed primarily towards obtaining a sample of manageable proportions. The time period delineated was chosen to comply with the remarks made earlier[3] relating to use of current case records, and the memory factor. It was felt, further, that such a

sampling/....

1. Kerrich, Professor J.E., Department of Statistics, University of the Witwatersrand, personal communication, Feb. 1964.
2. Idem.
3. Chapter II, page 25.

sampling method would in no way influence the representativeness of the sample, as, during a six-month period, it was highly probable that a typical cross-section of all types of patients usually treated would be obtained.

2. The finding of source-lists had to be considered next. It was decided that reliable ones would be the admission books of the two wards, as hospital regulations lay down that the name and other personal details of every patient admitted to a ward have to be entered into that ward's admission book, and close supervision covers this procedure. Thus a complete list was drawn up of all patients admitted in the specified time period, and a list of 346 patients in this way obtained, made up of 147 females and 199 males. This did not give a true picture of the number of individual patients admitted, as no attention was paid to rate of re-admission, and this was simply a "flat rate" of admissions. When re-admissions had been deducted from the list, 295 patients remained, consisting of 124 females and 171 males.[4a,b.]

Table/....

4a. Average number of admissions per month for the time covered -

Including re-admissions:	Male	-	33.3
	Female	-	24.5
Excluding re-admissions:	Male	-	28.5
	Female	-	20.6

It is interesting to speculate on the reasons for this higher number of males, both with and without re-admissions. While no explanation is attempted here, it is interesting to consider whether possibly the women had families more often than the men, and were protected by them for as long as possible, or whether other cultural factors were operative. World figures do not indicate so wide a disparity in incidence of mental disease between men and women, though there is a trend in this direction (Landis, C. and Page, J.D., Modern Society and Mental Disease, Farrar and Rhinehart, Inc., N.Yk., 1938; p.93).

b. These totals, in other words, reflected the number of individual admissions within the period of the study, though not the number of first admissions within this period.

TABLE I - NUMBER OF ADMISSIONS AND READMISSIONS OF PATIENTS DURING THE PERIOD OF THE STUDY.[5]

	Total Admissions	No. excluding Readmissions	No. of Readmissions.
Total	346	295	51
Male	199	171	28
Female	146	124	23

3. Once these lists of patients had been obtained, they had to be divided into groups of those patients who had seen, and those who had not seen, a social worker, as the object was to trace case records which could be used to analyse function of the social worker, and obviously those patients who had not been seen by her would be eliminated from the sample. This was thus the second sampling technique. It may have introduced some bias in the sample, in that it could be postulated that the characteristics of the group referred for social help would differ from the group not referred for such help at least in some respects, viz., those surrounding the need for such help which the other group may not have had.[6] However, as the characteristics of the group were not to be investigated, but the volume of social work help given was to be, this was not considered significant.

Ascertaining which patients had been referred to the social work department was carried out by checking through the records in the department. As a

record/....

5. Table I indicates that higher rate of readmissions of male patients is not the reason for the disparity, as the readmission rates are roughly proportional to the number of admissions.
6. It is also possible, of course, that some members of this group might have had problems, but not been referred for help with them.

record is kept of every patient referred, this was considered a reliable method of tracing the records. The step was executed as follows:

(a) The alphabetical cards of the old recording system[7] were carefully examined by the writer, and those cards which were found were extracted.

(b) The alphabetical index cards of the new system were then scrutinized, and the appropriate files removed.

(c) Where no files could be traced by either of these methods, the departmental files of certification papers[8] were checked.

(d) As no other records are kept in the department, it was surmised that any records in existence would have been traced by the above procedures, but it was decided to make a double check, and the writer thus -

(i) carefully searched through every "old" card, from A to Z; and

(ii) carefully went through all the "new" files, this time not only by index card but by number, in case any file had been omitted accidentally from the index.

4. A total of 140 case records of patients (62 female; 78 male) was obtained in this way, this figure being just less than half of the number admitted (295). Of these 140 patients, 119 patients had been admitted

only/....

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7. See Chapter II, pages 20 - 21.
8. Certifications in terms of the Mental Disorders Act. Very occasionally files are not opened for such cases, and the official papers then constitute the record.

only once in the six-month period, and 21 patients more than once.

5. The next step in delineating the sample was to select those patients dealt with only by the researcher, as these were to be the subject of the analysis.[9] Each of the 140 case records was read carefully and the group was then divided into three sets:

(a) Those concerning patients who had been seen only by the writer, and only while in-patients after March 1st, 1963, and where the record had been written up entirely by the writer - 59 in number.

(b) Those concerning patients who had been seen during admissions other than psychiatric ones, and/or only by other workers either prior to or after March 1st, 1963: and those concerning patients who had been seen only by the writer, but during an admission prior to March 1st, 1963, or after August 31st, 1963 - 26 in number. Among these were included three records which, though written by the researcher about patiehts seen in the specified time period, were clearly too brief for purposes of analysis. Two contained only one sentence, and the third was a set of certification papers (the only set found under 3 (d) above).

(c) An intermediate group, consisting of those

patients/....

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9. See later in this chapter, page 45, for comments on this.

patients seen by the writer for part of the period of contact from March 1st, but also seen by a student (under the writer's supervision, but with the record partially or wholly written up by the student) while in the psychiatric wards, or by another member of staff (e.g. during the writer's absence on leave) - 55 in number. This group was carefully read a second time, and each record then placed into Group (a) or Group (b). The criteria used for this decision were:-

(i) Where a file had been entirely written up by a student and the researcher had had little real contact with the patient, the records were filed under (b) - 16 in number.

(ii) Where the work done by the student or other member of staff was judged to be of an equal or greater amount than that done by the researcher, and where a positive relationship seemed to have been built up with the other worker, the records were filed as (b) - 7 in number. Thus the number added to group (b) was 23, bringing the total to 49.

(iii) Those cases where the researcher had clearly been the main worker with the patient, or had simply asked the student to write up part of the record for purposes of the student's training, although the worker had been the interviewer, were included under (a) - 14 in number.

(iv) Records/....

(iv) Records of those patients who had been assisted by other workers after March 1st, 1963, while the patients had been in wards other than the psychiatric ones, but were seen by the researcher from the time of their subsequent admission or transfer, from 1st March, to 31st August, to the psychiatric wards (i.e. from the time of becoming psychiatric in-patients), were grouped under (a).[10] Only the latter parts of such records were utilized for the research analysis. A further six case records were selected in this way, and (iii) and (iv) thus added a further 20 records to Group (a), bringing the total to 79.

(v) Those records where there was still some uncertainty as to grouping - there were 12 of these - were read for a third time, and where there was still doubt, placed into Group (b), but where it was subjectively felt by the researcher that

they/....

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10. Thus - one elderly woman had been treated in a surgical ward and seen by the social worker for that ward during her stay there; when the surgeons had dealt with her surgical complaint, she was transferred to the female psychiatric ward, and the present writer took over the social work role

they should be placed in (a) were placed there.[11] This resulted in a further 9 cases being assigned to Group (a), bringing the total in that group to 88, and a further 3 to Group (b), bringing the total to 52.

TABLE II - GROUPING OF CASE RECORDS ACCORDING TO VARIOUS CRITERIA.

	Original Reading	Second Reading	Third Reading	Totals
Group (a)	59	14 + 6	9	88
Group (b)	26	16 + 7	3	52
Intermediate Group	55	12	0	0
				140

6. Group (b) were then discarded as not representing function of the social worker in the psychiatric wards, and the remaining 88 records (44 for female, and 44 for male, patients) making up Group (a) were retained as the "working"

sample/....

11. The element of subjectivity introduced here was considered acceptable, as the writer's specialised and intimate knowledge of the cases qualified her to make such a judgment if no other criteria could be used. The reasons for such a decision could readily be given by the researcher, and so the whole method of dividing the records was repeatable. (Levitt, E.E.: "The Basic Philosophy of Experimentation," Smith. Coll. Stud. in Social Work, Vol. XXX, No. 1, Oct. 1959; p. 64 - a study to be scientific, must be able to be repeated).

sample."[12a,b.] In other words, all those records in which the present researcher had functioned as a social worker in the psychiatric unit were retained, to form the basis of the study. The aim of the analysis was to show function relating to in-patients of the psychiatric wards, and although the 52 cases rejected had been seen by social workers, they had not necessarily been seen while in a psychiatric ward. Thus, a patient might have been seen in October, 1962, during an admission to a medical ward, returned to the hospital in May, 1963, and been admitted to the psychiatric ward, but not

referred/....

12a. It is of note that the numbers of male and female patients were equal, although more males were admitted to the wards. While no explanation is offered here, it is interesting to postulate whether perhaps the sex of the worker made it easier for female patients to approach her, and whether perhaps this, added to the fact that she was younger than most of the men, might not have led to their feeling less able to discuss intimate problems with her. Had she been unmarried, this might have had additional effects. Referral as a further influencing factor is discussed in Chapter VI, pages 141, foll.

b. For purposes of this thesis, these 88 records will be regarded as a purposive sample, although there are two schools of thought on this matter. On the one hand, this group is regarded as a census or universe of all patients having the specific characteristics "admitted as in-patients to the psychiatric wards, and seen by the researcher." (Lever, Mr. H., Department of Sociology, personal communication). On the other hand, the sample can be regarded as given above, and as being a sample of all persons who would form a sub-population of all psychiatric in-patients if chosen by these techniques. (Kerrich, Professor J.E., Department of Statistics, University of the Witwatersrand). However, this is perhaps a moot point and a question of terminology which cannot be solved here. The most important reason for drawing a representative sample is that it can be used for statistical purposes. However, as descriptive statistics and not probability statistics are to be drawn up in relation to this sample, which is to form the basis of an analysis of social work function, the terminology used in the text was considered satisfactory.

referred to the researcher during that admission. Such a record would have been selected in the original gathering of record, but would have been rejected in the first grouping.

The resulting size of the sample may be considered small, but the main reason for this was that it was difficult to determine the number that would result after carrying out the above procedures. The reasons for difficulty in anticipating size are based mainly on the fact that in-patient work is only one part of the total work of the social worker in the psychiatric unit. Thus, although the social worker could estimate how many patients she saw a month, such an estimate would include psychiatric patients referred from Casualty, from the Out-Patients Department, from the day-patient section, or from outside sources,[13] as well as those patients who returned to see her without re-admission to hospital. In other words, such an estimate would be a general one, and not give any specific indication of how many patients would remain after only in-patients had been selected, and, further, only certain in-patients.

While the aim of the study was not to investigate the characteristics of the group, it was nevertheless convenient to have some of the external

variables/....

13. Community agencies, family members, etc.

variables which would affect these controlled.[14] The common factors of severity of illness together with the common experience for each in-patient of hospitalization[15] were items which, although they might influence the type of service rendered,[16] would not necessarily do so, and would not be significant if they did. The main object of selecting service to in-patients as the unit of study was that these patients are usually seen for longer periods and more concentratedly than out-patients and Casualty patients, and the records for these patients would thus be longer and fuller.[17] It appeared from practice that although the service rendered to the two groups might differ quantitatively, qualitatively that rendered to

in-patients/....

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14. E.g., inter alia, differences in degree of illness, i.e., severe enough to merit hospitalization, or not; differences in the effect of unemployment on a patient in a sheltered (hospital) or open (community) environment.
15. Although hospitalization is accepted generally as having different meanings for different people, it does create certain homogenous problems, and often, particularly in informal wards such as these, a sense of comradeship.
16. Once hospitalized for a mental illness, the patient may no longer be able to deny the illness; nor may the family. This may lead to the beginnings of dealing with problems previously denied because their admission would have acknowledged the existence of the illness.

    Further, hospitalization may bring up fears in patients which have to be worked through; or may lead to problems of finance which a working patient may not have; a problem relating to care of children which a mother sick at home may not encounter.
17. These patients are often seen briefly and/or sporadically and case records reflect this and do not supply much of the "meat" required for analysis. However, this does not reflect a true difference in type of service but only a difference in amount of type.

in-patients would include the types of service rendered to the latter group. In other words, the type of help given at this level was similarly given at the in-patient level, but additional services were also given. Thus an analysis of "in-patient" help would cover "out-patient" help. Further, "day-patient" help would, in fact, not be excluded, because day-patients are usually drawn from the ranks of the in-patients. These, hence, would be included in the study, as it was decided to continue analysis until the close of case, including, if necessary, day-patient care. Thus, although the sample may at first have appeared limited, it could instead be regarded as very representative of the type of social work service rendered.

The careful selection of in-patients which followed the decision to use them in the study was based on the need to control certain facts (such as the influence of other workers) rather than on the basis of an hypothesis[18] and was not aimed at limiting the size of the sample, as stated. Although the subjectivity of using her own records was recognised by the writer, she felt it was counteracted by the fact that this lent consistency to what was covered in the case records.[19] Also, because records were practice records and hence possibly not always meticulously complete[20] certain data would be missing. These could not be filled in by the writer for other people's

records/....

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18. Levitt, E.E., op. cit., p. 68.
19. See previous comments, Chapter II, pages 23 - 24.
20. Idem.

records, but could be done for her own.[21] An important aspect, too, was that the analysis was to reflect function of the social worker in a psychiatric unit, and records about psychiatric patients in other wards, to which they might not necessarily even be admitted for psychiatric reasons, would not reflect this. It might be argued that records of patients who were seen by the worker while in the psychiatric wards (e.g. during the researcher's absence on leave) could have been included, as these would have reflected such function, but the above factors of inconsistency and incompleteness would still have been operative. Further, these records were very few in number, as in most cases the patients had been seen only briefly by the other worker, and were thus included under Group (a) by virtue of this fact.[22] In addition, it seemed possible that a worker taking over the wards for a short period, such as one to two weeks, would still be "settling in" at the end of that time, and one might therefore be analysing a slightly different factor, viz., the function of a learner not yet secure in her role, as contrasted with the function of a worker confident in and accepted by the group. Certain variables might in this way be introduced. Finally, it was felt that once the researcher was aware of the subjectivity possible, she would be on her guard against this, and, furthermore, it was decided that, as an outside judge was to take part in the study,[23] any gross subjectivity which might/....

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21. Memory factor, see Chapter II, page 25.
22. See this chapter, page 39, point (iii).
23. See Chapter IV, pages 80, foll.

might influence the analysis would be revealed.

In summary, then, the 88 cases which finally emerged intact from the process of selection included only those patients admitted to the wards from 1st March, 1963, to 31st August, 1963, and then referred to the social worker, but not those admitted before March 1st and referred to the social worker in March or subsequently. In other words, selection was not based on referral to the social worker during the period specified, but on admission to the wards during that time, and referral to the social worker at any time from March 1st onwards, but during the same admission. In this way, a patient admitted in August and discharged in August, then re-admitted in September and referred only during that admission, would not be included, though a patient admitted in August and referred in September, while still in hospital, would be included.

Thus, although it was acknowledged that the sample was not large, it was considered to be a carefully and validly drawn one, and, importantly, large enough for the purposes for which it was required, as well as representative of the types of service rendered by the social worker in such a unit.

B. DRAWING UP THE CLASSIFICATION SYSTEM.

Once the sample had been defined, some system of function classification had to be worked out, as no such system was apparently available. Faced with 88 case records, how was the researcher to reduce all

the information contained therein into organized categories? How was objectivity to be provided, yet sensitivity retained to capture the peculiar characteristics of social work praceice?[24] While "a research methodology may stand up well as an objective instrument, ... it will not help us if it obscures or even distorts what we want to discover."[25]

It was decided that if the researcher arbitrarily drew up a list of what she considered were the functions of the social worker in the psychiatric unit, and then proceeded to adapt this to the needs of the study, the entire study would be unsoundly and subjectively based. Yet a basis of some kind had to be found. It was therefore decided to approach the other three social workers in the department,[26] and ask them to draw up lists of what they considered function to be. The common elements of these lists could be abstracted, and a single list thus formed. Although these lists would not reflect psychiatric function, they would reflect overall social work functioning in a general hospital, and it had been the empirical experience of the writer that much of this was carried over to the psychiatric wards. When these lists had been obtained,[27] the researcher

added/....

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24. Bartlett, H.M.: "Ways of Analyzing Social Work Practice," The Social Welfare Forum, Proceedings of the National Conference on Social Welfare, 1960; Columbia University Press, N.Yk., 1960; p. 199.
25. Ibid., loc. cit.
26. In order not to introduce bias, only lists submitted by other caseworkers were used, and the functions of the supervisor not included, as these encompass mainly administrative duties and little direct contact with patients.
27. Sincere thanks are due to Miss H. Botha, Mrs. A.B. Osmond and Mrs. W. v.d. Merwe, for their assistance.

added to the list of central functions which emerged those services which, in addition, were provided in the psychiatric wards. In order to affirm or negate these, she conferred with a trained psychiatric social worker[28] in a somewhat similar setting,[29] and the resulting list of functions formed the basis of the first content analysis of the case records.[30]

(1) Assistance relating to finance, including help with pensions, sick benefits, poor relief, and other economic problems.

(2) Assistance relating to accommodation, including the finding of new accommodation, and arrangements to hold old accommodation during hospitalization.

(3) Assistance relating to employment - mainly the finding of such for patients.

(4) Other/....

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28. The writer's debt to Miss J. Dettman, P.S.W., Tara Hospital, must here be recorded. She gave willingly of her time and thought, and her help is much appreciated.
29. Although Tara Hospital differs in many ways from the unit under discussion, the work of the social workers remains essentially the same, and hence consultation is valuable. Furthermore, as Miss Dettman is a fully trained psychiatric social worker, her expertness in the field enabled her to give an expert opinion.
30. Definitions of the terms used are not given here, but appear in the final form of the classification system, on pages 53, foll., and particularly in the discussion of each section in the text of the thesis.

(4) Other environmental manipulation - specifically concerning the hospital situation, such as referral to other hospital departments, consultation with staff members, etc.

(5) Help relating to patient's problems with people in his environment, such as landladies, and employers.

(6) Advice-giving, logical discussion, psychological support, clarification, and counselling were all grouped together, as it was generally felt that little of the latter two was done, and separate categories were unnecessary.

(7) Follow-up and supervision of patients.

(8) Placements under the Mental Disorders Act - both certifications and voluntary placements.

(9) Placements other than under the Mental Disorders Act, i.e. all placements specifically psychiatric (except those in mental hospitals), and including, for example, placements at Northlea or Mount Collins,[31] and Tara Hospital.

(10) Collection of specific psychiatric information - from home visiting, other agencies, etc. - for use generally in group meetings with other staff, at ward rounds, and at other meetings.

(11) Referral/....

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31. These are the retreats for alcoholics, sponsored by the Rand Aid Association, mentioned in Chapter I, page 14, footnote 35.

(11) Referral to, and working with, other agencies.

(12) Contact with the family, both about the patient, and/or in an attempt to help the family per se with any of the above problems.

(13) Miscellaneous - to include any specifics not covered above.

(14) Time - this would include number of interviews per patient, telephone calls, letters written about the patient, and, if possible, length of contact.

(15) Relationship. It was felt that it would be interesting to attempt to assess the nature of the relationship between the patient and the social worker, particularly as there might be some correlation between this and several other items, as well as between relationship and time spent with a patient. As it was extremely difficult to draw up an a priori list of the degrees of strength of relationship, it was decided that each case would simply be subjectively placed by the researcher into one of the following categories - very good, good, fair, poor - and that these categories would then be defined a posteriori, on the basis of an analysis of what had determined the researcher's judgment in placing them in the different categories. In other words, the categories were to be defined after the first

set/....

set of judgments, and on the basis of an analysis of what factors had determined these judgments.

This classification system was not regarded as final, but rather as an outline to be tested for adequacy. However, that it had validity, and analyzed what it claimed to analyze (i.e., function) was not questioned, because it had been based on group opinion in the form of functions described by workers in the field, but whether it did so fully enough had still to be ascertained. To test this, it was decided to apply the system to the sample, in a "trial run", and to see whether any omissions or duplications became apparent.

The files were shuffled and reshuffled until they were thoroughly mixed, and retained no semblance of alphabetical order or arrangement by sex. Then each file was carefully perused, and any activity by the worker classified under one of the thirteen points above. In addition, a note was made of "relationship." However, it soon became apparent that no reliable note could be made about time, as this was not recorded specifically for each interview, and often interviews were collectively recorded in summarized form, so that the record, while reflecting what had actually been done, did not reflect how long a time, or what effort by the worker, had gone into the "doing."[32] It also appeared that certain sections

of/....

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32. It is interesting that Goldman, in a similar study, was also unable to assess time. (Goldman, F.: "What are Social Workers in General Hospitals doing for Long-Term Patients?" Social Work, (N.Yk.), Vol. V, No. 4, Oct. 1960; p. 75.

of the system needed breaking down, with finer differentiation between different aspects of the same broad function, while subsections of some needed to be classified on their own. This latter point applied particularly to the social worker's collaboration with staff, and it was decided that this should be removed from inclusion under (4) and allocated a separate position in the scheme, and that such consultation should, further, be divided into formal and informal meetings between staff member and social worker. In addition, the category "contact with the family" did not give enough information as to the nature of such contact, and it appeared that much of the assistance given to patients was also given to their families; thus it was decided that some indication would have to be given of this in the scoring system.

The classification system which emerged from this preliminary testing had enough categories to reflect specifics of the social work role, yet not too many to be unmanageable or not to reflect broad trends. It was based both on logical and on practical foundations, and on the thinking of the researcher, confirmed by others and by testing. In its final form, the scheme appeared as follows:

A. <u>TRADITIONAL FUNCTIONS OF MATERIAL ASSISTANCE AND ENVIRONMENTAL MANIPULATION.</u>

1. <u>Assistance relating to Finance.</u>

(a) Help in obtaining, or with problems in regard to, Old Age, War Veterans, and Military Pensions; Disability/....

Disability Grants, Workmen's Compensation; Trade Union benefits and sick benefits (including the obtaining of necessary documents). This subsection covered financial aid which was government sponsored or to which the patient was "entitled".

(b) General poor relief, including the obtaining of financial help from other agencies· food parcels; clothing; and all similar aid, mainly where certain means tests were involved, and/or where aid was typically of a "charitable" kind.

(c) Other, including particularly problems where special arrangements had to be made for the necessary assistance, and routine channels, such as those of (a) and (b), could not be worked through. This formed a type of miscellaneous section, covering all financial assistance which could not be put under (a) or (b). It was necessary to include this sub-division to cover such aid as that relating to obtaining spectacles for patients, false teeth, special monies e.g., from the departmental Samaritan Fund for bus fares for patients seeking work - and salaries still outstanding to patients.

2. Assistance relating to Accommodation.

This referred specifically to working with patients who had no place to which to return on discharge from hospital, and embraced not only the finding of accommodation in hostels or homes, but also working with relatives of patients in order to enable them to undertake care of the patient.

3. Assistance/....

3. Assistance relating to Employment.

Whether the worker found employment for a patient, referred the patient elsewhere for work, or was instrumental in keeping his previous job open for him, was irrelevant; all were considered to fall under this heading.

4. Other Environmental Manipulation.

Because the hospital consists of many departments, and because an understanding of its administrative procedures and much of its "red tape" eludes the average patient or layman, the social worker often has to arrange or co-ordinate various intra-hospital arrangements for patients. This division was therefore introduced specifically to cover such responsibilities - inter alia, making appointments for patients, arranging meals in the hospital, instituting reclassification proceedings,[33] and arranging various services for patients by other departments.

5. Help relating to Patients' Problems with People in the Environment.

Because modification of attitudes and behaviour of people in the patient's environment is often termed environmental manipulation or modification in the

literature/....

33. Assessment of hospital fees is based on income, and a patient may be wrongly assessed or classified, or stay in hospital for so long that he has to be reclassified to a lower-paying-category - the social worker has much to do with this administrative procedure. Details of classifications are given in Chapter V, pages 111, foll.

literature,[34] and because it seems to occur frequently in hospital psychiatric work, where landladies, employers, and lawyers are often involved in patients' affairs, a separate section was devoted to such work, and any contacts between the social worker and these people, or any attempts by the social worker to modify the attitudes or gain the sympathy and understanding of persons in the patient's environment, towards or for the patient, was placed under this head, with the exception of such work with family members, which was considered to be a distinct category, separated from work with individuals usually more peripheral in the patient's life. It was anticipated that this would often be linked with functions under 1 (c), 2 and 3.

B. ENVIRONMENTAL FUNCTIONS WHICH ARE SPECIFICALLY PSYCHIATRICALLY ORIENTED.

6. Placement under the Mental Disorders Act (1916, as amended 1944 et al),[35] including all arrangements connected with this, such as the booking of beds and ordering of transport.

7. Placements other than under the Mental Disorders Act, but specifically psychiatric in nature.

C. Indirect/....

34. Inter alia: Hollis, F.: "The Techniques of Casework," in Kasius, C. (Ed.), Principles and Techniques in Social Casework, F.S.A.A., N.Yk., 1953; p. 414. Bibring, G.: "Psychiatric Principles in Casework," in Kasius, C. (Ed.), op. cit., p.372. Seawright, T., A Social Casework Approach to Marriage Counselling, Witwatersrand University Press, Johannesburg, 1961; p. 97.

35. See Appendix B, page 442, for provisions and procedures of this Act.

C. "INDIRECT" SERVICES TO PATIENTS: COLLECTION OF SPECIFIC PSYCHIATRIC INFORMATION, AND THE SOCIAL WORKER'S FUNCTION IN DIAGNOSIS AND TREATMENT.

8. Collection of specific information, psychiatric and other, for use generally in group meetings with other staff members, social work reports at ward rounds, and other similar purposes, by means of:

(a) Home visiting.

(b) Exploratory interviewing with the patient, contacting employers, other social work agencies, institutions, and community resources, and the family when not visited at home.

9. Collaboration and Consultation about patients with staff members.

(a) Informal contacts with doctors, nurses, and other staff members.

(b) Formal contacts at meetings and ward rounds.

D. FUNCTIONS WHICH MAY AISO BE REGARDED AS METHOD.

10. Information-giving, advice-giving and logical discussion.

Because of the nature of the hospital as an institution, such explanations to patients and families about various departments, procedures, and alternatives although often grouped under "supportive techniques"[36] in the literature, were here separately treated as it

seemed/...

36. E.g., in "Method and Process in Social Casework - Report of a Staff Committee," Community Service Society of N.Yk., F.S.A.A., N.Yk., 1958, pp. 16 and 17.

seemed that they might form a substantial part of total function.

11. Psychological support was given the explicit meaning of any methods used by the social worker which contributed to an "increased feeling of security in the patient,"[37] and from which he seemed to gain reassurance, strength or comfort, and which enabled him to face his problem with at least somewhat renewed vigour, and a greater degree of confidence.

12. Clarification, Counselling and Insight Development were grouped together and defined as any processes aimed at helping the patient to modify his adaptive patterns through understanding of certain aspects of his problem or himself, and to see and understand relationships between these aspects which he either previously did not recognize at all or could not formulate. Further, by these terms was meant that verbal and emotional interaction between patient and worker which enabled the patient to modify or adapt his attitudes and behaviour.[38]

E. WORKING WITH THE FAMILY.

13. For purposes of the study, working with the family was not intended to mean working with every member of

the/....

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37. Knight, R.P. (Ed.), Psycho-analytic Psychiatry and Psychology, Internatnl. Universities Press, N.Yk., 1954, p. 76; quoted by Selby, L.: "Supportive Treatment : The Development of a Concept and a Helping Method," Soc. Ser. Rev., Vol. XXX, No. 4, Dec. 1956; p. 406.

38. These definitions are based on references given in Chapter IX, pages 237, foll.; and are elaborated there.

the family, but with those members most in need of help,[39] or who came for help, or who were most concerned with the needs of the patient. Further, it was decided that only function of the worker to relatives about the patient would be included here, and that function to families per se would be included under the appropriate columns outlined above, but indicated as such to family, not patient. (See scoring system, Chapter IV, page 72). Further, while Otto Pollak's statement that "a family exists when people related to one another by blood or the sharing of a home consider themselves responsible for one another on a more comprehensive basis and at a higher degree of intensity than they consider other people"[40] would possibly have resulted in more patients having "families," this was not taken as the definition for the study; rather, the term "family" was taken to mean only blood relatives of a patient or those legally related to him whether of the family of orientation or procreation of the patient, whether near or distant to that patient, and whether or not such relatives had been closely associated with the patient. One of the reasons for this specification was the legal responsibility of relatives during time of illness. Where friends played the parts of family members, work with them was placed under (5).

F. FUNCTION CONCERNING THE PATIENT IN RELATION TO THE COMMUNITY.

14. Referral to, and collaboration with, community agencies/....

39. Editorial, British Jnl. of Psych. Social Work, Vol. VII, No. 3, 1964; p. 122.
40. Pollak, O.: "Social Determinants of Behaviour," Social Work (N.Yk.), Vol. 8, No. 3, July 1963. p. 96.

agencies and institutions.

15. After-care services. This included follow-up and supervision of patients after discharge from hospital. The criterion distinguishing this from other help was that the problem and/or help involved contact with the patient following discharge. Only where such contact was carried out after discharge instead of during hospitalization, and where the purpose was not to assist the patient in his return to the community, was this service not termed after-care. Thus, a patient seen about work, who was discharged before such arrangements as had to be made were completed, and subsequently seen about the same arrangements after discharge, though normally he would not have been seen again, was classified as having received help with employment, but not as having been "followed-up." However, where arrangements for work had been finalised with a patient, and the worker then contacted the patient to determine outcome of the arrangements, or whether the patient had settled into the work, this was regarded as follow-up. Similarly, where the worker, for any reason, re-established contact with a patient in order to assess the status quo of that patient, such action was regarded as follow-up, or after-care - depending on the activities involved[41] - as was continuation of contact, without a break, for this purpose.

16. Miscellaneous. As before, this category was included to cover any specifics not dealt with in the

previous/....

41. See Chapter XI, pp. 337, foll., for elucidation of definitions.

previous divisions, and within it fell such functions as fetching clothes for patients, bringing newspapers for a patient who could not afford these, and arranging work references and repatriation for patients.

The category "time" was eliminated from the classification system, as discussed earlier (page 52), but that of relationship was not.

G. RELATIONSHIP.

17. Considered by Rockmore to be the crux of the helping process in social work,[42] relationship was here defined as the intangible, emotional, and dynamic interaction between patient and worker, characterized by "the caseworker's warmth, compassion, helpful intent, and objectivity, and, on the client's part, by trust and some readiness to carry his share of the work to be done. Within this relationship, acceptance and expectation combine to make for a working partnership....." between patient and worker.[43] Perhaps the implication of this last sentence is of the greatest importance in the establishment of "relationship". For it cannot be one-sided, and, without the movement of feelings and emotions between worker and patient, there can be no relationship. Whether what moves between is positive or negative in nature is not crucial, but that exchange of some kind takes place between the two is vital.

The/....

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42. Rockmore, M.J.: "Casework Today in a Psychiatric Setting," Jnl. of Psych. Social Work, Vol. XXI, 1951: p. 27.
43. Perlman, H.H.: "Social Casework," In Kurtz, R.H.(Ed.), Social Work Year Book, 1960: N.A.S.A., N.Yk., 1960: p. 536.

The next problem was the "rating" of this intangible in terms of degree. In the preliminary trial, it had been found that relationship with the patient varied during the time of contact. Accordingly, a patient with whom a "good" relationship had been established at opening of the case might relate "poorly" at the end of contact, or vice versa. To cover this, it was decided not to make an assessment of the relationship as it changed throughout contact, but to place particular emphasis on the nature of the relationship at closing of the case, or by December 31st, 1963, whichever occurred first.[44]

The second point which had to be considered was that the assessment of relationship was being unilaterally made, i.e. by the worker only, without inclusion of the patient. While it was realized that this would perhaps influence the rating, it was not possible to obtain an opinion on relationship from the patient, mainly because it seemed that patients would not give an honest opinion to the worker who had seen them, and hence a distorted picture would result. In addition, contact had been lost with many patients for several months, and even had an outside worker been asked to interview patients about this subject, many blanks would have been drawn, and problems of confidentiality might have arisen.

In terms of the above limitations, and on the basis of the preliminary trial, the following categories were defined:

(a) Very/....

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44. See Chapter IV, page 74, footnote 12.

(a) Very good. The patient seems to "make contact" with the worker and to show warmth in and confidence towards her, which elements the worker also feels towards the patient.[45] There is, further, an element of trust in the relationship, and the patient menifests this feeling in a greater ability to express his emotions (both positive and negative) and to talk freely to the worker. He appears to feel accepted and understood by the worker, and shows a real desire and need to return to see her. He often returns of his own accord, after termination of the contact, either for further help, or simply to "say hello."

Thus, Mr. A., a homosexual drug addict, aged 28, after himself initiating contact with the worker, soon was able to relate to her in a strongly positive manner, talked with great feeling about his problems, and eventually was able to turn to her, long after his discharge from hospital, for help in admitting himself to a treatment centre for drug addicts; thereafter, he contacted her frequently from the centre to tell her how he was progressing, and, when he no longer needed her assistance, was still returning from time to time to tell her what he was doing.

(b) Good was considered to be similar to very good, in that the elements in such a relationship were essentially the same, and the quality of the relationship was apparently or possibly the same, but appeared to the worker to be to a greater or lesser degree

superficial/....

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45. Responses of the worker are consciously disciplined; however, to be sincere and dynamic they must also be spontaneous.

superficial, or to have an element of superficiality in it. This type of relationship was typified by Mr. B., aged 50. An alcoholic, he was a construction worker who, when sober, had held down several good jobs. He had been admitted to the male ward on more than one occasion, following various "binges," and in times of such crisis would see the worker regularly for a short time, relating warmly and confidently to her. His relationship with the worker during an admission falling within the study period was characterized by this warmth, confidence, and ability to talk freely, but emotion was expressed only superficially, and although the working relationship during his stay in hospital was "alive," it seemed to be related to no really deep need in him; his visit to the worker once he had found work was in the nature of a courtesy call, and he was not seen again until his next "binge."

The relationship which a regressed psychotic is able to establish with a worker is often also well-placed in this section. For while, in terms of the patient's capabilities, the relationship may be a very good one, and a constant one, compared to those established with non-psychotics it has in it an element of unreality, and the intangible. In this way, Mrs. A., a 33-year-old schizophrenic,[46] would and weep with the worker, and was able to tell her of her hopes and fears; but the "silliness" typical of her illness would prevent her from seeking out the worker

for/....

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46. See Glossary, page 457, for definitions of psychiatric terms used in the text.

for help, though when she was with the worker she would ask for this. Many, though not all, psychotics appeared to have just such working, warm, meaningful, yet superficial or fluctuating relationships with the worker.

(c) Fair. This type of relationship can best be described as falling midway between good and poor, the next category, and as containing elements of warmth in it, but less trust, and a feeling on the part of the worker that she was making contact with the patient, but perhaps not -

(i) deeply and penetratingly; or

(ii) to a degree of great warmth; or

(iii) with great liking of each party for the other.

Mrs. B., a depressed patient of 54, seemed to have little emotion over for contacts with others. She responded positively to the worker's efforts to assist her, and warmth was expressed in terms of acknowledgment of the worker's presence and an attempt to communicate with her; but she was too depressed to be able to throw herself into a relationship with the worker, and while appearing to be pleased to see her, showed no great liking for her. The worker, though filled with pity for her, did not respond to her in any other manner. Thus, such a relationship is a fairly adequate working one, but not deeply meaningful to the patient.

(d) Poor, where the relationship appears to be:

(i) very superficial, or "contact" cannot be made; and/or

(ii) where/....

(ii) where interaction takes place between the worker and patient, but this is emotionless and directionless, and nothing seems to "happen" in the interview; or

(iii) the patient shows marked negative feelings toward the worker;[47] or

(iv) there seems to be a conflict or incompatibility of personalities between patient and worker;[48] or

(v) the worker is unable to fulfil the expressed and/or unexpressed needs of the patient, and this seems to lead to feelings of misunderstanding and rejection on the part of the patient; or

(vi) where the worker purposely did not fall in with the patient's request, and was supported in this by the doctor because the request was asocial or against hospital rules or policy, and where such action resulted in (ii).

(c) This/....

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47. Of course, the expression of negative feelings is not necessarily "bad," and does not, per se, indicate a poor relationship. The expression of such emotion may indeed be an indication of the strength of the relationship or one may find that a patient who has expressed extreme hostility towards a worker returns at a later date because he has felt that the worker has helped him (be it by accepting him, by enabling him to speak out, or for one of many other reasons), or that he has gained something, of which he desires more, from the contact. However, for purposes of this study, the strong expression of negative feelings towards the worker was regarded and classified as "poor," because the relationship actually or apparently in existence at the time was assessed, and this seemed at the time to be such.

48. In such cases it is often best for the worker to acknowledge this and seek transfer of the case to another worker, with, if possible, discussion with the patient of the reasons for this, to alleviate feelings of rejection in the patient.

This latter category is perhaps most applicable to the so-called psychopathic personality, or to those patients who "go along with" the worker as long as she does what is requested of her, but, in the face of firmness or resistance to manipulation on the part of the worker, express malevolent invections against her, or become aggressively demanding and/or obstructional.

While Mr. C., aged 27, was being assisted with various financial matters, he began to use the services of the typist in the social worker's office for his private correspondence. When it was pointed out to him that this was not permitted, he became sullen and resentful. Attempts to discuss the matter with him were unsuccessful in reviving what had been a "good" relationship, and consultation with the doctor confirmed the worker's feeling that she should not "go along with" Mr. C. He then became so aggressive that the worker subsequently could not see him alone, and contact was terminated on the advice of the doctor.

Miss C., too, related well to the social worker until it became apparent that the social worker, though accepting her, was not hoodwinked by her apparent charm, and would not be manipulated by her. The ensuing interaction was characterized by negative feelings, which the worker could overcome, on the part of the patient.

Inability to find a point of contact characterized the worker's relationship with Mrs. D., an immigrant, who could not understand why the worker had come to

see/....

see her, and with whom communication was made difficult because of her fear of interference by an outsider.

(e) Nil - where the patient was not seen at any stage, but contact was made with relatives or friends. No attempt was made to assess strength of relationship with these latter, as insufficient data were recorded, and it was felt, in addition, that this would add too greatly to the complexity of the study.

(f) The symbol X was used to denote an inability by the worker to make a judgment due to the existence of insufficient evidence in the record, or where the writer was unable to assess the nature of the relationship because of the nature of the illness. Although a relationship existed, for instance, with a grossly disturbed patient, the positive or negative aspects of the patient's "true" relationship with the worker could not be clearly assessed. An example of the latter was Mr. D., a schizophrenic certified to a mental hospital, who reacted to the worker, but whose illness made it impossible to assess relationship per se. Mr. E., on the other hand, was seen only fleetingly and no note made in the record about his reactions or attitudes to the worker.

The research instrument was now, hopefully, ready for use. A list of 16 functions, some containing sub-sections, had emerged, and was ready to be used in analysis of the 88 case records selected. Unlike

Berkman's/....

Berkman's[49] and Knee's[50] classifications, the present system did not group services together in forms of time or stages in the patient's hospitalization when such services were rendered (pre-admission, reception, during treatment, discharge, etc.), but grouped them according to type of service, no matter when rendered, and the only "time-related" category was that of after-care. A section dealing with relationship had been carefully defined and added to the list as a last section.

One of the limitations of the system was that it dealt only with direct functions to patients, and did not cover any of the "facilitating" or indirect services to patients.[51] However, it was decided that this was not a serious limitation, as discussion of such functions was to be a subsidiary part of the thesis and so they did not have to appear in the main research instrument. The scheme was thus ready for application, and the testing of its reliability.

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49. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953: pp. 35 - 52.
50. Knee, R.I. (Ed.), Better Social Services for Mentally Ill Patients, Amer. Assocn. of Psych. Social Workers, 1955: p. 47.
51. See "Scope of the Study," Chapter I, page 2.

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C H A P T E R IV.

THE CONTENT ANALYSIS.

Although the classification system for use in the analysis of the case records had been carefully worked out, analysis into the various categories listed still depended on the judgment of the researcher. While Mary Macdonald states that "considerable interest has recently been manifested in the use of professional judgment in social research, including those made by the worker covering the case,"[1] this was seen by the present worker as one of the major limitations of the study, and confirmed as such by Miss Macdonald when, in a different article, she wrote: "The worker who carried the case brings the most knowledge to bear on the judgment, but he also has the greatest investment in the outcome, and consequently his judgment is naturally suspect."[2] One of the solutions which Miss Macdonald offers to this problem is that of "judgments by the worker and an independent reviewer,"[3] stating that this is a less expensive method of testing reliability than many others, and, most importantly, that "if there is a high degree of reliability, we may have confidence in the results."[4] In view of these comments, it was decided that this method of determining repeatability of results would be adopted after the application of the system. That the instrument

was/....

1. Macdonald, M.E.: "Research in Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960, N.A.S.W., N.Yk.; 1960; p. 508.
2. Macdonald, M.E.: "Some Essentials in the Evaluation of Social Casework," Jnl. of Psych. Social Work, Vol. XXII, No. 3, April 1953; p. 136.
3. Ibid., p. 137.
4. Ibid., loc. cit.

was indicating what it purported to indicate, i.e., social work function, was already accepted.[5]

A. THE RESEARCH ANALYSIS.

The drawing up of a record sheet on which function could be noted down during the analysis of the case records was accomplished by placing the names of patients in a column down the right-hand side of a broad sheet of paper. On the top horizontal "axis" of the paper were written in, by code numbers[6] and in columns, the various functions of the social worker as listed in the classification system. This is illustrated by Figure I, below.

FIGURE I - FORMAT OF THE ANALYSIS SHEET.

Name	1(a)	1(b)	1(c)	2	3	4	Etc.→	17	Age	Sex	Etc.→

The constants of the research (age, sex, etc.) were also reflected in columns on the sheet and, in addition, it was decided to make notes from the records of certain other information which might be of interest. There was thus finally a column, in addition to name of patient and categories 1 - 17, for each of the following: age of patient, sex, marital status, religion, residential area, occupation, financial

position/....

5. See Chapter III, pages 47 and 48.
6. Each function was simply given, as its code number, the number it held in the classification system. Thus 1(a) signified financial assistance relating to government grants: (15) signified after-care, etc.

position (hospital classification[7]), whether or not patient had a family, diagnosis on this admission, patient referred to social worker by (doctor, nurse, himself, etc.), problem for which referred, number of previous referrals to Social Welfare Department at any time,[8] number of previous admissions to hospital for a psychiatric illness, whether or not patient had attended at the Out-Patient Department prior to this admission, and length of hospital stay on this admission.

The scoring[9] on marking system was simple. Where function was regarded as having taken place in regard to a patient, a tick (✓) was made in the appropriate column. As noted previously,[10] help to the family was not adequately shown if only the column relating to this indicated such help. It was therefore decided to mark this column with a tick (✓) where the family had been seen about the patient, and to mark in the appropriate column, by the symbol F, such help as was rendered to the family per se. Thus, a patient might be referred for help with work, and during the course of working with the patient his wife be seen about him (e.g., in an effort to explain the nature of his illness). If, during this contact, she was referred

for/....

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7. See Chapter V, page 111, for details of categories. As details of income were missing in many cases, hospital classification was considered a reliable indication of income group as it is based on annual income of patients.
8. Some patients might be found to have been referred on most admissions, others not.
9. Although the term scoring is perhaps not used here in a completely correct way, it seemed the best word to describe what was meant.
10. Chapter III, page 59.

for a food parcel for herself and the children, the following functions would appear on the scoring sheet;

FIGURE II - SCORING SYSTEM.

Name:	1(a)	1(b)	1(c)	2	3	4	5	6	7	8(a)	8(b)	9(a)	9(b)	10	11	12	13	14	15	16	17
Jones Mr. A.		F			✓									F[a]			✓[a]				Good[b]

a. While the markings under 1(b) and 3 are clear, a note of explanation is necessary about 10 and 13. Because the wife was seen about the patient, 13 was marked with a tick (✓); however, the record showed also, much discussion and explanation with her about various problems, and thus 10 was also marked (F). Other function to the patient is not shown, as the main purpose of this figure is to show scoring of help to the family.

b. Relationship with the patient is noted and fully written in.

The "factual" information appearing on the marking sheet was not coded at this stage, as it was felt that there might be some loss of detail if this were done on the scoring sheet. Thus each column was headed by the name of the item which it recorded, and neat notes were made in each column of such information obtained from the record.

FIGURE III - RECORDING OF FACTUAL D.I.

NAME	1-17	Age	Sex	Mar. Status	Relig.	Res. Area	Occup.	Hosp. Class[a]	Fam.	Diagnosis on this adm.	Ref. by	Prob for which ref.	No of previous ref. to S.W.	Previous address for Psych. illness	O.P.D. attendance	Length of Hosp. stay this adm.
JONES Mr. A.		35	M	M	C/E	Jappe	Unemploy-ment.	P/PE	Yes.	Depression	Doc.	Employ-ment.	1	1	No	3 Weeks

a. See Chapter V, pages 111, foll.

It was decided that two separate analyses of the case records would be done, in order to check the consistency of the worker's judgments, and the degree

of/....

of agreement[11] between two applications of the same classification system. It seemed that, if agreement was high between the two, this would indicate some reliability of the system in indicating social work function, and that if an outside observer, using a sample of the same case records, obtained a high degree of agreement with the researcher's results, this would be a further indication of reliability of the system, in keeping with Macdonald's comments, quoted above.

For the first analysis, all the records were placed in alphabetical order and each one then carefully examined for function, which was entered on the analysis sheet in the manner described above.[12]

A/....

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11. The term "correlation" is not used in the text to describe amount of agreement indicated, as it is considered to have too technical a meaning, and one not really applicable here. "Agreement" was used in its stead. (Kerrich, Professor J.E., Department of Statistics, University of the Witwatersrand, Johannesburg, personal communication, August 1964). Further, where the term "significant" is used in the text, this does not indicate "statistical" significance but qualitative significance.
12. Only those parts of the record were analyzed which dealt with services rendered by the social worker following a patient's admission after March 1st. Thus, where a patient had been seen in January, 1963, and seen again in March after a second admission in that month, only content for that admission was analyzed, not content covering the first admission. Similarly, cases were analyzed only from the point at which they were taken over by the researcher from another worker, and only up to such time as they were transferred by her to another worker. Because the researcher resigned from her post in the psychiatric unit on 31.12.63., records were analyzed only to this point; this did not apply to those already closed at this stage, and it did not appear that it would bias content of the few cases still in progress. Elsewhere it has been pointed out that analysis was not stopped at the end of August, 1963, as this would have cut off a great many cases in the sample with whom work was just starting.

A total of 644 functions evolved from this procedure. Only after each record had been analysed for function was the "factual" information extracted, as it was felt that, if this information was noted during the content analysis of function, it would distract the researcher's attention from this main work. As the analysis was carried out approximately one month after the "trial run," and as the files here were completely differently ordered, it was felt that there was no "carry-over" from the trial run to the first "real" analysis.

In order to avoid the influence of memory in the second analysis, this was carried out one week after the completion of the first.[13] Also, the analysis sheets seemed to indicate an increase of function for those cases falling in the middle of the group, and a decrease at either end, and it was questioned whether the fairly low scoring at the beginning was due to lack of practice on the part of the worker, and that at the end too tiring. In order to control this, the second analysis was started in the middle of the group, i.e., at case number 44 on the alphabetical list. Each record was then carefully scrutinized, as though it had never before been analyzed, and entered onto a new analysis sheet. A total of 639 functions resulted from this procedure, all falling into approximately the same "scatter" as those of the first analysis. Practice and tiring were therefore

eliminated/....

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13. Both analyses were completed in February and March, 1964, in order to comply with the comments made (Chapter II, page 25) about memory reliability.

eliminated as forces having any bearing on the scoring.

These 639 markings were then transcribed, in colour, onto the first analysis sheet,[14] and it was found that they coincided with 605 of the 644 markings on the original sheet. This left 39 of these first markings and 34 of the second markings scored only once. Expressed differently, the first analysis sheet now had a total of 678 marks of any kind shown on it. Of these, 605 were double markings, indicating concurrence in function scored in both analyses. However, 73 were single markings, made up of 39 scored in the first analysis but not in the second, and 34 scored in the second analysis but not in the first. These latter 73, then, showed disagreement between the two analyses, and the first 605 showed agreement.

If 678 is regarded as the total number of functions scored, i.e., as 100% of all markings on the sheet, then 605 of this total is 89.23%.[15] In other words, there was 89.23% agreement between the scores in the two analyses. Thirty-nine, or 5.75% of functions, were scored in the first analysis only,

and/....

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14. Thus:

1(a)	1(b)	1(c)	2	3	4	5	6	7	8(a)	8(b)	9(a)	9(b)	10 →
✗			✗	✓	✗				\		✗		

✗ = Agreement.
✓, \ = Disagreement.

15. Percentages worked to the nearest decimal point.

and 34, or 5.02%, in the second analysis only. Thus the total of 73 markings which did not coincide resulted in a 10.77% disagreement between the two analyses.

TABLE III - PERCENTAGE AGREEMENT AND DISAGREEMENT ON FUNCTION BETWEEN TWO ANALYSES - RESEARCHER.

	No. of Markings.	%.
Total.	678	100.00%
Agreement.	605	89.23%
Disagreement.	73 (39 + 34)	10.77% (5.75%+5.02%)

The likelihood of this high rate of agreement between the two analyses being due to chance was infinitesmal,[16] and the figures indicated a measure of real, but not perfect, agreement, showing that the system reflected reality and hence could be considered useful as an instrument for assessing social work function in this unit.[17]

Relationship with each patient was assessedfrom the records during both analyses, and agreement on this between the two runs was found to be slightly less than on function. Thus, of the 88 patients rated for relationship, there was agreement between the two sets of ratings on 69 or 78.41% of patients and disagreement on 19 or 21.59%. The reason

Table/....

16. Kerrich, Professor J.E., personal communication, August 1964. According to Professor Kerrich, no test of significance was readily applicable to these figures, but chance concurrence to this extent was highly improbable, and reliability could therefore be accepted.
17. Kerrich, Professor J.E., idem.

TABLE IV - PERCENTAGE AGREEMENT AND DISAGREEMENT IN ASSESSING RELATIONSHIP - RESEARCHER.

	No. of patients.	%
Total	88	100.00
Agreement	69	78.41
Disagreement	19	21.59

for this lower rate of agreement is possibly that the assessment of relationship was global: had each record been rated on the presence or absence of factors considered to make up a good, poor, etc., relationship, results might have shown greater agreement. But this percentage agreement was nevertheless accepted as showing consistency in judgments by the worker, and as being a useful indication of the reliability of the scheme for assessing relationship.

When the 19 "incorrect" scorings were reviewed, it was found that eight differences could be accounted for in terms of "pure error" in the first trial, i.e., these eight were given ratings when in fact they should have been classified under X or nil (inability to make a judgment, or patient not seen) or vice versa. Of the remaining 11, eight classifications were in "lower" categories and three in "higher" categories than during the first assessment. The trend during the second assessment was thus to under-rate rather than to over-rate quality of the relationship.

Of the eleven "non-error" changes noted, one was from very good to good; three from good to fair; four from fair to poor; one from poor to fair; and two from good to very good. Thus, there were no changes greater than one step interval, and this seemed to

indicate/....

indicate that possibly the intervals were too close to one another or not clearly enough defined. However, it indicated, on the other hand, that judgment of the researcher did not differ grossly from one assessment to the next, and was a further indication of consistency and reliability of the method.

TABLE V - TYPES OF CHANGE IN ASSESSMENT OF RELATIONSHIP.

1st Assessment.	2nd Assessment.	No. of Total
Lower		
Very Good	Good	1
Good	Fair	3
Fair	Poor	4
Higher		
Poor	Fair	1
Good	Very Good	2
	"Pure" Errors	8
	Same in both	69
	Total:	88

However, these high rates of agreement by the researcher with herself were not considered sufficient to show reliability of the classification system, and it was felt necessary to see whether an independent judge obtained similar results.[18] Further, because "even where a researcher achieves highly reliable judgment based on case records, these judgments are only as accurate as the record permits, "[19] it appeared that, if such an independent worker obtained similar results, it would further justify the use of these records as the basis of the research.[20]

b. Testing/....

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18. I must at this point record my very sincere thanks to Mrs. A.B. Orsmond, of the Social Welfare Department, General Hospital. Not only did she give unsparingly of herself and her time in assisting with this part of the research (which could not have been carried out without her help), but she also gave continued encouragement and other assistance to the writer throughout the project.
19. Shyne, A.W.: "Evaluation of Results in Social Work," Social Work (N.Yk.), Vol. 8, No. 4, Oct. 1963; p. 29.
20. See discussion Chapter II, pages 20 - 26.

B. TESTING RELIABILITY.

The social worker at the time holding the psychiatric social work post at the Johannesburg Hospital was approached, and she agreed to analyse a sample of records for function. As an "old" member of the Social Welfare Department of the Hospital this worker, while dealing with wards other than the psychiatric ones, had been one of those involved at the start of the study in drawing up the lists to form the basis of the classification system.[21] However, it was felt that this would not influence her use of the scheme, as much had been changed in it since those early beginnings. Further, her experience in the field was sufficient at that time (she had held the post for some three months) to make her familiar with it, and to enable her to understand it, but not yet sufficient to make her so familiar with it that this would bias her interpretation of categories or make her project into the records data which were not there.

A sample of 10 cases was randomly drawn for her analysis,[22] but before these and the classification system were given to the independent worker, a session of about one hour in length was spent with her, during which time all points in the system were elaborated and re-defined for her, hypothetical examples were given to illustrate these where necessary, and the scoring system was carefully explained. She was asked, in addition, to assess degree of relationship from the records, and the categories were delineated for her,

again/....

21. Described in Chapter III, page 48.
22. Every twelfth case record (an arbitrary number) was chosen.

again with examples. She then took the case records away and analyzed them on her own, once each.[23]

Of the 94 "function" markings made by the independent judge and the 88 such markings (for the same cases) made by the researcher, 78 coincided [24] and 26 differed (16 independent judge; 10 researcher). Thus, of the 104 combined markings appearing on the sheet after transcription, 78, or 75%, showed agreement and 26, or 25%, showed disagreement.

Table/....

23. The confidentiality of records was here not considered to have been violated, as this worker was the person who had taken over the researcher's work, had access to all such records in the social worker's office in any event, and would possibly see many of the research group of patients at a later date (it so happened that none of the case records analyzed by her at any time were of patients already known to her).

24. The markings by the researcher were superimposed on those of the independent worker; this meant that the combined markings of the researcher were compared with the single markings of the independent worker. Thus:

1(a)	1(b)	1(c)	2	3	4	5	6	→
✓\		✓\	✓	\	✓\	\	✓\	

✓, \ = Researcher, \ = Independent Judge

It was decided that where all three markings (as in 1(a)) or two of the three markings (as in 1(c)) coincided, this would be regarded as concurrence; where each worker had no marks agreeing (as in (2), (3) and (5)) this would be considered disagreement. This was in some respects an arbitrary decision, but in others based on the rationale that agreement on two of the three could not be disregarded, and that such agreement confirmed the performance of such a function, even though only recorded once by the researcher.

TABLE VI - PERCENTAGE AGREEMENT AND DISAGREEMENT ON FUNCTION BETWEEN RESEARCHER AND INDEPENDENT JUDGE (GROUP I).

	Number of markings	%
Total	104	100.00
Agreement	78	75.00
Disagreement	26 (10 + 16)	25.00 (9.62 + 15.38)

The likelihood of the agreement between the two analyses being due to chance was again regarded as infinitesmal,[25] and the figures were therefore accepted as indicating the reliability or repeatability[26] when the classification system was used by an independent judge. It seemed to indicate, further, that the system was specific enough to prevent gross differences due to misunderstanding of categories and individual attitudes of separate judges, and that inter-judge reliability was also high for the system.

However, the agreement between the two workers was slightly lower when relationship was considered. Of the ten patients assessed on this, there was total agreement between the two workers on only five. Three differed completely, and in two the researcher had in her two assessments given two different ratings, with one of which the independent judge had agreed. The same system of scoring was supplied as before,[27] and the agreement reflected on the above was 70%, while disagreement was 30%. This still reflected a high rate of agreement, but

in/....

25. See footnote 16, page 77.
26. Kogan. L.S.: "Principles of Measurement," in Polansky, N. (Ed.), Social Work Research, N.A.S.W., N.Yk., 1960; p. 99.
27. See footnote 24 of this chapter, page 81.

TABLE VII - PERCENTAGE AGREEMENT BETWEEN RESEARCHER AND INDEPENDENT JUDGE IN ASSESSING RELATIONSHIP (GROUP I).

	Number of patients	%
Total	10	100.00
Agreement	7	70.00
	(5 + 2)	(50.00 + 20.00)
Disagreement	3	30.00

in spite of both results the independent judge felt that she had been doubtful of some points in the scheme and in scoring, and should do a second analysis on a further group of records. After discussion of the points with which difficulty had been experienced, a further ten case records were sampled.[28] This, it seemed, would also give a better indication of reliability, as ten was, in fact, a very small sample of the group and if similar results were obtained on a further ten (i.e., 20 in toto), these would lend greater weight to any conclusions drawn about the system.

The results which were obtained on the function analysis of the second ten records were, in fact, almost identical. Of the 79 markings made by the independent judge, and the 80 markings made by the researcher, 68 coincided and 23 differed (11 independent judge; 12 researcher).[29] For the combined 91 markings on the

paper/....

28. This was again randomly done, continuing with every twelfth case until the ten were selected. It may seem questionable that from 88 cases 20 could be selected in this manner, but this was done by repeating the list from beginning to end as though it was one long list. Thus 1 - 88 - 1 - 88 - 1 - 88.

29. The similarity in numbers not concurring indicated a possibility that these functions might be the same functions but differently classified. As the degree of concurrence was already high, however, this was not investigated further, though had this been found to be so, it might have indicated high inter-judge reliability as regarded recognition of function, and the existence of one or more categories in the scale which were not sufficiently clearly defined.

paper, there was therefore 74.73% agreement, and 25.27% disagreement.

TABLE VIII - PERCENTAGE AGREEMENT AND DISAGREEMENT ON FUNCTION BETWEEN RESEARCHER AND INDEPENDENT JUDGE (GROUP II).

	Number of markings.	%
Total	91	100.00
Agreement	68	74.73
Disagreement	23	25.27
	(12 + 11)	(13.19 + 12.09)

The difference of less than 0.50% between the two sets of markings by the independent judge was considered insignificant, and seemed to indicate that the training given to the independent judge on the first analysis had had little or no effect.

On relationship, however, there was a big drop in score. There was agreement between the two assessors in only five of the ten cases and disagreement between them in five. Thus the percentages of agreement and disagreement were identical, each being 50%. The possibility of chance being responsible for whatever agreement occurred here could not be ignored.

TABLE IX - PERCENTAGE AGREEMENT BETWEEN RESEARCHER AND INDEPENDENT JUDGE IN ASSESSING RELATIONSHIP (GROUP II).

	Number of patients.	%
Total	10	100.00
Agreement	5	50.00
Disagreement	5	50.00

However, certain other factors might also have come into play. On so small a number of records, the possibility of one or two of the judgments being extremely difficult might have introduced bias in that the one or two formed a greater proportion in this

size/....

size sample than they would have in a larger sample, where they would have passed almost unnoticed.[30] Further, in assessing relationship, inferential judgment was used to a much greater extent than in analyzing functions, as the latter were more clearly defined and also more easily recognizable in the record, whereas the nature of a relationship, in addition to being a far more subjective quality, was often not clearly indicated in a record, The inferential judgment which these factors necessitated may have introduced unreliability in the judgments[31] of relationship, and may also explain why theagreement here was lower than for function. Further, training of, and instructions to, the judge might not have been adequate on this point, and this emphasises the necessity, also, of defining terms and qualities clearly, All the above does not explain why the first group showed a higher degree of agreement on relationship than the second, and no "real" explanations can be given except the ones tentatively offered above. It might, however, be added that the higher degree of agreement by the researcher with herself than with the independent judge might have been due to the fact that the researcher, having been involved in the relationships, was more likely to give the same assessment of a relationship in two separate trials than was the independent judge, who had to base her judgment on the

case/....

30. This, of course, is the basis of random sampling, however.
31. Young, C.W.: "The Quality of Judgment about Patient Communication Based on the Case Record," Abstract of thesis in Smith Coll. Stud. in Social Work, Vol. XXIX, No. 2, Feb. 1959; p. 141.

case record only. This may indicate a basic lack in material in the case record, which the researcher was able to fill in, but the independent judge was not. In general, therefore, this low score did not necessarily indicate that the categories or scheme used in assessing relationship were invalid, but could have been due to this lack in the information to be analyzed.

In spite of the above, it was decided to combine the two groups of ratings by the independent judge, as additional training had not seemed to have any effects,[32] and to see what amount of total agreement and/or disagreement existed between her analyses and those of the researcher. The adding together of the markings resulted in a concurrence of 146 points out of the total of 195 marked, and a divergence of 49 markings (27 independent judge: 22 researcher). The percentage concurrence was 74.87%, and divergence 25.13%.

TABLE X - PERCENTAGE AGREEMENT AND DISAGREEMENT ON FUNCTION BETWEEN RESEARCHER AND INDEPENDENT JUDGE. (COMBINED GROUPS I & II).

	No. of Markings	%
Total	195	100.00
Agreement	146	74.87
Disagreement	49 (23 + 26)	25.13 (11.63 + 13.50).

Combination of the scorings on relationship gave a total

agreement/...

32. This is contrary to the results of Hunt and Kogan, who found that training improved judgment of their workers. (Hunt, J.McV., and Kogan, L.S., Measuring Results in Social Casework, F.S.A.A., N.Yk., 1952; p. 20).

agreement of 12 out of 20, and disagreement of 8 out of 20.

TABLE XI - PERCENTAGE AGREEMENT AND DISAGREEMENT ON RELATIONSHIP BETWEEN RESEARCHER AND INDEPENDENT JUDGE (COMBINED GROUPS I & II).

	No. of patients	%
Total	20	100.00
Agreement	12	60.00
Disagreement	8	40.00

The possibility that these degrees of agreement on function between the researcher and the independent judge could be due to chance was, again, regarded as infinitesmal,[33] and even the slightly lower percentage of agreement on relationship was not considered to negate the reliability of the judgments or of the system as a useful instrument for assessing function and degree or kind of patient - worker relationship. The results obtained by the researcher had been able to be repeated to a significant degree,[34] and the necessity of "demonstrating reliability where the data are composed of inferences and made by one person[35] had been met, while it appeared that the categories of the system could be identified and applied with a fair high degree of accuracy by an independent judge.[36]

In/....

33. Vide remarks on page and footnote , page
34. That results can be replicated or verified is an important principle in any research project. (Levitt, E.E.: "The Basic Philosophy of Experimentation," Smith Coll. Stud. in Social Work, Vol. XXX, No. 1, Oct. 1959. pp. 64 and 161.)
35. Steinzor, B.: "The Development and Evaluation of a Measure of Social Interaction." Human Relations, Vol. 2, 1949; p. 11+.
36. Ibid., loc. cit.

In a final view of the total system and its applicability, it thus appeared that it was a useful indication of function and relationship, and could be applied reliably by one or more workers. Results obtained by the writer with herself or by the writer with an independent judge showed a considerable amount of agreement, signifying that, in terms of the comments made by Mary Macdonald, and quoted at the beginning of this chapter, the system and its results could be accepted with confidence.[37]

The two analyses of function described above were therefore used as the basis for describing the functions of the social worker in the Psychiatric Unit of the Johannesburg General Hospital, as it appeared that they did in fact, reflect such practice and function. Those functions noted by the independent judge were not included in describing function, as they had been intended for use only in assessing reliability and formed no part of the actual content of the study. The next chapter will deal with general characteristics of the patients in the group analyzed, and the detailed information about social work as carried out in relation to such patients in such a unit, and drawn from the analyses, will follow in the succeeding chapters.

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37. Macdonald, M.: "Some Essentials in the Evaluation of Social Work," Jnl. of Psych. Social Work, Vol. XXII, No. 3, April 1953, as quoted on page 70 of this chapter.

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C H A P T E R V.

THE PEOPLE OF THE STUDY - SOME SOCIAL CHARACTERISTICS.

Working with people is a dynamic, changing, moving kind of working, and cannot take place without some knowledge and understanding of the people with whom the work is being done. So, with a view to providing the background necessary to knowing those to whom social work help, as analyzed, was given, the "factual" information on the analysis sheet was collected.

A. AGE.

The first characteristic which was investigated in the group was that of age. This was taken for each patient as age at time of seeing the social worker, because it seemed that this was the age at which problems were being experienced, at which contact was made with the social worker, and interaction took place. So, although it was realized that calculation of age for each patient at, for instance, 31st December, 1963, would have given a slightly more uniform picture of this attribute, it seemed that any slight differences which might occur through not doing this would not be of any importance, and it was decided to use the more dynamic basis for this estimation.[1]

When patients were grouped into age categories, it was found that the majority of the sample were

between/....

1. For patients who saw her more than once in the period March 1st, 1963 - August 31st, 1963, age was taken as that at first contact.

between 20 and 39 years of age, there being 26 patients of 20 - 29 years, and 24 of 30 - 39 years. The next biggest group was that of 40 - 59 years old, Twelve patients fell into the 40 - 49 year-old group, and 14 into the 50 - 59 year-old one.[2] Below 20 and above 59, there were only a sprinkling of patients - five 19 years or less, and seven 60 years or more. This last group was divided into those 60 - 69years old (four patients) and those 70 years of age or more (three patients). While the youngest patient was a lad of 14, the oldest was a man of 86,[3a,b] and the average age for men and women combined was 37.57 years. There were many more.patients under 39 years of age

TABLE XII - AGE GROUPINGS OF ALL PATIENTS.[a]

Age in Years:	Total Group.		Male.		Female.	
	No.	%.	No.	%.	No.	%.
19 and under	5	5.68	2	4.55	3	6.82
20 - 29	26	29.55	13	29.55	13	29.55
30 - 39	24	27.27	15	34.09	9	20.45
40 - 49	12	13.64	4	9.09	8	18.18
50 - 59	14	15.91	8	18.18	6	13.63
60 - 69	4	4.55	1	2.27	3	6.82
70 and over	3	3.41	1	2.27	2	4.55
Total:	88	100.01	44	100.00	44	100.00

a Although it is realized that "totals" should form the last column of the table, the columns were arranged in present order as this was the order in which they were discussed in the text. To maintain consistency this order will be used throughout the text.

than 40 years of age - 55 in the first group and 33 in the second, i.e., 62.5% and 37.5% respectively. Thus approximately two-thirds of the group were less than 40 years of age.

A/....

2. It is interesting that this so-called "menopausal" age group showed a slight increase in numbers.
3a. Fourteen is the minimum age of admission to this hospital. Younger patients are treated at the Transvaal Memorial Hospital for children.
b. The age span of patients in the wards is thus
c considerable, and the effect of this experience on a young person should be borne in mind.

A similar picture obtained when the ages of men and women were viewed separately. Among the male patients, 28 fell within the age group 20 - 39, and among the women 22. A total of 30 men were below 39 years of age, and a total of 14 were 40 years or more, i.e., 68.18% and 31.82%, respectively. The youngest in this group remained the boy of 14, and the oldest the man of 86, with an average age for the group of 36.39 years, In the group of women, 25 or 56.82% were below 39 years of age, and 19 or 43.18% above 40 years of age. The youngest woman in the group was 18, and the oldest 80, while the average age of the group was 38.75 years. Thus, although the general trend between the two groups was the same, the actual age categories into which men and women fell were somewhat different. The different age groupings between males and females are shown also in Table XII above.

Consideration of this table shows, further, that most men fall into the 30 - 39 year age group, while most women were within the 20 - 29 year age group. However, the number of men in this latter group was identical to the number of women. Among the men, just over two-thirds were 39 and under, while, among the women, only slightly more than half were 39 years of age or less.

These figures merit discussion on two separate points. In the first instance, the incidence of mental illness was found by Landis and Page, in a study of mental illness in the United States of America and

Europe/....

Europe, to increase with age,[4] while Elliott and Merrill report a similar trend in suicide rates,[5] a sub-category of mental disorder. The figures presented here do not correspond with this general trend, and it is interesting to postulate why the younger age groups are better represented than the older. It is possible that the policy of selection, in Casualty, of cases for admission results in the referral elsewhere of those who cannot benefit from treatment in this sort of unit.[6] There may thus be a tendency for younger patients to be admitted. It may also be, however, that the sample was so specifically chosen[7] that it is not representative of

the/....

4. Landis, C., and Page, J.D., Modern Society and Mental Disease, Farrar and Rinehart, Inc., N.Yk., 1938; p. 28.
5. Elliott, M.A., and Merrill, F.E., Social Disorganization, Harper & Bros., N.Yk., 1950. p. 308.
6. See discussion on Casualty Service, Chapter I, page 13.
7. See comments on this in Chapter III, page 42, footnote 12. When the ages of the original 346 patients (including readmissions) sampled from 1.3.63. to 31.8.63. were grouped, it was found that the following emerged:

	19 years and under	20-29 years	30-39 years	40-49 years	50-59 years	60-69 years	70 years and over.
Male	9	46	68	27	16	12	4
Female	7	37	33	33	16	10	8

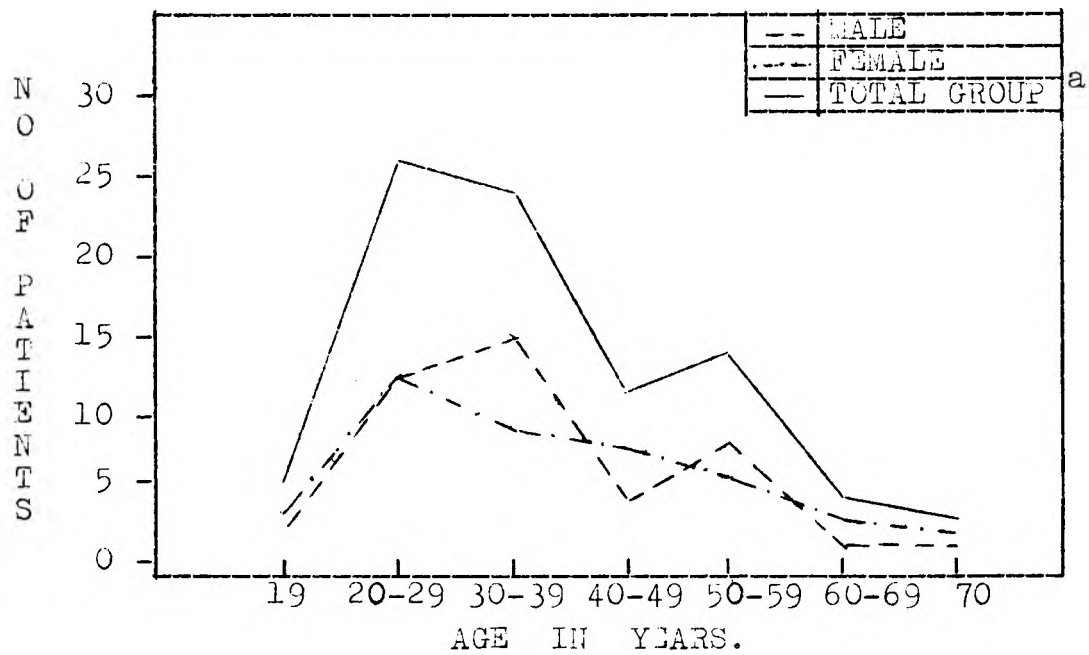
These groupings showed that the younger age groups were again predominant. Although there were about a third again as many men as women (199 to 147), the difference between the two sexes tended to be roughly the same. Thus, there were proportionately more men under 39 years of age than there were women (123 to 77), and proportionately more women over 40 years than there were men (67 to 59). Further, the greatest cluster of men was in the 30 - 39 year age group, and of women in the 20 - 29 year age group. That the groupings found in the sample tend to follow the same age groupings as the larger sample seems to indicate, however, that the "final" sample is not biased as regards age.

the population of patients admitted to the two psychiatric wards, and this age distribution has occurred only by chance. Again, the old and/or senile are often brought to hospital with a presenting medical, rather than psychiatric, complaint, and this may result in many of these older patients being admitted directly to medical wards and discharged without transfer to the psychiatric ward, though with psychiatric consultation in the medical ward and help from the appropriate social worker. Again, the fact that psychiatric treatment in a general hospital does not attach stigma to the patient, may tend to attract those who feel there is something wrong, bu would be loathe to attend elsewhere for treatment, and who might otherwise wait until much later to seek help. This may result in younger patients attending of their own accord, and may also induce families to bring their sick to the hospital earlier.

The second point of discussion is that the average age of the women tends to be higher than that of the men. When age for the two groups is plotted graphically, the following picture emerges, showing female ages to be higher than male ones for four of the age periods, lower on two,

Figure/....

FIGURE IV - GRAPH SHOWING AGE GROUPINGS OF MALE AND FEMALE PATIENTS.



a This is added for interest, and to show the general age trend of the total group.

and the same on one. This generally higher age level in the women again raises the question, touched upon by Landis and Page,[8] and by the present writer,[9] of whether more women than men have families, and hence are cared for at home at least until they are older and/or the problem has become one which the family no longer can handle. Further, the question arises of whether mental illness in women tends to occur later than in men,[10] and this, in turn, leads to the query of whether different illnesses, with different ages of onset, afflict men and women. That differences do exist in the types of illness affecting the two sexes is accepted, and may account for this to some extent.

Cerebral/....

8. Landis, C., and Page, J.D., op. cit., p. 31.
9. This chapter, page 125.
10. Landis, C., and Page, J.D., op. cit., p. 77, state that there is an earlier onset of mental disease in men than in women.

Cerebral syphilis, alcoholic psychoses, and alcoholism without psychosis tend all to occur somewhat more in men than in women, but the senile psychoses, involutional melancholias and manic-depressive psychoses, as well as perhaps the psychoneuroses to a lesser extent,[11] tend to occur slightly more in women.[12] These are mainly illnesses of the latter years. schizophrenia, in bygone years known as dementia praecox because of its early onset and dementing progress, has its highest rate of onset in the age group 20 - 30 years, though schizophrenia of the paranoid type tends to occur somewhat later in life. Schizophrenia tends, further, to have a higher incidence in men in the younger age groups, but to be more frequent among women over 35 years of age, with its principal occurrence still in men,[13] That the diagnosis of psychopathic personality is limited mainly to men[14] may also have some influence on the age levels of the group.

It will be interesting to note, later in this chapter, whether an anlysis of the diagnoses of patients in the sample shows any relationship between diagnosis and age, especially as some of the illnesses mentioned as occurring somewhat more often in women than in men also tend to occur later in life. The slightly higher

number/....

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11. The psychoneuroses are influenced less by sex factors than by sophistication factors, which determine whether the illness will manifest itself in anxiety or hysterical states. (Hurst, Professor L.A., personal communication, August 1963).
12. Hurst, Professor L.A., personal communication, August 1964.
13. Landis, C., and Page, J.D., op. cit., pp. 40 - 41.
14. Ibid., p. 41.

number of women 70 years and over may be due to the greater longevity of women, but is so small in this group that it is hardly worthy of note.

A further point of interest is that of the age groupings round the menopausal ages of men and women. Associated with physical changes, menopause brings with it concomitant psychological changes, one of the most common of these being depression. If one regards the age of menopause in women as being between 40 - 49 years of age, and that of men as being 50 - 59 years of age - because this is the age at which most men have achieved or have not achieved whatever they have set out to do, and at which sudden realization that it is too late to do more, often strikes - the graph on page 94 indicates that both sexes show the same number of patients in this group, viz., eight. This perhaps evens out slightly the differences between the two groups.

However, all the above are merely postulations as to why, in the first instance, the patients in the sample under discussion tend to be younger rather than older, as in the population in general, and, in the second instance, why the women tend to be older than the men, and no final answer to these problems can here be given. Thus, simply <u>to recapitulate</u> while most patients are below 39 years of age (55 or 62.5%), more men than women fall into these years; and among the 33 patients (or 37.5%) above 40 years of age there are more women than men. On the whole, however, the group

is/....

is a younger rather than an older one.[15]

B. SEX.

Sex groupings of the sample have already been indicated in several places as being equal (44 males and 44 females), and the possible reasons for this postulated in terms of the worker's sex perhaps making her seem more approachable to women patients, and her apparent youth possibly making men patients see her less as a social worker than as a young woman, and hence less as a person able to give help. Again, of course, careful selection of the patients may have biased the groups towards equality in numbers, because not only do men show a higher percentage of mental illness than women,[16] but, as was shown earlier,[17] the group of all patients seen by any social worker contained more men (78) than women (62), as did the original sample of 346 patients selected from 1.3.63. to 31.8.64. (199 males: 147 females), and it was only after the last selection that equal numbers emerged.

C. Marital/....

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15. An interesting study would be to investigate whether those patients referred to the social worker are younger than those not referred, as it is possible that there might be some connection between potential "rehabilitativeness" of younger patients and hence their referral to a social worker for such help, where older patients were not referred. This is beyond the scope of the present study, however.
16. Landis, C., and Page, J.D., op. cit., p. 30, on the basis of the general population of the U.S.A. in 1938, give the rate of mental illness in males over 15 years of age as being 34% higher than that for females over 15 years of age. Rates for the different age groups vary from 20% - 50% higher than for women, with the greatest similarity occurring between 35 and 45 years of age (the present sample is grouped in such a way as to prevent assessment of this similarity here) and the most marked differences occurring after 65 years of age.
17. Chapter III, page 37.

C. MARITAL STATUS.

When marital status of the patients in the group was considered, it was found that 28 were married and 60 unmarried, this latter category being used to describe all patients not legally bound to one another, and including single persons, widows, widowers, and divorcees. Married patients living together and separated patients (i.e., those where the legal bonds of marriage were still in force, though the couple might be living apart) were included in the former category. If only patients living with a spouse at the time of admission to hospital were considered married, then only 25 patients fell into this group and 63 fell into the unmarried group, or those single and living alone, or separated from a living spouse. If marriage is regarded as an indication of stability or of some degree of social adaptation, the group would supposedly be showing a considerable degree of social disorganization and mobility. Even when the ten widowed persons are added to the married group living with spouses (because they had at some time in the past been married and might still have remained so if given any choice) this group contained only 35, as opposed to 53, persons. Part of this may also, of course, be accounted for by the number of young persons not yet married at all.[18] The greatest number of

patients/....

18. It might be interesting to investigate whether the number of single persons was proportionately greater than that in the total population, and hence possibly due to the personality instabilities or problems which, it goes without saying, are characteristic of psychiatric patients.

patients in any one category are in fact these single people (31), the next biggest category being that of people married and living together (25). The number of those divorced is also high, this group being the third largest (19), and here it can be noted that a high divorce rate is frequently considered an indication of social disorganization, as also of personal disorganization. The number of persons widowed was 10, while that of those separated was only 3. This latter is possibly an unexpectedly low rate, but if it is postulated that without help, and perhaps even with it, these patients may in time be added to the ranks of the divorced, this raises the divorce rate even higher. The above figures are reflected in the following table.

TABLE XIII - MARITAL STATUS OF PATIENTS.

Marital Status:	Total Group.		Male:		Female:	
	No:	%:	No:	%:	No:	%:
Single	31	35.23	18	40.91	13	29.55
Married	25	28.41	13	29.55	12	27.27
Divorced	19	21.59	11	25.00	8	18.18
Widowed	10	11.36	1	2.27	9	20.45
Separated	3	3.41	1	2.27	2	4.55
Total:	88	100.00	44	100.00	44	100.00

a Never married.
b Married and living together at time of this hospitalization. Any persons cohabiting but unmarried were listed under the group into which they legally fell. Remarriages were not noted separately, where these occurred.

Although Landis and Page report that married patients are the smallest group among the mentally disturbed,[19] the present sample reflects this statement only/....

19. Landis, C., and Page, J.D., op. cit., pp. 69 - 70.

only if all other groups are included under one head. Further, these two authors report that the marital status most frequently found among such patients is that of divorced, followed by single and widowed, and then married.[20] No mention is made of separated persons. The groupings found in the present study are somewhat different, as shown above, and, on the whole, are repeated in the tabulations for men and women.

However, two striking differences do occur - those between widowed men and women, and between single men and women. The greater number of widows than of widowers (9 to 1) may possibly have been one of the factors tending to make the average age of the women in the sample higher, for six of these women were over 53 years of age, two were well into their forties, and only one was less than 40. That widows formed 20.45% of the total group of women is also of note, and though why this should be so can not be interpreted here, it might be explained by inverting the statement above and saying that because the women were on the whole older than the men, more widows might be expected amongst them. It is also interesting to note that if widows are added to the group of married women for the purposes of defining a group were members may be assumed at one time to have known stability and family life, this would bring the total in that group to 21, which is considerably higher than the number of males falling into a similarly defined group, viz., 14: i.e., there would be 50% more

women/....

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20. Ibid., loc. cit.

women in such a group than men. Again, Landis and Page find that, in relation to the general population, more mentally ill women than men are married, and attribute this to the facts that women marry earlier than men, and that men tend to fall ill earlier than women.[21] Further, this makes the group of married women the largest single group, with single men the second largest, and is in keeping with Elliott and Merrill's statement that married women and single men have the highest rates of mental illness.[22] This is completely opposite to the findings of Landis and Page, and presented merely as a possible way of interpreting the above figures.

Although no real explanation is here attempted for this greater number of single men than women, it is perhaps influenced, also, by the tendency of women to marry at an earlier age than men. In a "young" group this is quite possible. However, in spite of this, only 15 of the 44 men were under 29 years of age, and the others would therefore presumably have been of marriageable age. That so few were married seems to indicate that an influence other than age was perhaps at work. Economic factors may, in part, have accounted for the high number of single men, for where a man is expected by society to be able to "afford" to marry, a woman is not. Then, also, it may be easier for a psychiatrically disturbed woman, who nees not necessarily fend for herself, to marry, whereas such a

man/....

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21. Ibid., p. 77.
22. Elliott, M.A., and Merrill, F.E., op. cit., p. 281.

man might not easily find for himself a woman prepared or able to fend for him. It might thus be considered easier (and possibly more acceptable socially) for a mentally disturbed woman to marry, than for a similarly ill man to do so.

By and large, however, the two groups correspond with each other fairly closely, mirroring the general trend which both together show, and the above must therefore be regarded only as tentative thinking on the subject.

D. RELIGION.

The study of the religion of psychiatric patients is often rewarding. For it is frequently in changes and vaccilations in this field that the patient's groping and seeking is most clearly expressed. Unfortunately, it was not possible to assess changes in the religion of patients in the sample, as these were not recorded, and so religion was taken simply as the current one given by the patient to the worker. Because this was, at times, a sensitive subject to the patient, direct questioning was avoided with several patients, and where other sources (such as clinical files) did not yield this information, the religion has been recorded as unknown (7 cases). A further two patients were thought to be Roman Catholic, but this was not confirmed. Of the 79 patients remaining, 53 were Protestants, (19

Dutch/....

Dutch Reformed Church, 13 Church of England, 12 Methodist, 3 Apostolic, and 6 other[23]), 17 Roman Catholics, 5 Jewish, 1 Greek Orthodox, and 3 without any religion. The following table indicates the various religious groups represented in the sample.

TABLE XIV - RELIGIOUS DENOMINATIONS OF PATIENTS.[24a,b]

Religion.	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
Protestant:						
Dutch Reformed[a] Church of	19	21.59	9	20.45	10	22.73
England	13	14.77	6	13.63	7	15.91
Methodist	12	13.64	3	6.82	9	20.45
Apostolic	3	3.41	3	6.82	0	0.00
Other	6	6.82	3	6.82	3	6.82
Roman Catholic	17	19.32	10	22.73	7	15.91
Jewish	5	5.68	1	2.27	4	9.09
Greek Orthodox	1	1.14	1	2.27	0	0.00
Nil	3	3.41	3	6.82	0	0.00
Unknown	9 (7+2)	10.23 (7.95+2.28)	5	11.37	4	9.09
Total:	88	100.01	44	100.00	44	100.00

a Including Hervormde and Gereformeerde Kerke.

Perhaps/....

23. 1 Full Gospel, 1 Presbyterian, 1 Congregational, 1 Baptist, 1 noted simply as "Christian", and the last a member of the School of Truth. This last patient was one who had changed her religion four or five times, in an effort to "find herself and to find something to hold onto." She now found such a haven. The patient who called himself simply a "Christian" stated that he knew he believed in God, and was a Christian, but knew nothing else.

24a. These figures and the comments on them should be viewed against the proportions of each religious group in the general population and the relevant figures for the Transvaal Province hence are given below. Figures in brackets show total religious groupings in South Africa.

Dutch Reformed (including Hervormde and Gereformeerde)	- 539,491 (1,326,344).
Church of England	- 137,207 (389,859).
Methodist	- 123,218 (269,825).
Apostolic	- 67,550 (107,700).
Other Christian	- 90,504 (166,089).
Roman Catholic	- 91,235 (192,799).
Jewish	- 74,221 (116,066).
Other and unspecified	- 37,635 (66,829).

It/....

Perhaps one of the most interesting characteristics of this table is the high proportion of Roman Catholic patients. The outward vestments and deep splendour of this religion may give something very tangible to the patient (and others) to which to cling - however, because no records were available, it was not possible

to/....

24a. (cont'd).

It is interesting that the Congrehational and Lutheran groups are not represented in the sample at all, while the one Presbyterian patient was grouped with "Other" though a separate category is assigned to this group in the table consulted - 50,196 (110,873) - Figures from Population Census, 1960, Bureau of Statistics; Government Printer, Pretoria, 1964; pp. 2 and 3.

b. It will be noted that the total in column 2 of the present table is 100.01%. It is a well-recognized feature of tables of this nature, i.e., where percentages of a total have been taken, that, although correct, these do not always add up to 100.00%. The alternatives of adjusting the "least" significant figure in the table in order to correct the percentage or of leaving the percentage as it stands are then open to the researcher (Lever, Mr. H., Department of Sociology, University of the Witwatersrand, personal communication, October 1964). It was decided, however, in view of the numerous tables to follow, that inconsistencies would be introduced throughout the text by correcting percentages, and the latter system was therefore adopted. Where totals thus appear as 99.99% or 100.01% these should be regarded in this light.

to determine how many patients had been born into Catholicism and how many had converted to it in later life. That there were 3 Apostolics is also interesting, for this is a sect renowned for its mysticism and elements of primitiveness, both of which may attract the seeking individual, or the individual already in a world of his own. The low number of Jewish patients admitted may be due to the close family ties typical of this group, leading to unwillingness to hospitalize a patient if any other plan could be made.[25] Of the three patients stating that they had no religion, one was a scientologist - the belief prevalent in this group that mind is all-powerful can understandably attract those who feel their minds to be in need of anchorage. Perhaps, again, rejection of "religious" religion is due to the nature of the illness, and/or perhaps to bitterness or frustration.[26]

There/....

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25. One Jewish woman, in fact, was removed by her family within 24 hours of admission, and sent to a private sanatorium, as the family could not bear to feel that they were not giving her the best treatment possible (they regarded this as private treatment), and could not face placing the patient in a mental hospital, as recommended, but wanted her as close to them as possible.
26. Two of these patients were schizophrenics (one a paranoid schizophrenic - it was he who was the scientologist) and the last was an alcoholic and so-called "psychopath." (Definitions of these terms appears in the Glossary, page 457.)

There are, further, differences in religions between men and women, but for none of these can the writer give any sort of explanation. Because there is only one Greek Orthodox patient, it seems that no significance can attach to his being male, and that chance accounts for this. However, why all three Apostolic patients should be men, as also all three patients stating that they had no religion, cannot be postulated; nor can any supposition be given as to the greater number of female Methodist and Jewish patients.

E. LANGUAGE GROUP.

That the greatest number of patients belonging to a single group belonged to the Dutch Reformed Church is accountable by virtue of the fact that this Church is one of the main Churches of the country, and, as a large proportion of patients were Afrikaans-speaking, it is natural that they should attend there.[27] This led to an interest by the researcher to investigate the

home/....

27. It is interesting, however, that when numbers of patients in the "English" Churches are added together, even excluding Apostolic and Other (which perhaps more often have members of both language groups than do Church of England, Methodist and Roman Catholic), a greater proportion of patients (42) belonged to these groups than to the "Afrikaans" ones (19). This may be associated with the urban/rural distribution of the two groups, rather than with a higher rate of mental illness in the "English" group, and to the different cultural patterns of caring for the sick in these settings.

home language of patients. However, records in no cases specified this, and although interviews were conducted as much in Afrikaans as in English, accounts of interviews were written in English, so that an attempt to do this, although possibly giving interesting additional information, was not made.

F. RESIDENTIAL AREA.

When the residential areas of patients in the sample came to be investigated, it was found that no complete classification system of such areas in Johannesburg existed. It was therefore decided to base division of areas on geographical criteria, and the writer's knowledge of the city. On the assumption that the upper class suburbs lie to the North of the city, the lower class ones to the South, with mixed suburbs - mainly of a lower class than to the North - in the East and West,[28] a broad system was devised which took into account also the factors of industrialization of areas and proximity of residential areas to non-White or mixed racial areas.[29a,b.] Five categories emerged from this division, viz., upper class, upper middle, middle middle, lower middle,

and/....

28. Seawright, T.R., A Social Casework Approach to Marriage Counselling, University of the Witwatersrand Press, Johannesburg, 1961: p. 29.

29a. Ibid., pp. 29 - 30. These latter two factors tend to lower the status of an area.

b. As all patients were White, the above description and division is applicable only to so-called White suburbs, including those which have some non-White residents, as in several of the suburbs classified as "lower class."

and lower. In addition, however, several patients were found to come from outside the Johannesburg area,[30] from institutions or homes of various sorts, or to have no fixed abode, while the address of one patient was unknown. These four categories were added, as well as a final one covering central city area, and Hillbrow area. This latter was included with central city as Hillbrow is a cosmopolitan area, with a changing population, and having many of the characteristics of a central city area. Ten residential area groupings thus emerged, and the areas in which patients of the sample lived were then classified into these. Where there was any doubt in the writer's mind into which category a suburb should be placed, the lists of Schreier[31] were consulted, and the decision made after comparison with these. Residential area was regarded as that in which a patient was living at time of admission to hospital, as several patients changed address during hospitalization, or left hospital to go to a new address. Although this very mobility of patients is interesting, it could not here be investigated, and on the basis of the above, the following residential distribution of patients was revealed.

Table/....

30. Although the hospital serves Johannesburg residents, the occasional patient arrives in Johannesburg from elsewhere and needs admission during his time in the City; certain patients from outside the City area are also sometimes admitted, usually by special arrangement.

31. Schreier, R.A., A Study of Some Aspects of a Selected Sample of Unmarried Mothers at the Queen Victoria Hospital, M.A. Thesis (unpublished), University of the Witwatersrand, Aug. 1960; Appendices, pp. 310, foll.

TABLE XV - DISTRIBUTION OF PATIENTS BY RESIDENTIAL AREAS.

Residential Area.	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
Upper Class	0	0	0	0	0	0
Upper Middle	4	4.55	2	4.55	2	4.55
Middle Middle	12	13.64	8	18.18	4	9.09
Lower Middle	22	25.00	9	20.45	13	29.55
Lower Class	8	9.09	3	6.82	5	11.36
City/Hillbrow	17	19.32	5	11.36	12	27.27
Institutions a and Hostels	8	9.09	5	11.36	3	6.82
No fixed abode	7	7.95	4	9.09	3	6.82
Outside Johannesburg	9	10.23	7	15.91	2	4.55
Unknown	1	1.14	1	2.27	0	0
Total:	88	100.01	44	99.99	44	100.01

a Of the five men in institutions, one came from an old age home, one from the Rand Epileptic Employment Association Farm, and three from Youth Hostels in the Braamfontein/City areas. Of the three women thus situated, one lived in an old age home and two in hostels in Doornfontein. Braamfontein was classified as a lower middle class and Doornfontein as a lower class suburb.

It is interesting to note that the greatest number of patients in the total sample live in the lower middle class areas. The second largest group is that of City/Hillbrow area, followed by that of middle middle class. If the City/Hillbrow area is regarded as being made up primarily of lower middle and middle middle class residential buildings - (which it may well be if rent and types of building are considered - then it would appear that the bulk of patients (51 or 57.95%) come from the middle middle and lower middle class areas. Further, those patients living in institutions usually were living in these because of lack of funds, and these may thus be included within this group, as may those in the "no fixed abode" group, as these

patients/....

patients seem to wander from place to place, often living apparently in poor areas. It is not possible to estimate the groups into which the nine patients living outside Johannesburg should be placed, but even if these and the one "unknown" are grouped within the upper middle class division, the greater proportion of patients (74 or 84.09%) fall in a below the middle middle class group. It is noteworthy that no upper class residents are included in the sample. Again, while selectivity of the sample may influence this distribution of patients by residential areas, it is more likely here to be due to the fact that the minimal cost of hospitalization, and the means test applied - which are to be immediately discussed - attract the less wealthy people of the City for medical care, while the richer go to private medical practitioners and nursing homes.

Where the men were distributed fairly evenly through the ten groupings, it is interesting to note that 25 or 56.82% of the women were living in a lower middle class suburb or the City/Hillbrow area. Of the total number of men, 34 or 77.27% lived in middle class and lower class areas, while among the women this proportion was 40 or 90.91%. If several of the nine men living outside the Johannesburg area should in fact not have been classified with the upper middle class group, the proportions would be almost the same.

G. ECONOMIC STATUS.

Residential area is closely linked with economic status and this characteristic will therefore be

discussed/....

discussed next. Because patients, on admission to hospital, are classified according to income, it was decided that the hospital classification of patients would be used as a basis for financial grouping of patients. This provides a uniform method of classification, and probably a more consistent method than that of taking information from the records, which frequently are not completed in this regard, because of the availability of this and other information. Hospital classification of patients is always available from the patient's clinical file, if not from the social work record.

In terms of Administrator's Notice No. 638 (Transvaal Province), issued on 29th August, 1958,[32] the following classifications are operative for White patients admitted as in-patients to Transvaal Provincial Hospitals:[33]

(a) A patient who has no income whatsoever is classified as a free patient;[34]

(b) a/....

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32. As published in Hospital and Persion Ordinances and Regulations, Reprints of Ordinances 14, 19, and 21, Department of Hospital Services, Transvaal, Compiled February, 1961, pp. 97, foll.
33. Out-patient rates are not here given, as they are irrelevant.
34. No hospital fees are charged at any time.

(b) a patient having a computed income[35] of not more than R600.00 per annum is classified as a part-paying patient, Rate E;[36]

(c) a patient having a computed income exceeding R600,00 per annum but of less than R1,100.00 per annum is classified as a part-paying patient, Rate D;[37] and

(d) a patient having a computed income exceeding R1,100.00 per annum is classified as a private patient.[38]

Any/....

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35. In terms of Administrator's Notice No. 638, 29 August, 1958, p. 101, income means the nett case income of a person and the nett cash value of any benefit received by him during the year immediately preceding his admission to hospital. To this total is added the income of any dependent of that person who earns less than R300,00 per annum. From the sum of the income calculated in this way there is deducted in respect of every dependent of every person whose income is included in the sum of the incomes thus calculated the amount of R400.00. Financial classification of a patient on admission to hospital is based on this computed annual income. Where a patient is dependent on a parent or guardian, the income of the person legally responsible for the patient is calculated as above.
36. An admission fee of R1.00 is paid, and no further charges made for treatment.
37. Such patients pay hospital fees of R2.00 per day, but nothing further.
38. These patients are divided into three groups: Private C, consisting of patients admitted as such at their own request, irrespective of income, and paying R2.00 per day plus all extras, except theatre fees. Private B, consisting of those patients admitted as a result of income, and paying R3.00 per day plus all extras and, finally, full-paying patients who pay R4.50 per day plus all extras - into this group fall all patients, such as Workmen's Compensation Act cases, for whom hospital fees are paid, e.g., by the Government. (Information on hospital fees taken from roneod Johannesburg General Hospital Circular, dated 4.5.62.).

Any patient may appeal for reclassification to a lower paying category, the grounds for this appeal, until May, 1964, being that the total cost of hospital care would amount to 5% or more of the computed income, over the past year, of such a patient.[39] However, in that month, an amendment to this regulation was issued which stated that, in addition to the above, a patient could be reclassified to a lower category if his hospital costs amounted to more than could reasonably have been expected at the time of the patient's admission to hospital.[40] Reclassification at all times takes place only once, and only by one downwards interval. Any further appeal for classification has to be made through the Hospital Board, and is granted only at the discretion of this Board.

The above, then, formed the basis upon which the financial characteristics of the group of patients in the study were assessed, and from this emerged the following table.

Table/....

39. Administrator's Notice No. 638 (Transvaal Province), 29th August, 1958, as quoted, P. 107.
40. Administrator's Notice No. 423, 20th May, 1964: page unnumbered.

TABLE XVI - FINANCIAL STATUS OF PATIENTS.[a]

Hospital Classification.	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
Full-paying	0	0	0	0	0	0
Private B	5	5.68	3	6.82	2	4.55
Private C	0	0	0	0	0	0
Part-paying D	8	9.09	7	15.91	1	2.27
Part-paying E	67	76.14	30	68.18	37	84.09
Free	4	4.55	2	4.55	2	4.55
Staff (free)	2	2.27	1	2.27	1	2.27
Unknown	2	2.27	1	2.27	1	2.27
Total:	88	100.00	44	100.00	44	100.00

a. Classification is taken as that classification which resulted after classification had taken place. Although this is perhaps not as accurate an estimation of income as classification on admission, and does influence numbers slightly, it was unavoidable, as patients were occasionally reclassified before referral to the social worker, or were reclassified by her after referral, and records did not always reflect this, so that more consistency resulted if reclassifications were taken. In some ways this might be regarded as a clearer indication of the patient's "living" financial position as opposed to his income per se.

As can clearly be seen, the greatest proportion of patients feel within the part-paying E category, and when the category "free" is added to this, 69 or 80.69% of patients have the low computed income of R600.00 per annum or less.[41] This figure is congruous with the high proportion of patients found earlier to live in or "below" middle middle class areas (84.09%). It also is in keeping with the findings of Landis and Page

that/....

41. The two free hospital staff patients are not included in this figure, as their classification is based on the fact that they were members of staff, not on income. It is coincidental to note, however, that both were low paid workers (one a clerk and one a hospital help), and lived in a lower middle and the Hillbrow area, respectively, and would in all probability have been classified as part-paying E had they not been staff members.

that admission to mental hospitals for mental illness is "higher for .... the economically dependent than for the economically comfortable."[42] Although this statement applies to mental hospitals, it may possibly be carried over to general hospitals insofar as these also public hospitals. For Goldman, in a study on patients suffering from physical illnesses in general hospitals, reported a similar feature in these patients, and, again, although the illness differed, the parallel, it seems, can be drawn.[43] The fact that so many patients referred to the social worker fall within this financial group may also, of course, be due to the fact that these patients may be, or may seem to be, in need of social work help more often than those in better financial circumstances, and disproportionate referral thus results, rather than due to the fact that more mentally ill patients are poor than rich.[44] Further, a greater proportion of "lesser privileged" than wealthier patients are admitted to the hospital,

as/....

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42. Landis, C., and Page, J.D., op. cit., p. 93. On pp. 56 - 68 these authors give information on the types of illness associated with various levels of economic dependence. This, however, is beyond the scope of the present study.
43. Goldman, F.: "What are Social Workers in General Hospitals doing for Long-Term Patients?" Social Work (N.Yk.), Vol. 5, No. 4, October 1960; p. 76.
44. Goldman, op. cit., loc. cit., reports social work service to only a small percentage of private and semi-private patients. He advances possible reasons for this as being, inter alia, that private doctors may not know of any need for casework services to their patients, may not want to "hurt the feelings" of their patients, and may not wish to share responsibility with social workers. He further remarks that such patients themselves may be against social work help, and comments on the attitude, prevalent in hospitals, that financial aid and services to the "under-privileged are the principal functions for which social workers are employed."

as the latter group often enter private nursing homes. It is interesting to note the greater proportion of men than of women (10 : 3) in the part-paying D and private B groups, and this, together with the other figures, does not seem to conform with the suggestion made earlier that more men than women may have been single because of low financial status.[45]

H. OCCUPATIONAL GROUPINGS.

Closely linked up with both residential area and economic status is the variable of occupation, for these will depend largely on the wage resulting from a specific occupation, and the latter also on the necessity or otherwise to live near the place of employment. As it was the empirical impression, based on experience, of the writer that a great number of patients had no work on admission to hospital, and were referred to her for help in finding this, and as the analysis sheet had shown many patients to have been unemployed on admission to hospital,[46a,b] it was decided to assess the ratio of employed to unemployed patients before going on to analyse types of occupation held by patients in employment at the time, and last known occupation of those unemployed at the time. The table

illustrates/....

45. This chapter, page 101.

46a. This was the point at which occupation was analyzed, as it provided information on this unemployment rate, which would have been unobtainable had only last known occupation been analyzed.

b. Because little information was obtainable on patients' levels of education, this characteristic was omitted, and, as it appeared that this might be reflected in type of occupational training, it was not felt to be a serious omission.

illustrates the first theme, and shows that, in fact,

TABLE XVII - EMPLOYMENT STATUS OF PATIENTS.

Employment Status.	Total Sample.		Males		Females.	
	No.	%	No.	%	No.	%
Unemployed	47	53.50	27	61.36	20	45.45
Employed	26[a]	29.55	10	22.73	16[a]	36.36
Pensioners	11[b]	12.50	6	13.64	5	11.36
Unknown	4	4.55	1	2.27	3[c]	6.82
Total:	88	100.00	44	100.00	44	99.99

a. Includes 9 housewives who, though not employed in the accepted sense of the term, fall within a recognized occupational category.

b. Includes those on pension following retirement (i.e., retired and on pension from an ex-employer) and those in receipt of Government pensions (Old Age, War Veterans, etc.) - 4 and 7 respectively.

c. One patient in this group was an alcoholic woman, who appeared neither to be employed nor to be a housewife, and lived with a man whom she stated was her ex-husband, She was physically ill and could perhaps be regarded as an invalid. She refused to apply for any sort of pension.

more than half of the patients in the sample were unemployed at time of admission to hospital, while less than 30% of the total group were actually in employment, the balance being pensioners of various kinds or occupation being unknown to the writer. This confirmed the writer's impression that many patients were unemployed, and it will be interesting to see later in the text, whether the same number of patients as shown here was referred for help with work. Although length of unemployment was not considered, this high rate of such may also account for the number of patients classified as part-paying E and less (classification is based on the income for the past

year/....

year, so apparently few had been continuously unemployed for that length of time, as more than four patients would then have been classified as free, i.e., as having no income whatsoever), and living in lower class areas.

To produce a detailed chart of occupational classifications for the group was somewhat more difficult than simply to assess the employment status of the group, as, again, it was found that no system existed which was specific to South African conditions.[47] An adaptation of the United Nations International Standard Classification of Occupations[48] was therefore used as a basic system, and modified slightly by the writer on the basis of her own knowledge of occupational groupings and through comparison with the works of Seawright[49] and Schreier.[50] The following occupational categories were derived in this way:

(a) Professional and related workers, including a teacher and trained nursing sister;

(b) Managerial and administrative workers, including a regional organizing secretary of a large concern;

(c) White collar, including clerical and related workers: eleven clerks and two commercial artists;

(d) Sales/....

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47. Lever, Mr. H., Department of Sociology, University of the Witwatersrand, personal communication, August 1964.
48. A roneod copy of this was borrowed from the Department of Sociology, University of the Witwatersrand, entitled "Definitions for the Coding of Occupations," Classifications and Examples taken and adapted from the United Nations International Standard Classification of Occupations, Supplemented with Examples, from Committee of the 1950 Census of the Americas, U.N. Ref. XIII, 1951 - 1952.
49. Seawright, T.R., op. cit., pp. 33 - 36.
50. Schreier, A., op. cit., Appendix C, pp. 319 - 320.

(d) Sales workers, including both "counter" salesmen and "travelling" salesmen, as well as agents;

(e) Skilled workers, including skilled artisans (cabinet maker, welder, blacksmith, draughtsman, 2 ladies' hairdressers, 1 machinist, etc.);

(f) Semi-skilled workers, such as apprentices and nurse aides;

(g) Unskilled workers, including one labourer and one unskilled factory hand;

(h) Housewives;

(i) Other, under which were included nine men and four women;[51]

(j) Pensioners - both retired employees and Government beneficiaries;

(k) Unknown - this indicated not only a lack of knowledge of occupation, but complete lack of information as to whether or not the patient was employed on admission to hospital. It therefore differed from the "unknown" included

under/....

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51. Amongst the men were an art model, an ex-university student, a lad who had been at the Air Force Gymnasium, one man in sheltered employment, an alcoholic who had been known to the writer for several years and at no time been known to hold a job, and four patients who were unemployed, and for whom last position held was unknown. Of the women, one was a fashion model, one employed in a sheltered employment project, and two unemployed and last occupation unknown to the writer.

under (i) above.[52]

The following rather complicated table emerged when occupations of patients were classified according to this system.

Table/....

52. The United Nations category "mine workers" was omitted, as it so happened that no patients in the present sample were employed in such occupations. Those workers who would have been classified as "service workers" (nurse aides, masseuses, etc.) under the United Nations system were classified as skilled or semi-skilled according to their training, and the draughtsman classified in the United Nations scheme under "professional, technical, and related workers," was placed under "skilled workers," as it appeared that his training and qualifications were not "generally accepted professional" ones. (Seawright, T.R., op. cit., p. 34). The two commercial artists classified under the United Nations system as professional workers, were placed under "white collar" by the writer, also for this reason, and because this seemed, to her, to be more appropriate, as they had no professional training. The United Nations category of "Workers in operating transport occupations" was omitted, and the lorry driver and plant operator who would have been included under this head placed into the semi-skilled and skilled (building - other) groups, respectively, after Schreier, A., op. cit., loc. cit. The inclusion of apprentices under "semi-skilled" was based directly on the United Nations system.

TABLE XVIII - OCCUPATIONAL GROUPINGS OF PATIENTS : A.

	UNEMPLOYED GROUP.						EMPLOYED GROUP.					
OCCUPATIONAL GROUP.	TOTAL	%	MALES	%	FEMALES	%	TOTAL	%	MALES	%	FEMALES	%
Professional, etc.	1	2.12	0	0.00	1	5.0	1	2.44	0	0.00	1	4.17
Managerial, etc.	1	2.12	1	3.70	0	0.00	0	0.00	0	0.00	0	0.00
White Collar, etc.	13	27.66	7	25.93	6	30.0	3	7.32	1	5.88	2	8.33
Sales.	4	8.53	3	11.11	1	5.0	1	2.44	1	5.88	0	0.00
Skilled.	13	27.66	8	29.63	5	25.0	1	2.44	0	0.00	1	4.17
Semi-skilled.	5	10.64	2	7.41	3[a]	15.0	6	14.63	4	23.53	2	8.33
Unskilled.	1	2.12	1	3.70	0	0.00	1	2.44	0	0.00	1	4.17
Housewives.	0	0.00	0	0.00	0	0.00	9	21.95	0	0.00	9	37.50
Other.	9	19.15	5	18.52	4	2.00	4	9.76	4	23.53	0	0.00
TOTALS:	47	100.00	27	100	20	100	(26)	(63.42)	(10)	(58.82)	(16)	(66.57)
	Pensioners:						11	26.83	6	35.29	5	20.83
	Unknown:						4	9.76	1	5.88	3	12.50
							41	100.01	17	99.99	24	100.00
Final Proportions of 88	47	53.41	27	30.68	20	22.73	41	46.59	17	19.32	24	27.27

a Two masseuses were included amongst the women - one was apparently a trained person, and hence included under skilled workers: the other, however, was thought to be a prostitute masquerading under this title and hence classified, on the basis of her claim to being a masseuse, as a semi-skilled worker.

Perhaps one of the most interesting points shown by this table is that the number of male patients unemployed is considerably higher than that of females, while this position is reversed as regards numbers employed - i.e., more women than men in the sample held down work.

If the data in this table are added together, in order to find the total proportions of patients having certain occupations, irrespective of the number employed or unemployed, the following table emerges.

Table/....

TABLE XIX - OCCUPATIONAL GROUPINGS OF PATIENTS - B.

OCCUPATIONAL GROUP.	TOTAL GROUP NO.	%	MALES: NO:	%	FEMALES: NO:	%
Professional, etc.	2	2.27	0	0.00	2	4.55
Managerial, etc.	1	1.14	1	2.27	0	0.00
White Collar, etc.	16	18.18	8	18.18	8	18.18
Sales.	5	5.68	4	9.09	1	2.27
Skilled.	14	15.91	8	18.18	6	13.63
Semi-Skilled.	11	12.50	6	13.64	5	11.37
Unskilled.	2	2.27	1	2.27	1	2.27
Housewives.	9	10.23	0	0.00	9	20.45
Other.	13	14.77	9	20.45	4	9.09
Pensioners.	11	12.50	6	13.64	5	11.37
Unknown.	4	4.55	1	2.27	3	6.82
TOTAL.	88	100.00	44	99.99	44	100.00

This table reflects last known or last held posts, and shows that the greatest number of patients were white collar and clerical workers, while the second largest category was that of skilled workers, followed closely by "other." That this latter group is so large may be an indication that the more unusual (certainly unclassifiable) types of work attract psychiatric patients, though this supposition is rendered somewhat unreliable by the fact that the occupations of 6 of the 13 were unknown to the writer! Pensioners and semi-skilled workers formed the next two largest groups, each having 11 patients. If occupations from "skilled" up are regarded as being relatively well paid, and those from semi-skilled down as being somewhat less well paid,[53] it could be postulated that, if all

those/....

53. Although some retired persons received a fairly adequate pension, and some clerks received fairly low wages, these would probably even out.

those patients falling into the better paid group were in employment, 43.18% of the group would be reasonably "comfortable" financially. The nine housewives in the series are the only people in the group who apparently did not have to work or be self-supporting, and these bring this total to 53.41%. It is thus possible that, were it not for personality disturbances and/or adverse environmental conditions, a larger proportion of patients might be better situated economically than is the case. It would be interesting to investigate whether the very high rate of unemployment reported for the group is due to internal or external pressures on the patient. It is, of course, quite possible that the sample is completely biased on this point in view of the fact that employment was a problem for which patients were thought to be frequently referred to the social worker, and hence such a sample would naturally reflect a great proportion of unemployed persons. On this point, certainly, the sample may not be representative of the general population admitted to the wards.

I. PATIENTS HAVING FAMILIES.

The next characteristic of the group which was investigated was that of the number of patients having families, as this would possibly indicate how many patients were "alone in the world," and how many might perhaps be assumed to have some stabilizing influence

in/....

in their environments.[54] It was found that 81 patients (92.05%) had families, though not all were living with or close to these families. No attempt was made to assess the relationships between patients and their

TABLE XX - PATIENTS AND THEIR FAMILIES.

Existence of Families.	Total Group.		Males.		Females.	
	No.	%	No.	%	No.	%
Families spatially close to patients.	66	75.00	30	68.18	36[a]	81.82
Families distant from patients.	15	17.05	9[b]	20.45	6[c]	13.63
No families alive.	5	5.68	4	9.09	1	2.27
Unknown.	2	2.27	1	2.27	1	2.27
Total:	88	100.00	44	100.00	44	99.99

a. One patient in this group had as her only relatives her young children.
b. Seven of these patients had relatives outside Johannesburg, including one in Great Britain, while the parents of one had disowned him, and the mother of one was a certified patient at Valkenberg Hospital, Cape Town.
c. Four patients in this group had relatives outside Johannesburg, the family of one of these being in Rhodesia; the mother of another of these patients was a certified patient at Sterkfontein Hospital; and the last, although living with a man friend, in terms of the definition given in Chapter III, page 59. had "family" only in Natal.

families, as this was considered to be beyond the scope

of/....

54. This is not really an acceptable assumption, if the psychiatrically ill patient is regarded as coming from a sick family. (Vide, inter alia, Ackerman, N.W., The Psychodynamics of Family Life, Basic Books, Inc., N.Yk., 1961; passim; and Overten. A., et al, Casework Notebook, Family Centred Project, Greater St. Paul, Community Chest and Councils, Inc., St. Paul, Minnesota, 1959; passim) and it might be better expressed as "how many patients had roots of some kind in the community?"

of the present study. It is noteworthy, however, that even when those patients with families outside Johannesburg are subtracted from the total group with families, 75% have families presumably close enough geographically to have some contact with them and able to come to the hospital. And even excluding the patient with young children, 65 or 73.45% of families are thus situated.

When function of the social worker in relation to families is analyzed, it will be interesting to observe whether the families of so large a percentage of patients were seen by the social worker. The relationship anticipated between the higher age of women and their having families who look after them,[55] is perhaps indicated to some extent by the fact that the above table shows 81.82% of women as having families in Johannesburg, while 95.45% of the whole group have families living; these percentages for the men are 68.18% and 88.63% respectively. It thus seems that, while there may be no relationship between these two variables, women do more often have families, and families to whom they are close at least spatially, than do men. This may result in their having at least some feeling of "belongingness," while those without families may tend to drift into hospital as a source of refuge, or, because of lack of anchorage, show greater social and geographical mobility.

The/....

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55. This chapter, page 94.

The social worker thus may supply to them the "added support which the family might have given, to carry them through the stress of illness."[56] It will be interesting to see whether indeed the persons of this type falling within the sample, that is, those separated from their families and/or living alone, are given such "added support" more often than are the others, and are, in the words of Bartlett, "a special concern for the social worker."[57]

J. SUMMARY.

These various characteristics discussed above, then, may be termed the general social characteristics of the group and show, in summary, that the group tended, on the whole, to be a young one, having an average age of 37.57 years, and that it consisted of equal numbers of men and women, only 28.41% of whom were married and living with their spouses. Seventy-five percent, however, had family members living close to them. While the majority of patients were Protestants, a large group of Catholics was included, with a sprinkling of other religions. The majority of the patients lived in middle middle and lower middle class areas, and did not have high incomes, while more than half were unemployed. Certain general trends thus emerged, and in spite of the selectivity of the sample, several, though not all, of them, as shown in the text, concurred with general findings on the social characteristics of the mentally ill.

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56. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p. 204.
57. Ibid., loc. cit.

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C H A P T E R VI.

THE PEOPLE OF THE STUDY - SOME PSYCHIATRIC CHARACTERISTICS.

The verbal picture drawn of the patients involved in the present study remains unfinished without mention of various of their psychiatric characteristics and the last categories of the "factual" section of the analysis sheet, designed to obtain these, yielded much interesting data.

A. PSYCHIATRIC ILLNESSES.

The classification of the psychiatric illnesses[1] for which patients were admitted presented some problems. Apart from the difficulty of categorizing people, and the finer points of their illnesses, other difficulties also arose. It was decided to consider diagnosis at discharge, or on 31.12.63.,[2] as indicating the nature of the illness, because at this point in time the patient would have been thoroughly examined and the diagnosis made only after careful consideration, whereas diagnosis on admission was frequently of a tentative nature. However, diagnoses were still in some cases not finally made by then, and in other cases a patient was considered to be suffering from more than one type of illness, or to have one or more associated psychiatric problems. In these latter

cases/....

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1. See Glossary, page 457, for definitions of illnesses.
2. See earlier comments, Chapter IV, page 74, footnote 12. All patients still in hospital at this time would have been there since at least 31.8.63., i.e., for a minimum of four months.

cases, it was decided to classify according to the illness considered to be predominant, and in the former a separate column was kept for "uncertain" diagnoses. Diagnoses for all patients were confirmed from the clinical files, and the psychiatrist's word (rightly so) taken as final. Only where more than one problem or diagnosis was noted, and not differentiated into primary and secondary illness, did the worker, for purposes of classification only, assign the patient to one or other diagnostic category. This was done, however, on the basis of her past collaboration with the doctor, knowledge of which disease or problem was generally regarded by him as the predominant one, attendance at meetings at which the patient was discussed, and her general knowledge of the problems which the patient presented for help, as well as her general knowledge of psychiatric illness.

In deciding what classification system was to be used, several points had to be considered. First, a brief survey of the diagnoses listed showed that many patients were admitted as alcoholics and/or drug addicts, without being psychotic. Although these might have been classified under Disorders of Character, Behaviour and Intelligence in terms of the International Classification of Diseases, currently in use in Britain,[3] it appeared that not only the number of such patients might warrant their being separately classified, but also

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3. Henderson, D., and Batchelor, I.R.C., Henderson and Gillespie's Textbook of Psychiatry, 9th Ed., Oxford University Press, London, 1962. p. 27.

the possibility of there being some significance attached to admission of so large a group of these patients. In addition, there was a desire to separate them from the "psychopathic personality" category included within this group. There appeared to be a fair number of patients diagnosed as "reactive depression," and this was not covered by either the International Classification given by Henderson and Batchelor, or by the "Suggested Scheme" of Henderson and Gillespie,[4a,b] both of which covered only manic-depressive illness and involutional melancholia. Although the reactive depressions might have been included in the category Psychoneurotic Disorders (neurotic-depressive reaction) in the former system, it seemed more appropriate to classify them with the other depressions under a general heading of Affective Illnesses, as, although aetiology might be different, the element of depression was consistently present. It was decided that attempted suicide would be listed on its own, where the underlying illness prompting it was not defined, i.e., where it was not stated whether the reaction was a psychotic or psychoneurotic one, or one related to a character disorder. Henderson and Gillespie stress the differences between a classification system based on the fundamental underlying disease and one based on the temporary symptom-complex displayed,[5] and it was decided that the attempt here would be to

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4a. Henderson, D., and Batchelor, I.R.C., op.cit., loc.cit.
b. Henderson, D., and Gillespie, R.D., A Textbook of Psychiatry, 8th Ed., Oxford University Press, London, 1956; p. 27.
5. Ibid., p. 22.

use the former type of scheme, based on the psychiatrist's diagnosis, rather than the latter. However, where this was not possible - such as with attempted suicides - the latter basis was accepted. Differentiation between illnesses was not made on the basis of psychotic and/or neurotic illness.

After careful consideration of the various classifications given by Henderson and Batchelor and by Henderson and Gillespie,[6a,b] and after a preliminary attempt at classification based mainly on the two systems already mentioned,[7] the following <u>classification scheme of psychiatric illness</u> was drawn up for use in the present study.

(a) <u>Affective Illnesses</u>,[8] including under this heading patients termed endogenously depressed,[9] those

termed/....

6a. Henderson, D., and Batchelor, I.R.C., op. cit., Chapter III, pages 27 - 29, and including pages given above.
b. Henderson, D., and Gillespie, R.D., op. cit., Chapter II, pages 17 - 29, passim, and including pages given above.

7. As being more appropriate to the present study than the American classifications given in both references.

8. The term "illnesses" was used in place of the term "psychoses," as in the British Classification System (Henderson, D., and Gillespie, R.D., op. cit., p. 22), because not all patients under this head were psychotic, and instead of the term "Reaction Type" used by Henderson and Gillespie in their own scheme (op. cit., p. 27), as it was felt that this term, while "expressing the point of view which concentrates upon the study of the individual as a psycho-biological organism perpetually called upon to adapt to a social environment" (op. cit., p. 26), did not include within its meaning sufficient of the "inborn" nature of some diseases. The term "state", also used by these authors (op. cit., p. 27 - "psychopathic state"), was therefore also used later in the classification system, in its stead.

9. Several patients were described as endogenously depressed without specification of the type of endogenous depression. Thus this group included all these as well as the one involutional melancholic.

termed reactively depressed, those regarded as suffering from "mixed" depressions, and those diagnosed as manic-depressive.

(b) Schizophrenic States.

(c) Paranoid States.[10]

(d) Psychopathic[11] States, including primarily those patients termed "psychopathic personalities." Although some patients diagnosed as alcoholics and drug addicts by the ward psychiatrists were also regarded as psychopathic personalities, Where the problem of "drinking" or "drugging" was acute, these patients were classified under:

(e) Addictions, which included alcoholics and drug addicts. Where patients were suspected drug addicts, but were admitted solely for treatment for attempted suicide, due to an "overdose" of some medicine, these were placed in the category

(f) Attempted Suicide, with those others discussed above, and/or who had attempted suicide by some other means.

(g) Organic Illnesses included the senile states, general paralysis of the insane (G.P.I.), and various other illness or symptoms caused by

general/....

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10. This category, based on the Meyerian Classification System propounded by Henderson and Batchelor (op. cit., passim), and Henderson and Gillespie (op. cit., passim) includes paranoia, paraphrenia, and paranoid schizophrenia. Kraepelinian systems would include the latter illness under schizophrenic states, thus giving four types of schizophrenia instead of the three of hebephrenic, catatonic, and simple schizophrenia.

11. The use of this term is discussed in the Glossary of Definitions of Psychiatric Illnesses, page 457.

general physical illness or brain changes. Although not, strictly speaking, falling under this head, the one mentally defective patient found in the sample was included here, as the condition was regarded by the writer as organic.

(h) Epilepsy.

(i) Psychoneurotic Illnesses covered hysteria, chronic anxiety, and amnesic states considered to be of hysterical origin.

(j) A section was also set aside, as mentioned earlier, for illnesses which could not be finally diagnosed on discharge, and these were simply called "uncertain."

(k) The perennial group of "other" illnesses was also assigned a category, as was that of

(l) "Unknown."

When diagnoses were classified according to this system, the following table resulted.

Table/....

TABLE XXI - DIAGNOSTIC CLASSIFICATION OF PATIENTS.

Diagnosis.[a]	Total Group. No.	Total Group. %	Males. No.	Males. %	Females. No.	Females. %
(a) Affective Illnesses.	18[b]	20.45	2	4.55	16	36.36
(b) Schizophrenic States.	16[c]	18.18	9	20.45	7	15.91
(c) Paranoid States.	5	5.68	4	9.09	1	2.27
(d) Psychopathic States.	7	7.95	4	9.09	3	6.82
(e) Addictions.	12[d]	13.64	9	20.45	3	6.82
(f) Attempted Suicides.	3	3.41	2	4.55	1	2.27
(g) Organic Illnesses.	8[e]	9.09	5	11.37	3	6.82
(h) Epilepsy.	5	5.68	4	9.09	1	2.27
(i) Psychoneurotic Illnesses.	4[f]	4.55	1	2.27	3	6.82
(j) Uncertain.	4	4.55	1	2.27	2	4.55
(k) Other.	3[g]	3.41	2	4.55	2	4.55
(l) Unknown.	3	3.41	1	2.27	2	4.55
Totals:	88	100.00	44	100.00	44	100.00

a. Taken as diagnosis on admission during period of the study, or, where more than one admission occurred in this time, as diagnosis on first admission.

b. 3 Endogenous depressions (1 male, 2 female); 1 Manic-depressive (female); 1 Involutional Melancholia (female); 11 Reactive Depressions (1 male, 10 female).

c. All types except paranoid schizophrenia (see foot-note 10, page 132) were included here; no distinctions could be made between the different types (catatonic, etc.), as only some were specifically defined and others not. With the exception of one patient termed "schizophrenic reaction," all patients were "full-blown" schizophrenics.

d. 6 Alcoholics (5 male; 1 female); 6 drug addicts (4 male, 2 female).

e. Two senile patients (1 male, 1 female); I.G.P.I. (male); 1defective person (female); 4 other (3 male, 1 female).

f. 1 Hysteric (female); 1 chronic anxiety state (female); 2 amnesias (1 male, 1 female).

g. 2 Homosexuals (1 male, 1 female); 1 adolescent behaviour disorder (female).

That the affective illnesses formed the largest group is surprising in view of the general youth of the

total/....

total group, as such illnesses tend to occur in later life.[12] However, when this group is broken down, it appears that 16 of the 18 patients are women, and this is in keeping with the older average age of female patients, as well as with the facts that these types of illness tend to occur more often in women than in men,[13] and are often associated with the menopause. The anticipated number of men in this group did not occur.[14] The second largest group is that of schizophrenic states, and this is in keeping with the generally younger age levels of the patients.[15] Paranoid states were separated from the group of schizophrenias, as this seemed to be general procedure in the classification suggested by Henderson and Gillespie,[16] but if the four male patients diagnosed as paranoid schizophrenics[17] were included with the general group of schizophrenics, the proportion of men to women would be 13 : 7, or almost double, and this would be in keeping with the comments made by Landis and Page about the ratio of this disease in men and women.[18] Of the addictions, 9 of 12 occurred in men,

which/....

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12. See discussion in Chapter V, page 95.
13. Idem.
14. Idem.
15. Idem.
16. Henderson, D., and Gillespie, R.D., op. cit., p.27.
17. The female in this section was diagnosed simply as suffering from a "paranoid state," and was at one time thought to be paraphrenic.
18. Landis, C., and Page, J.D., Modern Society and Mental Disease, Farrar and Rhinehart, Inc., N.Yk., 1938; pp. 40 - 41; also as discussed in Chapter V of the present text, page 95. Paranoid schizophrenia tends to occur later in life, but this observation is in relation to ratio of the disease in men and women, and no longer refers to age.

which is in keeping with the general occurrence of this problem in the two sexes,[19] and this may perhaps be due partly to the greater social pressure brought to bear on women who indulge in alcohol or the taking of drugs.[20] Of the 12 "addicts", only two men were married and living with their spouses: all the others were divorced or single, and the occurrence of both types of addiction, but especially of that to alcohol, in such people may have been associated with loneliness and lack of primary contacts.[21] That such a large number of alcoholics and some addicts are admitted to the unit, in spite of the admission policies and referral of these patients elsewhere,[22] is, in the opinion of the present writer, an indication of the inadequacy of other treatment facilities for such patients in the community,[23] as these patients would

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19. See Chapter V, page 95.
20. Elliott, M.A., and Merrill, F.E., Social Disorganization, Harper and Bros., N.Yk., 1950, pp. 194 - 196, state that these pressures have lessened since the two World Wars, but it is unlikely, in the opinion of the present writer, that mores of such long standing, in relation to this problem, would completely disappear within so short a time, especially among a primarily middle and lower class population, where customs and traditions do not change readily.
21. Elliott, M.A., and Merrill, F.E., op. cit., p. 186 - 188. Which probably occurred first, however, could not here be assessed.
22. See discussion of Casualty referral service, Chapter I, pages 13, foll.
23. In addition to those facilities organised by the Rand Aid Association (see Chapter I, page 14. footnote 36), to which admission is voluntary or by commital, the only treatment centres for alcoholics which are proximal to Johannesburg are the mental hospitals, to which admission, though voluntary, has to be for a minimum of six months, and the various rehabilitation centres (established in terms of Act No. 86 of 1963 to replace the work colonies), to which admission is gained through a Court Committal. Committal is something unappealing to the patient, and this limits resources further.

be treated in those if accommodation was available, and are only admitted to the unit when no other accommodation is available for them, or in cases of dire emergency.

That the diagnosis of psychopathic state is limited mainly to men[24] is not borne out in this sample, but it seems to conform to the tendency for psychoneurotic illnesses to occur more frequently in women.[25] It is interesting that in spite of the elements of selectivity possibly present in the drawing of the present sample, the incidences and types of illness represented in it tend to comply with the general trends reported in the population as a whole.[26]

An over-all view of the diagnoses classified shows that few organic and senile cases are admitted,[27] and that those patients admitted are in fact seldom chronic ones, but, rather, those who might be considered as able to benefit from short-term intensive care. Nevertheless, the whole gamut of mental illness is here represented,[28] and this is in keeping with the general admission policies of the unit, which caters

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24. See Chapter V, page 95.
25. Idem.
26. Idem., loc. cit., and passim.
27. This latter point was commented on in Chapter V, page 93.
28. Perry, S.: "Implications from the Viewpoint of Psychiatric Social Work in General Hospitals," Discussion of a paper by Berkman, T.D., on 'Research Study' and Professional Education for Psychiatric Social Work," Jnl. of Psych. Social Work, Vol. XXI, 1952: p. 107 - confirms that all types of emotional disturbances are dealt with in such units.

for all types of the mentally ill, though not for the mentally subnormal or defective[29] or the grossly psychotic or unmanageable patient, except in transit to a mental hospital.[30] It is fitting that a unit such as this, situated in, and serving, both the hospital and the community, should treat all diagnostic groups of mental illness.

B. LENGTH OF HOSPITALIZATION.

Having been admitted to the unit for whatever illness, how long do patients stay? The unit is generally regarded as providing short-term, intensive treatment - what does this mean in terms of time? In order to determine length of hospital stay, patients' dates of admission and discharge were noted, and the days from admission to discharge, inclusive, added, and then grouped into 7-day, or weekly, categories. Of the group of 88 patients, 15 had been admitted more than once in the 6-month period of the study, and the "second" admissions were grouped separately from the first.[31]

Table/....

29. These patients are usually admitted only because of an associated psychosis or other illness, e.g., epilepsy.
30. Legal provisions and lack of adequate staff or facilities, as well as some as yet unchanged attributes towards psychiatric patients, combine in bringing about this position. Further, the wards are "open" and cannot take certified patients.
31. By first admission, here, is not meant first psychiatric admission ever, as it was not considered necessary to limit the sample in this way, but first admission during the 6-month period studied. First and second admissions in their "real" sense, i.e., as first ever plus subsequent, are discussed later in this chapter, pages 154, foll.

TABLE XXII - LENGTH OF IN-PATIENT TREATMENT PERIOD.

Length of hospital stay, in days.	Total: 1st Adm.	%	2nd Adm.	%	Males: 1st Adm.	%	2nd Adm.	%	Females: 1st Adm.	%	2nd Adm.	%
0 - 7	19	21.59	5	33.33	10	22.73	4	44.44	9	20.45	1	16.67
8 - 14	6	6.82	1	6.67	3	6.82	1	11.11	3	6.82	-	-
15 - 21	10	11.36	-	-	5	11.37	-	-	5	11.37	-	-
22 - 28	9	10.23	3	20.00	4	9.09	1	11.11	5	11.37	2	33.33
29 - 35	13	14.77	2	13.38	6	13.63	-	-	7	15.91	2	33.33
36 - 42	7	7.95	-	-	3	6.82	-	-	4	9.09	-	-
43 - 49	1	1.14	-	-	0	0	-	-	1	2.27	-	-
50 - 56	2	2.27	-	-	0	0	-	-	2	4.55	-	-
57 - 63	2	2.27	-	-	1	2.27	-	-	1	2.27	-	-
64 - 70	3	3.41	1	6.67	3	6.82	-	-	0	0	1	16.67
71 - 77	2	2.27	-	-	0	0	-	-	2	4.55	-	-
78 - 84	1	1.14	-	-	0	0	-	-	1	2.27	-	-
85 - 91	2	2.27	-	-	1	2.27	-	-	1	2.27	-	-
92 - 98	1	1.14	-	-	1	2.27	-	-	0	0	-	-
99 - 105	1	1.14	-	-	0	0	-	-	1	2.27	-	-
Unknown	9	10.23	3	20.00	7	15.91	3	33.33	2	4.55	-	-
TOTAL:	88	100.00	15	100.00	44	100.00	9	99.99	44	100.01	6	100.00

This table shows that, of first admissions, 19 patients were in hospital for 7 days or less, while 44 or 50% of patients were in hospital for less than 4 weeks. When readmissions are included, 53 of 103 (88 + 15) or 51.4% of patients were in hospital for this length of time. When the average length of hospital stay for the group[32] of "first" admissions is taken, it is found to be 28.9 days, while that for women is 30.5 days and for men 27.1 days. This is somewhat less than the average 45 days reported by Gillis for in-patients at Tara Hospital, the hospital in Johannesburg, most similar to the present unit,[33] but/....

32. Total number of days = 2283 for 79 patients; length of stay for 9 patients was unknown.
33. Gillis, L.G., "The Psychiatric Day Hospital : An Evaluation of Four Years' Experience," S.A.M.J., Vol. 32, No. 36, 6 Sept. 1958; p. 883.

but is in keeping with the average of 3 - 4 weeks reported by Hudgens, for the psychiatric unit at the North Carolina Medical Centre.[34] When the average length of stay of the "second" admissions is taken, it is found that the female patients averaged 30.5 days on readmission, but the males only 7.33 days. This is a large difference and not really explicable in any terms except by stating that, although 9 men were admitted more than once, the length of hospital stay for 3 was unknown, while of the 6 remaining men, two were in fact admitted, absconded, and readmitted on the same day, so that this brought the average length of additional admissions down somewhat drastically.

In any event, however, the length of hospital stay for males was lower than that for females, and why this was so is difficult to determine. Possibly, the greater number of male alcoholics and drug addicts admitted was to some extent responsible for this, as these patients are often simply tided over their acute episodes and then discharged, while the greater number of affective disorders in women, requiring, perhaps, more intensive therapy, resulted in these patients being kept in hospital for a slightly longer time. However, the difference between the two groups is at any rate not great, and as all figures average one month or less, the unit may quite clearly, as regards these 88 patients at least, be considered as giving short-term treatment.

C. Referral/....

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34. Hudgens, R.W.: "Psychiatric In-Patients at a Teaching Hospital," Arch.Gen. Psychiat., Vol. 9, No. 4, Oct. 1963; p. 385.

C. REFERRAL.

Because of the short-term nature of the treatment, and the brief period for which patients are in hospital (only 15 or 17.05% of patients were in-patients for more than 6 weeks), the social worker's contact with the patient has to be made quickly and effectively, and an important influence in determining how a patient will react and relate to a social worker in a hospital is that emenating from how and by whom the patient is referred. In most agencies the "clients come to (the social worker) at a point where they feel helpless,"[35] and application for help is predominantly of a voluntary and seeking nature. However, the patient coming to a hospital is requesting medical care, and is frequently unaware that social work is part of the medical service which he seeks, or that it can be of assistance to him personally.[36] Because he is thus usually informed about and referred to the social worker by someone else, the voluntary nature of his approach, as to an outside social agency, is changed, and, even though he may agree (and wish) to come, the contact is usually not initiated by him. The attitude towards social work of the referring person may thus influence the patient's already existing attitudes, while the status and authority - in the patient's eyes - of that person may influence his coming at all. For even if he does not wish to do so, the

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35. Feldman, Y.: "Integration of Psycho-Analytic Concepts into Casework Practice," Smith Coll. Stud. in Social Work, Vol. XXX, No. 2, Feb. 1960; p. 150.
36. Bartlett, H.M., Social Work Practice in the Mental Field, N.A.S.W., N.Yk., 1961; p. 78.

suggestion of the doctor that he see the social worker may bring him to her - together with his resentments about her, and attitude that he is there because he was told to come, though he does not know why.[37] Conversely, the authority of the doctor may have a positive influence on the patient's approach, and not all patients referred by him, or other staff members, resent such referral.[38] Again, some patients do ask for help themselves, either through the doctor, or directly, if they are aware that such help is available. Where the social worker initiates contact with a patient, resistances may also be encountered - often associated with the patient's (cultural) conception of her role - and the skills of the social worker are often serverely tested by much of the above. It is interesting to note, here, that "seeing the social worker" is never made compulsory for patients, as are other parts of treatment, such as attendance at

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37. Lesser, W.: "The Team Concept - A Dynamic Factor in Treatment," Jnl. of Psych. Social Work, Vol. XXIV, No. 2, Jan. 1955: p. 124 - comments that "it would be unrealistic to anticipate that a 'patient's resistance' to seeing a social worker is dispelled once the introduction is accomplished."

38. Bartlett, (op. cit., p. 86) points out, in this connection, that "The Social Worker shares the area of authority in the medical institution, which encourages the patient to have confidence in the social worker's understanding of the medical problems and social expertness." To this the present writer would add that this sanction of the social worker's actions and role by the medical institution gives her help a certain status that "purely" social agencies may not have, and may make her services more accentable to the patient than "ordinary welfare" ones would be. Through this she often reaches "upper" class patients, and those who would usually not come into contact with or accept social work service.

occupational therapy, and to ponder whether this is a realistic policy, or whether the difficulties associated with compulsion could be overcome.[39]

When an analysis was made of the persons by whom the patients were referred, the following figures obtained.

TABLE XXIII - PERSONS REFERRING PATIENTS TO THE SOCIAL WORKER.

Referred by.	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
Doctor	74	84.09	33	75.00	41	93.18
Nursing Staff	1	1.14	1	2.27	0	0.00
Other Staff	0	0.00	0	0.00	0	0.00
Social Worker	2	2.27	2	4.55	0	0.00
Self	8	9.09	6	13.63	2	4.55
Other Patients	1	1.14	0	0.00	1	2.27
Outside agency or person	2	2.27	2	4.55	0	0.00
Total:	88	100.00	44	100.00	44	100.00

This table confirms Bartlett's comment that in "current hospital practice, social work cases are most frequently obtained through individual referral by the medical staff,[40] and conforms with Cockerill's

statement/....

39. Vide such work as that with resistant and "hard-core" families reported by Overton, A., Tinker, H. and associates, in "Casework Notebook," published by the Family Centres Project, Greater St. Paul Community Chest and Councils, Inc., St. Paul, Minnesota, 1959; passim and Power, M.: "Casework in the Shoreditch Project." British Jnl. of Psych. Social Work, Vol. V, No. 1, 1959: pp.10-18.

40. Bartlett, H.M., op. cit., p. 117

statement on referral,[41] as also with Tennant's finding that the majority of referrals to the social worker are from the (medical) therapist.[42] However, it must be noted here that the rate of referral by medical staff may be slightly, though not much, too high, as there was no way of assessing how many patients themselves requested referral through the doctor, but, because the doctor actually approached the worker first, were noted as referred by the doctor. That the high rate of referral by medical staff indicates good liaison between them and the social worker may be possible, and it is also possible that many referrals took place actually at staff meetings, during the course of discussions. The influences mentioned above would thus have come into play with many patients, though where "the person really needs and wants help, it probably does not in the end make any fundamental difference whether he himself takes the actual step of getting to the social worker or reaches her through someone else to whom he has directly or indirectly manifested his need" but where this is not the case, such ramifications may well result.

In spite of the comments made earlier that men may have been more loathe to approach the social worker than were women,[43] the rate of self-referral by them was

considerably/....

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41. Cockerill, E.E.: "Medical Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, N.A.S.W., N.Yk., 1960; p. 378.
42. Tennant, M.A.: "Psychiatric Social Work in a Private Mental Hospital," Jnl. of Psych. Social Work, Vol. XXIII, No. 4, June 1954: p. 235. Although this finding is in relation primarily to relatives of patients, it appears relevant here.
43. Chapter III, page 42, footnote 12a.

considerably higher than that amongst the women (6 : 2). That staff members other than doctors referred no cases in this sample is puzzling, because in general this is not the position, though they normally refer only a few; but it may be due to the hierarchy operating in the hospital, which vests authority in deciding treatment means with the doctor, and the ethical code which results in his conferring directly with the social worker, not referring patients through other staff members. Of the two patients with whom the social worker herself initiated contact, one was a patient already known to her, and the other one who responded to the letter routinely sent out by the Social Welfare Department to patients admitted to the hospital.[44] That only two patients were referred from without the hospital seems to comply with Berkman's finding that referral to the social worker originates almost exclusively from within the hospital,[45] and once more it appears that, in spite of the selectivity of the sample, this feature of it conforms roughly to general patterns.

Because of the short-term nature of treatment in the psychiatric unit, it follows that the patient should be referred as early in treatment as possible, if not actually at intake. It was not possible, in

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44. This policy was introduced in an attempt to provide some sort of overall cover to the hospital by a social work staff too small and pressed for time to see all patients admitted. Intake and admission policies of the Department will be mentioned later in the text, Chapter XIII, pages 432, foll.

45. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; p. 15.

the present study, to assess how long after admission patients were usually referred, as such data were often missing from the record, and dates of referral and of first interview sometimes did not coincide. However, it need not be stressed that early referral in short-term work facilitates development of the patient-worker relationship, as it provides more time for its growth. Such referral, further, enables the social worker to carry out her part of the team effort more effectively than does last minute referral to her.

A further reason for early referral is that psychiatric-hospitalization, especially where it is occurring for the first time, may be, to the person and his family, a crisis situation, involving tremendous amounts of anxiety and tension, and accompanied by stresses and threats to stability and life goals which seem catastrophic and insurmountable and, because, often, "crisis is a catalyst, disturbing old habits, invoking new responses, and becoming a major factor in charting new developments,"[46] both patient and family may at this time be more receptive to help than at a later stage, when the emergency has faded into the routine of daily events, or has in some been resolved.[47] Often, further, the disease

precipitates/....

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46. Thomas, W.I., in "Symposium on Preventive and Social Psychiatry," Walter Reed Army Medical Centre, Washington, D.C., 1957, p. 158, as quoted by Parad, H.J., in "Brief Ego-Oriented Casework with Families in Crisis" in Ego-Oriented Casework : Problems and Perspectives, Parad, H.J., and Miller, R.R. (Eds.), F.S.A.A., N.Yk., 1963; p. 147. Definition of "crisis" is also based on this text, p. 146.

47. Sampson, H.; "Family Processes and Becoming a Mental Patient," Amer. Jnl. of Sociology, Vol. 68, No. 1, July 1962; p. 95; and Irvine, E.E.: "Psychosis in Parents : Mental Illness as a Problem for the Family, British Jnl. of Psych. Social Work, Vol. VI, No. 1, 1961; p. 24.

precipitates the need for help, or makes it clear, and help given has then to be of an immediate nature. When the stress precipitated by the illness is not one new to the patient and his family, as in the case of a readmitted patient or of a chronically ill one, anxieties are exacerbated at the time of admission, and the patient and his family may, further, both feel a need for help greater than that experienced as adaptations begin to be made, and as the situation settles. Thus, early referral frequently leads to more effective help than does later.

The moment in time at which the patient is referred is often related, however, not so much to the above as to the nature of the problem for which the patient is being referred. Thus, had it been possible to assess the time elapsing between admission and referral to the social worker, it might have been found that certain help, such as that relating to certification to a mental hospital, was requested earlier than that pertaining to work, that problems urgent, or immediately apparent, were referred before those of less urgency, or which only later became apparent.

D. PROBLEMS FOR WHICH REFERRED.

As it was not possible to determine this length of time between admission to hospital and referral to the social worker, it was decided simply to proceed to an analysis of the nature, as such, of the problems for which patients were referred to the social worker. However, to classify these problems was not an easy

task/....

task, for, with no generally accepted system for problem classification available in social work,[48] the researcher was once more faced with drawing up a classification system, with little reference material on which to base it, while that which was available was related to medical social work.[49] On review of the research lists of "problems for which patients were referred," it appeared that several patients were referred for help with more than one problem. As previously, with type of mental illness, it was decided to classify problems on the basis of the main or presenting problem, and to discuss the additional problems separately. Problems were grouped in terms of why the patient was referred for help - e.g., for work, for accommodation, for financial help, etc. - and the meanings of such problems were defined in terms of the classification system developed for function,[50] in order to give consistency to the categories. Not only would classification of

problems/....

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48. Bartlett, H.M., op. cit., p. 143.
49. Bartlett, H.M., op. cit., p. 146, gives a table of "Types of Medical-Social Problems in Terms of Relative Dominance of Medical and Psychosocial Elements." Although useful to some extent as a guide, this table was not specific enough for the present investigation, and, especially, the category "Personality Disturbances or Defects" is dealt with by the psychiatrist in the present setting, rather than by the social worker.
50. See Chapter III, page It was not considered sufficiently detailed, for the purposes of the present study, to classify in general terms, such as socio-economic problems, family problems, etc., as done by Bartlett, H.M., as quoted in footnote 49, above.

problems in this manner show why patients were referred to the social worker, but it would also indicate for what types of problem the social worker was seen as providing assistance, as well as what types of social problems patients were seen as having, by themselves and other staff members. On these lines, the following table was drawn up.

TABLE XXIV - PROBLEMS FOR WHICH PATIENTS WERE REFERRED TO THE SOCIAL WORKER.

Problems.	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
Social histories	24	27.27	9	20.45	15	34.09
Certification	16	18.18	9	20.45	7	15.91
Work	12	13.64	8	18.18	4	9.09
Accommodation[a]	13	14.77	6	13.63	7	15.91
Care of Children	2	2.27	0	0.00	2	4.55
Financial	12	13.64	8	18.18	4	9.09
Reclassification	1	1.14	0	0.00	1	2.27
Advice	3	3.41	2	4.55	1	2.27
Support and/or Counselling	2	2.27	1	2.27	1	2.27
Other[c]	3	3.41	1	2.27	2	4.55
Total:	88	100.00	44	99.98	44	100.00

a Included help with placement in hostels, back with family, nursing homes, etc., i.e., placement privately and in institutions, of the able-bodied and the physically ill.

b "Government" help - 6; "Relief" - 2; "Other" - 4.

c Clothing fetched for one patient; emergency home visit to arrange admission for one patient; identification, through press and other means, of an amnesic patient.

While the first two groups - social histories and certifications - are perhaps problems with which the doctor seeks the collaboration of the social worker, rather than her direct aid to the patient, though

this/....

this may result, the latter categories cover problems concerning the patient directly, and with which he himself needs assistance.

When it is noted that 40 or 45.45% of patients were referred for social histories or certification to a mental hospital, i.e., for these problems with which the doctor needed the social worker's help, one of the reasons for the high rate of referral by doctors is immediately apparent. It is interesting that 54.55% or only just over half of all patients referred were referred for help needed solely by themselves, and noteworthy that 40 or 83.33% of these were referred for help with "environmental" or "tangible" problems.[51] These figures seem to indicate that the social worker's help is seen by staff as encompassing far more than the traditional role of Lady Bountiful, but that material assistance seems still to be regarded as one of her major functions, and that the traditional role of history-taking still remains. This will not be discussed further here, however, but such discussion included in a later part of the text.

That the table shows more men than women seeking help with employment is appropriate, in view of the greater number of men unemployed. However, that the number of referrals for employment is so small a proportion of the total is surprising, in view of the large number of patients in the group who were unemployed. That more men than women were referred

for/....

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51. This percentage does not include the problems under "other," even though two of these might have been added.

for financial assistance also fits in with the greater rate of unemployment among the men of the sample, but that women, who more often than men had families living close to them, sought help with accommodation as frequently as did men (7 : 6) is interesting.

Even when the "additional" problems are studied, bringing the total of problems for which patients were referred to the social worker to 112 for the 88 patients (68 patients referred for one problem, 16 for two problems, and 4 for three problems), employment was noted as problem in only three additional cases, bringing the total up to only 15 patients with such problems, i.e., in toto, 17.05% of the 88 patients regarded help with employment as needed. Accommodation was the associated problem occurring next frequently (7 times), then financial (5 times - all three types included),[52a] then "other" (4 times),[52b] then social history (twice), followed finally by

certification/....

52a,b It is of note that one problem in each of these groups was related directly to problems existing in families of patients. Both were referred by the psychiatrist, one requesting help to his wife in finding employment, and the other asking the social worker to assist his wife financially for the duration of his stay in hospital. The other referrals for family problems were usually associated with requests by the doctor to investigate the social background of a patient, and only two direct requests for such help were made, viz., the two patients needing help with care of children. (See Table XXIV, page 149) while one of the patients referred for financial assistance subsequently transpired to have meant such assistance to his wife.

certification, advice, and counselling (once each). When these figures were added to the others, the order of frequency was only somewhat changed, first still being social histories (26), but accommodation (20) coming next,[53] followed by financial assistance (17) and certifications (17) third, with work (15) still fourth. Material assistance was thus again seen as important, as were the obtaining of social histories and help with certifications, these first two functions being, again, traditionally those of the social worker.

E. PREVIOUS CONTACT WITH A SOCIAL WORKER.

As was remarked previously, some patients did themselves ask to see the social worker, and their doing this, as well as their attitudes and feelings about doing it, are a product of any prior experience which they may have had of a social worker. It was thus interesting to investigate whether any patients had been referred to a social worker in the hospital previously, even if not to the psychiatric one, as this would show how many of the group knew about the service, and for how many of them the experience of seeing a social worker there was not a new one.

Of the 88 patients in the sample, 62 had never

seen/....

53. This was reported by Goldman, F., op. cit., p. 71, as being, in the form of discharge planning alone, or discharge planning associated with other needs, the major reason for referral of medical patients to a social worker.

seen a hospital social worker before,[54] while 26 had, 8 of these patients having seen a social worker more than once previously. Further, 20 of the patients

TABLE XXV - NUMBER OF REFERRALS TO SOCIAL WORKER.

No. of Referrals to a social worker.	Total Group:		Males:		Females:	
	No.	%.	No.	%.	No.	%.
1st Referral	62	70.45	28	63.64	34	77.27
2nd Referral	18	20.45	11	25.00	7	15.91
3rd Referral	1	1.14	0	0.00	1	2.27
4th Referral	3	3.41	3	6.82	0	0.00
5th Referral	0	0.00	0	0.00	0	0.00
6th Referral	2	2.27	1	2.27	1	2.27
7th Referral	0	0.00	0	0.00	0	0.00
8th Referral	1	1.14	1	2.27	0	0.00
9th Referral	0	0.00	0	0.00	0	0.00
10th Referral	1	1.14	0	0.00	1	2.27
Total:	88	100.00	44	100.00	44	99.99

referred previously had been seen by the psychiatric social worker only, 2 by other social workers only, and 4 by both the psychiatric and another worker. Thus, not only was the experience of seeing a social worker at the hospital not a new one for 29.55% of patients, but for the bulk of this group seeing the psychiatric social worker was not a new experience. Whether previous referrals had been for help with the same problem or not, i.e., whether patients returned for help with a chronic problem, or whether multiple problems were dealt with - a different one, or several, on each admission - was not determined.

But/....

54. Previous contact with "outside" workers could not be assessed, but even contact with such workers did not per se mean that the patient knew of the hospital service, though it might have influenced his attitude towards it, This, however, could not be controlled in the present study.

But that the social worker was seen as a refuge, and as her only source of support, was true for all referrals of the female patient seen for the tenth time, and it is interesting that the empirical experience of the writer was that many patients, not able to obtain help from other sources, turned to her as a last resource, and continued to see her after all other avenues had been closed to them, as out-patients if necessary.

F. PREVIOUS PSYCHIATRIC ADMISSIONS TO GENERAL HOSPITAL.

It seemed likely that, if some patients had been seen by the psychiatric social worker more than once, they would also have had more than one psychiatric admission to hospital. And this was indeed the case, 34 patients or 38.64% of the sample of 88 previously having been admitted once or more to the psychiatric wards, the admission during the period of the study being a first one for only 54 or 61.36% of patients.[55] Of the 34 "past admission" patients, 19 had had only one previous admission, while 15 had had more than one, the highest number of readmissions for any one patient being eleven. Of the 26 patients seen previously by a social worker, even though not by the psychiatric social worker, all had had previous psychiatric admissions. Thus 76.47% of patients readmitted to the ward had seen a social worker during a previous admission, though not necessarily the psychiatric one, and 24 or 64.71% had been seen

previously/....

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55. The 15 additional readmissions during the study period are not included here.

previously by the psychiatric social worker during a psychiatric admission.[56] Only 8 patients admitted previously had not been seen by any social worker previously.

When the readmission rates are tabulated, the following table results.

TABLE XXVI - NUMBER OF PREVIOUS PSYCHIATRIC ADMISSIONS OF PATIENTS.

Number of previous psychiatric admissions:	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
No previous Admission	54	61.36	29	65.90	25	56.82
2nd Admission	19	21.59	9	20.45	10	22.73
3rd Admission	12	13.64	5	11.37	7	15.91
4th Admission	1	1.14	0	0.00	1	2.27
5th Admission	1	1.14	1	2.27	0	0.00
11th Admission[a]	1	1.14	0	0.00	1	2.27
Totals:	88	100.01	44	99.99	44	100.00

[a] No readmissions between 5th and 11th.

The rate of patients readmitted to the wards is somewhat higher than the one-fifth readmission rate to mental hospitals reported by Landis and Page for the U.S.A.,[57] but this may perhaps be accounted for by virtue of the fact that admission to a general hospital is less difficult, both legally and

geographically/....

56. This statement is not contradictory, as only previous psychiatric admissions were noted, but not only previous psychiatric social work referral. Thus, it is quite possible that two patients seen only by other workers had been seen during admissions other than psychiatric ones, i.e., that of the 34 patients readmitted only 24 had been referred to the psychiatric social worker while in the psychiatric ward.

57. Landis, C., and Page, J.D., op. cit., p. 130.

geographically, than that to a mental hospital, and also carries with it less stigma, so that patients may be more willing to return to its psychiatric wards, while some may suffer from illnesses which recur but do not fall within a mental hospital program, thus also giving a higher rate. Of the patients readmitted, 9 were alcoholics, 4 psychopaths, 8 schizophrenics, and 13 "others" including 5 depressed patients. Of those readmitted previously and seen by a social worker previously, 9 were alcoholics, 7 schizophrenics, 3 psychopaths, and the 7 "others" included only 2 depressed patients. These figures may tend to show the close relationship of alcoholic, psychopathic, and schizophrenic disorders with social problems, though, once more, the selectivity of the sample prevents any final conclusions being drawn on this point. The frequency with which patients with these diagnoses, as opposed to others, relapse is also indicated, and it is interesting to note that the general number of readmissions for males and females is roughly the same, in spite of the fact that these illnesses occur with differing frequency in males and females, but that more males than females tend to see the social worker more than once.

G. OUT-PATIENT TREATMENT.

The last psychiatric characteristic which was analyzed for the group was that of attendance at the Psychiatric Out-Patient Department, as it seemed that this would indicate those patients who had had some

previous/....

previous psychiatric treatment, even if not as in-patients, and also the rate of medical follow-up for the group. It was found that 39 patients, or 44.32%, had neither been seen previously, nor followed up afterwards, while 10 patients or 11.36% were seen as out-patients before admission but not after, 19 or 21.59% as follow-ups only, and 11 or 12.5% both before and after in-patient admission. Thus 21 patients or 23.86% had had some psychiatric treatment prior to admission, and 30 or 34.09% were given follow-up care. Only 15 of the 21 patients seen at the Out-Patient Department.

TABLE XXVII - PSYCHIATRIC OUT-PATIENT ATTENDANCE OF GROUP.

Out-Patient Attendance:	Total Group.		Males.		Females.	
	No.	%.	No.	%.	No.	%.
No attendance	39	44.32	20	45.45	19	43.18
Prior to admission	10	11.36	8[a]	18.18	2[a]	4.55
After admission	19	21.59	9[b]	20.45	10[b]	22.73
Both	11	12.50	3	6.82	8	18.18
Unknown	9	10.23	4	9.09	5	11.37
Total:	88	100.00	44	100.00	44	100.01

a If the 3 men and 8 women seen both prior to and after admission are added to these figures, 11 men and 10 women received out-patient care before admission.

b If the same numbers are added to these figures, 12 men but 18 women received follow-up care, indicating a considerable difference between the two sexes. Whether this is due to differences in types of illness between thetwo sexes, and hence in need of follow-up, or to different attitudes of the two sexes towards follow-up, or to greater need of the women to hold onto treatment, cannot be stated.

before this admission, had previously been admitted to the ward, and the remaining 6 patients had received

out-patient/....

out-patient treatment alone until the illness or asscciated stresses became so severe as to necessitate hospitalization. Of the 21 patients attending the Out-Patient Department prior to the admission of the study period, 8 had been seen by the social worker while out-patients, and not during a previous admission, even though such might have taken place.

H. SUMMARY.

In summary, then, an analysis of the psychiatric characteristics of the group shows that the patients in it suffer from the whole gamut of psychiatric illnesses, staying in hospital for treatment of these for shorter rather than longer periods. Coming to hospital for medical care, the bulk of them presumably are unaware of the help available to them from the social worker, as they are referred to her predominantly by the ward psychiatrists. The problems for which they are referred to her are varied, as are their illnesses, but tend in general to be associated with material difficulties, and problems in which the social worker's collaboration is needed by the doctor. The rate of relapse of these patients is fairly high, about one-third of them having had one or more previous psychiatric admissions to the hospital, while slightly less had had out-patient treatment prior to admission. Of those patients

previously/....

previously admitted to hospital, approximately two-thirds had been seen by the psychiatric social worker during such hospitalization, and about one-third attending out-patients prior to admission had been seen by her. She had, of course, been associated with all 88 patients during their admissions falling within the period of the study.

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C H A P T E R VII

FUNCTIONS OF THE SOCIAL WORKER - GENERAL.

The nature of these patient-social worker associations is to form the content of the following chapters. Why they came to her originally has been discussed, but what happened thereafter now remains to be shown - what she did with and for them, and what interaction took place in the doing.

A. TOTAL AMOUNT OF SOCIAL WORK FUNCTION.

This information was obtained from the application of the classification system, as described in Chapters III and IV, which yielded most interesting results. For, although the 88 patients were referred to the social worker for help with only 112 problems, in fact far more help was found to have been rendered by her - in terms of functions noted - than merely that relating to these problems, and 605 functions were recorded on the analysis sheet.[1] Thus, although less than one-quarter of the group were referred for help with more than one problem,[2] function rendered showed that an

average/....

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1. Actually, this figure was 678, but 73 of these functions were noted only once on each run, i.e., not confirmed, and it was therefore decided that, in order to ensure that only function reliably indicated was included, only those functions appearing twice would be regarded as having been rendered. Footnotes will be made in the text of differences between the two sets of figures, where these are of interest.
2. Twenty of 88 patients. As stated in Chapter VI, p.151, 16 of these patients were referred for help with two problems, and 4 for help with three, thus giving the total of 112 - 68 + 32 + 12.

average of 6.87, or almost 7, types of help were rendered to each patient, with the modal number of services rendered to the group as a whole, and to the men and women separately, being 5, though more patients received help five or more times than received help less than five times. Only two patients were assisted with only two problems, and the rest received help with three or more.[3]

Thus, although 88 patients were referred for help with only 112 problems, many more problems were actually involved by the end of the study period, and much more service was rendered than simply that relating to these original, specific difficulties. It is interesting that this should be so, and shows, perhaps, that once patients are aware of the social work service, and/or have overcome any negative or ambivalent feelings they may have about it, they are able, and need, to make wide use of it. Or perhaps it reflects the frequency with which social problems are associated with one another, or that one (perhaps minor) problem may be a symptom of a deeper problem, or problems,[4] or that the

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3. Problem and function are not always equated, i.e., a patient may need work and be referred by the worker to an outside agency, while the worker herself also looks for employment for him, i.e., she is dealing with the same problem, but providing two services with which to solve it. Again, such a patient may need temporary financial assistance, and thus two separate problems arise. It is therefore not stated here that all 605 functions rendered were actually also separate problems, but only that actual problems dealt with were two only for two patients, and three or more for the rest.

4. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.YK., 1961 ; p. 81.

real need may be different from the original request for help.

When number of patients was tabulated by amount of help received, the following table emerged.

TABLE XXVIII - NUMBER OF PATIENTS BY NUMBER OF SERVICES RENDERED BY SOCIAL WORKER.

Number of services rendered:	Total Group:		Males:		Females:	
	No:	%	No:	%	No:	%
Two	2	2.27	1	2.27	1	2.27
Three	8	9.09	5	11.37	3	6.82
Four	7	7.95	4	9.09	3	6.82
Five	15	17.05	8	18.18	7	15.91
Six	12	13.64	6	13.63	6	13.63
Seven	11	12.50	5	11.37	6	13.63
Eight	10	11.36	6	13.63	4	9.09
Nine	6	6.82	2	4.55	4	9.09
Ten	5	5.68	2	4.55	3	6.82
Eleven	5	5.68	2	4.55	3	6.82
Twelve	4	4.55	3	6.82	1	2.27
Thirteen	2	2.27	0	0.00	2	4.55
Fourteen	0	0.00	0	0.00	0	0.00
Fifteen	1	1.14	0	0.00	1	2.27
	88	100.00	44	100.01	44	99.99

With the subdivision of the 605 services into the numbers rendered to men patients and the numbers to women, it was found that 323, or 53.39%, services were offered to women, and 282, or 46.61%, to men. Thus, women in general received more help than did men, averaging 7.34 services, while men averaged only 6.41. Explanations for this cannot really be given here, as the aim of the study is not to provide these, but simply to show type and amount of service carried out by the social worker. But it is interesting to speculate whether this greater

amount/....

amount of service to the women of the group is due to some specific characteristic of the women, such as type of illness, and hence need for additional care; or whether, in spite of the fact that men referred themselves more often than did women,[5] something in the nature of the age and sex of the worker, as postulated previously, did, after all, influence their ability (and hers) to relate effectively to her and hence to accept help and/or discuss problems; or whether this is simply a chance distribution of function.

As was discussed in Chapter IV,[6] function was analyzed not only in relation to patients, but also to their families, and the composite figure of 605 functions recorded includes both sets of function, being made up of 540 functions (89.26%) rendered directly, or in relation, to patients, and 65 (10.74%) concerned with patients' families and their needs. These latter 65 functions were distributed among 36 families, with the majority of families receiving help on two points. But 36 is not the total number of families seen - indeed, the families of 56 of the total 88 patients were seen, but 20 were interviewed solely about the patient. Of the remaining 36, two received help only to themselves, but the balance of 34, in addition to presenting problems with which they themselves needed help - either material wants, or difficulties associated with their feelings and problems surrounding the patient's illness - also assisted around care of the patient. So, in all, the families of 63.64%

of/.....

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5. Chapter VI. p143, See Table 23.
6. Chapter IV. p.72.

of patients were seen.[7]

However, these "bare statistics" do not have any meaning unless the background to them is understood, and the dynamics of them formulated. It is not sufficient to know how much function is provided, unless the interaction taking place between patient and worker, and the patient's approach and feelings about the situation are understood. Then function can be broken down into its various types, and meaning given to these in terms both of statistics and processes.

B. THE IMPACT OF MENTAL ILLNESS ON PATIENT & FAMILY.

In order to paint this backdrop against which function took place, some space will be devoted here to a discussion of the impact of mental illness on the patient, and on his[8] family. Hospitalization has already been described as a crisis situation to both patient and family,[9] but what this actually means to the patient and his family, not only in terms of the stresses it imposes on them, but in terms of how it colours their perceptions of things, and their reactions and attitudes, has not been discussed.

(a) The Patient.

The functions and structure of the General Hospital,

and/.....

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7. The details of work to and with the family are discussed in passim throughout the text, and drawn together in Chapter XI, pp. 332, where they are more appropriately elucidated.
8. This term is used here to indicate male or female patients, in order to avoid the clumsiness of using the pronouns and adjectives of both sexes in an and/or manner.
9. Chapter VI, p. 146.

and its purpose in the community, all results in its being a place to which patients come when they need help i.e., at the moment of illness, and in an unprepared way, rather than in a planful way, and the vast majority of psychiatric patients are admitted in this manner. To many of these patients awareness only that something is not right, rather than awareness of what it is that is wrong, brings them to hospital, or leads their families to bring them, protesting, "to the doctor." Other patients arrive more bizarrely ill, some knowing the nature of their illness, some fearfully suspecting it, some denying it. A few patients return to hospital for repeated admissions, and a sprinkling may come from the out-patients department, or from Casualty, where they have been supported by the psychiatrist till room is available for them in the ward.[10] There is thus only very occasionally any kind of pre-admission or intake service to patients, and the experience of coming to hospital for help and being referred to a psychiatrist, or told he is mentally ill, may be a shocking and unforeseen one to the patient, his first contact with such illness; or it may be a distressing confirmation of a fear. Even for the patient readmitted or somewhat prepared for treatment, anxieties may be exacerbated at the time of admission, though for a few the need for hospitalization may be so great as to make its achievement a relief. For those patients who deny the illness, and to whom the threat of it is too great, hospitalization may not be

possible/...

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10. As discussed in Chapter I, p.15.

possible, and the voluntary nature of admission to the unit makes it un-enforcable; but/to others, being shocked into facing the problem squarely, while bringing with it new problems, may alleviate some of the old, and their associated doubts and uncertainties and fears. That admission is to a general hospital may reinforce denial or minimization of the illness by some patients, the rationalization being that they may be ill, but if they were very ill or really ill they would be in a mental, not a general, hospital. For others, again, by virtue of this treatment being in a general hospital, the stigma of it is largely removed, and the common denominator of "sickness" in a general hospital lessens also the stigma of the actual disease, though it may not remove it completely, and though it may not have this effect immediately.

For the patient who is admitted to hospital without real awareness of the nature of his illness, and without insight into it, or with blunted perceptions and impervious reactions, diagnosis and admission are perhaps not so fraught with anxiety. But to those with understanding of the diagnosis, and especially to those with fear of mental illness, the "final diagnosis" may bring with it many uncertainties. Reactions to it will be based not only on those responses emanating from the nature of the illness itself, but on past experiences of mental illness, on knowledge or lack of this about it, and on social class and cultural attitudes towards mental illness, and will be associated with uncertainties relating to what will happen to him, what mental

illness really means, whether he will get better, whether it will "happen again."

And added to this is the strangeness of being in hospital, and of the physical being of the hospital, a place with again culturally determined connotations and perhaps associated in the patient's mind with unpleasant treatments, and with limitations of personal freedom, and conformity to regulations which he finds hard to tolerate. The unfamiliarity of the environment, and the strange faces surrounding him, may aggravate the symptoms of one patient, or may reinforce the insecurities of another, or may, in spite of their strangeness, give a third something onto which to hold, an orientation otherwise missing. For other patients, again, where the illness is used, either consciously or unconsciously, as a way of escaping from an unpleasant reality situation, these fears may be non-existent, and in their stead a wish to stay. Then, too, because the hospital is community-centred, some patients admitted, such as alcholics not yet psychotic, are those who would normally not reach a psychiatric treatment centre, or who might be admitted to a general ward if such a centre did not exist, and, without insight that they have a problem, or with aggression that others regard them as in need of help, have reactions in keeping with these attitudes. Again, the fact that admission to the unit is not based on legal procedures may enable such patients as the psychopath, arriving with a valid presenting symptom, to be admitted to a ward which can be used until his purpose has been served, and then vacated without

legal/.....

legal complications.[11] The attitudes and reactions of such patients will, again, be different.

Thus, reactions of patients to diagnosis and to admission to hospital are varied, each patient having his own associated problems. By and large, however, the situation may be regarded as one of crisis and uprooting for the patient from his "normal" environment, and even though these immediate reactions in relation to the experience may begin to settle and subside after a few days,[12] they may not, and may come to be supplemented, or replaced, by other fears. So, the married patient may worry about his family, the mother about her son, the single patient about who will help him when he is discharged, what will happen to him if he falls ill again. And with each step forward in treatment may come additional problems, until the final one of discharge has to be faced. To those patients who have become dependent on the hospital or its staff, and who cannot let go of treatment, or to whom change, even of a "good" nature, is threatening, this may present difficulties, while others may try to prolong the hospital contact through fear of facing the community again, or uncertainty about whether they are well enough to do so. And so the dynamics of the situation fluctuate and change, but are always there.

(b) The/....

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11. This sort of patient at one time presented several problems to doctors in the unit - inter alia, they often could not be summarily dismissed from Casualty in case of legal or other ramifications on the doctor; once admitted they were difficult to dislodge from the ward; they frequently exploited the facilities of the unit; they were often felt to be "blocking" beds needed by other patients.
12. See Chapter VI, p. 146.

(b) The Family.

With the family, too, this is the case. For, "unlike other stressful situations which may befall the family, such as death or physical illness, in which expectations regarding behaviour are relatively clear, and in which forms of help and sympathy from others are socially prescribed and formalized, no similarly clear guides or patterns for response are apparent in the case of mental illness," [13] and the family, faced also with a crisis situation, may not know how to react. Shock and fear, as with the patient, may flood in, and these must be viewed in terms not only of the present situation, but also in terms of the events leading up, and related, to it.[14] Not only may the family's knowledge, or lack of this, and prior experience of mental illness influence how its members will react, but the behaviour of the patient prior to admission may also do so. In other words, family members may try to "normalize" the patient's behaviour - i.e. extend the bounds of normality and of normal behaviour - in an effort still to define the patient as well,[15] and if such behaviour is not bizarre, it may be difficult for a resistant family to accept the doctor's diagnosis and patient's hospitalization.

Again/.....

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13. Yarrow, M.R., Clausen, J.A., and Robbins, P.R.: "The Social Meaning of Mental Illness," Jnl. Soc. Issues, Vol. XI, No. 4, 1955; p. 23.
14. Parad, H.J.; "Brief Ego-Oriented Casework with Families in Crisis," in Parad, H.J., and Miller, R.R. (Eds.), Ego-Oriented Casework: Problems and Perspectives, F.S.A.A., N.Yk., 1963; p. 149.
15. Yarrow, M.R., et al: "The Psychological Meaning of Mental Illness in the Family," Jnl. Soc. Issues, Vol. XI, No. 4, 1955: pp. 15, foll.

Again, if the behaviour is so strange as to force some sort of action, this does not necessarily mean that the family will accept the hospital's interpretation of the patient's illness,[16] but once hospitalization of any sort is recommended and takes place, a stressful and unaccustomed state of affairs results, to which family members have, nevertheless, to adapt.

Not only must this adaptation take place in relation to the family's acceptance of the hospital situation, even where relief is associated with the removal of the patient for treatment, and the respite to the family thereby gained, but family interaction - the unique day-to-day patterns of family behaviour and management[17] - will change, and various problems arise in the course of treatment. Wives and children will have to face the responsibility of caring for themselves, or fathers that of caring for their children, or the remaining spouse settle into loneliness. The changes in intra-familial relationships and roles, associated with illness of any kind,[18] will have to begin, and the family start to cope

with/....

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16. Ibid, loc. cit., especially p.23. These authors actually discuss reactions of wives to husbands' illnesses, but it seems to the present writer that these generalizations are able to be extended to other family members as well.
17. Scherz, F.H.: "Family Interaction: Some Problems and Implications for Casework," Smith Coll. Stud. in Social Work, Vol. 3, No. 2, Feb. 1961; p. 88.
18. Parsons, T., and Fox, R.: "Illness, Therapy and the Modern Urban American Family," Jnl. Soc. Issues, Vol. VIII, 1953: pp. 31 - 44, passim; and Smith, B.J.: "Impacts of Emotional Disturbance on Family Life," Abstract of thesis, in Smith Coll. Stud. in Social Work, Vol. 31, No. 1, Oct. 1960; pp. 60 - 61.

with its problems, not least among which may be the anxiety and guilt generated by the fear that the illness was caused in some way by the family, and the fear of "who next?" in the family.[19]

At the moment of admission, not only do uncertainties crowd in, together with fear of the outcome of the illness, but, in spite of the admission being to a general hospital, feelings of stigma, as with the patient, may emerge, and community attitudes be feared,[20] while constraint in discussing the problem with others may prevail both during and after the period of hospitalization.[21] As the immediate crisis situation settles into a constant one, relatives will want to know what the outcome of the illness will be, may be troubled about treatment procedures and their necessity, and wonder how - and whether - to plan for the patient's discharge. Conversely, where rejection of the patient by the family and surrendering of their responsibility for him result because the threat or stigma of the illness is too great for them to bear,[22] or because they

cannot/.....

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19. Irvine, E.E., op. cit, pp. 23 - 24;
Hughes, K.M: "Resistance in Relatives of the Hospitalized Mentally Ill," Smith Col.Stud. in Social Work, Vol.XXIX, No 1, Oct., 1958; p.40; stresses the first anxiety.

20. Freeman, H.E., and Simmons, O.G: "Feelings of Stigma Among Relatives of Former Mental Patients," Social Problems, Vol.8, Spring, 1961: p. 312 - 321. These authors found that feelings of stigma varied with degree of bizarre behaviour manifested by the patient, with the social class and identification of family members, and with their personality characteristics.

21. Deasy, L.C., and Quinn, O.W: "The Wife of the Mental Patient and the Hospital Psychiatrist," Jnl. of Social Issues, Vol. XI, No. 4, 1955; p. 49.

22. Shea, M.M. : "Planning for Psychotic Patients at Home," Social Casework, Vol. XXXI, No. 10, Dec. 1950; p. 422.

cannot face the responsibility of once more caring for the patient,[23] attitudes and reactions will once more differ, and different problems arise.

C. PATIENT - WORKER RELATIONSHIPS.

It is only when function is regarded in the light of these fears and ambivalences, uncertainties and doubts, that any real understanding of it and the role of the social worker can occur. For interaction between patient and worker will take place not only in terms of the patient's illness and related problems, his background and cultural history, but in terms of how he feels about his illness and how, in view of this, he reacts to the hospital staff with whom he comes into contact.

Thus, out of all this will arise not only function, but relationship between patient and social worker in the carrying out of this function, this relationship being the quality on which all interaction between the two will rest. Yet, conversely, function will determine relationship to some extent, and the two are closely intertwined. For the depth of the relationship may determine what will be indicated by the patient to be a problem, and what he feels secure in revealing, while the more he feels able to reveal, and the more problems with which the social worker is able to help him, the deeper, in most instances, the relationship will become.[24] Had

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23. Irvine, E.E.(Ed.), Ventures in Professional Co-operation: Mental Health in Clinic, Hospital and Community, A.P.S.W., London, 1960; P. 49.

24. Though fluctuations may occur, sometimes being associated with withdrawal by the patient after expression of deeply meaningful material.

it been possible to analyze time spent with patients, some association might have been found between this and the nature of the relationship between patient and social worker.[25] However, even without an assessment of time, it is possible to postulate that, because the period for which patients were in the ward was short (average 28.9 days), the time available to the worker in which to establish such a relationship with a patient was limited, even though follow-up work was carried out with some patients;[26] for this latter was not done with patients not yet known to the social worker, and hence where some kind of relationship did not already exist.[27]

When relationship for each patient had been "rated", it was found that relationship for 69 of the 88 patients had been assessed identically on both trials, but that for the balance of 19 patients a different assessment had been given.[28] In order to determine, for purposes of discussion, what sort of relationship existed between patient and worker for these 19 cases, it was decided that the second "ratings" given would be regarded as the correct ones, as these had been found, on the whole, to be somewhat lower than the first,[29] and it seemed that any

tendency/.....

25. See Chapter III, p. 51. Item (15).
26. As discussed in Chapter XI, pp.337 foll. & esp.p.346.
27. See Chapter III, p. , for definition of relationship. As outlined in this chapter. relationship was assessed in relation to each patient, and was classified, according to various criteria, as very good, good, fair, or poor, in nature, and the additional categories of "nil" and "X" provided to cover, respectively, those cases where the patient was not seen at all, though his relatives or friends might have been interviewed, and those cases where there was insufficient data in the record to make a judgment, or where the patient's illness precluded the making of such a judgment.
28. As discussed in Chapter IV, p. 79.
29. Idem.

tendency to over-estimate relationship would thus be controlled, and that the second assessments were therefore the more reliable. On this basis, it was found that relationship with 17 patients was classified as very good, with 14 as good, with 9 as fair, with 17 as poor, with 19 as "Nil" and with 12 as unable to be assessed. Therefore, of the 57 patients for whom relationship could be assessed, 31 patients, or the same number as were not assessed, were defined as having good or very good relationships with the worker, while the patient-worker relationship for 26 patients was defined as being only fair or poor. Nevertheless, 40 patients, or almost half of the group, had some kind of positive relationship with the worker,

TABLE XXIX - NATURE AND NUMBERS OF PATIENT-WORKER RELATIONSHIPS.

Assessment of Relationship:	Total Group:		Males:		Females:	
	No:	%	No:	%	No.	%
Very good	17	19.32	6	13.63	11	25.00
Good	14	15.91	5	11.37	9	20.45
Fair	9	10.23	4	9.09	5	11.37
Poor	17	19.32	10	22.73	7	15.91
Nil	19	21.59	12	27.27	7	15.91
X	12	13.64	7	15.91	5	11.37
Total:	88	100.01	44	100.01	44	100.01

and only 17, or approximately one-fifth of the group, a negative one. In spite of the presumably short-term nature of the contact and the types of illness represented, in only 12, or about one-eighth of cases, could relationship not be assessed. Almost one-quarter of the

group/.....

group, or 19 patients, were not seen at all (nil), 9 of these patients having been referred for certification to a mental hospital, 8 for social histories, and 2 for planning in which they were too ill to participate. The practice and ethical considerations involved in not seeing patients but carrying out services for them, or through their relatives, will be discussed in later and more appropriate sections of the thesis.

Of the 17 patients with whom a very good relationship was described as existing, none had received less than five kinds of help, and the average number to the group was 9.71, with a maximum of 15, whereas for the 17 patients for whom patient-worker relationships were assessed as poor, the average number of services rendered was 6.17, with a minimum of 2 and a maximum of 14. Thus approximately 50% more service was rendered to the first group of patients than to the second. It must be stressed again, however, that whether the greater amount of service rendered to the "very good" group was due to there being such relationships between the worker and patients, or whether the "very good" relationships between them facilitated the rendering of more service, cannot be stated. However, while it is possible that each influenced the other, and that the two factors are inseparable,[30] it must be noted that "relationship is not

built/.....

30. It must here again be pointed out that relationship was assessed at the end of contact, or at 31.12.63. Although it is quite possible for relationship to be established as good (or bad) at the first meeting of patient and worker - due to those elements of spontaniety which remain so essential a part of the professional relationship - the more controlled or "deeper" relationship between patient and worker, resulting from their association at a "working" level, is here discussed. The statement to which this footnote is appended must be understood in this context.

built in vacuo, but develops as specific human needs for support and relief from tension are met by an intuitively understanding, clinically competent person,"[31] and that "the significance of the relationship increases as both client and worker develop the ability to communicate with and to understand each other."[32]

When amount of service rendered to the "good" and "fair" groups was investigated, it was found that, for the former group, the average number of services rendered was 6.86, with a minimum of 3, and a maximum of 10, but that these for the latter group were 7.89, with a minimum of 5, and a maximum of 11. Had these averages been reversed, it might have been possible to postulate a proportional association between amount of service rendered and type of relationship existing between patient and worker. But, in view of the results obtained, the most that can be conjectured is that there seems to be some association of a positive relationship between patient and worker (very good, good, or fair) with a higher number of services rendered by the worker (average of 7.60), and of a negative relationship between patient and worker (poor) with a lower number of services rendered by the worker (6.17). The limitations of the sample preclude the determining of whether or not these differences in number of services rendered are statistically significant, however.

It is particularly interesting to note that, of the

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31. Parad, H.J., op. cit., p.151.
32. Feldman, Y.: "Integration of Psycho-analytic Concepts into Casework Practice," Smith Coll. Stud. in Social work, Vol.XXX, No. 2, Feb.1960: p.156.

17 patients falling within the "very good" group, only one had no known family, and 9 lived alone, through choice or because their families were not in Johannesburg, or because they were estranged from their families; two had as their only "interested" relatives young children for whom they were responsible;[33] and only 5 were living with relatives at the time of their admissions to hospital. Not one of the group was married and living with a spouse, while 5 were divorced, 2 widowed, and the rest single. It might therefore be postulated that perhaps the bulk of this group thus had no-one else to whom to turn for general help and support, that the social worker was regarded by them as the only person showing any interest in them, or as a last refuge, and that possibly these factors contributed to the strength of the relationship. No such marked lack of family interest showed in any of the other three groups assessed. When the predominant diagnostic category for the "very good" group was sought, it appeared to be that of affective illnesses (6) followed by addictions (4) and schizophrenic and paranoid states (4); the balance (3) were varied. This grouping did not seem to be significant in any way, and all these illnesses were found in the "good" and "fair" groups, the only apparent difference between groups being between "very good" and "poor", for in the latter group there were no schizophrenic patients, while in the former there

were/.....

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33. The sons of one of these women were removed from her care in terms of the Children's Act, No. 33, 1960, during the period of the study.

were no psychopathic patients, though 5 of the 7 patients diagnosed as such fell into the "poor" group. It is interesting that the 3 schizophrenic patients in the "good" group were placed there only in terms of the definition given of this group,[34] and would otherwise have been classified under "very good." For 5 of the group "X", relationship could not be assessed because of the nature of the illness, rather than because of lack of information in the record, and it is of note that this quality could not be assessed, due to such lack of information, in only 7 or 7.95% of the total group of cases.[35]

A variable which, it was thought, might have influenced relationship positively was that of previous contact with a social worker, and it was found that, in fact, 9, or 34. 62%, of the 26 patients who had seen a social worker previously fell into the "very good" group, 3 into the "good," 3 into the "fair," 6 into the "poor"[36]/.....

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34. Chapter III, p.64 "... in terms of the patient's capabilities, the relationship may be a very good one, and a constant one, (but) compared to those established with non-psychotics, it has in it an element of unreality, and the intangible."

35. In spite of the fact that records were not research ones (see Chapter II, pp. 20 foll.), and that this intangible is not routinely described in the records kept.

36. Interestingly, 3 of these were psychopathic personalities, 2 alcoholics (for one of these the additional diagnosis of psychopathic personality was made), and one an attempted suicide (also query psychopathic personality). This possibly indicates that at some time, as predicated in Chapter III, p. 66 , i.e., item (d) (vi), the relationship between patient and worker had been different.

"poor," 3 into the "Nil," and 2 into the "X" groups. Thus, more than half of those patients with a very good relationship with the social worker had seen her previously, and more patients of the group who had seen her previously fell into the "very good" group than into any other single group. It also seemed possible that, although the point in time, after admission, at which a patient was referred to the social worker, could not be assessed, a long hospital stay might be associated with a chance of longer contact with the social worker, even if the patient was not referred shortly after admission, and that, at least, a longer period in hospital might make the patient feel more comfortable in relation to the hospital and its personnel in general, and that some of this attitude might carry over to relationship with the social worker, even if the patient was referred shortly before discharge. Whether these or other factors were the operative ones could not, of course, be finally declared, but there did seem to be some slight connection between length of hospital stay and relationship of patients with the social worker in that the "very good" group averaged 40.12 days in hospital, and the "poor" 32.23 days. The "good" and "fair" groups averaged 28.29 and 26.00 days, respectively, which, however, possibly negates this relationship to some extent. It is of note that the 7 patients for whom relationship could not be assessed[37] were in hospital for an average of 44.71 days.

Whether/.....

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37. There were 12 in this group, but 5, as already noted, were classified into it because of diagnosis, and it therefore seemed relevant to discuss only the remaining 7 here.

Whether inability to assess relationship was due to poor records and inability on the part of the worker to supplement these from memory, or whether these patients were referred and seen briefly and/or shortly before discharge is difficult to say, and hence the meaning of this figure cannot be given. In any event, all the figures given above relate, in their significance - if any - only to the present sample, and, again must be viewed in this context.

Emphasis was placed, in the preceding chapter, on the importance of the person referring the patient in determining patient attributes towards the social worker, and it seemed of consequence that the bulk (12) of the patients in the "very good" group had been referred by a psychiatrist, while of the 8 patients self-referred to the researcher, 5 fell within this group, and one into the "good" group. The remaining two, diagnozed as psychopathic personalities, had maintained good working relationships with the writer until she had, as described in Chapter III,[38] refused to continue complying with their wishes. It might be postulated that the doctor's influence here was thus possibly a positive one. Further, however, where a patient needs help, whether or not he approaches the social worker directly, will make no fundamental difference,[39] the actual degree of his motivation may in fact facilitate a positive relationship, and certainly seems to militate against a poor one.

Finally/..

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38. Page 66 , item (d) (vi).
39. Chapter VI, p. 144.

Finally, it seemed that not only the person referring the patient, but the number of problems for which the patient was referred, might have some bearing on relationship, as possibly a patient with more needs would be more receptive to someone able to help with these than one with less. However, distribution on this point was equal in the four groups assessed, and no such trend appeared in the "Nil" and "X" groups.

A brief return must be made here to Table XXVIII, for the apparent differences in degree of relationship with the worker between men and women cannot be ignored. While the several variables discussed above, rather than the sex, per se, of the patients may have had the greatest influence on relationship with the worker, the already oft-raised question[40] of whether men found it more difficult to relate to a young female worker than did women must again be brought up, as also the query of whether the worker herself was less able to work with men than women, with older than younger persons, or with patients

suffering/.....

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40. E.g., pages 42 and 144.

suffering from some rather than other diseases.[41] It must not be forgotten, that such differential trends as appear to exist in the sample may be due solely to the selectivity of it.

Viewed in perspective, it seems that 17 or 29.82%

of/.....

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41. The age groupings for the sample showed no trend that the older or the younger patients fell into one or other relationship group specifically. Further, empirically, the writer had at no time noticed, or felt herself, in practice, more able to relate to women than men, but was aware generally of her greater ability to work with patients other than "psychopathic" ones, and the great number of this group (5 diagnosed clearly as such, and 2 with this as an additional diagnosis) among those having a "poor" relationship with the worker, and the fact that 5 were males may in part account for this greater number of men than in women with a negative relationship with the worker. This tendency of the worker to prefer working with patients in other diagnostic groups was often attributed by her to a feeling that, with limited time in which to see and assist patients, she preferred to work with those patients who might benefit from help rather than with the "hard-core" patients whom the unit was not really geared to treat.

    It is interesting to note, here, that Edgren, reporting a study on initial interviews in relation to sex differences of the interviewer - a male psychiatrist and a female social worker - found that both male and female patients preferred treatment by psychiatry and by the male sex, but showed greater liking for the social worker as a "friend", regarding the psychiatrist as a paternal authority figure. Further, the men as a group preferred male help in problem-solving areas, but female in relationship centred ones, with both sexes preferring help from their own sex to figure out a tough problem and to get an understanding of puzzling behaviour. This latter statement is perhaps of most significance in the present study. (Edgren, S.F.: "Initial interviews with Relation to Sex Differences", Smith Coll. Stud. in Social Work, Vol.XXXIV, No. 1, Oct. 1963, pp. 78-79).

of 57 patients assessed for relationship (i.e. falling into the categories very good, good, fair, and poor), is not an excessive proportion for whom a "poor" relationship is defined. For, although the professional, controlled response of the worker, determines her part of the relationship, it would seem to the present writer unrealistic for all relationships, with all patients, at all times, to be positive, whether strongly or lesserly so, even with great exercise of self-awareness on the part of the worker. Further, this is not the only influence operative in relationship, and the worker, while able to control her own reactions, is not able to control completely those of her patients; even though "the caseworker's response, which contains the elements of compassion, impartiality, respect, spontaniety, and stimulation, ordinarily results in a relationship that is predominantly one of confidence in the caseworker,"[42] the feeling of the present writer is that both the apparently short-term nature of the contact, as well as some of the factors outlined above - especially diagnosis, and hence the ability or otherwise of the patient to form a strong working relationship with the worker, - even though the relationship may be meaningful to the patient - may also determine the nature of the relationship.

D. SUMMARY.

Because relationship is viewed by the present writer as/.....

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42. Community Service Society of New York: Method and Process in Social Casework, Report of Staff Committee, F.S.A.A., N.Yk., 1952; p.7.

as the basis on which, and the tool through which, service is rendered to the patient by the caseworker, and "not an end in itself, but a dynamic that is used by the caseworker to influence the client's motivation to seek and use help in any phase of the casework process,"[43] and because its assessment formed a sizeable portion of the research project itself, it seemed appropriate that time should be spent in discussing it in the present chapter, not only as a part of the results of this research, but in the hope that, against this background of relationship and of the fears and anxieties concomitant upon psychiatric diagnosis and hospitalization, the figures of function given at the beginning of this Chapter take on some depth. For, as has been pointed out, function is not carried out in vacuo, but against this whirl of interactions, interrelationships, problems, and reactions.

But the figures still remain general ones, relating only to function in general, and indicate only how great an amount of service, rather than what kinds of service, were rendered. When broken down into types of function, and viewed, in addition, against the backdrop of this conglomeration of influences, it is hoped that far more meaning will attach to function, and the following chapters will attempt, not only to describe and discuss, in a more detailed way, functions of the social worker to the group of patients in the sample, but to relate these back to this background, and the types of relationship which accompanied the rendering of various types of service.

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43. Ibid, loc. cit.

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C H A P T E R VIII.

THE TRADITIONAL FUNCTIONS OF THE SOCIAL WORKER: MATERIAL ASSISTANCE AND ENVIRONMENTAL MANIPULATION.

In some ways, the title of this chapter is a misnomer, for, as was pointed out earlier,[1] psychiatric social work began not only as an effort to assist the indigent insane, but as an after-care service for mentally ill patients discharged from hospital. Later the social worker began, characteristically, to deal with families of patients,[2] and to obtain social histories about patients.[3] However, in terms of the history of social work in general, and particularly as illustrated in the development of the various Charity Organization Societies,[4] the alleviation of destitution through the provision of material services formed the earliest kind of help provided by social workers, and, in this sense of history, the present chapter is named.

A. Material/...

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1. Introduction, pp. (xiv) - (xv)
2. Idem, p. (xv); and Timms, N., Psychiatric Social Work in Great Britain (1939-1962), Routledge and Kegan Paul, London, 1964; p. 114.
3. Lieberman, A.A.: "A Psychiatrist Views the Role of the Psychiatric Social Worker in the Mental Hospital," Jnl. of Psych. Social Work, Vol. XXII, No. 4, June, 1963; p. 196.
4. As discussed, inter alia, by: Mowat, C.L.: "Charity and Casework in Late Victorian London : The Work of the Charity Organization Society," Soc. Serv. Rev., Vol. XXXI, No. 3, Sept. 1957; pp. 258-270, passim.
   Pumphrey, M.W.: "The 'First Step' - Mary Richmond's Earliest Professional Reading, 1889 - 91," Soc. Serv. Rev., Vol. XXXI, No. 2, June 1957, pp. 144-163, passim.
   General texts on social work.

A. MATERIAL ASSISTANCE AND ENVIRONMENTAL MANIPULATION.

(a) General.

While "material assistance" is a term clearly understandable, that of "environmental manipulation" is slightly more ambiguous, and here is extended beyond the traditional one of dealing with tangibles or constants in the patient's environment, such as finding him employment and accommodation, to include, as well, "modifications of the .... social and human environment of the client."[5]

Environmental manipulation or modification is seen by Schmidl as a technique of supportive treatment,[6] and, under the name of "Direct Intervention" viewed similarly by the Staff Committee of the Community Service Society of New York.[7] However, the present writer, while agreeing with the statement that by such work is meant "the caseworker's action undertaken to achieve changes in the client's reality situation,"[8] and "used for the purpose of enriching the environment or reducing or eliminating avoidable and unnecessary stresses,"[9] is of the opinion that while, in some instances, such action may be a part of supporting the patient,[10] it is also,

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5. Hollis, F.: "The Techniques of Casework," in Kasius, C. (Ed.); Principles and Techniques in Social Casework, F.S.A.A., N.Yk., 1953; p. 414. This point is elaborated in Chapter III, p. 55, item 5.
6. Schmidl, F.: "A Study of Techniques in Supportive Treatment," Social Casework, Vol. XXXII, No. 10, Dec. 1951; p.418.
7. Community Service Society of New York: Method and Process in Social Casework; Report of a Staff Committee, R.S.A.A., N.Yk., 1958; p. 18.
8. Ibid., loc. cit.
9. Ibid., loc. cit.
10. Supportive work is discussed in Chapter IX, p. 232, foll.

in the general hospital psychiatric setting, a social work method - or way of working - and function, on its own. Thus it is here separately discussed as such.

Berkman terms such "concrete practical services" simply "Tangible Services"[11] stating that this term seemed more appropriate than the older "environment manipulation", which appeared infrequently in her study,[12] and that it implied a difference "not in the nature of what was needed and provided but in the attitude and philosophy expressed by the worker."[13] This approach was shown in the provision of such service when the patient was too ill to provide it for himself, but with the emphasis remaining on the patient's responsibility for meeting his own needs as far as he was able to do so.[14] That a supportive value to the patient is "inherent in the provision of concrete services"[15] and that "supportive and concrete services represent two facets of a service provided directly to the patient himself on a level dictated by needs resulting from a severe, incapacitating illness,"[16] are statements somewhat more acceptable to the present writer than those regarding such "concrete" help solely as a part of the

former/....

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11. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Phys. Social Workers, N.YK., 1953; p. 43.
12. This study is outlined very briefly in Chapter II, pages 27, foll.
13. Berkman, T.D., op. cit., p. 44.
14. Ibid., loc. cit.
15. Ibid., p. 43.
16. Ibid., loc. cit.

former, though agreement with these, as stated, holds to some extent.

Although working with community agencies and resources is seen by Berkman as a part of tangible service,[17] in the present study this is classified separately, as it was regarded as something slightly more specific in the hospital setting, where not only does the social worker (often) refer a patient to an "outside" agency for care, if the problem is one not directly related to his getting well,[18] but she also refers the patient to appropriate community agencies on his discharge from hospital.[19] This function was therefore assigned its own category, and is discussed later in the text.

The material here included under "material assistance and environmental manipulation" is thus seen to encompass both tangible services and work with persons in the patient's environment, and appropriately designates "the steps taken by the caseworker to change the environment in the client's favour by the worker's direct action."[20] These steps form in themselves both an independent method of social work, involving certain types of function, and a part or associated technique of supportive treatment of the patient.

While/....

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17. Ibid., p. 44.
18. Stroup, H., Social Work - An Introduction to the Field, American Book Co., N. Yk., 1953; p. 363. This statement is in the present context perhaps too limited, but is useful in that it stresses the amount of such work carried out.
19. Knee, R., Better Social Services for Mentally Ill Patients, Amer. Assocn. of Psych. Social Workers, N.YK., 1954; p. 73.
20. Hollis, F., op. cit., p. 413.

While environmental help is usually carried out by the worker only when the patient cannot deal with the problem himself,[21] in a hospital it is perhaps carried out slightly differently, for the internal structure and hierarchy of the general hospital, of which social work is only a part, and hence must adapt to its host, often lay down the correct channels through which, and the people by whom, certain functions must be carried out. Again, the social worker often has easier and more effective access to agencies providing various grants and financial assistance than does the patient. These, and all other financial assistances, as well as the various "red tape" or administrative and organizing functions of the social worker in the hospital were included under the head "Material assistance and environmental manipulation." Assistance given by the worker in relation to a patient's accomodation or employment was also included here, and that relating to the patient's "human" environment, as discussed above, also placed in this section.[22] It is interesting that Berkman includes, as does the present writer, such functions as various arrangements with landlords, and those relating to handling of patients' legal problems, in this section.[23]

Within/.....

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21. Ibid., p. 414: and Berkman, T.D., op. cit., p. 44; and as already discussed in this Chapter.
22. In order to avoid duplication, the reader is referred to Chapter III, pages 53, foll., for details of what functions are here included and their division into sub-groups.
23. Berkman, T.D., op. cit., p. 43. It is of note that the present writer had formulated this group before discovering the inclusion of these points in it by this author.

Within the terms of this broad definition, it was found that 135 functions of this kind had been performed, of the total 605, in relation to the 88 patients in the sample, and during the period of the present study.[24] Thus 22.31% of functions rendered, or more than one-fifth of these, were concerned with environmental modifications. Even when the group of functions relating to modifications of persons in the patient's environment were subtracted, in order to limit the type of function to its very narrow and original meaning, it was found that 116 or 19.17% of the 605 functions rendered fell within this group. It is interesting that of the total 135 activities performed, 72 were to women, and only 63 to men. When function to patients and families was separated, it was found that only 5 functions had been rendered to the families of patients, being divided among three families, and that all of these were related to male patients, and dependent upon them. Furthermore, the 135 functions were divided among 57 patients, or 64.77% of the group, as 31 of the group received no help of this kind. Only 18 of this former group received environmental help to themselves or their families once only, the balance of 39 each being assisted twice or more often.

(b) Sub-Groups.

However, when the sub-groups of this category are separately viewed, perhaps more specificity as to the amount of function rendered is obtained.

(i) In/....

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24. Including those functions scored only once, this figure was 158, or 23.33% of 678.

(i) In taking, first, the three-fold division of "Assistance Relating to Finance," it is found that 46 separate functions were rendered here - 22 to women, and 24 to men, with that in relation to 3 of the latter group being to family members. Thus, although only 7.61% of all help and 37.78% of material help was actually related to financial assistance, this was given to 30 patients, as opposed to the 12 originally referred for such help, and even the 17 referred when additional problems were included.[25] Of this total of 46 functions to 30 patients, 26 (12 males;[26] 14 females) were related to help with government grants and pensions, 9 (5 male;[27] 4 females) to "general relief", and 11 (7 males; 4 females) to "other" financial assistance. That 1(a)[28] was the predominant type of financial assistance given is logical, as much of this covered the obtaining of sick benefits for patients,[29] and, especially as women were more often employed than men,[30] that they should have received slightly more help of this kind is to be expected.

The routine channels through which much of this work is done[31] may at times lead to the question of whether such services could be carried out by an untrained or partially trained worker. Thus, the Welfare

Medical/....

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25. See Chapter VI, pages 151, foll.
26. Including 1 family.
27. Including 2 families.
28. Code numbers as described in Chapter IV, page 71, footnote 6, and relating to the classification system.
29. See this chapter, p.195, footnote 42, for explanation of this procedure and Act governing it.
30. Chapter V, p.118, Table XVII.
31. With the exception of 1(c), usually.

Medical Care Project of the New York Hospital, New York, employs case aides to deal with such routine problems as the obtaining of prostheses for patients,[32] and the Travellers' Aid Society, Chicago, Illinois, in 1962 reported the introduction of a similar scheme, whereby, inter alia, clients "with concrete problems" were assigned to case-work assistants for help by means of "concrete services."[33] Heyman, in 1961, described the differential use of staff in a hospital setting, and discussed the use not only of case aides to assist in service to clients - including help with financial assistance - but also of agency secretaries.[34] In both these latter schemes, cases could be transferred from one level to another.[35] Rooney and Mason, as far back as 1952, wrote of a scheme, introduced by the United States Army, for the training of psychiatric social work technicians, to assist generally in the military psychiatric social work programme.[36]

Special training is instituted for these technicians and the case aides reported in the other schemes frequently had had years of experience in the field, albeit as untrained workers.

All/....

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32. Dennis, M.A., and Goodrich, C.C.: "Co-ordinated Medical Care of Public Welfare Clients: Implications for Medical Social Work Practice," Social Casework, Vol. XLIV, No. 1, Jan. 1963; pp. 11 - 18.
33. Epstein, L.: "Differential Use of Staff : A Method to Expand Social Services," Social Work, (N.Yk.) Vol. 7, No. 4, Oct. 1962; p. 71.
34. Heyman, M.M.: "A Study of Effective Utilization of Social Workers in a Hospital Setting," Social Work (N.Yk.), Vol. 6, No. 2, April 1961; pp. 36 - 43.
35. Ibid., p. 38; and Epstein, L., op. cit., passim.
36. Rooney, W.S., and Mason, M.A.: "The Psychiatric Social Work Technician, Jnl. of Psych. Social Work, Vol. 21, No. 4, June 1952; pp. 181 - 186.

All these services were introduced to overcome the shortage of (trained) social workers, and have done not only this, but increased the case-load carried by the various agencies and hence the amount of service rendered, further, to more patients needing assistance. Nevertheless, the opinion of the present writer is that, where such workers have no direct contact with the patient, but provide a "facilitating" service to the social worker, relieving her of certain duties not requiring the use of skilled social work techniques, their services can be of enormous value. However, where direct contact between aide and patient occurs, it seems that this may interfere with the developing relationship between patient and worker, and interrupt the casework process,[37ab] except, possibly, where a strong positive relationship already exists between patient and worker. Further, environmental manipulative services, and those of a routine nature, often serve as an "entering wedge" into a relationship with the patient,[38] especially where he is resistant to the social worker, or where the social worker has to "prove" herself to him, as is

so often/...

37a. Thus Heyman, M.M., op. cit, pp. 37 & foll., discusses such routine services as courtesy and explanations and preparing lists of appropriate facilities. But the present worker would disagree with her categories of information gathered from relatives or patients, and discharge planning. That the Secretary of a Department can and should deal with routine matters of filing, answer queries (especially telephonic ones), post off and obtain various forms needed in the office, make appointments, etc., etc. goes almost without saying and possibly such services could be increased.

b. Although casework is carried out simultaneously with treatment by the psychiatrist, somewhat different areas are dealt with by each worker, (see Chapter IX, pp. 238, foll., e.g.), and this criticism does not apply. Further attention is paid to this topic in Chapter X, pp. 281 - 299.

38. Knee, R., op. cit., p. 53.

so often the case within the hospital. Where the patient is to remain in hospital for only a short time, any point of entry, or facilitating influence in establishing a case-work relationship with him, is welcomed by the social worker, and it has been the empirical experience of the present writer that these tools are of great use in such work.[39]

The following case history, while not illustrating this last point, shows well the general functions carried out under 1(a) - especially those relating to obtaining sick benefits for a patient - as well as the way in which a routine service can become somewhat more than this.

Mrs. Z.,[40] a forty-one year old woman, was admitted to the female psychiatric ward with a diagnosis of reactive depression, following a hysterectomy.[41] Originally referred to the social worker for the obtaining of a social history, it transpired that she had several problems associated both with hospitalization and with difficulties arising some time prior to this. In the

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39. On the other hand, in America caseworkers seem to do "therapy" to such a great extent that environmental helping, etc., might be regarded by the client as something quite apart from the casework service, and so not to be regarded as interfering with this. That this situation does not obtain in South Africa must be remembered.
40. Anonymity of patients has been maintained by assigning a letter of the alphabet to each case used in the text. This has been done by working from A - Z for male patients, and from Z - A for female patients. There is thus no connection between the letter assigned a patient and the patient's real name or initial. Other identifying data have been kept intact.
41. Surgical removal of the uterus.

first interview, she asked particularly for help in obtaining the sick benefits to which she was entitled but stated that she did not have the necessary documents for applying for these.[42] A duplicate, blank U.I.F. card (see footnote 42) was obtained for her from the appropriate Government Department, the 50 cents needed by her for this having been obtained from the Hospital Social Welfare Department's Samaritan Fund.[43] Before benefits could be claimed, this

card/.....

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42. Every person falling under the Unemployment Insurance Act, No. 53 of 1946 as amended, is issued with an Employment Record Card (here referred to as a U.I.F. Card) on which each employer records the period of service worked for him by the individual. Before unemployment or sick benefit monies can be claimed, this card has to be completed, and, in the former case, taken by the individual to the Department of Labour (Government) and submitted there. For the duration of the granting of these monies, the individual is required to sign personally, twice weekly, the Unemployment Register at the Department. In the case of sick benefits, the card has to be submitted (by post, if necessary) to the Department, together with a special form (U.F.86A), signed by the patient and doctor. Payments begin 3 weeks after the onset of the illness, for a period of up to six months, or, if the patient has not contributed to the Fund for long enough, one week of every six that he has contributed, provided he has worked and contributed to it for at least 13 of the past 52 weeks. Contributions are made by employer and employee on a proportional basis, and are proportionate to the patient's earnings. (Confirmed by personal communication with the Claims Officer, Department of Labour, Johannesburg.)

    It is interesting that these monies are paid out only to patients suffering from "genuine" mental illnesses, such as the various psychoses - and that only for the past few years - and not to patients suffering from alcoholism or addiction. Only by claiming for an associated or subsidiary disease can these patients obtain benefits, even though they may have contributed to the fund for several years.

43. Monies for this fund are obtained from cake sales, etc. It is an unofficial fund instituted internally by the social workers of the department, as no provisions for "extras" are made by the hospital administration, with the exception of the granting of a limited number of bus tickets monthly.

card had to be filled in, and the patient, who, after a few days in the ward, had become difficult and uncooperative, refused to make use of her day-leave privileges to take this card to her various ex-employers.[44] Because she gave, as the reason for this, her feelings of shame at having to face these people, it was decided that she would not be pressed, and the social worker handled the matter by correspondence. Due to delay by several employers on the long list in returning the card, this procedure was lengthy, and the patient became agitated by it. As she was approaching time of discharge from the ward, it was decided, at a ward staff meeting, that, to facilitate matters, the social worker should go with the patient to her various ex-employers. In this manner, the patient would not be directly manipulating the worker, and would at the same time be supported in her return to what she regarded as a shameful situation. Such action by the worker would fit in with the diagnosis both of psychopathic and/or inadequate personality, which by this time had become the differential diagnosis for Mrs. Z. It seemed to the worker, further, that such action might facilitate a better relationship between her and the patient, with whom positive contact had been difficult to establish.

Although/...

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44. As the time of the social worker was too limited to permit of her doing this, and as it seemed that such "self-help" efforts on the part of the patient were often beneficial, this procedure was frequently adopted on the wards. Where a patient could not assist himself in this manner, relatives or friends were asked to help, and where none existed, the social worker arranged the matter by correspondence, except in very urgent cases. The case for an untrained or voluntary worker to assist here is clear.

Although this in fact did not occur, the remainder of the procedure progressed to a materially successful end.

Where the emphasis with Mrs. Z. was on obtaining for her monies to which she was entitled, the accent in work with two of the three families previously mentioned as needing material assistance was on the "poor relief" aspect of this, both being referred to a relief-giving agency, and one, although referred for a government grant, referred for one having connotations of relief associated with it. The dynamics operative in all three cases were those of understanding the helpless feelings of these wives, and those of referral, to be discussed later in the text.

(ii) "Assistance relating to accommodation", including both that in private homes and institutions, was found to have been given to 27 patients, and formed 4.46% of all function rendered, and 20.00% of environmental functions rendered. Just more than double the number of patients referred originally and primarily for such help were therefore assisted with accommodation problems. When accommodation as an additional problem is included in the total, however, only 7 patients more than were originally regarded as needing such help were given it.[45]

Of/....

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45. These statements are not contradictory to the findings in Table XV (Chapter V, p.109), which show only 7 patients with no fixed abodes and 1 unknown. For, as pointed out on p. 49 of Chapter III, patients were frequently assisted with changing accommodation, and were not referred for help with accommodation only if they had no place to which to return on discharge.

Of the 27 patients thus assisted, 15 were women and 12 men. The selectivity of the sample precludes the determination of significance of this difference, but the difference is proportional to that found in referral of patients for such help, and the same comments apply.[46]

Problems relating to accommodation frequently arise at or near the patient's time of discharge from hospital, i.e., at a time when these cannot be escaped, and when something has to be done about them immediately. For this reason, referral to the social worker may be at this time, and late in treatment,[47] and she be regarded as a " 'disposition agent' with all the implications of such a role".[48] The caseworker may hence "do some superficial invironmental manipulation, but avoid involvement on deeper levels of casework treatment...."[49] Conversely, however, various problems relating to accommodation, such as the holding open of such for the patient, or the paying of his rent,[50] become manifest immediately on the patient's admission, and thus result in early referral. In the present sample, in fact, only one patient was assisted with accommodation only,[51] and the implication here is that other patients were referred, of not on admission, at least soon enough prior to discharge for such other services to be rendered.

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46. See Chapter VI, Table XXIV, p.149 ,& surrounding text.
47. Parks, A.H.: "Short-term Casework in a Medical Setting," Social Work (N.Yk), Vol. 8, No. 4, Oct. 1963; p.89.
48. Goldman, F., op. cit., p. 76.
49. Parks, A.H., op. cit., pp. 89 - 90.
50. This type of help may thus often be associated with 1(c) and 5.
51. This patient was one of the two in relation to whom the social worker carried out only two functions, the second of these functions relating to consultation with the psychiatrist.

It is likely that the urgent needs of these for rent to be paid, etc., was not the only factor precipitating fairly early referral, but that the psychiatrists' awareness and orientation to such problems resulted in their referring patients even before these, or actual accommodation problems, became apparent. Early referral of all "placement problems" is advantageous not only to the establishment of a relationship with the patient, and to the gaining of his co-operation in planning (especially if he sees discharge as a rejection of himself by the hospital), but facilitates the practical arrangements related to finding accommodation, whether these involve the actual locating of a place of residence for the patient, or working with family members to help them overcome any emotional or spatial difficulties which they may be experiencing in relation to accommodation of the patient.

As was discussed earlier,[52] relatives may be loathe to resume care of the patient, and particularly where estrangement between patient and relatives has preceded hospitalization, efforts to "extend the family circle ad hoc by attempting to change attitudes of unconcern into attitudes of willingness to serve as a family resource[53]/....

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52. Chapter VII, pages 171 - 172.

resource"[53] usually meet with little success,[54] and have even less chance of this if time is short. Where relatives have changed and adapted to new roles, and have closed ranks against the patient without prior estrangement, discharge planning is also difficult, and even for families willing to have the patient home, and especially where some residue of the illness remains, various problems and anxieties have to be overcome. A useful tool in facilitating discharge of patients to their families is that of the "trial visit" system,[53] and this has been implemented in the unit under discussion by allowing patients to go home for weekends, when they become well enough to do this. Although this is not the traditional system of provisional discharge after treatment, but involves "leave" during therapy, it serves well as a period during which patients and relatives can test out their reactions to one another, knowing that hospital staff are there to support them and help them in working out difficulties which arise.

While in certain respects "placement" help may be regarded not only as related to arranging accommodation for a patient, but also as supportive and counselling help,[55]/....

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53. Pollak, O.: "Social Determinants of Family Behaviour," Social Work (N.Yk.), Vol. 8, No. 3, July, 1963; p. 96. This author points out, further (p. 98), that where such family attitudes prevail, post-hospital planning needs to be done as much, of not more, with the patient, as with the family.

54. See, e.g., article by Shea, M.M.: "Planning for Psychiatric Patients at Home," Social Casework, Vol. XXXI, No. 10, Dec. 1950; passim, and especially p. 421.

help,[55] and may involve both services from the social worker, in the case of Mr. G. the help given was related primarily to finding accommodation. Aged 32, he was an epileptic, with a drinking problem, who had arrived in Johannesburg from Durban, having left both his flat and job behind him. A sister, living in Johannesburg, refused to accommodate him for fear of his possibly harming her two small children. Only after some discussion and reassurance that she could consult the social worker and/or psychiatrist about any difficulties which might arise in relation to the patient, and that they would be willing to assist with these, did she concede to taking him home until his return to Durban.[56]

Arranging accommodation for patients may bot always be accomplished as easily as in the case given above, however. Thus Mr. K., aged 52, and suffering from Friedreich's ataxia,[57] was admitted to the psychiatric ward in May, 1963. Some weeks previously, he had

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55. To be discussed later in the text; and as defined in Chapter lll, p. 58.
56. The help given to the patient was in relation to accommodation; that to the sister supportive, etc.; "scoring" thus was done accordingly, and covered all services rendered. Perhaps one of the factors pointed up by this is the fact that service directed towards solving a problem is seldom of one kind, for problems, as pointed out earlier (Chapter Vll, p.161), are seldom unrelated to one another, and hence functions may overlap.
57. A degenerative muscular condition.

been discharged from a general medical ward in the hospital to a private nursing home in a small reef town, as this was the only home, having a vacancy at the time, which would accept him for his disability grant of R24,50 per month.[58] His wife had refused to have him home at the time.

His readmission to hospital was precipitated by reports, from the Matron of the nursing home, that he was kicking and biting the staff, and appeared mentally confused. She stated that she could no longer keep him at the home, and asked that he be admitted for psychiatric observation. Once in the ward, the patient manifested none of the behaviour described, sitting flaccidly in a chair all day, and unable to move. He reported his great unhappiness at the home, and begged not to be sent back, asking only to return to his wife. It took some time to get Mrs. K. to the hospital to see the worker,[59] and when she came, she refused to have the patient home, stating that she could not afford to have him, could not care for him, etc. Further, she

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58. Community resources for the chronic and indigent sick are few and far between in Johannesburg. Those homes run by official welfare organizations are normally full, and in many of those run privately, particularly in the towns around Johannesburg, conditions are shocking; the present writer frequently refused to make use of these so-called "facilities."

59. In this particular instance, a home visit was not done, as it was felt that the wife's attitude to the husband, which had been negative previously, would possibly be indicated to some extent by her willingness or otherwise to come to the hospital. It was!

had the patient's brother, also a sick man, living with her and demanding her attention. She could not see that her first responsibility was to her husband, and refused to change the standing arrangements. She was, however, quite prepared to send her husband to another chronic sick home. She was immovable, and the worker therefore discussed with her his placement at Edenvale, a provincial hospital having some chronic sick beds. (The problem was by now medical, rather than psychiatric.) To this she agreed, and the forms were filled in after the matter had been discussed with the patient, who was most upset, though he was not told directly of his wife's attitude.

When Edenvale, on various grounds, refused to accept the patient, new plans had to be made for him. The few appropriate nursing and old age homes in Johannesburg had no vacancies, or refused to take him in view of his comparative youth, and it was decided that application would be made to a hostel in Pretoria, catering specifically for the aged chronically ill, but prepared to accept him. That this was not a really satisfactory solution to the problem was apparent, but none other was possible. His wife was again called in to sign the necessary forms, but stated that she would not part with his grant to pay for his board and lodging. The worker very clearly pointed out her general unco-operativeness, but realizing that this was unimportant to her, stated that the Department of Social Welfare, responsible for issuing the pension, if necessary, would be informed of the change in the patient's address, and that she

would/....

would in fact have little say in the matter. Thereupon, she agreed to giving up the money,[60] and application was made to the Pretoria home, the fact that it was some twenty-five miles away distressing her not al all.[61] After some two months' delay, about which doctors and ward staff were particularly co-operative, a bed fell vacant at the home, and the patient was transferred there, his disease having progressed sufficiently to make him less aware of his surroundings than previously. It was arranged that the social worker of the home would contact the writer in the event of any psychiatric difficulties, as previously alleged, arising.

(iii) Because the psychiatric social worker is so often the link between hospital and community, whether the hospital is a general or a mental one, it usually falls to her to assist patients with <u>problems relating to employment</u>, whether these involve the finding of work for patients, or contact with an employer to hold a post open for a patient, or a request to extend sick leave. In dealing with "job placement, employer contact and other aspects of vocational rehabilitation,"[62] the Social Worker may encounter unreceptive and intolerant

attitudes/....

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60. She still had remaining the brother-in-law's pension and her own Disability Grant.
61. While some may argue that a different approach on the part of the worker, and greater acceptance by her of the wife, might have been helpful, the opinion of the writer is that she was an "immovable object", and that the situation was of such long standing that little could be done about it, and certainly nothing in a short time.
62. Hartlage, L.C.: "<u>Employer Receptivity to Former Mental Patients</u>," Social Casework, Vol. XLIV, No. 10, Dec. 1963; p. 587.

attitudes in employers.[63] Placing a psychiatric patient from a general hospital perhaps has less of these elements in it, however, for the implications of the general type of care received there may tend to lessen the severity or specific psychiatric nature of the illness in the employer's mind, and provide a "halo effect" protection to the patient. Where, however, patients are already well-known to their employers as, for instance, with alcoholics or drug addicts employed by the same firm for some time, this does not hold.

Further problems associated with help relating to employment were that patients often had poor work records, had been unemployed for some time prior to admission,[64] or had little training of any kind. When the element of psychiatric illness was added to his background, work placement became very difficult, irrespective of the availability of employment. Because patients were aware of this latter factor, they were inclined not to want the worker to recommend or discuss their applications for work with prospective employers. This, together with the worker's inability to function effectively as a work placement officer, due to lack of time and employer "contacts", resulted in the general policy in the unit being for the worker to refer patients directly to the Special Placement Section of the

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63. Hartlage, idem., passim, found that these attitudes related more to certain aspects than to others. For example, employers feared that the mentally ill patient might act on impulse, or be prone to sudden violent action, but were not concerned that he might be more prone to dishonesty than the non-patient, or have a higher rate of absenteeism.

64. See Chapter V, page 118, Table XVII.

Department of Labour, either for help in finding work on the open labour market, or for placement in one of its sheltered employment projects;[65] or to several private agencies which did not charge a fee until a placement had been made; or to appropriate trade or other unions. Patients were also encouraged, where possible, to make use of ward day-time leave privileges[66] to keep such appointments and to seek work, and it was only for certain specified patients, referred particularly for her help or support, that the worker directly sought employment.[67a,b.] However, all problems related to helping a patient keep a position held on admission to hospital, or in which patients' employers were directly approached for any reason, were dealt with directly by the social worker.[68]

The/.....

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65. Vocational Rehabilitation Centres of the kind described in the U.S.A. (reported on, inter alia, by Black, B.J.: "Vocational Rehabilitation", in Kurtz, R.H. (Ed.), Social Work Year Book, 1960 N.A.S.W., N.Yk., 1960; pp. 535 to 539; and Knee,P.I., and Lamson,W.C.: "Mental Health and Mental Illness", in Kurtz,R.H. (Ed.), op. cit., p. 389, do not exist in South Africa, and the Department of Labour provided the only services similar to these at the time of the present study.

66. Chapter I, page 12, footnote 33.

67a. The medical ethics of disclosing diagnoses were often discussed by the ward staff, but the social worker felt, strongly, that any educative function she might have in relation to the community would be nullified if an air of secrecy pervaded contacts with employers, or if employers accepted patients "under false pretences." A compromise was therefore reached in that disclosure was always discussed with patients for whom she found work, and only in very rare instances were at least most of the facts not given.

b. The philosphy of whether in fact the social worker generally should be an employment officer, or whether she should act as such only in the absence of vocational rehabilitation officers, is not discussed here, but practice, as it occurs, and in terms of which such a role is not possible, presented.

68. Such help may, again, include functions under (5) - see footnote 44, and relevant discussion in the adjacent text.

The liaison and educative nature of these functions of the worker are clearly apparent.

The ward system of allowing certain patients to work from the ward, for a shorter or longer period, provided a form of support to the patient in relation to his job similar to that resulting from the weekend leave provisions in relation to his family, and, furthermore, gave the psychiatrists an opportunity to see whether or not the patient could cope with employment and its concomitant stresses. Both of these "leave" arrangements enabled the patient to deal with one change at a time, rather than several at once, and were useful in helping him to return, without multiple and concurrent stresses, to life in the community.

After this preamble, how many patients were in fact assisted with various aspects of employment? The total of 22 services in relation to employment is disproportionate to the 47 patients in the sample unemployed at time of admission to hospital,[69] and becomes more so when the 4 patients assisted, not in finding work but in keeping work already held, are subtracted. Possibly the referral policy of the department was responsible for many patients who needed such help not wishing to approach the social worker, but, in spite of this and of these figures, it remains the empirical impression of the worker that many more patients, in general, were referred to her for help with work problems than are found to have been so in the present sample. This raises the question of whether the selectivity operative

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69. Table XVII, Chapter V, p.118.

in drawing this sample has in some way influenced this this factor. For, with the addition of the one family member to the group of 22 assisted in this way, the total of 23 functions of this nature rendered is only 3.80% of the total number rendered, and 17.04% of the environmental ones rendered. It is interesting that more women (13) than men (9) sought or were given such help, in spite of the higher employment rate of women in the sample. Only 1 of the patients who was helped to keep work was a woman, so this cannot be regarded as the factor accounting for this discrepancy.

This patient, Miss Y, was a lass of 19, regarded as suffering from an adolescent behaviour disorder. Shortly before her discharge from hospital, her psychiatrist asked the social worker to discuss with her then employer the possibility of extending her sick leave, for she was baulking at returning to work, using as her excuse that this return was too soon. During an extended period, the psychiatrist felt, he could work through these attitudes with her, but she would remain tied to the reality situation of having to return to work at the end of that time, or of being proved a malingerer. After discussion with Miss Y, this arrangement was made with her employer, but, as anticipated, did not lead to her return to work. As this was told the social worker only some weeks later,[70] there was

little/....

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70. Due to careful planning by the patient, who was aware that social work follow-up was not routine, and who cancelled several appointments with her doctor for seemingly valid reasons.

little she could do to repair the damage done to later generations of psychiatric patients seeking work at the particular firm employing Miss Y.

Mr. I. was a young man of thirty, homosexual, with a rather varied work history. Matriculated, he had a qualification in speech and drama teaching, and was interested in working in that field. However, he was, at the time of referral, willing to do clerical or similar work, in an effort to stabilize himself somewhat simply by having some sort of position. This desire was supported by his psychiatrist, who thought, furthermore, that some benefit might derive to the patient if he worked within the hospital, and hence remained under the remote influence of the psychiatric unit. Function of the worker in this instance was thus multiple.[71]

In the first instance, the problem was discussed with Mr. I, who was agreeable to visiting an official at the Department of Labour, but wanted, also, to see what he could do about finding work for himself. The referral to Labour was made telephonically, during the interview, and the patient also given the names of several private employment agencies to which to go. He related that he intended putting an advertisement in the newspaper, as well. The social worker agreed, in the time before the next interview, to speak to the staff

clerk/....

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71. Where function of one kind was rendered more than once, it nevertheless was "scored" as though only once given, for too many complications arose in the scoring system if any other system was adopted, and it appeared in the trial application that this system would still delineate types of function and indicate approximate proportions of these.

clerk at the hospital about a vacancy for Mr. I., and the second interview progressed from this point. But help did not remain limited to only one contact by the social worker with these various "outside" people, for communication had to be maintained with them throughout in order to facilitate and check on progress.

The only family member assisted to any extent with employment was the wife of a patient admitted for attempted suicide. In a state of great agitation, the patient had signed himself out of the ward after one night, saying that he would lose his post with the Municipality if he did not return to work. The doctor's efforts to calm him were unsuccessful, and he refused to allow the worker to contact his employer. His wife, who accompanied him to see the social worker, was anxious about him, but as he was not certifiable in terms of the Mental Disorders Act, he could not be detained at the hospital. However, during the interview, she asked whether the worker could assist her with work, and a careful referral was made to the Department of Labour. She was asked to return if unsuccessful in obtaining work in this manner, but did not do so, even though good rapport seemed to have been established with her during the interview.

(iv) Environmental assistance related to the hospital and its various facets is a function of the worker which is specifically related to the nature of the hospital situation. As discussed in the classification system,[72]

many/.....

72. Chapter III, p. 55 , Item (4).

many patients are unable to deal with the complexities of the hospital's organization, or to understand the intricacies of its functioning, and the social worker is often called upon to assist them in this regard by providing concrete services of various kinds. And it is interesting that, although no patient was referred directly for such help, the social worker functioned in this manner with 19 or 21.59% of the group of 88 patients in the sample, in addition assisting the wife of one patient in this way. Thus 20 functions or 3.31% of the total rendered, and 14.81% of environmental assistance given, fall within this category. It is worthy of mention that no differences between the two sexes occurred here, for 9 such functions were rendered to women and 10 to men, and in addition one to a "male" family. Many of these services were associated with other activities by the social worker, or their need became apparent during interview. Thus, it might transpire that a patient referred for assistance in obtaining a grant was found to be a paying patient, and this remedied by the social worker through re-classification of the patient, and a request to waive the account. Or, again, the relative mentioned above requested to see a surgeon, and this appointment was arranged by the social worker far more quickly than the wife would have been able to do it, partly because of the social worker's knowledge of the channels through which to arrange this, and partly because of her official status in the hospital.

(v) The/.....

(v) The category "Help relating to patients' problems with people in the environment"[73] is a broad one, and by its very nature often linked up with the first groups of function discussed in the present chapter. Thus, the arrangement with an employer that he hold a post open would fall not only under (3), but also within this category, being a twofold type of assistance, while interviewing a difficult landlady to persuade her to hold accommodation for a patient involves, especially if it is successful, both modification - or an attempt at this - of her approach to the patient, and the arranging of accommodation for him. It is thus interesting that 18 of the 19 functions under this section were associated with some other type of environmental help rendered.[74] For the remaining patient this help was associated with a tangible service falling under the heading miscellaneous and still being environmental modification of a sort.[75]

The/.....

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73. See Classification System, Chapter III, p.55,Item (5), for details.

74. This close association between (5) and other functions raises two questions. First, does it indicate the overlapping of categories in the classification system?
If so, this is possibly related to the difficulty of categorizing social work activities, and the artificiality often associated with doing this, because of the frequently overlapping activities carried out. Secondly, is (5) actually a method of achieving (1), (2) and (3), and hence both function and method?
Attention will be given to these points later in the text.

75. See later in this chapter, p. 222 , for discussion of miscellaneous functions.

The total of 19 activities of this nature formed 3.14% of the total number of functions rendered, and 14.07% of the group of general environmental functions rendered. That 13 of these patients were women and only 6 men is incongruous with the fact that, although no more women than men were married, women, more often than men, in general, had families who could possibly have assisted with such problems. However, if such modification of the human and social environment of the patient is seen as involving certain social work skills - as it is by the present writer - it is to be expected that families possibly could not function effectively in this manner. Further, this seemed to be a category related to patients, for no such help was rendered to family members.

Miss X, aged 19, was a nurse aide diagnosed variously as reactively depressed and/or schizophrenic, and thought possibly to be addicted to drugs. She had run away from the small-town hospital at which she had been employed, fearing that she had harmed a patient, and leaving behind various belonging, and her U.I.F. card. As she wished to apply for sick benefits, a letter explaining the patient's situation, and asking for additional information about her, was written to the matron of the hospital, and she was requested to send the patient's various goods, and especially the card to the social worker. No response was obtained to this and a subsequent note, and a trunk call was therefore put through to her. Aggressively, she pointed out that the girl ha left owing various monies to staff members, had been unreliable, etc., etc. After a

lengthy/....

lengthy(and costly!) call, however, she agreed to deduct from the patient's outstanding salary the amount owed by her, and to send on the balance and other articles.

This same patient, after a reckless spending spree, had left behind her debts enormous, compared to her salary. One of these had been referred, by the shop-keeper concerned, to his lawyer, and the girl asked for help with this matter.[76] Much letter-writing again took place, and, although this lawyer's "basic" attitudes were probably not modified, he was able to be persuaded to defer legal action against the patient until her discharge from hospital and return to work, or at least allow an opportunity for this latter to occur.

B. "PSYCHIATRIC" ENVIRONMENTAL FUNCTIONS.

Although environmental functions which are specifically psychiatrically oriented perhaps do not fit entirely into a general definition of concrete or environment modifying services, as given at the beginning of this chapter, both are varieties of "placement" help, and both are rooted in the necessity for concrete action to be taken. While being associated to a large extent with supportive and other techniques, especially to relatives, these latter aspects will be mentioned only briefly here, and delegated, as far as possible, to the later and more appropriate chapter dealing with such functions.

(a) For/....

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76. Classified both as 1(c) - help with debts - and (5), under the latter scoring being once (see this chapter, footnote 71) only, and not marked for both activities carried out.

(a) For purposes of the classification system, the column on placement of patients under the Mental Disorders Act[77] referred only to the actual technicalities of certification - the filling in of forms, the booking of a bed, the arrangement of transport to the mental hospital, the contacting of relatives - where available - to sign forms, and a host of other activities. While these may appear to be routine functions, they have various overtones. For frequently booking a bed involves more than simply finding one vacant. Discussion of the patient's illness and of type of certification in relation to it takes place between the superintendent of the mental hospital and the social worker, who frequently acts as a liaison between this superintendent and the general hospital psychiatrists, and has to be able to present their findings adequately. Then, too, while the completing of forms may appear simple, and, superficially, ideally performed by an aide, in fact these forms and their implications are the focus of much feeling on the part of both relatives and patients, and their completion involves the use of those skilled supportive and other techniques mentioned above. For whether relatives are unwilling to certify a patient, or whether they do so, the person assisting them has to deal with their associated emotions and attitudes.[78] And where

there/.....

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77. Provisions of this Act, promulgated originally in 1916, are given in Appendix B, p. 442. All activities under this section are carried out in accordance with its regulations and in terms of its administrative procedures.

78. Knee, R., op. cit. p. 49 - Confirms the importance of this service.

there are no relatives, and the social worker herself has to make the necessary application for committal, the patient has to be interviewed. Even if he is not really aware of the purpose of the interview,[79] the interviewer has to be able to elicit from him such information as is needed and this may require some skill on her part. While the processes of support and interpretation will not be discussed further here, but elaborated in the following chapter, these aspects of the technical procedures of certification must not be overlooked.

After completion of the application forms, the social worker co-ordinates these with those of the psychiatrists, and has responsibility for seeing that all are correctly filled in and sent to the Magistrates Courts or the (mental) hospital direct, whichever is appropriate. Her role as co-ordinator of the certification process is an important one, and results in her involvement in all certifications from the two wards. This column in the scoring system thus reflected not only that she has been involved in such activities, but the number of certifications carried out amongst the 88 patients in the sample. However, it does not include associated services to patients, or any to relatives.

That as many as 26 or 29.55% of patients in the sample became certifiably ill merits consideration, especially in view of the fact that only 16 were originally

referred/....

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79. Though no patient, however ill, is ever sent to a mental hospital without interpretation to him of the procedure and reasons.

referred to the social worker for such placement. Neither of these figures reflects the number of patients originally admitted in transit to a mental hospital, but a survey of the dates of admission and discharge of this group of patients reveals that only about 14 of the total were probably admitted with the specific or contemplated intent of transfer to such a hospital.[80] The implication here is possibly that many more grossly disturbed patients come to a general hospital unit for treatment than is realized, or, again, that this is realized, but that attempts to treat these patients in the community require facilities - such as those necessary for insulin coma treatment, or legal control - not yet available, and patients have to be transferred elsewhere when those facilities existing have been stretched to capacity.

The total number of 26 such functions performed is 4.30% of the total number of functions rendered, and it is interesting that 14 and 12 of these functions were rendered to men and women, respectively, for even though no statistical significance can attach to these small figures, they fit in with the general trends in mental illness discussed in Chapters V and VI.[81]

(b) General/....

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80. If patients were in the wards not for only a few days, it is likely that, even if not admitted in transit, they were admitted for observation, with the possibility of transfer to a mental hospital, if necessary.

81. Case histories are not given here, as the types of services covered by this category are self-evident. Further, separation of these facets from the supportive, etc. ones, would not give a full picture, and will therefore be pended till later in the text.

(b) General psychiatric placement of patients, other than under the Mental Disorders Act, refers primarily to the placement of patients in hostels or institutions designed to cater for and/or treat certain categories of psychiatric patients. Thus, placement of a senile psychotic patient in the chronic sick section of an old age home would not fall under this head, but placement of such a patient in the appropriate section of Tara Hospital would be regarded as such. The category was, however, designed specifically to cover the placements of alcoholic patients and drug addicts in institutions, such as Mount Collins and Northlea, caring particularly for them.[82] Although it was anticipated that the number of such placements would be minimal, because of the frequent direct referral of such patients from Casualty, without in-patient admission to the hospital, this category was included, as it was felt to be a function distinct from both "accommodation" placements, and those in terms of the Act.

It was therefore not surprising that only 3 patients were assisted in this manner, i.e., only 3.41% of patients in the group, and that this category represented only 0.5% of the total number of functions rendered. However, what is surprising is that 12 patients in the sample were diagnosed as alcoholics or drug addicts and not referred on.[83] It can only be assumed that the remaining 9 patients so diagnosed were admitted in an acute phase of illness (e.g., delirium tremens) and on recovery were not

willing/....

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82. As discussed in Chapter VI , p. 136 , footnote 23.
83. See Chapter VI, p. 134, Table XXI.

willing to undergo further treatment. Or perhaps that such patients were, as seemed sometimes to happen, admitted to the ward temporarily, until room was available elsewhere, because of the urgent need for help, but, on removal of this immediate need, refused transfer. Again, some patients perhaps could accept treatment in a general hospital without needing to accept the nature of their illness, while other could accept neither such treatment nor their need for more specialized treatment, and so left hospital.[84] That all 3 patients so assisted were men is proportionate to the findings in relation to the occurrence of this type of illness in the sample (9 males : 3 females).[85]

Because the patient's acceptance of treatment for alcoholism or addiction is often associated with traumatic insights, or is frequently a much resisted step, support and encouragement frequently need to be given to him, both in taking the decision to undergo treatment, and in making the practical arrangements related thereto. As opposed to the previous section, these elements are inextricable from the case history, and will therefore be included, where necessary.

Mr. J., aged 51, divorced, and an alcoholic of many years' standing, had been known to the worker for

three/....

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84. Because admission to the unit is voluntary, they could not be held at the hospital. Similarly, referral and admission elsewhere could not be enforced, except in terms of the then Work Colonies Act (See Ch. VI , p.136, footnote 23), a procedure intensely disliked within the unit and carried out only once during the writers 3 years within it.

85. Chapter VI, p. 134., Table XXI.

three years. His present admission to hospital had resulted from an attempted suicide, which was regarded by ward staff as an attention-getting symbol of the patient's despair and inability to cope in the community. He had frequently in the past used the ward as a refuge, and it seemed that at this stage he required sheltered - and possibly permanent - care. He refused, however, to go to Northlea or Hedge Farm saying that, within a short time, "if only he could find work," he would be fine again. He had glimmering insight into his condition, and fought a denying and despairing battle with himself, in an effort to maintain his ego intact. Interviews with the psychiatrist and social worker (with whom he had built up an excellent relationship over the years) did not result in any change in his attitude towards admission to Hedge Farm, and the problem of his discharge from hospital was looming large when his daughter, with whom he had lost contact, unexpectedly arrived at the hospital with a gift of R20.00 for him, and then, as quickly, disappeared. Grasping onto the money - more than he had had for many long months - as a life-saver, he said that he would use it to live on, until he found work. Hoping that he would be able to re-instate himself in his daughter's eyes, and feeling that her arrival at the hospital had indicated some warmth to him, he left hospital on the Friday night, with a false and pathetic optimism that what he had not been able to achieve in years would now come easily to him.

Early on Monday morning, he arrived at the social worker's office, his money spent on a gigantic binge,

and/.....

and he, with no place to go, requesting readmission to hospital. Although the worker realized that it would be unlikely, she telephone his psychiatrist, who confirmed this. There followed a long and firm presentation of reality to the patient, and a forcing of him to view his position as it really was, this being accompanied by support and warmth from the social worker, and an emphasis on her understanding of the difficulty of the decision. Finally, faced with a situation of "no place to go," he decided to accept placement at Wedge Farm. The worker then proceeded to make all the necessary arrangements for this, inter alia, to book a place for him, arrange transport, and see that his few goods went with him. During these activities, he expressed his relief that the decision had been made, and, contrary to the many patients helped in time of crisis who revert back to their previous ways of functioning when the crisis has passed,[86] remained at Wedge Farm for some six months. The worker kept up contact with him during this time, and he with her,[87] and he left only after she had resigned from her post at the hospital, and thus her support was withdrawn - even though she had prepared him for this and arranged for a worker slightly known to him to take over the case.

C. The/....

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86. Hollis, F.: "Analysis of Casework Treatment Methods and their Relationship to Personality Change," Smith Coll. Stud. in Social Work, Vol. XXXII, No. 2, Feb. 1962; p. 100.

87. With, of course, the knowledge and consent of the staff at Wedge Farm.

C. MISCELLANEOUS.

This category was included in the classification system to cover those activities which were not able to be placed into any of the other categories listed. During the actual content analysis of the records, it transpired that these were all tangible or environmental services, such as those mentioned in Chapter 111,[88] and it was therefore decided to include this category in the present chapter.

Of the 22 functions of this nature reported - to 22 or 25% of patients, and forming 3.64% of total functions - most were, again, routine, and most of them might have been performed by an untrained worker. Some, such as the obtaining of work references or tracing identity of an amnesic patient, could certainly have been carried out by the secretary of the department, but others again provided a point of entry into contact with the patient. Thus a paranoid patient with whom the writer had been working for some two weeks,[89] and who was still somewhat reserved in her acceptance of the worker, was finally convinced of the worker's good intentions towards her, and prepared to accept her thus rather than as a threatening person, after the worker had begun bringing her the "employment" column of the daily newspapers.[90] On the other hand, the service provided by the worker to Mr. A., the young

homosexual/...

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88. Chapter 111, page 60, item (16).
89. While two weeks may not seem a long time in which to establish a working relationship with a patient, where time in hospital may be short, and discharge take place within the next two weeks, relationship needs to be established more quickly.
90. Of course, with a patient of this kind, exactly the opposite reaction might have resulted.

homosexual patient discussed in Chapter III,[91] was of a different nature. The fact that she was prepared to act as a "post depot" for him, and send on messages and post to Northlea, as he feared the stigma of being generally known to be there, perhaps served to reinforce the positive relationship existing, and to indicate to him the degree of her willingness to assist him. For, though the service in itself was not a big one, it was in fact beyond her "official" duties in that Mr. A. was now under the care of another agency, and no longer a hospital patient of any kind, nor was he really receiving follow-up care.

D. PATIENT-WORKER RELATIONSHIPS AND ENVIRONMENTAL HELP.

When environmental modificative help is extended to cover these last three categories, 75 patients in the sample of 88, or 85.23%, are found to have received such help. It is interesting that 39 of these patients had established a positive relationship with the worker (very good, good, fair) and that for 15 a negative (poor) relationship existed between patient and worker. Further, more of those with a positive relationship had received three or more kinds of environmental help than had received two or less kinds (22 : 17) while more of those patients with a negative relationship with the worker had received two or less services of this kind than three or more (9 : 6). While these figures are small/.....

91. See Chapter III, p.63..

small, and no real significance can be attached to them, they do follow the same trends as those found for relationship in general,[92] i.e., there is a tendency for more service to be associated with better patient-worker relationships. However, these figures do not indicate whether or not the nature of the relationship is associated with the type of function, or only with the amount thereof, and because such services were always rendered in conjunction with others, this former is difficult to state.

There does, however, seem to be some association between certification of patients and type of contact, for of those patients "rated" as "nil" - i.e., who had not seen the social worker - 10 of 13 were patients certified to a mental hospital, who themselves had not been seen, though their relatives or friends had been. Of the 8 patients rated "X", 6 were such patients, and contact with them, with the exception of two, had been limited to that at the time of certification only. It is interesting, however, that of the additional 10 patients certified, 6 were rated as having very good, 2 as having good, and 2 as having fair relationships with the worker, and none as having a poor relationship with her.

E. SUMMARY.

A few concluding comments should be made on the subject of material assistance and environmental modification, and these remarks related particularly to the amount of such services rendered to patients. For, although Joseph reports that such help by the social

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92. See Chapter Vll, p. 175.

worker is coming to play but "an occasional role in our modern therapeutic scheme,"[93] the present study shows that 186 of the total 605 functions rendered[94] to patients were of this kind. In other words, 30.75% or almost one-third of all social work activities fell within this broad category. Even when the "psychiatric" functions discussed in this chapter are excluded, to remove any possible ambiguity in functions, this number remains 157, or 25.95% of total functions. It is interesting that only 5 of these services were rendered to families of patients, these patients all being men,[95] while of the total group of 181 functions rendered - when these families were "subtracted" - 94 were in relation to female patients and 87 to male patients.[96]

Thus, in general, the present study shows a high proportion of such direct, tangible and manipulative services to patients, whichever of the percentages 25.95% or 30.75% - of total function is accepted. This finding conforms with Goldman's comments, even though in relation to medical patients, that such services are numerous in a general hospital,[97] and with Berkman's similar findings for patients in psychiatric hospitals,[98]

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93. Joseph, H.: "A Psychiatrist Considers Casework Functions," Social Work (N.YK.), Vol. 1, No. 2, April, 1956; p. 92.
94. Or 205 of 678, when unconfirmed functions are included.
95. Function to families in relation to psychiatric services, as discussed, were separately classified under categories 10, 11, and 12.
96. These differences have been discussed for each individual category in the text, and such discussion will therefore not be repeated here.
97. Goldman, F., op. cit., p. 73.
98. Berkman, P.D., op. cit., p. 43.

in spite of the possible selectivity of the sample. Neither of these writers finds it the largest category of services, however, and whether the present study will conform on this point, as well, remains to be seen in the following chapters.

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C H A P T E R IX

FUNCTIONS WHICH MAY ALSO BE REGARDED AS METHOD.

Perhaps social casework may be regarded as both a field and a method[1] of social work. In the former instance, it would be correct to call the ways of working within this field methods; in the latter instance, these could be called sub-methods,[2] or techniques, a technique being defined by Boehm as "a specific procedure which together with other procedures is characteristic of a given method."[3] For purposes of the present chapter, these ways of operating, included in the broad term "casework," will be referred to, interchangeably, as "methods" and "techniques," meaning the "how" of performing function.[4] But the goals of helping the client with those problems which he presents for assistance sometimes are achieved not only through processes regarded as methods, but through the same processes, which may simultaneously be regarded as functions, or "what" is being done. Thus, the social worker may assist the patient through the use of the methods of advice-giving, support, or counselling; but

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1. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., 1963; p. 28.
   Boehm, W.: "The Terminology of Social Casework," Soc. Serv. Rev., Vol. XXVIII, No. 4, Dec. 1954; p. 386.
2. Community Service Society of N.Yk.: Method and Process in Social Casework, Report of a Staff Committee, F.S.A.A., N.Yk., 1958; p. 15.
3. Ibid., loc. cit.
4. Ibid., loc. cit.

her function per se may be to give advice, to give support, or to give counsel. Boehm defines these latter not only as techniques of casework, but as (relationship) services to the client,[5] and thus confirms this dual use in the present text.

Various definitions and classification systems of these method/functions have been drawn up, and social work literature is filled with these. This, perhaps more than anything, reflects the difficulties not only of defining such terms, but of separating them one from the other, and delineating their boundaries, even on the basis of such elements as activity of the worker, type of worker-client relationship, and the depth of the material brought into treatment by the client.[6] Furthermore, meanings differing in degree of agreement, or totally unalike, are assigned these methods, and this leads to confusion in terminology. These factors must be borne in mind where the present definitions and divisions appear to differ from those of other writers.

A. INFORMATION-GIVING, ADVICE-GIVING, AND LOGICAL DISCUSSION.

As pointed out in the previous chapter,[7] environmental manipulation is considered, by some writers, a technique of supportive help. By others,

conversely,/.....

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5. Ibid., p. 387.
6. Hollis, F.: "The Techniques of Casework," in Kasius, C. (Ed.), Principles and Techniques in Social Casework, F.S.A.A., N.Yk., 1953; p. 415.
7. Chapter VIII, p.186.

conversely, it is regarded as a method on its own.[8] Similarly, information-giving, advice-giving and logical discussion are, by some authors, grouped with, or as a technique of, supportive or other help. In this way, Berkman lists "interpretation of the psychiatric illness of the patient, of its treatment, and of the problems and relationships growing out of the illness"[9] as being among the functions termed "help concerned with the feelings, attitudes, or conflicts of the patient or relative,"[10] which, in turn, included supportive treatment and various forms of "insight" and "relationship" therapy.[11] Hollis, again, terms the giving of suggestion, advice or admonition, techniques of "direct influence," and lists them with logical or reflective discussion, as technical processes of support.[12] Correspondingly, the Staff Committee of the Community Service Society of New York termed giving information, logical discussion, and advice and guidance three separate techniques of what they called the "Supportive

Treatment/.....

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8. Hollis, F., op. cit., p. 413; though this author later regarded such help in the latter manner - e.g., see later references quoted.
Austin, L.N.: "Trends in Differential Treatment in Social Casework," in Kasius, C. (Ed.), op. cit., pp. 327 - 328.
Hamilton, G., Theory and Practice of Social Case-Work, Columbia University Press, N.Yk., 1954; p. 242.
9. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; p. 42.
10. Ibid., p. 41.
11. Ibid., p. 43.
12. Hollis, F.: "Analysis of Casework Treatment Methods and their Relationship to Personality Change," Smith Coll. Stud. in Social Work, Vol. XXXII, No. 2, Feb. 1962; p. 115.

Treatment Method."[13] Schmidl, while not advocating the use of direct suggestion, included this as a special technique of supportive treatment.[14]

Although the present writer agrees with this general trend in classification, it seemed that, as pointed out in the classification system drawn up,[15] function of this nature might be found to occur to a large extent in the hospital, due to the nature of the hospital situation and the explanations often necessary of various aspects of it, and that this category should thus be separated from the perhaps broader one of support. Category 10 therefore came to include, in addition to the usually accepted aspects of assistance included thereunder (to be given immediately), such activities as were related directly to explanations and interpretations pertaining to the hospital situation, psychiatric illness, and procedures involved in such processes as admission and certification. The technique of information-giving includes not only that relating to such specifics, however, but also, generally, the supplying of "lacks in information when the client's need for (this) is apparent and his positive response to it will help him take constructive action."[16]

"Advice/.....

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13. Method and Process in Social Casework, as cited, pp. 16 - 17, and p. 15.
14. Schmidl, F.: "A Study of Techniques used in Supportive Treatment," Social Casework, Vol. XXXII, No. 10, Dec. 1951; p. 418. The terms technique and method, in relation to their use in advice-giving, support, etc. indicate a relationship the same as that of advice-giving, etc., to the field of case-work in general.
15. Chapter III, p. 57.
16. Method and Process in Social Casework, as cited, p. 16.

"Advice and guidance" again has this double connotation, and involves the caseworker's use of her "professional knowledge and authority to express opinions and make recommendations for the guidance of the client's decisions and behaviour."[17] This technique is used "when the client needs direction or permission to act either because of ignorance or because he is inhibited by fear, anxiety, or other restricting emotions from taking constructive action."[18] Such help from the social worker is effective where the client "is unable to find his own solution and when his need and motivation enable him to use direction or permission as a means towards achieving a.....goal."[19] However, this technique should be used cautiously,[20] and the meaning of advice to the patient first understood.[21] Further, in using this approach, the relationship between patient and worker is important; and while the results of advice are often temporary, to be effective (at all) this technique should be based on a good patient-worker relationship[22] and with a negative relationship should perhaps be used only protectively, and to relate the patient to reality.[23]

The technique of logical (or reflective[24]) discussion "employs the client's ability to reason,

assists/.....

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17. Ibid., p. 17.
18. Ibid., loc. cit.
19. Ibid., loc. cit.
20. Thayer, A.A.: "Advice : A Casework Technique?" Abstract of Thesis in Smith Coll. Stud. in Social Work, Vol. XXX, No. 1, Oct. 1959; p. 116.
21. Ibid., p. 117.
22. Ibid., loc. cit.
23. Ibid., p. 116; and Schmidl, F., op. cit. p. 418.
24. Hollis, F., op. cit. (footnote 12), p. 115.

assists him to perceive reality, to see alternatives, and to anticipate consequences."[25] Furthermore, through encouraging the client to "examine his own behaviour, and the nature and actions of other people and sometimes his own thoughts and feelings in specific situations, for the purpose of greater understanding of others and of external reality and better management of himself in relation to his home and social environment,[26] logical discussion "appeals to (the client's) capacity for rational behaviour,"[27] and is directed towards his thinking processes.[28] Hollis reflects that this technique of logical discussion approaches, though does not quite arrive at "the area of treatment called clarification,"[29] and postulates that this indicates a continuum rather than a dichotomization of treatment methods.[30]

B. SUPPORT.

Because the environmental and advice-giving functions of the social worker had been classified separately, support, in the present study, was delineated specifically as "psychological" support. This term included a wide variety of activities on the part of the social worker starting with those which

showed/.....

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25. Method and Process in Social Casework, as cited, p. 16.
26. Hollis, F., op. cit. (footnote 12), loc. cit.
27. Method & Process in Social Casework, as cited, loc. cit.
28. Hollis, F., op. cit. (footnote 12), loc. cit.
29. Ibid., loc. cit.
30. Ibid., loc. cit. However, for purposes of this dissertation, clarification will be regarded as separate, and discussed presently (pp.237, foll.)

showed her concern about, interest in, and reaching out[31] to the patient, and her wish to assist him in his difficulty. Thus it implied any activities which made the patient feel "less alone," and gave him a feeling that someone was helping him. It covered, also, any methods used by the social worker to give the patient an "increased feeling of security;"[32] and from which he seemed to gain reassurance, strength, or comfort; and which enabled him to face his problem again, and to feel more able to do this.[33] Such help was seen, then, as including sustaining and bolstering[34] techniques, but was not regarded merely as the traditional palliative and superficial help used only for "hopeless" cases,[35] but as a forward-going type of help which would enable patients to take hold of their problems and of reality, without feelings of despair or of being overwhelmed. Emphasizing the patient's strengths, and what he could do, it was a dynamic, not a static, helping approach, and fitted in with Schmidl's concept of an "active force" in the patient's life.[36]

Thus, this category included activities by the worker aimed at helping the patient both to maintain and to regain his equilibrium. As expressed by Hollis,

"psychological/.....

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31. Selby, L.G.: "Supportive Treatment : The Development of a Concept and a Helping Method," Soc. Serv. Rev., Vol. XXX, No. 4, Dec. 1956; p. 413.
32. Knight, R.P. (Ed.), "Psycho-analytic Psychiatry and Psychology," International Universities Press, N.Yk., 1954; p. 76, as quoted in Selby, op. cit., p. 406.
33. As stated in Classification System, Chapter III, p. 58, Item (11).
34. Selby, L.G., op. cit., p. 400.
35. Ibid., p. 403.
36. Schmidl, F., op. cit., p. 417.

"psychological support is useful in decreasing tension and guilt, increasing self-confidence, encouraging healthy functioning or a way of functioning that maintains the client's equilibrium, and in helping him to build up compensatory strengths and satisfactions."[37]

In 1955, she wrote, further, that supportive treatment "aims to improve general functioning of the person without substantial increase in the ego's understanding of previously hidden aspects of the self."[38] In 1958, the Staff Committee of the New York Community Service Society stated that, while the emotional form of the client's behaviour was modified by this method, internal processes, by intent, were not modified, though internal changes might occur as a contingent gain.[39] Conversely, clarification of self-awareness involves "insight" by the client, or understanding by the client of himself, his environment, and/or people with whom he is associated,[40] and more accurate and more complete understanding of previously hidden aspects of his own feelings and behaviour.[41] In 1962, Hollis again commented that, although adaptive patterns are said to be modified only when changed functioning results from an internal shift,[42]

i.e., through/.....

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37. Hollis, F., op cit. (footnote 6), p. 416.
38. Hollis, F.: "Personality Diagnosis in Casework," in Parad, H.J. (Ed.), Ego Psychology and Dynamic Casework - Papers from the Smith College School for Social Work, F.S.A.A., N.Yk., 1958; p. 84. Although published only in 1958, this paper was written in 1955 - vide footnote on p. 83 of article.
39. Method and Process in Social Casework, etc. p. 15.
40. Hollis, F., op. cit. (footnote 6), p. 418.
41. Hollis, F., op. cit. (footnote 38), p. 84.
42. Hollis, F., op. cit. (footnote 12), p. 100.

i.e. through insight, and through the technique of clarification, in fact supportive treatment could also bring about some adaptations[43] in the client's behaviour. She points out that many cases therefore may fall between the two classifications given, and, further, that one or the other type of method may be the predominant one used, but that elements of each may be involved.[44]

For purposes of this study, therefore, support was regarded as covering those techniques aimed at reassuring the client, and sustaining him, but also included activities resulting in a certain amount of change in the patient, where this had not been achieved through the application of specific techniques, but occurred as a by-product of the support given. Schmidl goes so far as to say that some interpretation is appropriate in supportive help,[45] and therefore such help, where it involved only conscious material, and no interpretations of preconscious or repressed material, was also included under this head. Similarly, confrontation, or pointing out to the patient various stereotyped or patterned episodes in his behaviour, attitudes, or feelings of which he needs to become aware and in addition can tolerate, in order

to improve/.....

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43. Adaptation is regarded here as the "coordination of motives and capacities which enables the person to maintain this sense of wholeness and balance while making some compromise between what he wants and what is realistically possible." (Method and Process in Social Work, etc., p. 13).
44. Hollis, F., op. cit. (footnote 12), p. 114.
45. Schmidl, F., op. cit., p. 418.

to improve his functioning, gives the client some self-understanding.[46] However, this, also, is not clarification, for it also does not involve pre-conscious data, and hence is included under supportive help.

Apart from these activities, and those of environmental manipulation and advice-giving, information-giving, and logical discussion - here discussed separately - support is regarded in the literature as encompassing several other techniques. Among these are reassurance, encouragement and praise, (which must be valid and reality-oriented[47]); demonstrating behaviour by the worker (which the patient can imitate); the setting of realistic limits for the patient, and protective action and exercise of professional authority, when needed; the opportunity for the client to ventilate such feelings as he has need to, and as he can tolerate; and the utilization by the worker of the patient's habitual pattern of behaviour, so that the patient "is helped to direct his energy more constructively, so that the outward form of his behaviour is modified, although by intent his internal changes are not modified."[48]

Both Selby and Schmidl point out that supportive help must be based on understanding of the patient's

problem/.....

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46. Method and Process in Social Casework, etc. p. 18.
47. If encouragement, for instance, is clearly unrealistic, the patient may well feel that the social worker is a well-meaning person but does not really understand him.
48. Method and Process in Social Casework, etc., p. 18; also pp. 16 - 18, passim, and Selby, L.G., op. cit., pp. 405 - 406.

problem and dynamics, and not arbitrarily given.[49] Further, supportive help is rendered more effectively to certain types of patients than to others. These patients fall into two main groups: (i) those who normally function quite well, but are reacting to some emotionally difficult external situation which has temporarily impaired integrative capacity; and (ii) those with weak ego-structures, who cannot tolerate further threats to their defensive systems.[50] This latter group includes, amongst others, psychotics, psychotics in remission, severe neurotics, individuals with infantile character structures and severely damaged personalities. Thus it appears that psychological support, as defined, is a most appropriate helping technique in a psychiatric unit, whether it is the sole method of helping, or an adjunct to other methods.

C. CLARIFICATION, COUNSELLING AND INSIGHT DEVELOPMENT.

If so wide a range of activities is included under psychological support, what is meant by clarification, counselling and insight development? Perhaps the most

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49. Selby, L.G., op. cit., p.410; and Schmidl, F., op. cit., p. 419.
50. Selby, L.G., op. cit., p. 407.

appropriate answer, in terms of the present study,[51] is that these methods are here regarded as aiming specifically at internal (ego) changes in the client, rather than as achieving these incidentally to support. Further, such changes are based on the client's understanding of both conscious and pre-conscious aspects of himself and of his behaviour,[52]

and thus/.....

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51. These definitions - as pointed out at the beginning of this chapter - although based on the literature, may vary slightly from commonly accepted definitions and divisions, but were thought appropriate to the present study. It is interesting that Bartlett, H., op. cit., p. 189, stresses that "clarity and agreement are still lacking.....as to what really happens in each form of treatment," and to what extent modifying techniques uncover previously hidden material and require psychiatric consultation. Thus, for instance, the three techniques grouped together here might all simply have been termed "counselling" techniques, aimed at helping the individual "enhance his capacity for social functioning.....this goal (being) achieved primarily through bringing about changes in the individual's feelings and through increasing his self-awareness." (Kasius, C.: "Principles of Counselling," in Harms, E., & Schreiber, P. (Eds.), Handbook of Counselling Techniques, Pergamon Press, N.Yk., 1963.) An even broader definition would have been to term counselling simply "the process of helping individuals cope with certain kinds of personal problems." (Nelson, A.G.; "Counselling : Some Historical Highlights," in Harms, E. and Schreiber, P. (Eds.), op. cit.) However, it was decided that the present definitions were more specific and that this latter one, particularly, might have included supportive techniques. Further, as the divisions used in this chapter were based primarily on the Community Service Society Report (Method and Process in Social Work, etc., passim) and Hollis's writings (various works cited, passim), in order to maintain consistency to some extent, these divisions and terminologies were retained. (It is interesting that Hollis has since changed her views somewhat (Seawright, Dr. T.R., personal communication), but her latest work is not yet available in this country, and hence the present texts are used.)

52. Method and Process in Social Work, etc. p. 21.

and thus enable him to understand the meaning of this, and to change with insight and emotion, rather than, perhaps, intellectually, or with only a "simpler" acceptance and recognition of his behaviour. Furthermore, these techniques relate present to past or remote, but remembered, events.[53] whereas supportive help does not, and they perhaps bring about "deeper" change, and change that may be more long-lasting, or may generalize to other aspects of behaviour. As such, they possibly border on the field of psychotherapy, but are more aim-restricted, in that they attempt to achieve moderate changes in some attitudes and relationships,[54] rather than any fundamental, though often selective,[55] changes in behaviour or personality structure. However, these techniques do not interpret unconscious material, as do certain forms of psychotherapy,[56] and also differ from these in techniques used, as well as various

other/.....

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53. Ibid., loc. cit.
54. Goldberg, E.M., et al. (Eds.), The Boundaries of Casework, A.P.S.W., London, 1956; p. 96.
55. Ford, D.H., and Urban, H.B., Systems of Psychotherapy, John Wiley & Sons, Inc., N.Yk., etc., 1963; p. 5.
56. It is particularly the analytic (Freudian, etc.,) forms of psychotherapy from which the techniques of casework have to be separated, for it is these, rather than behaviour therapy, which lent so much to social work, and with which confusion arises.

other respects.[57] In general, these methods are accompanied by supportive techniques, and such clarifying or general "modifying treatment methods,"[58] are regarded by Hollis as the "far end" of casework.[59]

For purposes of function analysis in the present study, no patient was classified as having received such help unless clearly preconscious and suppressed material had been elicited purposely, and various insights as to the why of his feelings, behaviour and defense mechanisms gained by the patient, these leading to internal or ego changes within him, manifesting in his changed behaviour and functioning. As such work is normally carried out with patients suffering from transient and the milder forms of personality disorder and disturbance, i.e. with patients with fairly well integrated egos,[60] it was anticipated that such social work function would occur infrequently in the present context.

D. PROPORTIONS/....

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57. Because "psychotherapy," of whatever sort, is always carried out in the unit under discussion by the psychiatrists or the clinical psychologist, it will here not be defined further; nor will the differences between psychotherapy and casework in general, or the "insight" techniques of some forms of psychotherapy in particular, be discussed, as this is beyond the scope of the present study. It is interesting that Hollis (op. cit., footnote 12,), p. 99 at any rate regards that psychotherapy which involves the use of free associations and unconscious materialas not a "part of the caseworker's competence."
58. Method and Process in Social Casework, etc., p. 19.
59. Hollis, F., op. cit. (footnote 12), p. 117.
60. Kaplan, A.H.: "Psychiatric Syndromes and the Practice of Social Work," Social Casework, Vol. XXXVII, No. 3, March 1956; pp. 111 - 112, passim.

D. PROPORTIONS OF SUCH FUNCTIONS CARRIED OUT BY THE SOCIAL WORKER.

When the group of 88 records was examined for the above functions, it was found that 127 of the 605 functions rendered,[61] or 20.99% of the total, fell into these categories. The most striking finding was, however, that these 127 functions were divided between the advice-giving, etc. category, (66 or 10.91% of total function), and the supportive category (61 or 10.08% of total function), with no function at all noted as having fallen into the "modifying" methods group. This latter more than fulfilled the expectation, noted above, that little such help would be found as rendered.

Several reasons may be postulated for this, in addition to the fact that patients admitted to the ward usually were suited, from a social work point of view, more to supportive than to "modifying" treatment methods. In the first instance, several patients were thought to have received such latter help, and were "scored" as such in one or other of the analyses, but not in both. Further, very careful analysis of function in terms of the discussion above showed that some patients, without the inclusion of interpretive and confrontation techniques as supportive, might have been included under Category 12 (clarification, etc.), but because of this inclusion, were not. The same principle applied in a sprinkling of cases with

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61. 147 of the total of 678, including both confirmed and unconfirmed functions.

whom the technique of reflective discussion had been used. Then, too, the overlapping and use of more than one technique, commented upon by Hollis and mentioned earlier in this chapter, resulted in a few patients being classified under Category 11 (support) in terms of predominant technique used. Again, because such techniques as clarification, counselling, and insight development, while remaining different from psychotherapy, nevertheless verge on it, they hence are often part of the psychiatrists' function in this particular unit, and are only occasionally used by the social worker.

Although Parad states that short-term (crisis) casework services involve "much the same in skill and method as long-term work,"[62] Sutherland states that more "intensive" work requires more time by the worker,[63] while Goldman found that counselling services were the most time consuming of those performed for medical patients in general hospitals.[64] The present writer would confirm these latter statements, and thus feels that clarification and counselling techniques were not used as predominant ones in the present study also for

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62. Parad, H.J.: "Brief Ego-Oriented Casework with Families in Crisis," in Parad, H.J. and Miller, R.R. (Eds.), Ego-Oriented Casework : Problems and Perspectives. F.S.A.A., N.Yk., 1963; p. 163.
63. Sutherland, J.D.: "Providing Psychotherapeutic Facilities : The Changing Role of the Social Caseworker and its Requirements," British Jnl. of Psych. Social Work, Vol. VII, No. 2, 1963; p. 70.
64. Goldman, F.: "What are Social Workers in General Hospitals doing for Long-term patients?" Social Work (N.Yk.), Vol. V, No. 4, Oct. 1960; p. 75.

these reasons. For not only are patients in hospital for a short time and often not referred to the worker immediately, but the time which the social worker then has available for them is limited by the pressure and amount of work having to be done by her.[65] Further, urgent problems, such as certifications, have often to be fitted into a crowded day, and not only can patients not be given the regular appointments characteristic of intensive work, but those appointments given have often to be postponed - an action needing to be compensated for by extra warmth and explanations from the worker, and conducive, in general, to feelings of rejection in the patient, even when "deep" problems and sensitivities needing consistency in the worker and in timing of interviews are not involved. This irregularity of interviews or interruption of regularity, is, moreover, a disadvantage in establishing working relationships deep enough for such help[66] with patients who frequently have not approached the social worker directly themselves.

It is interesting that Berkman, without as clear a definition of modifying techniques as that given

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65. The pressure of time and work in relation to this has been mentioned in several places in the text. Full attention will be given to it in Chapter XII, but in the meantime it should be noted that the 88 patients here dealt with form only a portion (sample) of the numbers dealt with during the 6-month period of the study.

66. Hollis, F., op. cit. (footnote 6), p. 422.

above,[67] found that only 7% of the workers in her study reported "therapeutic" activities other than supportive ones, and that many of those workers who did render such services qualified them as taking place "in a small number of cases."[68] That 93% of social workers in psychiatric hospitals and psychiatric units attached to other hospitals reported no such activities, indicates that the present study is not alone in this finding.[69] Furthermore, those workers who reported such activities stated that they were carried out "under the close supervision of the psychiatrist."[70] The necessity for psychiatric supervision of or consultation about social work "depth" help has been pointed out frequently,[71] and it is of note that all work done by the writer in the present study was carried out, not under psychiatric supervision, but

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67. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Assocn. of Psych. Social Workers, N.Yk., 1953; p. 43 - includes under the term "psychotherapy" or "therapy" the terms insight therapy, expressive therapy, and relationship therapy, but states that no elaboration of the meanings of these terms was given by the workers responding to the questionnaire.
68. Ibid., loc. cit.
Hollis, F., op. cit. (footnote 12), p. 113 also states that a small proportion of case-work of this kind is carried out.
69. Even though Berkman's study was carried out some ten years ago, it is unlikely that a complete "revolution" has taken place in this sphere; so that even if a greater amount of this work were to be found in such a vast study carried out today, it seems unlikely that all workers would report it, or report it as a predominant type of service rendered.
70. Berkman, T.D., op. cit., loc. cit.
71. E.g., by Hollis, F., op. cit. (footnote 6), pp. 425 - 426.

with psychiatric consultation at ward and staff meetings, and in a spirit of co-operation and teamwork.

The above comments apply only to the clarifying, counselling, and insight developing techniques of the social worker, and a return must now be made to discussion of those functions which actually were rendered. Of the 66 advice-giving and associated functions,[72] 35 were rendered to patients, and 31 to patients' families, but, in fact, only 61 patients (or 69.32% of the group) were either themselves helped in this manner or had relatives given this help. For in 5 cases, such help was given both to the patient and his family. Of the 61 patients or families thus assisted, 31 were men and 30 women, while of the 66 functions rendered, 19 were direct to women and 13 to their families and 16 direct to men and 18 to their families.

When supportive help was considered, it was found that the 61 "scorings"[73] of this were distributed among 57 or 64.77% of patients, 29 of these patients being women and 28 men. The 61 functions were made up of 35 to patients and 26 to families, with such help being rendered to both patient and family in 4 cases.[74]

Further,/.....

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72. Which formed 10.91% of total (605) functions rendered.
73. Which formed 10.08% of total (605) functions rendered.
74. I.e., 31 patients received such help.....31
22 families received such help.....22
4 patients and families received such help..... 8

57 = patients functions = 61

Further, of the 66 functions rendered, 21 were direct to women and 13 to their families, and 14 direct to men and 13 to their families.

Several comments are stimulated by these findings. First, it is illuminating to see that, although no patient was referred for either advice[75] or supportive help, 127 or 20.99% of total functions rendered fell within this broad group of functions, and that, furthermore, these were distributed among 69 of the 88 patients. In other words, 78.41% of patients were helped in one or both of these ways, the service being rendered wither directly to them or to their families. Secondly, such methods were employed in relation to other functions, and never independently. Thus support might be associated with helping a patient to get work, or information as to procedures and treatment methods at the mental hospital accompany a certification. For this reason, advice and support are perhaps mainly adjunctive services in the setting presently under discussion and though they may, once instituted, become independent services, they always result from or are associated or carried out concurrently with, other help.

When functions to patients and families come to be separated, it is interesting that 70 were rendered directly to patients and 57 to families - a far greater proportion of such to families than was found in the

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75. This term will be used in the text to indicate the whole constellation of factors under category 10 in the classification system, and discussed at the beginning of this chapter.

previous chapter.[76] This perhaps indicates the great stresses and strains - as well as lack of information about mental illness - imposed on families by such illness in a family member. Berkman's study shows that in "interpretation of psychiatric illness" more service was rendered to families than to patients,[77] but that in supportive treatment[78] service was generally to the patient himself.[79] When the two categories under discussion are once more viewed separately, it appears that, although in neither was help to relatives more frequent than help to patients, advice was given more often to families than was support, and support given proportionately more often to patients than was advice. So that, even though Berkman's findings were not repeated, the trend reported by her of more service of the former kind to relatives, and more of the latter to patients, was to some extent manifested in the present study.

It is of particular interest, in view of the comments made about advice, support, and certification, in the preceding chapter, that of the 31 families to

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76. Hughes, K.M.: "Resistance in Relatives of the Hospitalized Mentally Ill," Smith Coll. Stud. in Social Work, Vol. XXIX, No. 1, Oct. 1958; p. 46; and
Tennant, M.A.: "Psychiatric Social Work in a Private Mental Hospital," Jnl. of Psych. Social Work, Vol. XXIII, No. 4, June 1954; p. 241 - both report a high proportion of support to relatives of patients.
77. Berkman, T.D., op. cit., p. 42.
78. Ibid., loc. cit. Again, a loosely defined term in this study including, inter alia, "supportive therapy," "sustaining treatment," and "regular friendly contacts."
79. Ibid., pp. 42 and 43.

whom advice, explanations or information about various matters was given, 16 received such help in relation to certification of a family member, while 13 of these 16 also received supportive help around this procedure. Sixteen relatives of the 20 patients certified and having relatives available therefore received one or both kinds of such help. In addition, 3 of the patients whose families were assisted in this manner themselves received advice or supportive help. A further 6 patients (making up the total of 26), whose families were not seen, or who did not have families, received support and/or advice from the worker, thus bringing the total of certified patients and/or their families helped in this way to 22 of 26. Advice and supportive help to families thus centred mainly around certification, 29 or half of such help being related directly thereto, and being rendered to 16 of the 34 families receiving either or both of these types of help. The remaining 16 advisory and 13 supportive functions of the worker to relatives fell into three distinct groups. The first group included 9 relatives who had been given advice or information directly about patients and how to plan for them; 5 of these same relatives had also been supported in carrying through such planning to its close. The second group of relatives, 5 in all, were assisted with their own feelings and problems about the patient and the patient's illness; thus 4 of this group discussed various of their attitudes with the worker and explanations and interpretations of

relatives'/.....

relatives' illnesses were given, while all 5 were supported and encouraged during the period of their difficulty.[80] The balance of 3 advisory services were related to the environmental problems of those 3 relatives of patients who had received environmental help from the worker, and all 3 of these relatives were also supported in their efforts to achieve their aims.

When advice and supportive help to patients was examined, it was found that no such distinctive grouping occurred. Of the 43 patients[81] receiving

one or/.....

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80. While all support to all relatives obviously entailed at least some support to them in relation to their own feelings about the patient and his illness, it was only with these five relatives that this was the main function of support. But perhaps one family, classified with the group receiving such help in relation to a patient's certification should really have been included under this head as well. For although they were supported through a difficult certification of a young sister, they had for weeks prior to this received advice and support from the worker. However, in order not to skew the figures, and as this help was scored only once, in keeping with the general scoring procedure of the study, this help was grouped here only once.

81. The 69 patients receiving advisory or supportive help to themselves or their families were made up as follows:
34 Families of patients were assisted.
43 Patients themselves were assisted.
This total of 77 is reduced to 69 when the 8 patients for whom function occurred to both themselves and their families are counted separately.
Thus,
26 families of patients received help,
35 patients alone received help,
and
8 patients received help to both themselves and their families.

one or both of these types of help, only 9 received supportive, and only 3 of these explanatory, help in relation to certification specifically. The remaining 32 explanatory or advisory and 26 supportive functions of the worker were fairly evenly and proportionately associated with all other problems of patients, and did not fall into specific categories. This raises the question of whether or not such a distribution of these functions indicates not only that they are adjunctive to other types of help, but that advice - and information-giving to patients are perhaps characterixtic of a setting where (unknown) illness and procedure has to be interpreted, and that support is a characteristic need of the hospital patient faced with emotional and general upheaval.[82]

A further interesting feature of these techniques is that they were concurrently used, or used in close relation to one another, in 50 cases. In other words, 27 patients and 23 families were both supported and advised, these figures included 2 cases in which such help was rendered to both patient and family. Thus, in actual fact, these services related to only 48 patients, although 50 sets of associated function were reported. The corollary to this finding is that in only 21 cases was either advice or support given alone. It is interesting ti postulate whether or not the relationship between these two social work methods

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82. This latter is confirmed to some extent by Bartlett, H.M., op. cit., p. 188.

occurred by chance; or whether they occurred together so frequently because the first is a part of the second,[83] or whether, again, this was a result of the hospital situation, in which explanation of, and support in relation to, strange forces is so necessary, and may have to be given together.

Because a <u>case history</u> illustrative of advice-giving, reflective discussion, and supportive help has already been given in the outline of the history of Mr. J., the alcoholic patient assisted in reaching Wedge Farm,[84] no new one will be drawn up here, but this one commented upon.

Mr. J., as was pointed out, had known the worker for three years, and a strong positive relationship had developed between them. Because of this relationship, it was possible to use the technique of advice in helping the patient, and to combine this with much reassurances and support, in order to maintain his crumbling defences. At a staff meeting a few days after his admission, the advisability of Mr. J's going to Wedge Farm had been discussed. But the worker had not yet had the opportunity of going across to the ward to see him, when he himself arrived to see her for help in finding accommodation and work. This provided an appropraite opening for following up the psychiatrist's suggestions, and after the warmth of greeting had subsided, and the patient had explained his purpose in coming to see the worker, she broached the subject of

his/.....

83. As postulated in the literature, and discussed at the beginning of the present chapter.
84. See Chapter VIII, pp. 219, foll.

his going to Wedge Farm. Discussion proceeded from this point, and was slow and measured, but even with much support, encouragement, and acceptance of him by the worker, he was unable to accept the worker's advice that he go to Wedge Farm. This step seemed too great a threat to him, and meant the end of his refusal to acknowledge his problems and reality. Discussion proceeded through a number of interviews, in between which the social worker attempted - as he could not be forced to go to Wedge Farm, and some alternative had to be arranged for his ultimate discharge - to find accommodation and work for him. His lack of funds and long period of unemployemt militated against both aims, and, as he could not be helped to accept Wedge Farm Farm even as a temporary alternative,[85] the arrival of his daughter with R20.00 was, understandably, a great relief to him; although the worker realized the futility of such a solution to his problem, it appeared to her as perhaps a means to the end of helping him to Wedge Farm.

The anticipated outcome of his departure from hospital has been discussed in that part of the history given in the last chapter, and mention made of the techniques of confrontation and support used by the worker. These activities were not regarded by the worker as clarifying or insight-developing ones, for they involved, rather, reflective discussion, and

stressing/.....

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85. The history may read as though pressure was brought to bear on him; this was not so, and these aspects are emphasized only to show function.

stressing to him of reality and obvious aspects of it, with which he could not cope, and which he could not change. Although the aim of the technique used was not "internal change" in the patient, but, rather, protection of the patient, the former might nevertheless have resulted incidentally, and the pressing of reality onto him helped him to face his problem, for his six-month stay at Wedge Farm was significantly longer than that of a patient with total lack of insight.

A word should be said, here, about the fact that Mr. J's departure from Wedge Farm was associated, at least to some extent, with the worker's withdrawal of support, for some criticism may be levelled at her for the use of support apparantly indiscriminately and unwisely given. However, it must be pointed out that she was aware of the possible ramifications of this approach, but felt it better to risk these, and use this technique and the positive relationship existing between herself and the patient to keep him in treatment, than simply to leave him lost and alone again, albeit in a helping environment.

An example of the "simple" supportive techniques and approach of "going with" the patient, used with some psychotics, is shown in the case of Miss W. Aged 55, she was diagnosed as suffering from a paranoid state. Her delusional system centred round the belief that a "gang"followed her from job to job, maligning her to her employers and causing her to resign from each post before she could be told to go.

Medication did not affect this delusional system at all, but did serve to make her less agitated. It was felt by the doctors that an attempt should be made to help her in the community, and that when she was as well as possible, she should be assisted to find employment. However, when this stage was reached, the patient, already known to the worker, stated that she was not yet well enough to work. Recognizing that the work situation was the pivot of the patient's delusional system, the worker openly remarked that the patient need not worry about "the gang" in a new job, as, should its members approach her or her new employers, she could return to the worker, or doctor, for help. The record reads that after a long discussion with the worker, the patient "began to feel that perhaps she could return to work in the knowledge that if 'they' started on her again she would be supported against them by us here, and provided Dr. L. and I would then deal with 'team' and the employers concerned. She also felt that it would be a good idea if she could work from the ward for a while, as she would thereby feel more secure." It is interesting to note that, had the patient's fears been denied or disregarded, little progress would have been achieved. However, by accepting the patient's "reality" situation, and going along in it with her, the worker was able to help her, and to support her in returning to work.

The worker's functioning with Miss V. and her family (mentioned on p. 249, footnote 80), is a particularly good example of the type of help rendered

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to a patient's family during the certification of the patient, and also of that given to them prior to this time.

The history starts some time prior to Miss V's admission to hospital,[86] when, one morning, she arrived at the social work office, and saw the writer, who happened to be casualty officer for the morning. Talking emotionally and smiling blandly, she stated that she wanted work, had missed her appointment with thepsychiatrist that morning, and would go to the Department of Labour anyway, if the worker didn't send her. In order to hold her, and as she would not see the casualty psychiatrist, appointments were made for her at Labour, and to see both psychiatrist and worker the next week. To this she agreed, and in the interval between the two appointments, the worker contacted her psychiatrist, who happened to be one of the unit doctors.

She remembered Miss V. as a simple schizophrenic, and it was decided that the patient should be encouraged to seek sheltered employment. Thus, when she returned to see the social worker this was discussed with the patient, and she agreed to such placement. The social worker, however, felt that a home visit to the sister with whom the patient lived was called for, as Miss V. appeared so vague and unrelated to reality in her behaviour, that it seemed necessary to elucidate her full background and obtain the co-operation of her

family/.....

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86. The record was analyzed for function only from date of admission, however, and this part of the history is given merely as background, and not included in the scoring of function.

family in planning for her. The patient was agreeable to such contact being made. A visit to the sister, Mrs. C., found her a warm friendly person, in a state of great anxiety about Miss V., who, she said, had on one accasion attempted suicide, often disappeared for hours at a time, and was secretive about her activities. The family did not know what was wrong with her, or what to do about her. The explanation of the patient's behaviour and interpretation of her diagnosis was met with great relief by Mrs. C., who stated that "now she knew what it was all about, even though it was terrible," and expressed the relief she felt at having someone with whom to discuss the patient. She felt that it would be a good idea for Miss V. to work, if she could, as this would keep her occupied, and perhaps for her to stay in at a hostel near the factory, and coming home for week-ends.[87] She felt that she should discuss the whole matter with the rest of the family, and that Miss V. should in the interim remain with her, and be helped at first only with work, but be reassured that they would do whatever was best for her. She herself was reassured that she could contact the worker at any time, should she need to do so, and was asked to contact her, at any rate, to let her know whether or not to proceed with general arrangements for the patient.

The following day, she telephoned the worker,

asking/.....

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87. This has been discussed previously with the psychiatrist, who felt patient was well enough for such a plan, and might in fact settle in to a hostel quite well.

asking her to start implementing the plans for the patient, with whom the family had met the previous night, but saying that she was still very worried about the patient and afraid she was getting "worse." The worker offered to arrange for Mrs. C. to see Miss V's psychiatrist, in the hope that this would reassure her further, and this she did, but shortly thereafter, the patient broke down fairly severely, and had to be admitted to the ward. From this point, she was handled by the psychiatrist, and the family primarily by the worker.

Upset and yet relieved, Mrs. C. and her sister-in-law came in to see the social worker, and the explanations and support begun with the one prior to the patient's hospitalization were continued with both. As medication did not help the patient, and as she became more ill, both women were helped to deal with their anxieties by interpretations and discussions of the illness and of treatment procedures, and finally helped to accept the doctor's recommendation that Miss V. be sent to a mental hospital for treatment. The actual completing of the certification forms was stressful to both women, and to their husbands - who accompanied them - and continual reassurance had to be given to all about the correctness of the step they were taking. The patient's bed at the mental hospital was obtained while they were present, so that they could see that the hospital was a treatment centre, not an "asylum", and all the steps of procedure were explained to them, while, as well, they were told of

the provisions in the Mental Disorders Act allowing them to sign the patient out of hospital, if they so wished.[88] This latter gave them perhaps the most comfort, and they left the hospital slightly less anxious.

Regular contact was kept with Mrs. C. for about two months after this,[89] and she gradually settled into an acceptance of her sister's position. Interpretations of the illness were kept up, as necessary, and, as Miss V. began to become well again, Mrs. C. was helped to understand that the cure might not be permanent. Gradually, the support of the worker was curtailed, and she had not seen Mrs. C. for some two months, when, one day, she arrived at the office to say that Miss V. had been discharged from hospital, and that, although she realized that her sister might fall ill again, she would now know how to cope with the illness and what to do about it if Miss V. became too ill to keep at home. The worker telephoned her some weeks after this, to find out how matters were progressing at home,[90] but could get no reply. About one month later, Mrs. C. telephoned the worker to say that Miss V. had broken down again, this

time/.....

88. This provision applies to the temporary patient who may be signed out of the hospital by the person who signed him in. See Appendix B, p.442.

89. Although such follow-up was not routine, Mrs.C. had expressed a wish to keep in contact with the worker, and as she had no opportunity to obtain help from any other source close by, and had need of this contact, it was continued.

90. Arrangements for the patient's follow-up, work placement, etc., after treatment at a mental hospital are usually made by the Mental Health Society covering the hospital (at the time of the study there were no social workers in mental hospitals) and so the worker had no responsibility for this.

time in Pretoria, but she had taken her to the hospital there and arranged for her readmission to a mental hospital.

E. PATIENT-WORKER RELATIONSHIPS.

As was stated earlier,[91] relationship with families was not systematically assessed, and thus, although it would have been interesting to examine this in relation to advice and supportive help, especially as so many families received such help, it was not possible to do so. However, all patient-worker relationships were assessed, and it is interesting that several clear trends emerge in regard to such relationships and the techniques of advice and supportive help to the patient. Thus, of the 43 patients receiving one or both of these kinds of help, 17 had very good relationships with the worker, 12 good, 4 fair, 8 poor, and 2 "X" relationships with her. Among these patients were the 8 who had received such help both to themselves and their families. This dual role of the worker, however, did not seem to affect relationship particularly, for of these 8, 2 had very good relationships with the worker, 1 a good, 1 a fair, and 2 poor relationships with her. The remaining 2 were classified as "X".[92]

When relationship was assessed with patients whose relatives had received advice and/or support, but who had themselves received neither, it was found that the bulk of the 26 patients in this group were classified as "nil", i.e., as not having been seen by the worker (13), while those where relationship was

uncertain/.....

91. Chapter III, p. 68.
92. And, interestingly, were not certified patients.

uncertain, "X", were next (5), with poor and fair tying (with 3 each). No good or very good relationships were found in this group. Yet, amongst the 19 patients to whom and to whose families neither advice nor support were given, 2 had good relationships with the worker. Of the balance, 2 had fair, 6 poor, 5 "X", and 4 "nil" type relationships with the worker.

It thus appears quite clearly, and especially when Table XXX is viewed, that the general trend in relationship was for it to be strongly positive when the patient himself was either advised and/or supported, less positive when neither he nor his family received such help.

TABLE XXX - TYPES OF PATIENT-WORKER RELATIONSHIP ASSOCIATED WITH ADVICE AND SUPPORTIVE HELP.

Advice and/or Support given to:	Type of Relationship						
	Very Good	Good	Fair	Poor	X	Nil	Total
Patient (including 8 to families as well)[a]	17^{2}	12^{1}	4^{1}	8^{2}	2^{2}	0	43^{8}
Neither patient nor family.....	0	2	2	6	5	4	19
Family only.....	0	0	3	3	5	15	26

a. Figures above each number in the first row indicate number of family and patient help in each section.

and "worst" or least often in existence when only the family of the patient received such help. It is interesting that Diamond reported that although, in general, seeing the husbands of wives in treatment

facilitated/.....

facilitated improvement in the wives, in some instances it had the opposite effect.[93] Further, some patients may feel threatened if they are not included in all phases of planning, or if relatives with whom they do not get on well are seen.

It is interesting, however, that where no specific comment could be made about whether the nature of relationship in environmental help was due to type or to amount of help rendered,[94] in the present discussion it seems quite clear that positive relationships, and, in fact, strongly positive relationships, are associated with advice and supportive help, and that these do not occur to any great extent among either patients whose relatives were helped in these ways or those who neither themselves were helped thus, nor whose relatives were helped thus. Whether such positive relationships arise before advice and support are given, or whether these, and especially the latter, lead to such relationships is not shown in the present study. Further, that advice may be given to protect a patient, whether or not a good relationship exists between worker and patient,[95] was shown by the fact that of the 8 patients rated as having a poor relationship with the worker, 6 had received advice only from

her/.....

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93. Diamond, M.E.: "Effect of Husband's Involvement in Wife's Treatment," Abstract of Thesis in Smith Coll. Stud. in Social Work, Vol. XXXII, No. 1, Oct. 1961; p. 62.
94. See Chapter VIII, p. 224.
95. Thayer, A.A., op. cit., pp. 116 - 117.

her, and 2 only both advice and support. Again, of course, the giving of advice may have weakened an already not very strong relationship.

F. SUMMARY.

In general the findings presented above show that information-giving, advice, logical discussion, and support were techniques frequently used by the social worker in relation to the 88 patients of the sample. While information-giving and logical discussion are perhaps well-accepted methods of casework, advice is a somewhat more disputed one. However, Thayer points out that nine of the social workers interviewed by her in the Psychiatric Department of the Massachusetts General Hospital used this technique,[96] and this lends not only a cloak of acceptability to its use in the setting presently under discussion, but confirms that it is a recognised technique of social work, at least in such settings. Further, the frequent use of support reported in Berkman's research[97] is found in the present study, while that such work, as reported by Hughes and Tennant,[98] occurs frequently with relatives of patients is also confirmed (34 of a possible 66 families being helped thus).[99]

In terms/.....

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96. Ibid., p. 116.
97. Berkman, T.D., op. cit., p. 42.
98. Hughes, K.M., op. cit., p. 46; and Tennant, M.A., op. cit., p. 241.
99. Chapter V, p. 25 , Table XX and Chapter XII, p. 333, Table XXXI.

In terms of the discussion in the text of this chapter, the absence of clarifying and related methods of functioning by the social worker is not unexpected. In general, concurrence of the findings of the present project with those of previous studies is of particular interest when it is realized that this occurs in spite of the possible selectivity of the present sample.

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C H A P T E R X.

"INDIRECT" SERVICES TO PATIENTS : THE COLLECTION OF SPECIFIC PSYCHIATRIC INFORMATION, AND THE SOCIAL WORKER'S FUNCTION IN DIAGNOSIS AND TREATMENT.

Unlike several other reports on psychiatric social work,[1] the present study does not divide social work functions in the psychiatric hospital or its equivalent into those occurring at certain periods of time. In other words, services of the social worker were not here divided into those relating to pre-admission and admission services, services during the period of the patient's hospitalization, or those related to discharge planning and after-care, for the services of the social worker in the present setting are requested as needed, and as problems arise, not around specific phases of treatment, and most functions are rendered at most times. Thus, functions were grouped, in preference, according to type; and similar functions, related to similar problems, placed together. Further, some attempt was made to group together those functions to the patient which took place within and by means of the helping relationship between social worker and patient, and those which, while remaining directly related to the patient, his problems, and his welfare, did not necessarily make use of this relationship, or always involve direct contact with the patient, but usually were carried out with or through other people.

Such/.....

1. E.g., Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn, of Psych. Social Workers, N.Yk., 1953; pp.35 - 50; and Knee, R. (Ed.), Better Social Services for Mentally Ill Patients, Amer. Assocn. of Psych. Social Workers, N.Yk., 1955; pp. 47 - 59.

Such latter functions, termed here "indirect",[2a,b] are, particularly, those covering the obtaining of social histories, and those involving collaboration, both formal and informal, of the social worker with staff members.

A. HOME VISITING.

Because home visiting in general did not involve contact with the patient, it too was included in the "Indirect Service" section of the classification system, and, furthermore, noted, because of its frequent use as such, as a tool in obtaining the social history. Again, however, the difficulty of classifying the sometimes overlapping and sometimes mixed functions of the social worker into clear cut divisions[3] arose. For, occasionally, a home visit was made for purposes other than obtaining social data, or was made to or for a patient.[4]

By/.....

2a. The words direct and indirect are used only in this context, and not to indicate casework or group work, as opposed to supervision, teaching, etc., services. This is a somewhat different usage to that reported, e.g., by O'Keefe, D.E., in "Psychiatric Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960, N.A.S.W., N.Yk., 1960; p. 454, but is supported by:

b. Cooper, who discusses social work service to the patient as operating through two major channels which include giving direct service to individuals and groups, and working with and through the hospital staff and the general community to develop and improve the total service to the patient. (Cooper, J.W.: "The Social Worker's Role in the General Hospital," Hospital Progress, Vol. 44, No.1, Jan. 1963; p.48.)

3. Berkman, T.D., op. cit., p.41.

4. By "for" patients is meant doing something at the home for the patient, e.g., finding out for the patient how family members are coping or collecting clothing for him.

By and large, however, this categorization seemed the most logical, and home visiting more relevant to the social history and "indirect" section than to any other.

(a) General.

The home visit has had a long and uneven history in social work,[5] but, after a period of disregard and questioning, it has today again been dignified as a social work tool.[6] However, its use in the unit under discussion is perhaps slightly narrower than usual, for, where Paterson and Cyr discuss it as both a diagnostic and a therapeutic tool in helping the patient,[7] it is here seldom, if ever, used in the latter way. Nevertheless, its use as a method of obtaining social data about the patient may have the incidental effects of making the family[8] feel included in the hospital programme for the patient, or making relatives feel that the hospital is

interested/.....

5. Behrens, M.L., and Ackermann, N.W.: "The Home Visit as an Aid in Family Diagnosis and Therapy," Social Casework, Vol. XXXVII, No. 1, Jan.1956; p.11.
6. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p.67.
7. Paterson, J.E., and Cyr, F.E.: "The Use of the Home Visit in Present-Day Social Work," Social Casework, Vol. XLI, No. 4, April 1960; p. 191.
   Scherz, F.H.: "Family Interaction : Some Problems and Implications for Casework," Smith Coll. Stud. in Social Work, Vol. 31, No. 2, Feb. 1961; pp. 97 and 98 - makes this same point.
8. Unless there is no family and the visit has been made simply to ascertain physical aspects of the home.

interested in them and their problems.[9] Further, it serves as a means of getting to know family members and hence the resources and strengths available in the family which may be used to the patient's benefit (this is in a sense family diagnosis[10]).

In some senses, again, the home visit is used with broader purposes, perhaps, than in other agencies. For it may be used preventively, that is, to keep a patient in the community, or as a means of assessing whether or not the patient needs admission to hospital, and of bringing him to hospital if necessary. Again, if family members are unable to come in to see the social worker (as

with/.....

9. For discussion of these, and thereby at least some support in them and relief from them, often takes place during these visits. Again, of course, the visit by the social worker may not be welcomed: she may be regarded as a spy; as hostile and on the patient's side; she may be met with denial of the patient's illness or that anything is wrong; and she may be met with over-effusiveness and too-helpfulness. These attitudes can occur with and without careful preparation by doctor or social worker of the family for the visit and may or may not be able to be overcome. Especially where the family is seen only once may the latter occur.

10. Family diagnosis and therapy are usually a responsibility of the psychiatrist in the unit. This is contrary to much practice described in the literature,* but perhaps due to the fact that relatives, when seen by the psychiatrist about the psychiatric history of the patient, are not referred to the social worker unless a clear "social" problem is present, or unless the worker particularly asks to see them. Perhaps lack of time to see both patients and relatives, commented on earlier, has prevented her attempting any extensive presentation of herself in this traditional role of the social worker.

*E.g., Tennant, M.A.: "Psychiatric Social Work in a Private Mental Hospital," Jnl. of Psych, Social Work, Vol. XXIII, No. 4, June 1954; pp. 234, foll.
Behrens, M.L. and Ackermann, N.W., op. cit., passim.
Proceedings of the Dartmouth Conference, 1949: Education for Psychiatric Social Work, Amer. Assocn. of Psych. Social Workers, N.Yk., 1955; p.61.

with a mother who cannot leave a young baby, or an aged spouse who cannot move with ease), she can then go out to see them.

Home visiting in the unit is not a routine procedure, but occurs at the doctor's request (or occasionally at the psychologist's) or at the discretion of the social worker. Thus, she may feel that a depressed patient, returning to his one-roomed flat, should be visited from time to time, or that a social history would be made more complete by a visit to the patient's sister as well as to his wife. In addition, it is the social worker's decision as to whether or not she visits with or without some knowledge of the patient and his problems. Where the patient is already known to her, this latter is, of course, impossible, but where the patient is referred only for a social history to be obtained, she may know little more about him than his diagnosis, and where he lives. Behrens and Ackerman point out that the visitor without knowledge of the problem or of the background material achieves a "certain emotional neutrality, lack of selectivity, and avoidance of bias,"[11] but also feel that prior knowledge "helps the visitor to feel less a stranger, ... and ensures that central problems will be sufficiently noted."[12] The present writer tends to prefer this approach of "pre-knowledge" for several reasons, but primarily because most families are visited only/.....

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11. Behrens, M.L., and Ackerman, N.W., op. cit., p.14.
12. Ibid., loc. cit.

only once,[13] and it provides the worker with a point of contact which may lead to a quicker establishment of rapport, and which may enable her to elicit, during the one interview, relevant information and attitudes which might otherwise not emerge.[14]

In general, however, even where "verbal" information is not obtained, the home visit is useful, for it gives a clear picture "of the pervasive climate, of characteristic patterns of communication, points of stress, and of cultural values and standards"[15] in the family and home. Then, too, the "meaning and use .... of a home by the (patient and) family is often reflected in its

furnishings/.....

13. Unless follow-up work is being done. Usually, however, further contact, if possible, takes place at the hospital. For home visiting is a lengthy process, not only from the point of view of length of interview, but of time taken in getting to and fro. Even though the writer had the use of the departmental motorcar for this, she considered herself to have accomplished a great deal, if, after leaving the office at 8.00 a.m., she had managed to make four visits by lunch time. Reports of such interviews can take up the remainder of the day, and thus a disproportionate amount of time is devoted to a small part of total duties. However, a scheme allocating all visiting to one worker may have other disadvantages.

14. An added aid in this is that less stigma seems to attach to a visit from "the hospital" than to one from "the welfare." The influence of social class nevertheless remains, however, and, as Timms points out, home visiting seems to increase as one descends the social scale; and also to be met with less resistance. (Timms, N., Psychiatric Social Work in Great Britain (1939 - 1962), Routledge & Kegan Paul, London, 1964; p.104. Also see p. 267 , footnote 9, however.

15. Scherz, F.H., op. cit., p.97.

furnishings, its state of organization or disorganization."[16] Perhaps all this means only one thing - that, even where the patient and/or his relatives are seen, perhaps frequently, the worker, in the opinion of the present writer, does not gain the same "feel" of the home and background through this, as she does through even a short home visit.

(b) Number of Home Visits.

Yet, in spite of the writer's belief in this tool of social work, home visits were made in relation to only 24 or 27.27% of patients in the sample, while these 24 home visits formed only 3.97% of total functions carried out. Of these visits, 19 were made as part of the process of obtaining a social history, one of these, in addition, being made at the request of the patient, who was worried about her young children. Three visits were made as follow-up ones - one of these leading to the re-admission of a patient to hospital - one was made specifically in answer to a request from a patient that a psychiatrist visit her,[17] and one was made to fetch

clothes/.....

16. Ibid., loc. cit. Words in brackets those of the present writer. It is of note that one can sometimes pick up clues as to actual psychiatric diagnosis from the home of a patient. One particular instance which stands out in the writer's mind is that of the occasion on which she visited the flat of a single, depressed patient whose home was in a state of quite incredible disarray, because she simply had not had the "energy" to tidy it for weeks before her admission to hospital. This is also, of course, often found with the schizophrenic patient.

17. As psychiatrists from the hospital do not visit in the community, the social worker attends to such calls. This woman was persuaded to come into the hospital for treatment.

clothes from a patient's home, as she feared her husband would appropriate them.[18] Thus 19 visits fell into the "social history" category, or that of "indirect" service to patients, and only 5 were to or for patients and hence "direct" in terms of the discussion at the beginning of this chapter.

This total of 24 home visits, or 3.97% of total function, is only half the amount reported by Timms for psychiatric social workers in three teaching hospitals in England, where 8% of interviews and visits to in-patients were home visits.[19] This low total is explainable partly in terms of the comments, made in footnote 13 of this chapter, which point up the length of time taken up by home visiting, and partly because, although in several instances more than one person was visited for the obtaining of a social history[20] or the same patient was visited more than once in follow-up,[21] the scoring system did not reflect this.[22] This is perhaps the only

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18. This patient was married by ante-nuptial contract, so this could be done.
19. Timms, N., op. cit., p. 116. From the context of the comments, these hospitals were general hospitals - presumably with psychiatric units, because of the employment of psychiatric social workers.
20. Four additional people were in fact visited. However, no person from whom a social history was obtained was seen at home, for this purpose, more than once. But the patients whose families fell into this group were themselves followed up in four cases (2 followed up once only, 1 seen twice after discharge, and one 4 times after discharge).
21. One patient.
22. Data in footnotes 20 and 21 obtained from re-perusal of the necessary records. A total of 37 visits for 24 patients emerged in this way, but it was not possible to estimate percentage of function for this figure.

point on which the "single" scoring system did not reflect results adequately, and, when combined with the possibility of selectivity in the sample, this result may be somewhat inaccurate.

(c) Patient - Worker Relationships.

When the patient-worker relationship existing where visiting had occurred came to be examined, no "real" differences in type were found, possibly because the service, being indirect, did not affect relationship. Taking first the social history group, it was found that three patients had very good, 4 good, 1 fair, 5 poor, 4 "X" and 2 "nil" relationships with the worker. This last category particularly deserves comment, and can be explained by the fact that not all patients were seen by the worker, and some were asked by the doctor for permission to visit.[23] The 5 "poor" relationships were not due to the worker's visiting against patients' wishes, as this was considered incorrect, and done only in rare instances, as, for example, when the patient's judgment was considered grossly impaired.[24a,b] While no trend

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23. This was a policy which simply arose out of practice.

24a. However, strictly speaking, even this was not correct, as patients were not certified while in the ward, and hence, legally, were entitled to make decisions concerning themselves. The question of moral responsibility of medical and other staff in preventing harm to the patient by himself, or "doing the best for him," arises here, as well as the relationship of this principle to the client's right of self-determination.

b. No difference in relationship was noted in the 4 patients from this group later followed up. One had a very good, one a good, and 2 poor, relationships with the worker.

in relationship really existed where the function did not involve a direct contact with the patient, for the remaining 5 patients, who were themselves visited, relationship was very good (2), good (2), and "X" (for the schizophrenic patient readmitted to hospital). These relationships, in all except the last case, were already-established ones prior to the patient's discharge from hospital, but it is quite possible that the worker's visiting consolidated the positive feelings already existing.

B. THE SOCIAL HISTORY.

In turning to a discussion of the sources of social history other than the home visit, mention must be made of the fact that what is here termed "social history" refers only to that formal information seeking, leading to the drawing up of a formal report, which may occur during treatment of the patient. The social study and assessment of the patient's situation which accompany the casework process, and the services rendered to the patient, were not here separately considered. For this is a part of every social work interview, whether the patient's past or only his present functioning and problems are considered, and cannot be separated from general functioning. It was therefore decided to discuss, as separate functioning, only that history-taking which took place over and above this, and to consider such other social study as a sine qua non of this particular

setting/.....

setting.[25]

(a) Number of Social Histories.

Analysis of the records showed that "additional" social history taking occurred for 32 patients, or 36.36% of the total group. When the additional 12 patients for whom home visiting had taken place with this specific aim in view were considered,[26a,b] such function occurred in 44 cases or for half the group. Although only 26 patients were originally referred for this purpose,[27] the additional 18 patients were referred in the course of psychiatric treatment and/or while receiving other social work help. The reasons for most of these referrals were that the psychiatrist wanted to ascertain a specific aspect of the patient's history, such as his work record,[28] or wished to know a past

diagnosis/.....

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25. The approach here is neither that of the diagnostic nor that of the functional school. What is relevant to the problem is used, and such information may be concerned with past history or with the problem in its present context. For the rest, practice as carried out and as determined by the setting is what is here being reported.

26a. The figure 12 is obtained because although 19 home visits were made for history-taking purposes, both were done for 7 patients.

b. 5 Social histories were unconfirmed, i.e., possibly described "social studies", bringing the total to 37 of 678 unconfirmed functions.

27. See Table XXIV, Chapter VI, p.149, where fig. "24" is given, and text, p 151, where further 2 are added.

28. Perlman, H.H., Social Casework - A Problem-Solving Process, University of Chicago Press, Chicago, 1957; pp. 123-4 - points out that "data so gathered are not "against" the client, do not grow out of essential distrust of him, but are directed toward the end of more effective help to him."

diagnosis, or what the family's attitudes were to the patient, or because the patient was to appear at the formal weekly ward round, at which presentation of a social history by the social worker was routine.

Including the 19 "social history" home visits, function of the worker relating to the provision of this service formed 51 or 8.60% of the total 605 functions. Without home visiting, however, this total was only 32, or 5.29% of total functioning. Both percentages are small, and do not indicate that history taking, as stated by Berkman, is a major function of the social worker in psychiatric hospitals.[29a,b] However, when it is realized that this amount of function is distributed among 50% of the patients in the sample, then it appears that, in fact, a fairly large proportion of such service took place, and results are then slightly more in keeping with Berkman's statement. Further, that complete coverage of patients on this point does not occur is partly explained by the fact that the work in this particular unit is short-term and rendered in times of crisis, rather than over long periods of time, as in a mental hospital. Because social history taking can be a lengthy process, in the present setting, the urgency of some problems and the speed with which others have to be dealt precludes the giving of such detailed

history/.....

29a. Berkman, T.D., op. cit., p.39.
b. As in home visiting, more than one resource was often tapped for social data. Thus, with the 15 additional contacts of this nature, 47 sources of information were used for 32 patients.

history-taking and-obtaining as a routine service for each patient. While this point has often been discussed at social work staff meetings, it has always been concluded that service of this nature could not be performed in relation to each patient, or in relation to each patient on admission, until more staff were available, and this has therefore remained a service performed only when specifically requested.

(b) Sources of the Social History.

When such function is carried out, from whom is relevant information obtained? In the present study, the following sources were used - mental hospitals (for 7 patients); Tara Hospital (1 patient); social agencies (9 patients); employers (3 patients); other (5 patients);[30] family (6 plus 12 home visits); and the patient himself (once). This distribution of sources is in keeping with that found by Berkman, who reports that the "relative, social agency, and others who had had experience with the patient were the prime sources of the social history secured. Only in a small number of instances was the patient himself interviewed."[31a,b] It is interesting that, in the present study, it was the social worker, rather than the psychiatrist, who was responsible for obtaining medical information from other hospitals.

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30. School Teacher; University; Matron of a Hospital; Caretaker of a block of flats; and Matron of a hostel.

31a. Berkman, T.D., op. cit., p.40.

b. Even with the addition of the "extra" 15 sources, this statement holds, for 5 of these were mental hospitals, 7 were social agencies, 2 employers, and 1 a patient.

This practice arose primarily from the fact that it was she who had most contact with the mental hospitals and could telephone directly people known to her there; or, if the hospital was a distant one, could arrange for the departmental secretary to obtain the information by letter. Although this service required no social work skills, it became a traditional one in the unit. Other methods of obtaining the various social data needed varied through person-to-person interviews (in office as well as home), to telephone calls to employers, and, again, letter-writing.[32]

(c) Patient-Worker Relationships.

When patient-social worker relationship was assessed, it seemed that, as had been found with home visiting, this "indirect" service was not one which would really affect this relationship. Yet there was some difference, for it was found that only 14 patients were rated as having any sort of relationship at all with the worker - 3 very good, 2 good, 5 fair, and 4 poor. The remaining 18 patients either had not been seen by her (8) or were so ill, or had been seen so briefly, although much was known about their circumstances, that no relationship could be assessed for them (10). This would appear to indicate that the social history forms a point of contact between

worker/.....

32. It is interesting that Ruth Knee (op. cit., pp. 50-51) discusses the use of correspondence in obtaining social histories from relatives, and also the use of community agencies in approaching family members for data. The present writer found it much more satisfactory to interview relatives, or, if this were impossible, to telephone them - long-distance, if necessary.

worker and relatives or "others" far more often than it does between patient and worker. This again fits in with Berkman's finding, quoted above (and footnote 29a).

However, it also again raises the question, first brought up in Chapter VII of the present text,[33] of the ethics of working for the patient, but not with him; i.e., of not seeing the patient, though carrying out services for or about him. While it must be pointed out that, for certified patients and those in this section, but with the exception of the two patients too ill to participate in planning,[34] all patients were either briefly seen by the social worker,[35] or her role interpreted to them by the doctor. Again, as with home visiting, however, information was occasionally obtained against the patient's wishes, where it was felt to be essential to his treatment, and the same questions apply to this as are raised in footnote 24a of this chapter, even though care was taken not to disclose any information about the patient, or to make any move which appeared realistically detrimental to him.

It is interesting that, where Berkman comments that obtaining the social history was sometimes the first and only contact with relatives,[36] in the present study this seemed sometimes to apply also to patients. However,

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33. Chapter VII, p.175.
34. Idem.
35. Usually only once, in order to explain the need for social history, and hence also include the patient in planning.
36. Berkman, T.D., op. cit., p.97.

this was by no means always the case, and on many occasions the "history" contact formed the beginning of help to the patient and his family. For, as with the home visit, relatives often found relief in being able to discuss the patient and/or their problems with someone,[37] while to the patient it sometimes appeared a relief to know that he was "thoroughly" known, and accepted in spite of this knowledge.

(d) Content and Use of the Social History.

Because the social history was a dynamic, rather than static instrument in the hands of the worker, and did not have to conform to a formal outline, it covered far more than merely factual information about the patient's present circumstances. Sometimes early developmental history of the patient would be traced, together with his previous reactions to traumatic events and/or personal relationships.[38] Details of the onset of the illness and the pertinent attitudes or feelings on the part of relatives were included, and the social worker thus described and discussed, in addition to the factual data, the emotional and relationship aspects of the patient and his family, interpreting these and

presenting/....

37. Knee, R., op. cit., p.50.
38. Bosserman, E.V.: "Trends in Casework Treatment in In-Patient Service in Hospital Settings," Jnl. of Psych. Social Work, Vol. XXII, No. 2, Jan. 1953; p.62.

presenting them in the form of a social evaluation[39] of the patient, his strengths and weaknesses, and those of his family, rather than simply as a social history or account of these.

This vivid and interpretive picture of the patient, his family, and his home, which the social worker is able to bring - through general social study of each patient and specific study of some - to the other professional staff working with the patient, is perhaps her particular contribution to the collaborative diagnostic process of the team. It is, further, typical of her function not merely of representing the "outside" within the hospital,[40] but of bringing it into the hospital, that she shows her colleagues the patient moving through his life in relation to other human beings in a social setting,[41] that she presents "the little piece of culture in which the client lives."[42]

C. The/.....

39. Knee, R., op. cit., p.51.
Apropos of this statement, it is relevant to mention Knee's remarks on use of the technician for obtaining social histories. The present writer would agree to this only where direct contact with patient or relative does not take place, and where the service is routine - thus, the technician obtaining histories from mental hospitals, or from some social agencies would be acceptable. However, home visiting would not be so; nor would working with employers. Furthermore, the comment made by Knee that, even where trained, the technician does not obtain a social evaluation but only a factual social history, must be kept in mind. (Ibid., p.66.)

40. Timms, N., op. cit., p.118.

41. Knee, R., op. cit., p.62.

42. Little, R.W.: "The Social Side of Casework," Social Casework, Vol. XXXI, No.4, April 1950; p.162.

C. THE TEAM.

This mention of the social worker as someone contributing to the team working with the patient, and co-operating with colleagues, leads up to discussion of an aspect of social work service mentioned in the text only in passing, and from time to time, but which is vital and basic to the whole concept of social work carried out in conjunction with psychiatry, and in a setting such as the one presently under discussion. For the social worker is not the only person concerned with the patient's illness and recovery, and all that she does takes place within the context of group planning with and for the patient.

(a) Definitions and Principles.

This feature of teamwork or collaboration, frequently considered a characteristic of psychiatric and medical social work, distinguishing both from other fields of social work practice,[43] has developed with the growth of the concept of comprehensive care of the patient, and the realization that one profession cannot know about or deal with every aspect of the human being. Rather, each specialization must contribute its own particular knowledge to understanding and care of the patient.

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43. See, for example: Robinson, D.: "Some Aspects of the Integrative Process in a Psychiatric Setting," Jnl. of Psych. Social Work, Vol. XXIII, No. 1, Oct. 1953; p.31;
Education for Psychiatric Social Work, Proceedings of the Dartmouth Conference, 1949, etc., p.62.
Knee, R.: "The Open Question : Is There Anything Unique about Psychiatric Social Work?" Jnl. of Psych. Social Work, Vol. XXIII, No. 1, Oct. 1953; p.45.
Editorial Notes, Jnl. of Psych. Social Work, Vol. XXII, No. 2, Jan. 1953; p.54.

But the team doing this is more than a group of specialists,[44] contributing fragments of knowledge to such care of the patient. Rather, it is a group of dynamically oriented, fluidly interacting professionals working together in the interest of the patient, and in order to promote his well-being. To quote from Whitehouse's article, a team is "a close, co-operative, democratic, multiprofessional union devoted to a common purpose - the best treatment for the fundamental needs of the individual.....Just as the individual acts as an interrelated whole and not as a sum of his characteristics, so must the professions act, think, interpret, and contribute toward a diagnosis which is the product of all, and a treatment plan which is dynamic to accommodate the changes which a human organism is constantly making."[45]

Lesser, in his definition of the team in a psychiatric setting, gives a slightly different emphasis to that of Whitehouse, stating that the team ".... is a treatment unit, supervized by the psychiatrist member, which brings to bear the unique and overlapping techniques of each discipline for the diagnosis and treatment of the (patient)."[46]

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44. Whitehouse, F.A.: "Teamwork: Philosophy and Principles," in Social Work Pratice in Medical Care and Rehabilitation Settings - Monograph II - Teamwork: Philosophy and Principles, Amer. Assocn. of Med. Social Workers, Washington, D.C., 1955; p.7.
45. Ibid., p.8.
46. Lesser, W.: "The Team Concept - A Dynamic Factor in Treatment," Jnl. of Psych. Social Work, Vol. XXIV, No. 2, Jan. 1955; p.119. Underlining by the present writer.

This definition touches on a controversial point in the philosophy of teamwork, viz., who is in fact leader of such a team. Whitehouse propounds democratic, group control of the team, advocating that different members of it assume differing amounts of responsibility at different times.[47] And Bartlett, in a work published originally in 1940, but supplemented a decade later, writes, in this supplement, that "smooth teamwork requires co-ordination through a leader who, in the medical setting, is the physician," though "experience indicates that responsibility may change with the changing situation," and another worker assume the major role for a period.[48] However, various other writers, while supporting the democratic principles of teamwork, declare that, because, in the psychiatric (and medical) settings, ultimate responsibility for care and treatment of the patient rests, by law and custom, with the psychiatrist or physician, ultimate authority should be his. So, Gaukler and Wannemacher state unequivocally that the psychiatrist is the head of the hospital team,[49] while Robinson, although discussing the changing nature of the roles of the members of the various disciplines,[50] also

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47. Whitehouse, F.A., op. cit., pp. 8 - 10, passim.
48. Bartlett, H.M., Some Aspects of Social Case-work in a Medical Setting, N.Yk., N.A.S.W., 1958; p.279.
49. Gankler, R.J., and Wannemacher, E.S.: "Collaborative Process with Psychiatric Residents," Social Work (N.Yk.), Vol. 3, No. 2, April 1958; p.83.
50. Robinson, D., op. cit., p.33.

maintains that authority and responsibility remain vested, throughout, in the psychiatrist.[51]

In the general hospital unit presently being discussed, this latter type of authority operates. Thus, while each team member participates freely in discussion and recommendations about and for patients, and the opinion of one or other team member may be followed at different times, and while it is unusual for the psychiatrist to go against a group decision and far more usual for him to move with it, he has the power of veto, or, as leader of the team, with ultimate responsibility for the patient, the right to make the final decisions in the team.

However, although general definitions of the team have been given, and although its leader has been determined, at least in the present setting, no attention has yet been paid to the different types of teams which may exist, to the principles of teamwork, or to the persons making up the team.

Starting with the first aspect mentioned, namely, the types of team existing, what sort of team is it that operates in this general hospital psychiatric unit? Bartlett states that, in social work literature, the term "teamwork" has been loosely used "to describe any and all types of co-operation and collaboration - inside and outside of agencies, between all sorts of personnel,

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51. Ibid., loc. cit. This writer comments also on the reactions of various team members to authority, and the effects these may have on functioning of the team as a whole.

and in all kinds of activities."[52] She then distinguishes between interagency co-operation and multidiscipline practice, using the latter term to cover interprofessional collaboration under the auspices of a single agency.[53] This is perhaps what Benney refers to as "concurrent," as opposed to "serial," teamwork, the latter referring to co-operating agencies entering into the collaborative process at various points in treatment.[54] It is this former multidiscipline, or concurrent, practice which is operative between staff members of the present unit, but the social worker, in addition, because of her contact with community agencies,[55] operates in the other senses as well. However, for the present, only intra-agency collaboration will be discussed.

The definition which Bartlett gives of this is perhaps fuller than either of the two given above, and, while incorporating clearly several of the characteristics mentioned in them, does not touch upon the authority/democracy issue. She states that multidiscipline practice "rests upon two basic requirements: (1) unity of purpose, and (2) difference in knowledge and function. Since it grows out of specialization, each member must make his own expert contribution, distinct from that of others and appropriate to his particular focus. These

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52. Bartlett, H.M., op. cit., (footnote 6), p.72.
53. Ibid., pp. 72 - 73.
54. Benney, C.: The Role of the Caseworker in Rehabilitation," Social Casework, Vol. XXXVI, No. 3, March 1955; p. 119.
55. To be discussed in the following chapter; and already mentioned in this chapter, in connection with obtaining of social histories.

different contributions must be integrated through common objectives. Multidiscipline practice is a way of thinking, of keeping ideas related; a way of feeling, of readiness to share; and a way of doing, of adding one's contribution to that of others so that something larger emerges from the combination. It is a constant interweaving of all these phases of professional activity."[56]

A team of this nature does not simply form, however, and each member of it must contribute to its process, and have some understanding of its dynamics. Robinson comments, in this connection, that "the integrative process....is not natural and must be learned,"[57] and that each profession must know its role and function, where it fits into the particular setting, and what contribution it can make to the doctor's diagnostic thinking and treatment plan. Importantly, she does not ignore the possibility of rivalry in a multidiscipline group,[58] and stresses that each discipline participating in the group process must be aware of this, but, knowing his own function, "learn to know, accept, and respect the dignity and worth of the other professions and their functions."[59] Further, "the members of each profession need to have awareness of their own personalities, their reactions to authority,

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56. Bartlett, H.M.: op. cit. (footnote 6), p.73.
57. Robinson, D., op. cit., p.36.
    Drew, A.L., in "Teamwork and Total Patient Care," Jnl. of Psych. Social Work, Vol. XXIII, No. 1, Oct. 1953; p.27, makes this same point about the integration of team members.
58. Apropos of this point, Whitehouse (op. cit., p.14) makes the point that, further, team membership is not suitable for all people, and that not all are able to integrate into a team.
59. Robinson, D., op. cit., p.36.

and their way of working with others, and to keep at a minimum their acting out on the basis of previous experiences."[60] Simultaneously, each needs to be aware not only of his interactions with his team-mates but of the changing focus and qualities of his relationship with the patient.[61] And, finally, the professions must be able to communicate with one another, for only through communication can they share their experiences and thinking, and merge their contributions.[62]

Bartlett, in a short article published in 1963, perhaps adds a slightly different dimension to the social worker's knowledge and approach to the team process when she says that certain techniques and methods that are taught to the social worker for use in dealing with clients "are equally relevant in interpersonal relationships. Respect for and acceptance of the other person, the timing of activity in relation to his readiness, the worker's self-awareness, and a disciplined professional relationship are all as important in ..... teamwork as they are in casework."[63]

Although these principles apply to all teams, teams themselves may differ in size and in the professions constituting them and applying these principles. Thus

Lesser/.....

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60. Ibid., loc. cit.
61. Further, the patient may be able to relate better to one team member than to another, and this is an advantage of multidiscipline work in that it provides opportunity for contact with a patient which might otherwise be lost.
62. Robinson, D., op. cit., p.36; and on which this paragraph is generally based.
63. Bartlett, H.M.: "The Widening Scope of Hospital Social Work," Social Casework, Vol. XLIV, No. 1, Jan. 1963; p.5. Underlining by the present writer.

Lesser considers the team to consist only of psychiatrist, psychologist, and social worker,[64] but Robinson includes in this group the occupational and recreational therapists.[65] Drew extends membership somewhat more by defining two "types" of team. The first he terms the "fixed" team, which concerns itself with a specific disease entity, and which remains as a unit and functions with a dynamic, well-defined goal in mind, and the second he does not name, but discusses as changing with the needs of the patient, and including new and excluding old members as the case progresses.[66] This latter is possibly a kind of intra-agency as well as extra-agency "serial" type of collaboration.[67]

Perhaps his dual concept best describes the type of team functioning in the unit presently under discussion. For it consists of certain fixed members, who co-operate throughout treatment of the patient, though some more than others at various stages of his hospitalization - these are the psychiatrists,[68] psychologist, nurses,[69] occupational therapist, and social worker. In addition, the team consists of those persons who are called in at

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64. Lesser, W., op. cit., p.119.
65. Robinson, D., op. cit., pp. 35 and 36.
66. Drew, op. cit., pp. 26 and 27.
67. Benney, C., op. cit., p.119, and as discussed in the present chapter, p. 285 , and footnote 54.
68. All psychiatrists participate in group treatment planning for the patient, though the individual psychiatric registrar carries day-to-day planning for him, under the supervision of a senior.
69. All nursing staff in the ward are part of the therapeutic team though these are usually represented on the team by the ward sister.

certain times to assist with various additional aspects of treatment - thus, the radiologist, the physiotherapist, the various medical specialists. However, because these people do not really participate in team interaction, and may contribute their specific help in a rather isolated manner, perhaps at a consultative level,[70] in a sense they are not team "members", and the analogy to Drew's changing type of team only a remote one. For purposes of the present study, therefore, discussion will centre around the "fixed" team aspects of the unit only, and, further, the patient himself will not be looked upon as a member of the team, as he is by Whitehouse,[71] but rather as the focus of the team's activities and the person around whom these centre; i.e., as the purpose of the team's functioning, essential to its existence though not a member of it, and without whom it would not exist.

(b) Members/....

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70. The term consultation is here used in the sense of an expert being asked to give an opinion, or advice, on a problem about which he has special knowledge and competence. Such "knowledge and skills are transmitted in a relationship between the person consulted and the person seeking consultation for the purpose of problem solving," however, and do not necessarily take place within the team, though the process and outcome of consultation may be reported back to the team by the appropriate team member. (Based on Siegel, D.: "Consultation : Some Guiding Principles," in Administration, Supervision and Consultation, Papers published by the N.A.S.W., N.Yk., 1955; pp. 98, foll.). This specific meaning of the term is applicable in this instance in the text, but its use in other contexts of team work is less specific, implying rather, collaboration, discussion and conferring between team members, usually without attention to rank and status of such members.

71. Whitehouse, F.A., op. cit., p.10. This author, further, regards the patient as "captain" of the team, stating that he, "behind the scenes, is formulating the actions of the group around his needs."

(b) Members of the Team.

How does each team member function, within the present definition and structure of the group? A brief survey in the writer's mind shows each carrying out a separate and vital role. The psychiatrist, concerned with diagnosis and the pathological elements of illness in the patient, centres his treatment of the patient directly around these, using the various treatment methods described earlier in the text.[72] At the same time, he directs the activities of the other members of the team, requesting specific services from each, and using these to further the interests of the patient. His is the ultimate responsibility, as already pointed out, for both diagnosis and treatment.

As her special contribution, the clinical psychologist, by means of quantitative (psychometric) and qualitative (projective) tests, "contributes to the exposure and definition of areas of disability and functioning affecting the patient,"[73] and, through her interpretation of his responses and results, to a working diagnosis and understanding of him. Further, as noted in Chapter IX,[74] the clinical psychologist, depending on the time she has available, does a certain amount of psychotherapy, this, in view of her training, being psychoanalytic in orientation. To the group she therefore also brings general interpretations of the behaviour of patients,

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72. See Chapter I, p. 11.
73. Robinson, D., op. cit., p.35.
74. Chapter IX, p.240, footnote 57.

and a psychoanalytic approach to psychiatric illness.[75]

The occupational therapist, through the use of various activities, both physical or involving the acquiring of a skill,[76] and social,[77] carried out both in the wards and in the occupational therapy department, activates the patient daily to take hold of reality, to resume a routine of living,[78] and to mix with others. She is able to assess his ability to participate in activities, and able to obtain further clues about the nature of his illness and his personality through observation of what the activities are in which he participates, and how he reacts and behaves while carrying them out. She observes such factors as his ability to concentrate, to "stick to" an activity (and hence possibly to a job); his mode of interaction with other patients; and changes in his general behaviour. These observations she reports back to the team, and her activities thus are twofold, both contributing to diagnosis and forming part of treatment.

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75. It is noteworthy that the psychologist takes part also in research and teaching, as do the psychiatrists, and that the occupational therapist trains students, while nurses in training staff the wards. However, because the direct role of team members with the patient is presently under discussion, these aspects of function are not here mentioned. Their part in total social work function will be discussed in Chapter XII.
76. Such as weaving, basket-making, typing; i.e. "concrete" activities.
77. Such as games afternoons, "socials", and "entertainment" evenings. (To these latter, friends and relatives are invited).
78. Perhaps one of the greatest values of occupational therapy in the present unit is the reality which it imposes on the patient, not only through its routine activities, but by virtue of its compulsory nature - in wards otherwise flexible and permissive - which simulates the dictates of work, etc., in the outside world.

But the most important observation is perhaps that which is carried out by the nurse. For it is she who spends most of her time with the patient, who is with him after other staff members have left the hospital for the day, and who "assumes responsibility for all of (his) time except when he is being seen by other persons."[79] Thus she sees his reactions to the daily events of the ward, and she sees him in all his moods, and is able to note changes, however slight, in him. Further, it is she who, if not actually responsible for carrying out the doctor's instructions herself, has responsibility for seeing that the patient arrives to see the appropriate persons who are to carry out such treatment.[80] Then, too, it is often to her, as the person most easily accessible, that the patient turns for help, or who, in the dead of night, will find a patient distressed and fearful. She then can pass on this finding to the doctor, and he can bring to bear the appropriate source for assisting the patient.[81] Often,

however/.....

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79. Robinson, D., op. dit., p.35.
80. Thus, the nurse has not only to administer medicines, do dressings, etc., herself, but has to arrange that a patient scheduled for X-Ray reaches that department on time, or that someone is available to take him to the E.E.G. Department for an electroencephalogram; or that he is in the appropriate department, at the correct time, when scheduled for electric shock therapy.
It is significant that none of the nurses functioning on the ward are psychiatrically trained. This has certain advantages and disadvantages, but the only aspect really relevant to the present study is that orientation periods for nurses to incorporate them into the team, as well as to give them a background to psychiatric nursing, are thus necessary.
81. Confidentiality within the team will be presently discussed.

however, the patient will have gained relief from his contact with the nurse, and her compassionate concern for him provides a background against which he can function and recover.

Because the functioning of the social worker in this multidiscipline unit has formed the subject matter of the greater part of this text, and will continue to do so, it will not be further discussed here, but only a few additional aspects of it mentioned. The first of these is what Bartlett terms the "two contrasting manifestations" of the social worker's role in multidiscipline practice.[82] Because she is writing of the general medical team, rather than the psychiatric team, her comments are not as applicable to the present setting as they might otherwise be, but do have some validity in relation to it. For the characteristic social work approach of identifying with the patient and yet remaining a member of the clinical team, of presenting the patient's side of the problem to the team and yet of working with the team, and of being oriented toward the patient and his family, and towards the medical team,[83] still remains. This is perhaps a characteristic of none of the other professions, but the specific which, again, makes the social worker the person who relates the problem to the patient-in-relation-to-the-outside, and which is an identifying mark of social work practice in such a setting.

Secondly, because the specific contribution of each of the other team members to diagnosis and treatment of the

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82. Bartlett, H.M., op. cit. (footnote 6), p.86.
83. Ibid., pp. 82 - 92, passim.

patient has been pointed out, the threads of her function will briefly be drawn together to show both of these elements in the social worker's role. As was pointed out at the end of the discussion on the obtaining of social histories, this particular function is, more than anything, the social worker's contribution to diagnosis. For through it she is able to indicate to the team members those factors in the patient's material and human environment which have contributed to his breakdown, and what the process of his breakdown has been. From this same presentation comes a picture of those resources which the patient has available to help him back to health and/or to keep him in the community, and thus from this comes the reality against which, and within the limits of which, planning for the patient must take place. This is perhaps an aspect of social work functioning which cannot be overemphasized, for, as pointed out in the last paragraph, the social worker is the only team member who actively keeps the patient and his problem on this reality dimension, and can relate his needs to available resources.

The social worker's contribution to treatment of the patient is perhaps a broader and slightly less specific one. For it consists of all those activities carried out concurrently with treatment by the psychiatrist and other staff, and covered by the terms environmental-manipulation, advice and support, working with community agencies,[84] and working with the family.[85]

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84. See next chapter, pp. 308, foll.
85. Idem, pp. 320, foll.

In other words, her contribution to treatment is an ongoing one, adapting to the needs of the patient as these develop, and intertwining with all those efforts of the other team members aimed at "putting the patient back on his feet." Her special contribution in follow-up of the patient, shared only with the psychiatrist, will be discussed in the next chapter.

(c) Collaborative Processes.

These various activities of the team members remain unrelated and unco-ordinated, however, unless that communication between team members, which was stressed by Robinson as a basic prerequisite in effective team-work,[86] takes place. Klein perhaps expresses this idea most succinctly when he states that "Without adequate communication there can be no team, no co-operative effort toward a group goal, no understanding.. ....."[87]

But how and where does this communication between team members, this process which is essentially one of the transfer of meaning,[88] take place? In the unit presently under discussion, communication is not limited only to formal meetings and contacts between staff members. Rather, it takes place informally, at all levels, and through every contact of one staff member with another. For this reason, Category 9 in the

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86. See this chapter, p. 287.
87. Klein, A.F.: "Social Work in Non-Social Work Settings," Social Work (N.Yk.,) Vol. 4, No. 4, Oct. 1959; pp. 95 - 96.
88. Drew, A.L., op. cit., p.28.

classification system, termed "Collaboration and Consultation[89] about Patients with Staff Members," was divided into two sections. The first, (a), dealt with informal contacts with staff members, and was designed to cover the day-by-day exchanges between social worker and others, the discussions in office or ward, the chance meetings and talk at odd times, all relating to the patient.[90] The second part of this category, (b), relating to formal contacts at meetings and ward rounds, was geared to cover the weekly professorial ward round, really a formal and intensive case presentation which began as a ward round in the early days of the unit, and retained its original title in spite of its somewhat changed nature.

Starting at nine o'clock every Friday morning, this round began with a discussion by team members of any interesting events which had occurred in the past week, and any general group problems. Each member then brought up any specific problems which he or she was encountering, and after consideration of these, the meeting proceeded to deliberations on the case for the morning. There followed presentation of the psychiatric and life history of the patient by the psychiatrist, a

report/.....

89. Consultation is here used in the wider sense of its meaning, as given in this chapter, at the end of footnote 70, p. 289.

90. The daily coffee break so highly commended by Robinson (op. cit., p.34) in promoting good team relationships, was not scored on this category, as it was considered outside the bounds of function, being purely a few minutes of relaxation, in the occupational therapy department, for those who, on any particular morning, had time to meet there. While it no doubt brought the group closer together, it was certainly not noted in records as service to the patient! Hence, among other reasons, its exclusion from scoring.

report on the results and material obtained from psychometric testing by the psychologist, and presentation by the social worker of a social history or evaluation about the patient. After the appearance of the patient himself,[91] diagnosis of his illness and planning for him took place, based on the formal contributions of psychiatrist, psychologist, and social worker, the interview with the patient and any specific requests he might have made, and the informal comments of the occupational therapist and nursing sister, combined with the comments and opinions of other (visiting) professional persons present. Where diagnosis was already known, but handling and treatment of the patient presented difficulties, discussion would centre around those aspects of the problem. However, it was only very occasionally that psychological and social reports were not requested.[92a,b]

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91. This round, already referred to in Chapter I, pp. 9-10, was attended by "outside" practitioners and various students, as well as by ward staff. The ordeal to the patient of having to face an audience sometimes thirty strong was often great. Careful preparation of the patient by the doctor therefore always preceded the patient's appearance at such a meeting, but no patient was ever forced to attend.

92a. Such a meeting never ended before 12 noon, and usually ended nearer to 1 p.m.

b. This type of round fits in with the "study staff" or "case presentation" type meeting, in which inter-professional collaboration takes place, as reported by Berkman (op. cit., p.17). Also has features of the "administrative staff meeting including representatives of all disciplines" described by her (ibid., loc. cit.) insofar as policy and problems of the unit, though not of the hospital as a whole, were here discussed. It must be pointed out, however, that such conferences were not necessarily intake ones - presentation of a patient for consultation could take place at any point in the hospitalization period, depending on the condition of the patient and the need of the doctor for special help from the team. Further, not every patient appeared at these meetings; those who did usually being patients who presented unusual or difficult problems.

The "formal meetings" section of the classification system was also designed to include the somewhat less formal intra-staff conference held in the ward every Wednesday morning. Attended by the psychiatrists, psychologist, occupational therapist, social worker, and a representative of the nursing staff of each ward, this meeting lasted for four to five hours. During this time, an attempt - usually not successful, in spite of the length of the meeting - was made to discuss, briefly, each patient in the wards, and to assess his or her progress. Referrals by the psychiatrist to the various team members took place, and each in turn contributed to the group what knowledge he or she had of the patient. It is interesting to note that it was at this level that the social worker's informal studies of patients and their social situations were of most value to the team. It was also at this level that much exchange of ideas between group members took place, and that each, in informal discussion, learned particularly the contributions which the other could and was making to total patient care.[93] Such meetings, further, provided a dynamic opportunity for orientation of new staff to the team

approach/.....

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93. The stimulating, educational aspects of multi-discipline practice must here be mentioned. For not only does great benefit derive to the patient from such an approach, but similar benefit derives to each team member, and his horizons are widened and his knowledge deepened by a combined and close association with other disciplines.

approach of the unit.

(d) Proportion of Collaborative Functioning.

When the social worker's formal and informal functioning with staff members was assessed on the scoring sheet, the first (and only) limitations of the study imposed by the use of practice records for research became apparent. For in spite of the fact that every note in the records about either kind of collaboration was marked on the scoring sheet,[94] only 95 informal staff contacts, distributed among 88 or 100% of patients, and 24 formal contacts, distributed among this number of patients (27.27% of the total number), were noted. However, although not reflected on the scoring sheet, far more contact must in fact have occurred, as informal collaboration took place daily, and at every level, and it was not unusual for the social worker not only to discuss a patient with one or more members of staff, but to do so more than once. The pervasive quality of the team work thus carried out probably made it difficult

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94. These two categories were the only ones for which this was done, as it was anticipated that interesting differences in inter-professional relationships might be shown by this (especially by 9(a)). However, all that emerged was that informal contact with the doctor occurred in every case except one, which was with a nurse. Such contact, including this occasion, occurred three times with nursing staff, once with the psychologist, and twice with the occupational therapist. These figures are unlikely - see immediately following sections of text. Such contact with the doctor about a patient's family occurred only once. This, too, is unlikely, for work with both patients and families took place always in consultation with the psychiatrist.

to note each informal contact about the patient in the ward, unless specific attention was being paid to this detail, for it was so much a part of the work that it was simply accepted without comment. Further, although presentation of a case at the formal ward round was always noted in the record, discussion at the more informal staff conference was not, especially where no direct action resulted from such discussion. As every case was discussed at least once in these meetings, and sometimes more often, depending on length of hospital stay, the omission of such data from the case records again formed a source of bias in the results of this section of the study, for in neither case was the writer's memory[95] sufficiently clear to supplement the records on these points. Thus, the percentages of total function performed in these two areas - 15.70% for informal and 3.97% for formal function - do not really reflect the proportion of services of this nature carried out by the social worker. This presents a problem in comparison of the amounts of different services carried out, which may have to be overcome, in the conclusions of the study, by comparison rather of the numbers of patients to or about whom various functions were rendered.[96]

(e) Confidentiality in the Team.

An aspect of teamwork or multidiscipline practice which cannot be ignored is the question which arises

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95. See Chapter II, Problems of Methodology, pp. 24-25,
96. "Unconfirmed" functions in this section were low - 1 for (a) and 6 for (b) - compared to those for functions listed in Chapters VII and VIII.

concerning the confidentiality of matters discussed between the patient and any team member, or between team members with one another. Lesser, commenting on this point, seems to take it for granted that information from the client be discussed among team members, stating simply that "When several people are concerned with his (the patient's) treatment it is important that he appreciate that his productions are shared by the team,"[97] while Newcomb states unequivocally that there is a professional responsibility in the collaborative process for the social worker to inform the psychiatrist of the knowledge which she gains of the patient's personal problems, and current social situation, in order to help the psychiatrist see the patient's emotional conflicts in relation to his environment.[98]

Lesser states that the patient's understanding of this sharing process makes communication between team members easier in that the need for each to work through the patient's feelings around divulging a confidence falls away, and, in addition, the patient finally "gains by feeling a totality of contribution from the combined team personnel."[99] Jessica Seth-Smith adds to these comments that, although matters concerning the patient are discussed by the team, they are discussed still in confidence, and within the confines of that group.[100]

She/.....

97. Lesser, W., op. cit., p.125.
98. Newcomb, M.L.: "The Educational Role of the Social Worker in the Collaborative Process," Jnl. of Psych. Social Work, Vol. XXI, 1952; p.67.
99. Lesser, W., op. cit., loc. cit.
100. Seth-Smith, J.: "Modern Trends in Social Work," Social Work (London), Vol. 17, No. 3, July 1960; p.71.

She feels, further, that the worker who tells the patient about such group discussion and collaboration, will, if she has a strong relationship with the patient, usually strengthen this relationship.[101]

It goes almost without saying that no team practice can take place without frank and open exchange of information between staff members. Therefore, each team member has to work through any feelings he may have on this matter in order to be able to participate fully in multidiscipline practice. In the psychiatric unit now under review, unfettered discussion between staff members took place, whether meetings were formal or informal, and patients were aware of the "Wednesday meeting" and its purpose, of the "Friday round," and of the pervasive collaborative processes in operation in the wards. It was only occasionally that a patient would request the social worker "not to tell anyone," and an attempt would then be made to work through the patient's feelings around this. If this were not possible, the social worker would re-interpret the role of the psychiatrist as ultimately responsible for the patient's care and would present as a reality to the patient the fact that at least he (the psychiatrist) would have to be consulted before further planning could take place. In these instances, collaboration was indeed confined to communication between psychiatrist and social worker, and only taken further at the psychiatrist's discretion and after his or the worker's discussion of this with the patient. Very

occasionally/.....

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101. Ibid., loc. cit.

occasionally, the psychiatrist would himself come to a meeting and explain to the group that he had decided to pend the sharing of certain information with it for a time; but this was most unusual, and, when it occurred, accepted by the group as essential. It is perhaps an indication of the dynamic and secure interrelations in the team that such action by the psychiatrist in no way upset group functioning.

(f) Patient-Worker Relationships.

Unfortunately, it was not possible to assess whether relationship, as postulated by Seth-Smith, was affected positively by the collaborative process. For, as noted in the original discussion on relationship,[102] this quality was assessed at close of the case, not in relation to the before or after effects on it of specific types of service. Further, when an attempt was made simply to assess what such closing relationships were in relation to the collaborative process, the same grouping was found for 9(a), or informal collaboration, as was found for relationship in general,[103] and no significance could attach thereto. The only remaining way of assessing the effects of collaboration on relationship lay in relating 9(b), or formal collaboration, to it. However, the groupings which arose from this process (very good - 5; good - 4; fair - 3; poor - 5; nil - 4; X - 3) were directly proportional to those for the group as a whole,[104] and, with

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102. Chapter III, p. 62.
103. Chapter VII, p. 174.
104. Compare Table XXIX, Chapter VII, p.174 , and associated text.

no clear association of the two factors, such as occurred with advice and support,[105] it appeared that no connection could be postulated between formal collaboration and relationship. It is interesting to note, however, that the 7 patients noted as "nil" and "X" were probably "presented" at the formal ward round, and that the social worker's contact with them was limited to little apart from the obtaining of the social history for this collaborative process.[106]

(g) Case Histories.

Contact with Miss T.[107] began in this latter manner, but the collaborative process which accompanied her stay in hospital became intensive. That part which is to be described here was informal, rather than formal, however, and involved almost day-by-day exchanges between psychiatrist and social worker, and between other ward staff. The patient, aged 43, was a hospital help on the staff of one of the Johannesburg hospitals, and had gone into a severe depression after the death of her mother. After some improvement, she reached a plateau, and the psychiatrist felt that arrangements should be made for her to return to her job, kept open for her by the social worker. The occupational therapist confirmed that the patient could probably settle down into routine again, and, as group feeling was that she was unlikely to improve further, the psychiatrist began to prepare her for this step,

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105. See Chapter IX, p. 260.
106. See this chapter, p. 278.
107. The examples of collaboration which follow are of necessity brief, and designed only to show the general process, not its details.

while the social worker approached the personnel officer of the hospital concerned, asking him whether the patient could return to work within a period of about three weeks. She also spoke to the matron of the hospital, and began to prepare the patient's sister for her return home, dovetailing each step with the progress of the psychiatrist, and herself also seeing the patient, with whom, during her three-month stay in the ward, the worker had already established a very good working relationship. When, after the specified three weeks had elapsed, and many conferences between social worker and psychiatrist had taken place, the patient was still not ready to return to work, it was jointly decided that she should be "pushed" a little, and while the psychiatrist dealt with this aspect, the social worker arranged for her leave to be extended for a further few days. Contact with Miss T.'s sister was still being maintained, and preparations for the patient's return home were accelerated when she began to work from the ward some days later. After a very short while, however, Miss T. began to break down, and finally, without returning home at all, was fully warded again.

This excerpt shows the concurrent but interweaving roles of psychiatrist and social worker in preparing a patient to leave hospital; roles which are co-ordinated through informal collaboration, and which are geared to one another and to the needs of the patient, but in which the function of each worker remains distinct, and neither loses his identity.

Perhaps this latter factor, and the fact that, although thinking is shared by team members, each discipline can at times exert its influence in shaping planning for the

patient, is well-illustrated by a part of the history of Mrs.R. a drug addict, severely depressed, she refused admission to Mount Collins, and was terrified of admission to a mental hospital, where her mother had been for years. Without family of any kind willing to assist her (she was divorced and her father deceased), she became a "placement problem," and was referred to the social worker for accommodation. She arrived in the social worker's office some two to three days after the referral had been made, confused and obviously depressed. The social worker felt completely unable to carry out the psychiatrist's recommendation that the patient, no longer benefitting from treatment, be placed under supervision, in a hostel or institution, believing that it was unfair to place such responsibility on a psychiatrically untrained hostel matron. She felt that, in spite of the patient's fears about going to a mental hospital, this was the only placement suitable for her at the time. After discussion with the psychiatrist, it was decided to wait for a while longer to see whether any improvement in the patient's condition resulted. However, ironically, some days later she jumped from a fifth storey window of the hospital and was, after all, certified.

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C H A P T E R XI

THE PATIENT AND THE COMMUNITY

The discussion of the functions of the social worker which has so far taken place has related to services to the patient carried out within the hospital, or by hospital personnel. Although some mention has been made, in passing, of the patient in relation to the community, and of the social worker as the link between patient-and-hospital and the community, no concentrated attention has been paid to these topics, and her specific role of maintaining liaison with community agencies, and of utilizing and bringing these resources to bear on the patient's treatment, has not been elaborated. Similarly, some comment has still to be made on the role of the family as part of the community from which the patient has come, to which he will return, and as instrumental in his treatment. For, while help to the family has been discussed in the appropriate section of each chapter, the family as working with and for the patient has not yet been mentioned. And, finally, after-care and follow-up, or services to the patient after his return to the community, have not yet been reported.

The theme/.....

The theme of this chapter thus will be community-related aspects of social work service.[1]

A. WORKING WITH COMMUNITY AGENCIES

(a) General.

Community relationships are discussed by Knee as an aspect of function distinct from the other duties of the social worker,[2] and the present writer chose to make the same distinction. This decision has already been commented upon in the text,[3] and will therefore not be elucidated again here, further than to add that it is lent weight by Rice's regard of such knowledge and use of community resources as characteristic of the health field,[4] and Goldman's separate grouping of this category in his study on medical social work.[5]

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1. In terms of the definitions given in Chapter X, p 264 , and footnote 2a, b, p. 265 , such services would be a mixture of "direct" and "indirect" services to patients. For follow-up would be direct, in that the patient himself would normally be seen; working with the family would be "indirect" in that work would be through the relationship with the family rather than through that with the patient, and work with community agencies would be a mixture of both - that part of it involving referral being direct and with the patient, but the collaboration with the other agency being indirect service.
2. Knee, R., Better Social Services for Mentally Ill Patients, Amer. Assocn. of Psych. Social Workers, N.Yk., 1954; pp. 73 - 75.
3. Chapter VIII, p. 188.
4. Rice, E.P.: "Generic and Specific in Medical Social Work," Social Casework, Vol. XXX, No. 4, April 1949; p. 134.
5. Goldman, F.: "What are Social Workers in General Hospitals doing for Long-Term Patients?" Social Work (N.Yk.), Vol. V, No. 4, Oct. 1960; p. 74
   Note: Although both Rice and Goldman talk of medical social work, the analogy seems, to the present writer, to carry over to the setting under discussion.

Berkman, too, although including such work under the general head of tangible services, simultaneously recognises it as a category of service within this grouping which is stressed particularly by psychiatric social workers in hospitals.[6]

(b) As a Form of Teamwork.

The processes of communicating with outside agencies are not simple, nor is such communication routine and one-sided. Rather, the interaction is often complex. For interagency co-operation, as was pointed out in the last chapter,[7] is a form of teamwork. But instead of this being the close, day-to-day teamwork of the various disciplines collaborating within the hospital, it is a "serial"[8] or "long-range" type of partnership, one in which the members are not in the same unit or necessarily close together in space, but are nevertheless co-operating for a common goal, viz., the well-being of the patient.[9]

Thus,/.....

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6. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; pp. 43 - 44. These comments are not made to prove this a specific of psychiatric social work but only to justify such a separate division in the present study.
7. Chapter X, p. 285.
8. Benney, C.: "The Role of the Caseworker in Rehabilitation," Social Casework, Vol. XXXVI, No. 3, March 1955; p. 119. This term is explained in Chapter X, loc. cit.
9. Elledge, C.H., The Rehabilitation of the Patient: Social Casework in Medicine, Lippincott, Philadelphia, etc., 1948; p.86.

Thus, the same basic principles of give-and-take, of "readiness to share,"[10] and of teamwork in general, apply.

The question of leadership in this team - one consisting of social workers each with a social work orientation - is an interesting one. For, irrespective of the specific or general knowledge of each,[11] each makes a specific yet joint contribution to planning for the patient. Thus the social worker in the hospital setting should regard the agency social worker as participating equally, not merely as filling in gaps, in service. However, perhaps because she may be more intimately connected with the patient while he is still in hospital and is working with the psychiatrist - leader of the team - it is the hospital-based social worker who interprets his recommendations, and the (psychiatric) reality situation to the agency worker.[12] And, because all planning takes place in accordance with these, she perhaps gives dierection to the planning as it relates to them. Such is practice in the present unit, and it seems to be confirmed by Knee's comments that, "as long as the patient is within the hospital community, the hospital-based social worker has major responsibility in seeing that social services are provided for him."[13]

However, while this is practice as it has evolved in the particular unit under discussion, it

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10. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p.73.
11. The generic - specific elements of the present setting are discussed in Chapter XIII, pp. 418, foll.
12. Knee, R., op. cit., p.73.
13. Knee, R., op. cit., loc. cit.

may not be general policy. For Bartlett, writing in 1940, mentions two schools of thought on this matter - the first advocating that "leadership (either temporary or permanent) must inhere in one agency,"[14] and the second proposing that "a mutual division of roles is possible according to the changing needs of the case."[15] This latter aspect of the needs of the patient must always be considered, but in the opinion of the present writer it does not necessarily mean a change in leadership, but possibly only a change in amount of service by one or other worker, usually temporary; the change in leadership results only after discharge, when, if necessary, the patient is discharged or returned to the care of the outside agency. This policy is again confirmed by Knee, who states that while a community agency should continue to carry some responsibility and work co-operatively with the hospital social worker during the patient's hospitalization, after discharge the hospital social worker refers the case to the appropriate community agency.[16]

(c) The Dynamics of Referral.

This leads to a discussion of those responsibilities which association with, and use of, community

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14. Bartlett, H.M., Some Aspects of Social Casework in a Medical Setting, N.A.S.W., N.Yk., 1958 (first pub. 1940); pp. 221 - 222.
15. Ibid., loc. cit.
16. Knee, R., op cit., loc. cit.

agencies carry for the social worker. For appropriate referral to the correct agency is a responsibility of the hospital worker not only in relation to the outside agency, but also to the patient, who, further, has the right of choice in whether or not he utilizes the resources offered him.[17] In other words, not only should no community agency be used as a "catch-all" for mechanical referrals,[18] but "selective use should be made of agencies on the basis of the individual requirements of the patient and his family."[19] This leads not only to the maintaining of good interagency relationships, but to a furthering of the patient's confidence in the hospital worker as someone who knows how to help, or where to refer him for help which she herself cannot give. Additionally, and particularly where the patient's contact is an initial one with the other agency, it is more likely that such contact will be positive if agency function and client's need coincide!

However, this is not the only factor which will determine the patient's acceptance of referral, and perhaps the most important influence in this is the referral process itself. For referral is much more than a mechanical process, and is not merely a matter

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17. Newcomb, M.: "The Educational Role of the Psychiatric Social Worker in the Collaborative Process," Jnl. of Psych. Social Work, Vol. XXI, No. 2, Jan. 1952; p. 70.
18. Knee, R., op cit., p.74.
19. Ibid., loc. cit.

of giving information and encouragement to the patient, and expecting him thereafter to make the approach himself.[20] Rather, referral involves helping the patient to accept the services of another, preparing him to transfer his feelings to another worker and establish a relationship with her, and assuring him of continued support from the referring person, this latter through positive evidence of this support.[21] The referral process thus involves full participation by the patient, or by his family if he is too ill to participate, or if the problem centres in the family.[22] As with much of social work practice, the timing[23] of the activity is important, and thus referral not only about an appropriate need, but at an appropriate time of need, and at a time when the patient is psychologically ready for such referral, is also a dynamic of the process.

In the unit under review, the physical process of referral generally took place telephonically, the telephone call being followed up by a letter which the patient took with him to the first appointment.

Only/.....

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20. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p.188.
21. Church, G.M.: "Understanding Each Other to Achieve a Common Goal," Reprint from Amer. Jnl. of Nursing, Vol. 56, No. 2, Feb. 1956, pp. 201 - 204; p. 7 of reprint.
22. Bartlett, H.M. op. cit. (footnote 20), loc. cit.
23. Church, G.M., op. cit., loc. cit.

Only occasionally was referral solely by means of such a letter.[24] In the present sample the social worker did not herself take every patient to the community agency to which referral was being made, and there were two devices which she thus found particularly useful in the actual referral process. In the first instance, she would attempt to make the referring telephone-call in the patient's presence, so that he would not only participate in the event, but would see the interaction between the hospital and other worker, and know exactly what the latter knew of him.[25] Secondly, asking him to read the letter introducing him to the new worker had this same effect.

The ethics of disclosing diagnosis to outside agencies here arose again,[26] but were lessened in that communication was between professionals, and the principles of confidentiality within the team, discussed in the last chapter,[27] applied equally as much to the "long-range" team as to the intra-hospital one.

Part/.....

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24. Usually when the worker could not contact the community worker, and the matter was urgent; or if it was part of planning for the patient that he should take some initiative in the process.
25. Only occasionally was such a referral by intent not made in the presence of the patient, this usually occurring, for instance, when referral was a "last chance" of the patient. Thus, for instance, with a schizophrenic referred to Labour Department in a last effort to help him remain in the community, the Labour official would need to understand the implications of the referral, but such knowledge might prove disastrous to the patient.
26. This problem has been discussed briefly in relation to employers, in Chapter VIII, p.206, footnote 67a.
27. Chapter X, pp. 300 - 303.

Part of enabling the patient to accept referral involved helping him to recognize that the accepting agency could not help him adequately unless its worker had a full understanding of his problem. Only where such information could not be disclosed for legal reasons, or at the specific request of the doctor, was this procedure followed, and explained to the agency worker. The limitations which this usually placed on understanding of the patient are obvious.

Because patients were often referred to outside agencies in the course of treatment, not only did each social worker have to be clear about her field of action and responsibility,[28] but the patient had to be helped to understand this. From this point of view, it was perhaps easier both for him and for the community agency worker to accept the hospital worker's co-ordinating role when the patient was previously unknown to the community worker. Where patients were known to community agencies, slightly different elements entered the situation. Thus, where a physical meeting between the "first referral" patient and the community worker always had to take place - if the patient did not go to the new agency the worker would come to the hospital - contact between the "old" agency and the patient could be carried on through the hospital social worker, with or without direct contact between the two. The importance of the hospital social worker's maintaining contact, in either circumstance,

with these/.....

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28. As discussed at the beginning of this section, pp. 310 - 311.

with these agencies cannot be overstressed, and it is of note that such activities may incidentally promote fuller understanding of psychiatric illnesses and psychiatric patients by social workers competent in other fields.

Working with community agencies is not a one-way process, however, for just as the social worker in the hospital requests outside help, so the social worker in the community requests assistance from the hospital social worker. Goldman comments on this role of the hospital worker as consultant to community agencies, and as supplying them with needed information.[29] Bartlett, however, while also acknowledging it, points out the danger that such requests from outside agencies may be for the obtaining of medical information,[30] or help in getting the patient through the administrative procedure of clinic or ward, so that the social worker within the hospital may tend to be regarded as providing almost an administrative rather than a casework service.[31]

(d) Proportions of Such Service.

However, of the three patients referred by outside agencies for help from the writer,[32] none was referred for such a service, but all referred by the community

agency/.....

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29. Goldman, F., op cit., pp. 75 - 76.
30. In the present hospital such requests for this information have to be re-routed to the Superintendent, who deals with such matters.
31. Bartlett, H.M., op. cit.(footnote 14), p. 220.
32. See Chapter VI, p. 143, Table XXIII.

agency on or shortly after admission, with a request by the referring social worker that each be seen, and with a detailed history of background, and the problems with which the agency were dealing. In one case, work with the referring agency was brief, but in a second contact between the two workers was constant and close, leading finally to the certification of the patient by the hospital worker, while the community worker arranged for the giving up of the patient's accommodation, the packing of his belongings, and the general handling of his affairs.[33] Thus the division of social work services commented on by Stroup, whereby help relating to the illness is carried by the hospital social worker, and that concerned with other aspects of the situation is carried by the community worker,[34] is illustrated here, though frequently it is not as clear cut.[35]

These three cases were the only ones, of the total of 35 patients about whom contact was made with community agencies, who were referred in to the hospital worker by these agencies. The remaining 32 were referred out by the worker, while the families of an additional two patients were also referred out. In toto, therefore, 37 patients and/or their families, i.e., 42.05% of the group, had some contact themselves with community agencies during hospitalisation, and/or the social

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33. Until the appointment of a curator bonis, in terms of the Mental Disorders Act, to take charge of these.
34. Stroup, H.H., Social Work - An Introduction to the Field, Amer. Book Co., N.Yk., 1953; p.363.
35. Stroup, H.H., op. cit., p. 364.

worker collaborated with these agencies on their behalf.[36a,b.] This formed 6.12% of the total of 605 functions of the social worker. Of these 37 contacts, 16 involved detailed planning with the outside agency about the patient's affairs in the community (these patients were all previously known to the community social worker), and/or dovetailing with the community worker of the plans relating to the patient's discharge.[37] A further five patients were referred to community agencies for follow-up[38] and for the balance of 14 patients collaboration with, or use of, community resources was miscellaneaous. Thus 8 contacts related to the finding of work for patients,[39] and 4 to the obtaining of financial

assistance/.....

36a. This does not include the 16 contacts with social agencies for purposes of data collection, for this purpose was often separate from that of collaboration in planning for the patient. Thus in only two of these cases did inter-agency collaboration follow the obtaining of the social history, so that the contact with other agencies for either purpose was carried out for 51 patients (37 plus 14) or 57.95% of the total group. This figure also does not include those patients referred for help with financial and work problems, unless such referral then led to dynamic inter-agency collaboration and planning about the patient, as it was thought that duplication of scoring would thus occur. Therefore, where contact with the agency, although continued, was related only to one area of help, such as giving financial help and then ending service, this was scored as such help. But where this referral led to continued contact of worker-and-agency, and patient-and-agency, extending over more than two contacts between each, this was regarded as "positive" collaboration.

b. With the two "unconfirmed" functions, this number is 39 or 5.75% of 678.

37. This figure includes those patients referred by an outside agency, as discussed above.

38. See discussion later in this chapter, pp. 345, foll.

39. See middle of footnote 36a, above, for criteria of "work" collaboration.

assistance,[40] while in one instance the worker requested advice from a specialized community agency on the handling of a patient, with a view to working up to referral of the patient to that agency. In a further case, an agency was notified of the disappearance of a young lass thought to be known to its workers. The 2 families included in this section were 2 of the 3 given material assistance,[41] and about whom some collaboration with the agencies to which they were referred took place.

(e) Patient-Worker Relationships.

When patient-worker relationship was assessed for patients about whom collaboration with an outside agency had taken place, it was found that a high number of the patients referred (11) had very good relationships with the worker, and that 4 had good, 6 fair, 7 poor, 3 "X" and 4 "nil" relationships with her. Relationship with the 2 patients whose families were referred out were fair and "nil." While these figures are small, and thus probably no "real" significance attaches to them, they do seem to indicate a trend not only for more patients than in many of the other groupings to be known to the social worker, but for these to be well known to her. That almost half of these patients had strong positive relationships with her (11 very good, 4 good) seems to indicate that the process of referral is not a superficial one, but as Bartlett states, is arrived at through the casework relationship, with full participation of the patient.[42]

It seems/.....

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40. Idem.
41. See Chapter VIII, p. 190.
42. Bartlett, H.M., op. cit. (footnote 20), p. 188.

It seems less likely that collaboration with an outside agency strengthens relationship, but rather that such referral to and collaboration with an agency is often based on a strong relationship rather than on a weak one; perhaps patients with such a relationship are more able to tolerate referral, because they are assured of the worker's goodwill and do not feel rejected by her.

B. THE FAMILY.

(a) The Family as a Source of Assistance to the Patient.

(i) General.

Although the role of the social worker in helping the families of patients has been discussed throughout the text, the corresponding role of the family in helping the patient has not yet been elucidated. Category 13 of the classification system of social work function was designed specifically to cover such contact of the social worker with relatives in the interests of the patient, rather than about their own problems, and to include her mobilization of their resources in the patient's interests. This delineation has been elaborated upon in the appropriate section of the classification system, where, also, a definition of what is meant by "family" has been given.[43]

However, briefly to recapitulate, the family was regarded, for purposes of the present study, as including only blood relatives of a patient, or those legally related to him, "whether of the family of

orientation/.....

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43. Chapter III, pp. 58 - 59.

orientation or procreation of the patient, whether near or distant to that patient, and whether or not such relatives had been closely associated with the patient."[44] Although family closeness is determined neither by proximity nor blood relationship,[45] and although attempting to change attitudes of unconcern in disinterested relatives, into attitudes of willingness to serve as a family resource are often futile,[46] such an approach to, and definition of, the family had to be accepted in the present study, because of the legal responsibilities of family members during illness, and expecially because of the legally regulated procedures governing certain aspects of care of the mentally ill. Additionally, some hospital procedures require that relatives be seen. Members both of the immediate and extended family systems[47] were therefore included among the 52 relatives with whom contact was made for this purpose.

(ii) Extent and Type of Involvement of Relatives in Planning for the Patient.

As was noted in Chapter V, 66 or 75% of patients had families living within visiting distance of the hospital,[48] but only 65 of these families presumably were able to assist patients in any way.[49]

In other/.....

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44. Idem.
45. Pollak, O.: "Social Determinants of Family Behaviour," Social Work (N.Yk.), Vol. VIII, No. 3, July, 1963; p. 96.
46. Ibid., loc. cit.
47. Gillin, J.L., and Gillin, J.P., Cultural Sociology, MacMillan & Co., N.Yk., 1954; pp. 223 foll. and 231 foll.
48. Chapter V, p. 125, Table XX.
49. One family consisted of young children only, both of whom were in institutions. (This is the family referred to in Chapter VII , p. 177, footnote 33.)

In other words, 73.45% of the group of 88 patients had families who might be expected to take some interest in them, or fulfil the protective function of the family towards it's sick.[50] That 48 or 73.85% of these families saw the social worker about the patient, i.e., that only 26.15% of the families able, spatially, to assist in planning for the patient did not do so, shows, in the opinion of the present writer, a high proportion of family interest and willingness to accept at least some responsibility for the patient once contact with them had been initiated by the worker. This is especially so in view of the designation of these families as spatially, and not necessarily emotionally, close to the patient. The additional 4 families contacted were in the group of 15 families who lived distant from Johannesburg,[51] and were approached by letter. With the exclusion of those 2 patients whose only relatives were in mental hospitals and the one patient whose parents had disowned him,[52a,b.] this figure indicates that an attempt was made to include 33.33% of relatives spatially distant from Johannesburg in planning for the patient.

Thus, of/.....

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50. Gillin, J.L., and Gillin, J.P., op. cit., p. 368 It is interesting that these authors comment that this function of the family is steadily being encroached upon by social institutions of various kinds. In this particular study, such participation was, however, encouraged.
51. Chapter V, p. 125, Table XX.
52a. Idem., footnotes to Table XX.
b. Involvement of parents at this level was beyond the scope of the present setting or functions of the unit.

Thus, of a total of 77 families whose members might have been included in treatment of the patient, 64.94% were so involved. This section of working with the family for the patient formed 8.60% of the total 605 functions of the social worker recorded on the scoring sheet.[53]

Of these 52 relatives seen about patients, most (18) were involved in the certification of patients. Because this is a legal procedure and one by law demanding their participation, not all relatives necessarily participated voluntarily in this activity,[54] though many did, and were greatly upset by it, as evidenced in the number given advisory (16) or supportive (13) help around this problem.[55a,b] A further 15 relatives were involved in placement and accommodation planning for patients, either themselves taking patients home, or, where this was not possible, participating in the finding of alternative accommodation for patients. This latter was particularly important where relatives, unwilling to take patients home, were likely to criticize the placement made by the social worker, and in alleviating

the guilt/.....

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53. Only one such function was unconfirmed, bringing the number of these functions in the total of 678 to 53.

54. Relatives refusing to agree with the medical recommendations made were held responsible for patient care and planning, and requested to sign the patient out of hospital on an "R.H.T." form, indicating refusal of hospital treatment and removal of responsibility for the patient from the hospital.

55a. See Chapter IX, pp. 247 - 248.

b. Apropos of this finding,
Tennant, M.A.:"Psychiatric Social Work in a Private Mental Hospital," Jnl. of Psych. Social Work, Vol. XXIII, No. 4, June 1954; p. 238 - points out that the social worker's help to the family is needed largely as a release for anxiety.

the guilt feelings of relatives who wished to take the patient home, but simply could not cope with him. Three of the relatives contacted in this connection lived outside Johannesburg - of them, two agreed to having the patient home, while the members of one family refused to become involved in assisting the patient, a brother, to return to them in England.

Of the total of 52 relatives, only 9 assisted the patient financially, inter alia by lending him money until he received sick benefits, or by actually assisting with the "red tape" aspects of obtaining various grants. One of the relatives in this group was one of those living out of town; the patient, his brother-in-law, was involved in a business partnership with him and needed money from the business, which the worker was instrumental in obtaining for him. The relative's involvement here was neither willing nor gracious, and indicates, again, that the relative's help to the patient was not always voluntary but often urged by the social worker. It must be emphasized once more that both kinds of involvement of relatives were included in this section, though the possible ill-effects of the latter type were not ignored.

Four relatives were directly involved in follow-up activities concerning the patient, being asked for information as to his whereabouts, or to pass on a message where he could not be directly contacted. Only two family members were concerned with patients'

employment problems,[56] and a further four "miscellaneously" involved in help to the patient. Thus two relatives in this group were seen in an effort to gain their support of treatment for the patient, while a further two were asked to bring various articles to the hospital for the patient. Only one of this latter group co-operated, and it must be pointed out again that only actual functions performed, rather than the outcome of these, are here being reported upon, i.e., contact with the family about the patient, rather than whether the family involvement in treatment was voluntary or co-operative, successful or not.

(iii) Patient-Worker Relationships.

When relationship was assessed with patients whose relatives had been involved in help to them,[57] it was found that all categories except that of "nil" were fairly evenly represented. Thus, 8 patients had very good,[58] 9 good, 8 fair, 6 poor, and 8 "X" relationships with her, while 13 fell into the "nil"

category/.....

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56. One of these relatives also assisted with accommodation, as did one of those assisting a patient financially.
57. It should be remembered that relationship with relatives was not assessed. See Chapter III p. 68; Chapter IX, p. 259.
58. It is interesting that although only 5 of these patients were living with relatives at the time of admission to hospital (Chapter VII, p. 177), a further 3 relatives were involved in treatment. This nevertheless does not negate the comments made in Chapter VII, loc. cit., about the small number of patients, having good relationships with the worker, who had persons interested in them.

category. It is interesting to compare these figures with those, presented in Chapter IX,[59] resulting when relationship with patients was assessed when help was given to the relatives, not with relatives about or for the patient. For, in both instances, the "nil" group was equal, but for the other groups it was found that, where help was to family members, no good or very good relationships obtained with patients, while where it was with family members about patients, 17 were thus designated. This, in conjunction with the fact that only 6 patients in this group had poor relationships with the worker, seems to indicate a general trend, in spite of all the other variables possibly influential, for relationship with the patient to be positive[60] when relatives are included in planning for the patient.[61] Further, support seems to be lent by this to the advantages of including the family in total patient care.

(iv) Joint Interviewing of Relatives by Psychiatrist and Social Worker.

An interesting aspect of work with the family for the patient in the present unit is that relatives

are sometimes/...

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59. Chapter IX, pp. 259 - 260.
60. Twenty-five positive altogether.
61. For in the group of 29 patients whose families were not included in planning, for one or other reason, 8 had poor relationships with the worker, while 13 had positive relationships of one sort or another with her. Proportionately, therefore, more patients whose relatives were not included in treatment had negative relationships with the worker. While less, proportionately, had positive relationships with her.

are sometimes interviewed jointly by psychiatrist and social worker. For the psychiatrist may call in the social worker while interviewing the relatives himself, or the social worker may arrange for the doctor to see the relatives with her in order to confirm to them what she has said. Such interviews often are related to certifications of patients, where the relatives wish such confirmation from the doctor, or the doctor, having explained the necessity for such a procedure to the relatives, asks the social worker to participate in the interview in order to explain details of the process, and to take the matter from that point. In other instances also, however, each discipline calls upon the other to provide his or her special contribution to a difficult situation, and the working relationship between the two has to be strong and unified in order to overcome the complexities of a triangular interview.[62] Yet the two team members, while presenting a co-ordinated front, must not present a threat to the relatives, or seem to be attempting to pressurize them into unwanted action. The social worker's dual orientation towards the patient-and-family and the psychiatrist[63] facilitates this.

In only/.....

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62. Bartlett, H.M., op. cit. (footnote 14), p. 155 - confirms the complexities involved in such an interpersonal situation, but points out - p. 159 - the advantage to the social worker of being present and hence knowing precisely what the doctor has told the patient.
63. Bartlett, H.M., op. cit. (footnote 20), p. 313, and as discussed in Chapter X, p. 293.

In only two of the present instances of work with relatives was such interviewing carried out - once about a certification, and once in order to discuss accommodation planning with a patient's sister. This latter instance perhaps shows well the joint action of psychiatrist and social worker with a relative. The patient, a young Lesbian, was admitted to hospital during a depressive episode. Married, she said that she intended leaving her husband and child, and the sister with whom they stayed, and asked the social worker for help in finding hostel accommodation. Both psychiatrist and social worker independently pointed out that she could not summarily be placed thus, and that it seemed that she should discuss the whole situation jointly with her husband and the psychiatrist, or allow the social worker to go out and see him. This she refused to do, and left hospital several days later.

She was re-admitted the same night, claiming that husband and sister had driven her from the house. Early next morning, the sister was notified of the patient's re-admission to hospital, and came in to see the psychiatrist about her. She disclosed to him that Mrs. Q. drank heavily and was almost impossible to manage at home. She had not been driven out of the home the previous night, but frequently left of her own accord. The sister felt that temporary placement in a hostel or institution might benefit the patient, and the social worker was at this point called in to discuss with her the various resources available.

After some/.....

After some interpretation of these, and discussion with psychiatrist and social worker, the sister felt, however, that she could have the patient home just once more, and that, with support from the hospital, she might be able to deal with any difficult situations which arose. She indicated that she was the family representative, and it was therefore decided to discuss this plan with the patient.

The brief mention made, on page of the relatives' wish for confirmation of information, etc., by the psychiatrist, raises the point made by Tennant that relatives coming to a hospital expect to talk to the doctor about the patient's problems and progress.[64] Deasy and Quinn also report that wives of psychiatric patients feel the need to contact the psychiatrist "to secure information about the husband's illness, to get help with personal problems, and to attempt to alter the course of hospitalization".[65] Thus participation of the psychiatrist in interviewing relatives may be not only at the request of the social worker, but also directly at the request of the relative. Tennant reports the meeting of these requests by means of joint interviews of psychiatrist and social worker with the relative before implementing treatment changes for the patient,[66] while Bosserman

reports/.....

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64. Tennant, M.A., op. cit., p. 236.
65. Deasy, L.C., and Quinn, O.W.: "The Wife of the Mental Patient and the Hospital Psychiatrist." Jnl. Soc. Issues, Vol. XI, No. 4, 1955; p. 51.
66. Tennant, M.A., op. cit., loc. cit.

reports this same type of joint interview, adding only that the social worker is present at such meetings specifically so that she can reinforce in later interviews with the relatives what the doctor has said.[67] However, this latter writer points out that this type of interview centres only around such medical interpretation, and that more usually the social worker acts as a liaison between doctor and relatives, needing to be so competent in representing the hospital and what is happening to the patient, his progress, and treatment, that the need of the relative always to have access to the doctor is reduced.[68] Field, on the other hand, reports an organised programme of "family sessions" for relatives, in which their problems relating to interpretation of medical information, problems in planning for the patient's discharge, and problems in relation to the patient's adjustment to the hospital are discussed with the doctor and social worker at specific times each week.[69]

In the present unit, joint interviewing is not routine, as is indicated by the fact that only 2 of 48[70] relatives were interviewed thus.

The more/.....

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67. Bosserman, E.V.: "Trends in Casework Treatment in In-Patient Service in Hospital Settings," Jnl. of Psych. Social Work, Vol. XXII, No. 2, Jan. 1953; p. 62.
68. Ibid., loc. cit.
69. Field, M.: "Family Sessions : A New Co-operative Step in a Medical Setting," Social Casework, Vol. XXX, No. 10, Dec. 1949; pp. 417 - 421, passim.
70. The remaining 4 relatives lived outside Johannesburg, and joint interviews for all 52 were thus not possible.

The more usual procedure is for the social worker to refer for individual interviews with the psychiatrist only those relatives whose need to see him is obviously great, and to deal herself with those interpretations of medical diagnosis and treatment which normally arise,[71] and also with problems which the relatives are experiencing in relation to planning for the patient, or their own feelings about the patient.[72]

Work with the family as a role specific to the social worker thus is maintained in the present unit, and the psychiatrist's function in relation to the family is concerned mainly with seeking information about the patient's medical history.[73] It is unusual for him to discuss with relatives, more than briefly, various aspects of the patient's illness, and though he may advise them on certain points, and perhaps give support during and by virtue of an interview, he does not give relatives long-term help of any kind. His contacts with relatives are, rather, brief and limited, while the social worker's are more continuous, and concentrate on helping the relative with his own problems as well as with those of the patient.

(b) Total/.....

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71. As evidenced by the fact that 31 relatives were helped by advice around certain procedures. See Chapter IX, p. 245, passim.
72. Idem.
73. Though some aspects of this, as noted in Chapter X, p.276, may be obtained by the social worker in the course of drawing up a social history, through contact with the mental hospitals.

(b) Total Social Work Function with Families.

These considerations lead full-swing back to a discussion of the social worker's general role with the family, not only that with relatives for patients, and it therefore seems appropriate at this point to draw together the threads of all such service. Beginning with the comments made in Chapter VII,[74] the families of 56 patients were seen or involved in the patient's treatment. This forms 63.64% of the families of all patients. However, only 81 patients were known to have families either within or outside Johannesburg,[75] so that in fact a higher proportion of families were seen, i.e., 69.14% of the total number of families known to exist. Excluding the 3 relatives in the "far distant" group specified on page of this Chapter, but including all 66 families in Johannesburg,[76] 71.79% of the families who could have been assisted themselves or involved in function to the patient were so assisted or involved. Of these 56 families, 20 were seen solely about the patient, 34 were both seen about the patient and assisted with problems which had arisen for them out of the illness of the patient, and 2 were seen about themselves only, and not about the patient, though

the problems/...

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74. Chapter VII, p.163.
75. Chapter V, p.125, Table XX.
76. As, although the children of the women mentioned on page 321, footnote 49, of this chapter, could not help about the patient, but could (and were) have been helped themselves.

the problems they had were directly related to the patient's illness.

It is convenient to present the contacts with family members in tabular form, dividing them into the 65 functions direct to relatives, and the 77 contacts with relatives about patients:

TABLE XXXI - TOTAL SOCIAL WORK CONTACTS WITH RELATIVES

A. Relatives themselves assisted:		B. Relatives involved in patient's care:	
Type of help:	No:	Type of Involvement:	No:
Environmental	5	Through home visits	19
Advice, etc.	31[a]	Through social histories	6
Support	26[a]	Under section 13[b]	52
Informal conference with psychiatrist about relative	1		
		Total:	77
Referred to community agency	2	Plus A	65
Total:	65	Final Total:	142

a These functions were distributed among 34 families - see Chapter IX, p. 245 and Table XXX, p. 260.

b. Of the classification system, and as elucidated in this chapter, p. 320. With the exception of the 4 families included here, all other function to and involvement of relatives was with those relatives in or near Johannesburg, i.e. was divided among 52 families, or 78.79% of families in this group.

This total of 142 functions of the social worker with relatives forms 23.47% of the total 605

functions recorded for the sample, but it must be remembered that the 77 involving relatives in help to patients are in fact also regarded as functions to patients by the worker, and hence there is an overlap in the two groupings.[77] This percentage of services rendered to (10.74%) and with (12.73%) relatives does not conform with Bosserman's statement that "the psychiatric social worker is devoting a major part of her time to service to relatives and hopefully aiding them to become more helpful, sustaining individuals in relation to the patient,"[78] nor does it tally with Berkman's finding that in hospitals offering short-term psychiatric care, social service was more likely to be continuous and provided for the relative."[79] Rather, the proportion of service to families found in the present study fits in with this latter author's statement about social work in long-term psychiatric care, viz., that such is "more likely to be with the patient than with the relative."[80] This type of functioning is also reported by Irvine, who states, for social work in psychiatric hospitals in Britain, that less work is done with relatives and more with

patients/.....

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77. If 142 is regarded as the number of functions performed in a total of (605 + 77) functions, 20.82% of such functions were carried out with or to relatives. This is still one-fifth of total functions.
78. Bosserman, Z.V., op. cit., p. 64
79. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; p. 52
80. Ibid., loc. cit.

patients, rather than vice versa,[81] and that where, traditionally, "the main focus of the work has been with the patients' relatives.....most of the worker's time is (now) spent with the patients themselves."[82]

However, when a return is made to the actual number of families among whom this function is distributed in the present study, a different picture obtains, for over 70% of those families known and available were contacted. This, in the opinion of the present writer, is a high proportion of families with whom work of one kind or another was done, particularly in view of Knee's comment that it is not possible to provide casework services for all families of all hospitalized patients.[83] That the greatest number of families fell into the category of help to the patient (Category 13), and that all but two of the families seen were seen about the patient as well as about themselves, or about the patient only, is in keeping, further, with Knee's statement that "work with the family of the patient is centred on the patient and is focussed on the

illness/.....

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81. Irvine, E.E.: "Psychosis in Parents : Mental Illness as a Problem for the Family," British Jnl. of Psych. Social Work, Vol. VI, No. 1, 1961; p. 21. This study is also reported on by Timms, N., Psychiatric Social Work in Great Britain (1939-1962), Routledge and Kegan Paul, London, 1964; p. 116.
82. Power, M.: "Community Care: A New Social Service," British Jnl. of Psych. Social Work, Vol. III, No. 3, 1956, as quoted by Irvine, E.E., op. cit., loc. cit.
83. Knee, R., op. cit., p. 55.

illness of the patient."[84] But that only 3 families - those seen about material assistance - were referred to outside agencies.[85] is not in keeping with her recommendation that, whenever possible, "relatives should be encouraged to seek outside resources for help with problems that are not necessarily related to the patient's illness."[86] It seems unlikely that only 3 families of a group of 56, from a sample in which 80% of patients fell within a low income group,[87] did not need outside assistance, at least in regard to material help of one kind or another, while the breadwinner was incapacitated. And this low figure may be an indication of the pressure of time on the social worker, and the fact that she had none either to investigate the backgrounds of families more fully, or to work with them long enough for them to reveal to her any additional problems which they may have had.

(c) Summary.

In an over-all review of work with the family, it seems that the "family" approach so widely propounded in psychiatry today both is, and is not, a feature of social work in the unit presently under discussion. For, on the one hand, many families are seen, but, on the other, only a certain amount of function is rendered to them. The opinion of the present writer

is that/.....

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84. Ibid., loc. cit.
85. In two cases collaboration with the agency taking place (see this chapter, p.319), and in one not (see Chapter VIII, p. 210).
86. Knee, R., op. cit., loc. cit.
87. See Chapter V, p.115, Table XVI, and related text.

is that this latter is due not to policy of the unit, but to lack of time, on the part of the social worker, for dealing with both patients and families - and hence the closer and more proximate person is seen - and to the often urgent and usually time-consuming nature of the work done, which results in its being directed to the patient, with help to the family being regarded, with the exception of a few cases, almost as a luxury, rather than as a routine and necessary part of function. In the light of these influences, the fact that as many as 70% of families are seen is particularly significant.

C. AFTER-CARE AND FOLLOW-UP.

(a) Definitions and Goals.

The only time related activity of the social worker in the present setting is that of after-care and follow-up. For, as discussed in Chapter X,[88] all other services of the social worker occur at all times; but after-care and follow-up, by their very nature, are time-determined. By these terms, further, is not meant that discharge-planning which leads up to after-care - this is covered by all that has gone before - but only those activities of the worker which take place after the patient has left the hospital. Further, all such activities by the worker were included under one head, and will be discussed as such, although follow-up and after-care each indicates something slightly different. Thus

follow-up/.....

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88. Chapter X, p. 264.

follow-up implies learning the end result of treatment, or the position and condition of the patient after discharge, through contact with him.[89] Although involving the use of casework skills and often further casework help of one kind or another to the patient, it is not as much directed to this as is after-care which, on the other hand, denotes activities by the worker specifically designed to help and support the patient in his readjustments to the community, and to bring together those resources in the community which will be of benefit to him.[90] O'Keefe expresses well the goals of the social worker in after-care when he states that, through such care, the worker assists the patient to achieve more satisfactory interpersonal relationships, stimulates and sustains his interest in social and vocational activities, encourages his undertaking progressive responsibility, and helps him in his use of family and community resources.[91]

Ellis outlines additional goals of the social worker in after-care as being to increase the patient's capacity for favourable self-regard, to be a steady aid to him in his assessment of reality, to provide

him with/.....

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89. Bartlett, H.M., op. cit. (footnote 14), p. 216, and pp. 214 - 217, passim. The nuance that follow-up activities may benefit the hospital and research programmes, and be for the benefit of both patient and hospital, while after-care is directed at and for the patient only, should not be overlooked.

90. Based on Knee, R.I., and Lawson, W.C.: "Mental Health and Mental Illness," in Kurtz, R.H., (Ed.), Social Work Year Book, 1960, N.A.S.W. N.Yk., 1960; p. 388.

91. O'Keefe, D.E.: "Psychiatric Social Work," in Kurtz, R.H. (Ed), op. cit., p. 455.

him with a satisfying and non-threatening experience in relationship from which he may experiment with other significant relationships, and to help him to maintain and consolidate necessary defences in stemming the flood of his feelings.[92] The present writer would add that, in addition to supporting the patient through the difficult period of adjustment to community living following psychiatric hospitalization, one of the important functions of both after-care and follow-up is to make the patient feel he has not been abandoned, and that he can return to the hospital for help, if necessary. A further function of both is that they permit observation of patients whose adjustments in the community are precarious, and facilitate their re-admission to hospital, if necessary.[93]

While Knee and Lamson stress follow-up and after-care as "one stage in the continuity of care, treatment, and rehabilitation,"[94] hence implying their necessity for all patients, Timms discusses the difficulties of providing adequate social (and medical) after-care to psychiatric patients, putting forward the suggestion of the Association of Psychiatric Social Workers in Britain that such help should be rendered primarily to four groups of patients. These are, first, those who, having made

successful/.....

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92. Ellis, B.G.: "After-care of Mentally Ill Patients," British Jnl. of Psych. Social Work, Vol. VI, No. 4, 1962; p. 181.
93. O'Keefe, D.E., op. cit., loc. cit.
94. Knee, R.I., and Lawson, W.C., op cit., loc. cit.

successful recoveries, still need help in their adjustment to their social environments; secondly, partially recovered patients who may be enabled to remain in the community; thirdly, patients who discharge themselves from hospital against advice; and lastly, those whose personalities have undergone change through radical forms of treatment.[95]

(b) Policies and Procedures in the Unit.

The follow-up and after-care policies of the present department are not founded on any groupings such as these, but, rather, somewhat haphazardly based on a variety of factors. The psychiatrist may request that the social worker visit or contact a patient in order to see how he is progressing, or because he has not kept an appointment; or the social worker may follow-up a patient for these same reasons, but with the emphasis being on the social aspects of the patient's progress in the community. Again, she may feel that a specific patient particularly needs help and support in his return to the community, because of the nature of his personality or his illness, or because he is returning to a particularly difficult situation,

which/.....

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95. Timms, N., op. cit., pp. 118 and 119.

which has not been able to be modified.[96] Or the patient may be someone whom either she or the psychiatrist feels, for some or other reason, needs help in this sphere. In other words, follow-up and after-care by the social worker are not routine functions, partly because of lack of time by the social worker; on the other hand, lack of community resources[97] often necessitates her carrying long-term cases if follow-up and after-care of any sort are to take place,[98] and this makes the time-factor even more prominent. Thus, although some selection is operative in determining which patients shall be

followed/.....

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96. It must here be noted that just as admission to hospital is associated with problems to the patient, so does discharge have its problems for him. Thus he may feel threatened by loss of the hospital's protective environment, and anxious about the reactions of the community towards his illness, though this latter problem, particularly, is lessened by the fact that discharge in this instance is from a general hospital, for the stigma to the patient is lessened by this. The patient may anticipate family as well as community pressures upon him; may feel insecure about earning a living once more; may have unrealistic attitudes concerning the degree of his disability and how this will affect his adjustment; and may need much support in facing these difficulties. (Knee, R., op. cit., p. 58; O'Keefe, D.E., op. cit., p. 455).

97. See later in this chapter, pp. 349, foll. for community resources necessary and available.

98. This links up with the question of whether or not, and to what extent, the hospital-based social worker should engage in after-care. The answer to this question is possible determined in part by policy of the hospital, and whether or not the hospital accepts responsibility for the patient in the community. It links up also with the question of adequate community resources.

followed into the community and/or assisted there, selection is not on the basis of any fixed or clear criteria, and follow-up is not carried out in any systematic way,[99] and is not complete for all patients.

Because after-care and follow-up are so based, the social worker, on seeing a patient for the last time (all patients on after-care are known to her from ward contact before they leave hospital) always invited him to return to see her, if, at any time, he needed or wanted help. When and if these patients returned, they were made to feel welcome, and supported in that help which they requested.

Such/.....

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99. Timms, N., op. cit., p. 118, reports this problem in mental hospitals in Britain, as a result of the rapid turnover of patients in these hospitals.

Such contacts with patients were sometimes telephonic, or involved simply the arrival of the patient to see the worker.[100]

In general the procedures of follow-up were the home visit, the office interview (a sort of out-patient appointment made with the patient while he was still in hospital), telephone calls, and letters. The first two are traditional and conservative procedures, but the latter two perhaps slightly less orthodox. Nevertheless, all, in the present unit, are much-used means of post-discharge contact with

patients,/.....

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100. A sometimes added pressure in a busy day, but a contact which the writer regards as important. For frequently she is the patient's last link into the hospital from the community, as she is his link into the community from the hospital while he is an in-patient. As Berkman (op. cit., p. 50) expresses it, "the social worker...(is) the connecting link between the psychiatric hospital and the community. The patient who (needs) to return to the psychiatric hospital as a future date (can) initiate such contact, where it (has) ended-with the social worker." (Verbs in brackets as tenses changed from these of the text from which they are quoted). It is interesting that, empirically, the social worker has often found herself to be the last person to whom a patient feels he can turn, or whom he knows he can ask for help. Also, she is often the last person to whom patients may come, when they have tried everyone and everything else. She must be able to accept such patients warmly, and inspire others to do the same. Her associated role of helping the discharged patient back into hospital, if necessary, is a part of her function in after-care; the necessity for someone to be available to do this, with the advent of drug therapy and hence early discharge of patients who are sometimes still displaying (some) psychotic symptoms (Ellis, B.G., op. cit., p. 177; Knee, R.I. and Lamson, W.C., op. cit., pp. 388/9) is apparent, as is the patient's general need for after-care in this condition.

patients, and it is interesting that Ellis, in discussing specifically after-care of the mentally ill, points out "the crucial meaning (to the patient) of a letter or telephone call at the right time."[101] This latter statement particularly applies where contact is initiated by the worker, or where a patient has failed to return to see her, for it "provides concrete evidence to the patient of the social worker's interest in and help to him. (It) is something tangible by the caseworker....."[102] Thus, while not only reassuring the patient of her concern in him, it may precipitate the return of a wavering patient. It is surprising how often patients "needed" the telephone call or letter at the time it came.

Further support is given to the use of these types of contact by Bartlett, who, talking specifically of short-term work, mentions that in 1961 telephone contacts were being studied and evaluated,[103] by Knee, who discusses the use of correspondence in casework.[104]

Williams/.....

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101. Ellis, B.G., op. cit., p. 182. It is interesting that Schmidl ("A Study of Techniques used in Supportive Treatment," Social Casework, Vol. XXXII, No. 10, Dec. 1951, p.419) also points out the importance of the worker's interest in the patient being shown, for instance through the worker's initiating various contacts with the patient.
102. Williams, C.C., and Wien, J.: "The Casework Letter," Social Work (N.Yk.), Vol. 3, No. No. 1, Jan. 1958; p. 60.
103. Bartlett, H.M., op. cit. (footnote 10), p.310.
104. Knee, R., op. cit., p. 55.

Williams and Wien discuss this tool specifically in terms of the shortened hospital stays of patients and hence the very limited period of time the social worker may have in which to establish a working relationship with the patient.[105] It is interesting that these writers do not limit the use of either approach only to follow-up and after-care, but acknowledge both as useful instruments in ongoing casework.[106] Nor do they base the selection of correspondence as the means through which casework help is given solely on geographical distance[107] - and this is interesting, for in work in the present unit not all patients to whom letters are written, live far away from the hospital. However, the criteria used by these last authors for selecting patients for such help[108] are not used in the present instance.

Selection/.....

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105. Williams, C.C., and Wien, J., op. cit. p. 55.
106. In the unit presently being discussed, their predominant use is for follow-up, and only occasional usage in casework occurs.
107. Williams, C.C., and Wien, J., op. cit., p. 56.
108. Inter alia, evidence of the patient's strength in the area of taking help; evidence of the meaningfulness of a relationship with a helping person (the social worker) to the patient; his ability to use correspondence meaningfully; his feelings about written and verbal communication (and in some instances his difficulty in the latter face-to-face type of contact); that his basic security and self-worth were sufficient to prevent distortion of the written word; etc. (Williams, C.C. and Wien, J., op. cit., p. 56.)

Selection is, again, haphazard, and the strengths of the patient's personality not specifically assessed further than to consider his probable response to such an approach. Thus, although often some of the characteristics elucidated by Williams and Wien - given in footnote 108 on previous page - were incidental, more often it was the purpose of the letter which was considered, this being usually to enquire how the patient was progressing, and : requesting him to contact the worker to let her know; or supportive, to a patient needing such help. Also, contact was not always continued through the use of correspondence only, but other modes of contact interposed.

(c) Proportions and Types of Such Service.

Thus, of the 28 patients (31.82%) involved in follow-up or after-care (this figure being 4.63% of total function), 6 were contacted by letter, and 1 by letter and telephone; 8 by telephone only; 3 by telephone followed by office interviews; 3 were seen in office interviews only; and 7 were visited at home[109] one of these patients also came into the office once and was contacted by telephone on other

occasions/.....

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109. These 7 patients are those mentioned in Chapter X, p.271, footnote 20, and those noted in the text, Chapter X, p.270. With the inclusion of the latter 3, some duplication perhaps arises, but as function was being analysed, to omit the function of home visiting and include it as follow-up or vice versa, would have been to omit one type of function.

occasions. The 5 patients who were noted earlier in this chapter[110] as having been referred to outside agencies for follow-up care were included among this group, for contact was maintained with them by telephone (3) or interviews (2) for a short while after discharge. This latter referral to community agencies during discharge brings up the fact that much the same activities are carried out by the social worker, in the present unit at least, during after-care as during hospitalization. Thus the patient is helped with environmental problems which he may have, and given support and advice. In addition, the social worker has to deal with any hostility in the community towards the patient.[111] Primarily, however, the difference is one of orientation - where before emphasis was on helping the patient to adjust to the fact of his illness and to the hospital experience, and on assisting him in his return to the community, he is now in the community, and has to be helped in his adjustment to this.

Berkman, while emphasizing this point, emphasizes, also, that, in services to the patient associated with discharge, there is a shift away from work with the relative, to work with the patient,[112] and it is interesting that this trend is in evidence in the present sample. For no direct contact related to the patient's homecoming, is noted with relatives, although such services sometimes were

incidental/.....

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110. Page 318.
111. Knee, R.I., op. cit., p. 59.
112. Berkman, T.D., op. cit., p. 50.

incidental to help to the patient. It is interesting that this should be the case, in view of the fact that home-coming constitutes a period of adjustment for the relatives as well as for the patient.

(d) Patient-Worker Relationships.

However, what is perhaps more interesting is that, in spite of the smallness of the figures, and the possible selectivity of the present sample, there was a distinct tendency for a strong positive relationship with the worker to exist where follow-up services were carried out. Thus, of the 28 patients assisted in this manner, 13, or almost half, had very good relationships with the worker, 3 had good, 5 fair, 3 poor, and 4 "X" relationships with her. Thus 21 patients had positive relationships of one sort or another with her, only 3, or one-seventh of this number had poor relationships with her, and only 4 had relationships which could not be assessed, or which the records described only summarily.

It is difficult to say what the reasons are for this association of good patient-worker relationships with follow-up and after-care, however. While it is possible that follow-up and the hence demonstrated interest of the social worker in the patient led directly to such relationships, conversely, it may be possible that a good relationship was established between patient and worker prior to the patient's

discharge/.....

discharge from hospital, and hence the worker's warmth and interest in these patients led her, in terms of the unsystematic manner of follow-up in the department, to keep contact with them rather than with others. In either event, the value in follow-up of a worker whom the patient already knows, who is associated with a treatment centre to which he can return if necessary, who is aware of community resources available and appropriate to the patient's needs, and, above all, who has a good working relationship with the patient and whom kept trusts, are great. It would therefore seem that, even with the existance of adequate community facilities in a city - which there are not in Johannesburg - such follow-up activities should be expanded and developed through the addition of more social work staff to the unit, so that each member could carry a smaller and more intensive case load.

(e) Facilities for Follow-up and After-Care.

These comments lead back to a discussion of the apparently low number (5) of patients referred to community agencies for follow-up and after-care, though it must be pointed out that these were not only the only agencies giving care to the patient after his discharge from hospital. Rather, they were the only patients for whom such contact was new, for those 16 patients[113] already known to agencies which participated in planning for the patient during his time in hospital were also assisted by them after discharge, though/.....

113. This chapter, p. 318.

though not with psychiatric (medical) care, for which the hospital retained responsibility, but with general casework services. Thus the hospital-based social worker assumed responsibility for social work to the patient while he was in hospital, but referred him back to the community agency after the need for hospital treatment had been removed.[114] This is in keeping with Knee's comments on the use of general community agencies as well as specialised ones in after-care of patients,[115] and is particularly necessary in a community in which, as has already been mentioned in passing, few "specialized" services exist, and the most appropriate, outside the hospital, is only one, viz., the local Mental Health Society, an already over-burdened agency.

That some patients receive after-care at the hospital level, but not from the social worker, has been pointed out in Chapter VI, where it was stated that 30 patients attended psychiatric follow-up clinics.[116] In addition, some after-care value is inherent in the day and night hospital schemes of the unit, but these, as mentioned in the text,[117] are

selective/.....

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114. See discussion in this chapter, pp. 310 - 311.
115. Knee, R.I., op. cit., p. 59.
116. Chapter VI, p.157, Table XXVII and footnotes appended to the Table.
Of these 30 patients, 12 were seen also by the social worker; thus, of the total 88 patients, 46 or 52.27% received some kind of follow-up care at the hospital (18 - psychiatric only; 15 - social work only; 12 - both).
117. Chapter I, pp. 11 - 12.

selective and short-term, and there is no "half-way house" or other residential scheme to which patients can be sent during the transition from hospital to community.[118] Foster-home and family care is as yet non-existent,[119a,b.] and it is interesting to speculate whether this lack in services is due to community ignorance - and hence a need for the social worker to act as a community educator - or unwillingness to care for mentally disturbed or recovered patients.[120]

It is/.....

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118. Although the Rand Aid Association runs such homes for ex-patients of Northlea and Mount Collins, and very occasionally it is possible to arrange special accommodation there for a patient. This is not an organized, general mental health service, however.

119a. Stander (Mr. T.J., South African National Council for Mental Health, personal communication, July 1964) states that there is no placement of adult patients in foster homes in South Africa, and that there are only minimal services of this kind in existence for mentally defective children.

b. It is of note that, in America, Sculthorpe (1960) reported the use at Northport Hospital, Long Island, New York, not only of single-care for foster home placement of patients, but of multiple placement of patients in groups of two or more, reporting the advantages of this as being, inter alia, that the group experience often gave patients certain advantages which individual placements did not; that home visiting was easier for the social worker; that transport to treatment was easier for the patients; etc.
Sculthorpe, W.B.: "Multiple Placements of Psychotic Patients in Foster Homes," Social Casework, Vol. XLI, No. 10, Dec. 1960; pp. 517 - 523.

120. Barten, in this connection, reports a study carried out in Marion, Indiana, in which a sample of 5% of the total population revealed that 54% were willing to take mental patients into their homes if the patients were relatives or friends, and 28% would accept patients not related to themselves. Persons 35 - 54 years old were most willing to accept patients, and those over 55 less so. It is interesting to speculate whether or not as high a proportion of helpers would be found in Johannesburg. (Barten, W.E.: "Family Care and Out-Patients Psychiatry," Amer. Jnl. Psychiat., Vol. 119, No. 7, Jan. 1963; p. 666.)

It is here relevant that patients from a general hospital may be more willingly accepted than those from mental hospitals when such a programme is instituted.

The only groups in the community in which patients can participate are those run by the Mental Health Societies, and not all patients wish to attend these. The General Hospital unit does not have a social club - perhaps a rather serious lack, but one in part caused by pressure of other work on all staff members, and the short-term nature of contacts with patients - but does have an entertainment evening each week. Ex-patients attend these sessions, but no treatment takes place, and group activities are not geared to therapy, though some help to patients may result incidentally from them. The importance to a patient of finding a group from which he can gain support, and especially one which does not expect of him those assets and qualities which he lacks, cannot be over-estimated.[121]

With the absence of such facilities, however, general community resources and their personnel carry, along with their other duties, those of after-care and follow-up. And because, where patients are discharged to a community which does not have sufficient resources to help them stay out of hospital, they frequently return, it is necessary to build up such resources, and to use available personnel in the most advantageous manner.

Thus, for/.....

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121. Schmidl, F.: "The Psychotic Patient's Adjustment to the Community," Jnl. of Psych. Social Work, Vol. XXII, No. 3, April, 1953; p. 164.

Thus, for instance, the health visitor, who may have known the patient and his family for many years, in times of prosperity as well as of adversity, is often in a position not only to continue contact with the patient and family after the patient's discharge, but to recognise, by virtue of her knowledge of them, the first signs of stress and to detect the re-appearance or aggravation of psychiatric symptoms and illness.[122] Thus Gelber, in investigating the use of the public health nurse for follow-up of patients, found that, in America, training and experience are such that the "affirmed functions of public health nursing are appropriate in meeting the needs of discharged mental patients on tranquilizers."[123]

The use of the psychiatrically trained nurse is perhaps of even more value in the after-care of discharged patients than is that of the public health nurse. So, Hunter discusses a scheme, begun at a

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122. Based on "Working Together for Mental Health," A Statement by the Royal College of Nursing, the Institute of Almoners and the Association of Psychiatric Social Workers, British Jnl. of Psych. Social Work, Vol. VI, No. 3, 1962; p. 140.

123. Slear, M.G., Review of Gelber, I.I.: "Released Mental Patients on Tranquilizing Drugs and the Public Health Nurse," in Social Work (N.Yk.), Vol. V, No. 3, July, 1960; p. 124.
This is only one type of discharged mentally ill patient, however, and the author points out that the (general) potential limitations and contributions of such workers have still to be evaluated.

mental hospital in Britain, whereby certain members of the nursing staff are involved in the after-care of selected patients,[124] their functions being complementary to those of the psychiatric social worker,[125] and carried out always under the supervision of, and in consultation with, her.[126]

Closer to home, Moross reports the use of "domiciliary" nurses at Tara Hospital, in Johannesburg, pointing out that the use of these psychiatrically trained nurses began as an attempt to ensure that patients on the long waiting list for Tara, as well as their relatives, received support, within the competence of the nurses, until their admission to hospital.[127]

The first hint of the nurses perhaps going beyond these limits comes in his comment that a further of their functions was to refer to the psychiatrist "Social problems beyond (their) competence,"[128] and

the present/.....

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124. Hunter, P.: "The Changing Function of Professional Staff in the Mental Hospital : II," in Irvine, E.E. (Ed.), Ventures in Professional Co-operation : Mental Health in Clinic, Hospital and Community, A.P.S.W., London, 1960; pp. 48 - 50.
125. Ibid., p. 48.
126. Ibid., pp. 48 - 49. The author points out (p. 53) that not only does this leave the social worker time for other activities, and the fuller understanding by the nurses of social work, but it also gives the nurse fuller understanding of the patient as a member of his family and/or community.
127. Moross, H.: "The Development of Community Resources for Mental Health Care," S.A.M.J., Vol. 38, No. 19, 13 June, 1964; p. 417.
128. Ibid., loc. cit., For social problems are not correctly the province of the nurse, except in conjunction with social agencies.

the present writer frequently found such nurses involved not only in direct social work help to patients, but in the obtaining of social histories. In addition, after-care work, as opposed to pre-admission service, was frequently carried out (independently) by them, and this makes it necessary to point out, while propounding the value of help from the nursing services, that the nursing and social work roles are not interchangeable,[129] and that consultation to and supervision of nurses functioning in essentially social work fields is necessary, while further, it is important for any collaborating service to acknowledge and know the bounds of its competence.

(f) Case History and Summary.

Perhaps a case history would serve at this stage to illustrate many of the points made above, and a brief outline of the history of Mrs. P. will therefore be given. Aged 37, and with six children, she had been admitted to hospital, pregnant with her seventh child, and severely depressed, after the untimely death of her husband in a motorcar accident. A few days after her admission, she was referred to the social worker by the doctor, who said that she was in need of financial assistance, and that he would like a social history drawn up.

On interview, the patient was withdrawn and quiet, but showed some interest in the worker when she suggested that she would like to visit the patient's home/.....

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129. Liston, M.F.: "Psychiatric Nursing," Amer. Jnl. Psychist., Vol. 120, No. 7, Jan. 1964; p. 684.

home, and asked that she do so, and tell her how the children were. Over the 3½ weeks of the patient's hospitalization, a strong positive relationship developed between patient and worker, and the latter was able to assist her in many material ways, as well as to support her in her bewildered and uncertain state.

Because Mrs. P. seemed to gain so much help from the worker, it appeared both logical and essential to maintain contact with her after her discharge from the ward. She was thus visited at home shortly after leaving the hospital, and again on a further three occasions.[130] In addition, telephone calls were made to the patient between visits, and on one occasion she came to see the worker after keeping a psychiatric out-patient appointment.

During the course of working with her after discharge, the worker not only continued to give support to the patient, but arranged several minor financial matters for her, and arranged, with her, a move to a sub-economic housing scheme (this involving work with an outside agency, as did the financial matters). The move upset her greatly,[131] and for a while it seemed as though re-admission to hospital might become necessary.

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130. This patient is one of those mentioned in Chapter X, p. 271, footnote 20.

131. Much of her distress was associated with leaving her marital home, and much with her inability to cope, in her highly pregnant as well as depressed state, with settling into a new house. The need of home-maker services in Johannesburg is evidenced by this case, for the assistance of her aged mother was not sufficient to her, and did not provide the support which she needed at the time.

However, with considerable support, and increased medication from the psychiatrist after consultation between him and the social worker, Mrs. P. was able to remain at home.

As the end of Mrs. P's pregnancy approached, the worker began to encourage her to rely more on the social worker from the maternity hospital - to whom she had been introduced while still in hospital, and who had been seeing her since - than on the psychiatric worker, as it seemed that she and the health visitor[132] should take over major service to the patient after the birth of the baby. This plan was successfully carried out, and the social worker based in the psychiatric unit gradually relinquished her role as co-ordinator of the (social) after-care services to the patient, while retaining a consultative function to both other workers. By the time the baby was a few months old, the patient had settled back into a routine of living, and, although depressed from time to time, was coping fairly adequately with her life.[133]

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132. This visitor had seen the patient after the births of all her other babies (such visiting takes place until the child is two years old), and had, although this was unusual, seen the patient during the present pregnancy. In spite of the fact that Mrs. P had moved out of her "area", she agreed to continue contact, and gradually introduced her to the visitor for the area.

133 This is in keeping with the comments by Zigler and Phillips that a relationship exists between premorbid competence and prognosis. (Zigler, E., and Phillips, L.: "Social Competence and Outcome in Psychiatric Disorders," Jnl. Abn. Soc. Psychol., Vol. 63, No. 2, 1961; p. 268), for this patient was a relatively well-adjusted person prior to the tragic catastrophe which precipitated her illness.

This history does not indicate the need for or lack of community resources commented on previously, though possibly only because the hospital-based social worker was so particularly involved in the case described, rather than because these resources are not needed. It does, however, indicate the collaborative process carried out between this worker and other agencies, and the generally similar nature, although different orientation, of her functions in after-care to those in in-patient care. It also shows the procedures used in after-care, viz., home visiting, telephoning, and office interviewing, though not the use of letters. Perhaps the one aspect which it reflects somewhat incorrectly, however, is that of inter-professional co-operation within the hospital itself, as, although some took place with Mrs. P., this represents the exception rather than the rule. For the social worker is frequently left dealing with a patient when he does not, or has ceased to, attend even the out-patients department, and when other staff are no longer concerned with him. Thus that teamwork in after-care which is advocated by Ellis[134] ceases to some considerable extent within the hospital, though inter-agency co-operation continues. Further, after-care is exactly that "haphazard afterthought"[135] which the same writer deplores, and this field, perhaps more than any, is, in the present setting, in need not only of organization but also of extension.

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134. Ellis, B.G., op. cit., p. 179.
135. Ibid., loc. cit.

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C H A P T E R XII

ROUTINES OF THE SOCIAL WORKER

The topic of "scarcity of time" on the part of the social worker has been commented upon frequently in the discussion, just completed, of social work function. However, as was pointed out in Chapter III,[1] it was not possible to determine, from the case records used in the research project, the amounts of time devoted by the social worker to her various activities.[2] In order to overcome this possible deficiency in the study, it was decided to discuss the typical weekly routines of the worker, in this way indicating proportions of time spent on differing, though not necessarily specific, activities, even though precise amounts of time spent on each could not be ascertained thus. In addition, it was felt that the picture of the social worker's functioning should be completed by a discussion of those "facilitating" services to the patient, viz., recording, supervision, teaching, and community relations, which were mentioned in Chapter I.[3] Although these are the services usually designated

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1. Chapter III, p. 52.
2. It is of note that Goldman (Goldman, F.: "What are Social Workers in General Hospitals doing for Long-term Patients?" Social Work (N.Yk.), Vol. V, No. 4, Oct. 1960; p. 75) reports this same inability to determine hours directed to work and/or to particular activities
3. See Chapter I, p. 2. Scope of the Study, and footnote 4.

as indirect,[4] this term has already been used in the text to describe those functions to the patient which were immediately related to him, but did not take place through the worker's relationship with him.[5] In spite of the fact that Berkman defines facilitating services as those also not involving face-to-face contacts with the patient, she adds that they involve the concepts of distance and of derivation from the casework process, and facilitate the services provided,[6] so that it is in these senses that such services are termed facilitating and the others, for purposes of this study, designated indirect.

A. ROUTINES.

The forty-four hour week of members of the Social Welfare Department of the hospital is made up of five weekdays, 8 a.m. to 4 p.m., with an hour break for lunch each day, and Saturday mornings from 8 a.m. to 12 noon; thus it is, in fact, only a 39-hour working week.

In the general medical and surgical units, few, if any, meetings are held, and the bulk of this time is therefore spent in casework services to patients.

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4. E.g., O'Keefe, D.E.: "Psychiatric Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960; N.A.S.W., N.Yk., 1960; p. 454.
5. See Chapter X, pp. 264 - 265.
6. Berkman, T.D.: "Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; p. 84.

However, in the psychiatric unit, much time is spent at ward rounds and meetings. Thus, as pointed out in Chapter X,[7] the weekly ward round averages four hours, while the weekly intra-staff conference[8] lasts some 4-5 hours. Taking the former figure as the average, in order not to overestimate time spent in psychiatric conferences, it appears that a minimum of 8 hours per week is devoted to such activities. In addition, the social work staff meeting, held every Tuesday morning, lasts for two to three hours, and, again taking the smaller figure, a full 10 hours of each week therefore are taken up with meetings and collaborative conferences of one kind or another. This forms 25.64% of total time.

However, the 29 remaining hours are not utilized solely in direct work with patients. For 5 hours are devoted, each Thursday morning, to home visiting,[9] and the two hours of that afternoon[10] occupied by report-writing on the visits. This latter, of course,

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7. Chapter X, p.297, and footnotes 91, and 92a, p.297.
8. Idem., p. 298.
9. While this might be affected by urgent work in the ward, this was unusual, as visiting for the Friday morning ward round had always to be done then, and this figure is therefore valid.
10. The day is divided into periods from 8 a.m. - 1 p.m., and from 2 - 4 p.m. This means that the afternoons are short, and more work would probably be done if these times were 8 a.m. - 12 noon and 1 - 4 p.m., particularly as the lunch-hour would then coincide with that of patients. An alternative might be to introduce two sessions of 9 a.m. - 1 p.m. and 2 - 5 p.m.

cannot be rigidly enforced, for, after a morning's absence from the office, there are, on the worker's return, frequently matters awaiting her attention, some of these, by virtue of the problems involved,[11] requiring immediate handling. Additionally, one morning and one afternoon each week are spent "on Casualty", i.e., the social worker deals with any (not necessarily psychiatric) patients - from out-patients, the Casualty Department, or outside agencies - referred to the Department for assistance.[12] Thus a further seven hours per week are likely to be partially, if not fully, taken up by activities other than those directly related to (psychiatric) patients. By chance however, the writer's morning Casualty session fell on a Tuesday, so that, with two hours of that morning already taken up by the social work staff meeting, it could be said that only five hours, not seven, were taken off the 22 hours remaining when home visiting and "reporting" time had been subtracted from the first figure of 29. Thus it appears that only 17 hours per week, or 43.59% of time, could be devoted to seeing patients and handling their problems, either directly, indirectly,[13] or facilitatively, in terms of the definitions of the study.

It would/.....

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11. E.g., certification.
12. This system is mentioned briefly in Chapter I, p. 19. These duties are carried by all workers in the department.
13. Excluding formal conferences, but including informal contact with staff, and social history taking.

It would perhaps, however, be more correct to say that 10 hours per week were devoted to conferences; 5 hours to home visiting and 17 to seeing patients or handling their problems, i.e. 22 to working with and for patients; and 7 to various other activities which, depending on their amount, might allow a portion of that time to be devoted to psychiatric work. Expressed in tabular form, these figures would appear thus:

TABLE XXXII - AMOUNT OF SOCIAL WORK TIME DEVOTED TO VARIOUS ACTIVITIES

Activity:	No. of Hours:	% of Time:
(i) Formal Conferences:[a]		
Psychiatric	8	20.51
Social Work	2	5.13
(ii) Home Visiting	5	12.82
(iii) Work with or for psychiatric patients.[b]	17	43.59
(iv) "Borderline" time.[c]	7	17.95
Totals:	39	100.00

a. A note should here be made that, for a short period of the study, the worker was assisting at a psychiatric out-patient clinic, so that a further two hours were added to (i) and taken off (iii). However, this was dropped during the time of the study, and, because it in no way affected the intrinsic nature of the services rendered, was not considered significant. The more usual allocation of time was that given here and this clinic was not included in the "time" analysis.

b. I.e., including all those activities discussed throughout the text, with the exception of those specifically named elsewhere in the table.

c. Including the two hours designated for report-writing about home visits (other report-writing had to be done under (iii) and "Casualty" time, i.e. time which was ear-marked for other activities but might be able to be devoted to (iii).

From this table, it is clear that the time devoted to specific activities cannot be given, but only general broad proportions of time, related to general broad types of activities, worked out. Nevertheless, some conclusions can be drawn from these data, these being:

(a) that 25.64% or one-quarter of social work time is devoted to formal conferences each week;

(b) that 56.41% or more than half of social work time is available for all other activities to patients, including that to families;

(c) that the remaining 17.95% of time - almost one-fifth of total time - is devoted primarily to non-psychiatric patients;

(d) that although over half of social work time is given to casework to in-patients, in fact just less than one-quarter of this time (5 hours of the 22)[14] is specifically devoted to home visiting, so that only 43.59% or less than half of total working time actually falls within this category. In other words, in 17 hours a week the social worker has to see those patients and families referred to her or already known to her/.....

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14. This, as has been pointed out in Chapter X, p. 269, footnote 13, is a disproportionate amount of time to spend in carrying out a small part of total duties. However, if one of the social worker's particular contributions to total patient care is regarded as her ability to bring a picture of the patient's background, and those forces impinging on him, to the team, then possibly this allocation of time is not as disproportionate as it might otherwise be considered.

to her; deal with their environmental problems and give environmental modificative help, including all that discussed in Chapter VIII of the text; give support, advice and guidance to patients, i.e., carry out those functions described in Chapter IX of the text; carry out follow-up and after-care work; see relatives about patients; work with community agencies; draw up social histories (sometimes partly included in (iv) of Table XXXII) and take part in such informal collaboration with staff members as does not take place incidentally to formal meetings;

(e) The carrying out of those facilitating services which are to be discussed in the second part of this chapter has also to take place within this time.

Whether or not these proportions of time are generally prevalent in practice such as that being described in the present study is difficult to ascertain, for there appear to be little literature on the subject. Thus while Berkman gives percentages of social workers carrying out certain types of work,[15] and the stages in psychiatric treatment at which help is rendered,[16] she does not state how much time is devoted to these various services. However, both Timms[17] and Irvine,[18] independently reporting the

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15. Berkman, T.D., op. cit., pp. 85 and 98.
16. Ibid., pp. 32 and 33.
17. Timms, N., Psychiatric Social Work in Great Britain (1939 - 1962), Routledge and Kegan Paul, London, 1964; pp. 115 - 116.
18. Irvine, E.E.: "Psychosis in Parents : Mental Illness as a Problem for the Family," British Jnl. of Psych. Social Work, Vol.VI, No. 1, 1961; p. 21.

results of the study carried out to determine the amount of time spent by psychiatric social workers with patients, throw some light on this, even if not on the type of work carried out during this time. For they state that from 36% to 85% of social work time was spent in "visits and interviews"[19a] with patients, the average time thus spent being 56% This does not include home visits,[19b] and therefore the figure with which this time must be juxtaposed in the present study is that of 43.59%. Although this is within the range given, these figures are not strictly comparable, however, for the latter percentage includes activities other than direct contact with patients, and the information given by Timms and Irvine is therefore useful only in indicating general trends.

Goldman reports that most time was spent by the social workers in his study on various counselling services, with that spent on consultation services to staff members following.[20] Other services by his workers apparently absorbed less time, these being, in order, arrangements for after-care of patients at home and in institutions; interdisciplinary case conferences, and inter-agency case conferences; informational services to patients, families, or both; and, lastly, arrangements for financial aid.[21]

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19a,b. Timms, op. cit., p. 116
20. Consultation in the sense ascribed to it in Chapter X, p. 289, footnote 70.
21. Goldman, F., op. cit., p. 75

That interprofessional case meetings apparently ranked lower in time in his study than in the present one is interesting, while, if the brief time needed for financial assistance can be generalized to other material help, of which much was given in the present study,[22] this would appear to make it easier to carry out considerable amounts of such function within the time available in the present study.

The only other relevant study which the present writer located was one by Woodward, which, although dealing with psychiatric out-patient clinics, appeared to illuminate something of the division of social work time.[23] All staff members in the five clinics sampled recorded (in code) the activity in which they were engaged during every 15 minute period in four consecutive weeks. From these codings, it was found that 39% of social work time was used (a) in interviewing patients or collaterals; (b) group

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22. Vide Chapter VIII, p. 225, and Chapter XIII, pp. 403 - 405, and 409.
23. Woodward, L.E.: "Changing Roles of Psychiatric Social Workers in Out-patient Clinics," Social Work, (N.Yk.), Vol. VI, No. 2, April, 1961; pp. 74 - 81.

sessions with patients;[24] (c) significant telephone calls or interviews; (d) consultations with other professional persons outside the clinic or with persons not counted as patients; and (e) community service sessions, i.e., sessions with community groups for educational, consultative or community planning purposes. Approximately 30% of social work time was spent in dictation, record-keeping, and dealing with mail, while about 17% was spent in supervisory and

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24. It must here be noted that there are various ward groups for in-patients in the present unit, these consisting of patient meetings once a week for each ward. The values of the group experience to patients are great, and no doubt the social worker's presence at such meetings (psychiatrist, occupational therapist, and clinical psychologist attend) would carry with it several advantages, as well into line with the present trend for social workers in psychiatric settings to participate in both casework and group work activities (e.g., as discussed by Timms, N., op. cit., pp. 116 - 117; Berkman, T.D., op. cit., Table on p. 85,).
One of the advantages associated with such attendance by the social worker would be that it would integrate her more fully into the team and into the ward milieu, in the patient's eyes, and would make her more visibly a part of it all. The question of whether or not attendance at such meetings is "true" group work arises of course, however, as does that of whether, if it is, a caseworker is competent to do group work - even with a psychiatrist and clinical psychologist - concurrently with casework. However, because the worker is unable, through pressure of other duties, to participate in these groups, the matter falls outside the scope of the study and will not be discussed further.

other inter-disciplinary conferences.[25] Comparison of these figures with those of the present study indicates that less (clinic) time is devoted to conferences than is so in the present unit,[26] and when other service time is combined (as it is in the present unit), more (clinic) time is devoted to service to or about patients.

Thus all that emerges from a review of any of these studies, including the present one, is that more time is spent on working with or for patients than on any other activity, but exact proportions of this and other activities vary from setting to setting. One of the main divergencies of the present study is that time is devoted to other than psychiatric patients, and hence valuable hours are lost. While, on the one hand, such contact has the advantage of keeping the worker in touch with general medical social work without intrinsically affecting her role as psychiatric social worker, it does detract from her service to psychiatric patients by its taking up of time which could otherwise be devoted to them.

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25. Woodward, L.E., op. cit., p. 80. These percentages account for only 86% of total social work time. However, it is not clear from the text whether the 39% of time devoted to activities (a) to (e) is an average, or whether somewhat more time was devoted to these activities, for the "range" of time given for the five clinics is 31%, 34%, 45%, 48% and 49%, of which the average is 41% not 39%. This would still leave 12% of time unaccounted for.

26. However, in a unit in which all activities stem from collaboration and teamwork, the amount of time thus devoted is not disproportionate, but essential, and should not be lessened to facilitate the performance of other functions.

The institution of the present system of alternating "Casualty" days among the workers of the department was unavoidable because of staff shortages, and was seen as the only "fair" means of distributing the large amount of "transient" work which came into the Department. As a permanent measure, the appointment of one full-time "Casualty" social worker might have several advantages.

The amount of time available for each social work activity may sound quite reasonable in terms of percentages; however, these probably become slightly less adequate when given in terms of hours available. And when it is considered that the 88 patients with whom work was carried out during the 6-month period of the study are only a sample of all those seeing the social worker over the 6 months, it becomes apparent

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that time is very limited.[26] For even if one accepts that there are 20 hours a week (excluding home-visiting time, but including 3 hours of "borderline" time[27]) which can be devoted to patients and their problems, this means an average of 80 hours per month, or 480 hours over a six-month period. Adding in 40 hours,

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26. Departmental statistics were available to the writer for the months March, April and May, 1963 (original ones had been destroyed, but she had kept duplicates of these herself), and these showed that 195 patients had been seen by the psychiatric social worker over this 3 month period. While some of these were Casualty and out-patients, the bulk were in-patients, discharged patients, day-patients, etc. so that even if only 150 were considered as falling into this latter group, and this figure doubled for the six month period (300), time is indeed short. Further, it must be noted that these figures do not represent merely case load, whether active or not, but only patients currently and actively being seen. Also, this number includes each patient only once, i.e. individually, and whether seen once or more often. If the more usual procedure of counting patients seen each month, and regarding as "additional" patients those seen also during the second month, third month, etc., is adopted, an average of 92 patients are dealt with each month. It is interesting to compare these figures with those of Tennant, who reports that, in a 40-bed private mental hospital, there were 78 admissions (of which 8 were readmissions) over a 6-month period, and that 49 of these cases were referred for social work help. Although this is a long-term hospital (av. stay 3-6 months), the differences in "turn-over" and case-load are immediately apparent. (Tennant, M.A.:"Psychiatric Social Work in a Private Mental Hospital." Jnl. of Psych. Social Work, Vol. XXIII, No. 4, June, 1954; pp. 234 - 235)

27. Empirically, probably an average of three hours per week of "borderline" time would be devoted to psychiatric patients over a 6-month period, for in some weeks no time could be so spent, but in other weeks few Casualty patients were seen.

to cover extra weeks at ends of months, this means that approximately 520 hours were available for such work over the specified time period. In other words, if only 88 patients in toto were seen during this time, each would have about six hours of social work time devoted to him (and his family, if necessary). With far more patients needing assistance, the amount of time available to each is considerably decreased, even though many lunch hours are worked through and considerable "overtime" done. Thus the social work carried out in the unit can validly be regarded as short-term, not only on the criterion of length of hospital stay,[28] but also by virtue of Parks' definition that, "In terms of time and function, short-term casework is from one to five one-hour interviews with the client, including all activity connected with the interviews, and casework treatment as attempted in selected areas of the client's problem".[29] While some work in the unit is more long-term than is other,[30] by and large the bulk falls within this definition of short-term work. When it is considered that during this limited time, the social worker is expected, in addition, "to resolve problems, many of which have no satisfactory solution,"[31] such work is, indeed, work "under pressure; it is demanding, exhausting; it can

be threatening/.....

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28. As discussed in Chapter VI, pp. 139 - 140.
29. Parks, A.H.: "Short-term Casework in a Medical Setting," Social Work (N.Yk.), Vol. VIII, No, 4, Oct. 1963; p. 89.
30. E.g., follow-up and after-care work.
31. Esrera, P., and Richmond, C.: "Is Time so Scarce?" Social Work (N.Yk.), Vol. VI, No. 4, Oct. 1961. p. 99.

threatening as well as exciting and rewarding. It requires an ability to get a social history quickly and accurately, a horizontal view of the patient's problems and situation, and a selection with the client of some aspect of his problems that can be treated in the time available."[32] Perhaps, however, as Parad states, "In the last analysis, our troubled clients and patients care less about how "long" or "deep" their treatment is than they do about its relevance and usefulness in helping them in their everyday living arrangements.[33]

Nevertheless, short-term work should be the "treatment of choice,"[34] rather than forced because of pressure of work, and should be planned and co-ordinated. In the present unit, this is not always the case, and though it is likely that short-term casework would continue to be the predominant type carried out, even with more time in which to do it, such short-term work would, in the latter case, be more intensive and have less "hurried" elements in it.

The most effective way of achieving such a situation obviously would be to increase the number of social workers working in the psychiatric wards. Thus, if two were appointed to the unit, one dealing with each ward, or each carrying half the patients on each ward, probably far more effective service

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32. Parks, A.H., op. cit., loc. cit.
33. Parad, H.J., "Brief Ego-Oriented Casework with Families in Crisis" in Parad, H.J., and Miller, R.R. (Eds.), Ego-Oriented Casework: Problems and Perspectives, F.S.A.A., N.Yk., 1963; p. 164.
34. Parks. A.H., op. cit., loc. cit.

would be able to be given. If, in addition, general Casualty duties were removed, and these workers asked to deal only with psychiatric casualty- and out-patients, roughly the same number of patients would be seen by them as would be seen if each was doing the general coverage, but the psychiatric focus of the work would be maintained, and the necessity for such patients at any rate to be transferred to the psychiatric worker at a later date would be obviated, so that administrative and "red tape" activities would be cut down.

In the interim, the use of a case aide[35] or carefully selected volunteer might be of considerable assistance to the social worker - and to the patient. Because this topic has been mentioned in several places in the text,[36] it will not be discussed again here, further than to reiterate that all activities carried out by such a worker should be under the supervision of the social worker.[37] Further, it would be preferable for her to have no direct contact with patients - for as has been pointed out, even apparently routine duties often form a point of entry for the social worker helping a patient during a time-limited hospital stay - unless the contact was a minor one, or with a patient already well known to

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35. There are officially no such persons in social work in South Africa, but the use of part-time social work students or semi-trained social workers or experienced voluntary workers could be indicated by this term.
36. And especially in Chapter VIII, pp. 191, foll.
37. The time taken up by this activity would probably still be less than that taken up by the duties of which the aide would be relieving the social worker.

the social worker, as other contact might both be confusing to the patient and side-track him from the casework relationship.[38]

It is difficult, without comparative figures, to say how much staff would be needed in the unit, or what usual standards are. However, from experience, the writer would estimate that at least two full-time workers would be needed, with the aide possibly working part-time.[39] That some increase in staff is urgently needed is clear, for, in the words of Esrera and Richmond, no matter what skill and understanding the worker may have, these are of no value to the patient unless she has time to demonstrate them.[40]

B. "FACILITATING/.....

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38. This may appear a somewhat stultifying approach, but is necessary, for where, in long-term work, an aide might not have these influences, in a setting where the worker frequently has to "sell herself" to patients referred to her by others, and does not have much time in which to do this, extraneous contacts by others may assume (disproportionate) significance. However, it must still always be borne in mind that "we must be careful to leave our volunteers enough spontaneity to respond to patients in simple human terms, rather than by an over-structured approach," in any work which they do with patients. (Snyder, C.D.: "Auxiliaries and Volunteer Services," Hospitals, Vol. 37, No. 8, April 16th, 1963; pp. 56 - 57.

39. Although this would mean that each worker would cover only ± 16 in-patients beds, it must be remembered that caseloads would be considerably more. For turnover in the wards is rapid, and out-patients, day-patients, and discharged patients would be included as well as "Casualty" patients - whether general or psychiatric. Thus, taking the average quoted in footnote 26, p. 371, each worker would still deal with approximately 46 patients each month, the case aide carrying out various services for both workers.

40. Esrera, P., and Richmond, C., op. cit., loc. cit.

B. "FACILITATING" SERVICES OF THE SOCIAL WORKER.

In turning to a discussion of "facilitating" services to patients, it must be pointed out that, as mentioned in Chapter I,[41] the scope of this study was intended to cover the day-to-day activities of the social worker with both patients and staff, and only secondarily to describe facilitating services. These services therefore will be dealt with only briefly.

(a) Recording.

A beginning will be made with recording, as that activity within this category most closely related to the patient. For one of the explicit purposes of recording is that of "practice, to ensure adequate service to the client,"[42] or, as Bish expresses it, "to further professional service to the client,"[43] Other purposes of recording are teaching and supervision, administration, and research.[44] However, the records of the department presently under discussion were primarily practice records,[45] and although useable for research, were not designed for this purpose. Nevertheless, their utilization in

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41. Chapter I, p. 2.
42. Hamilton, G., Principles of Social Case Recording, Columbia University Press, N.Yk., 1956; p. 8.
43. Bish, B.: "Current and Future Trends in Recording," in Administration, Supervision and Consultation, Papers from the National Conference of Social Work (1954), F.S.A.A., N.Yk., 1955; p. 64
44. Hamilton, G., op. cit., loc. cit.
45. Chapter II, pp. 20, foll.

teaching and supervision occurred frequently, although little administrative use was made of them - in terms of evaluating the discharge of service to the patient[46] other than for statistical purposes.

The physical format and filing of records has been discussed in Chapter II,[47] as has the fact that recording was in process or (periodic) summary form. While this latter type of recording was often the one of choice, its use was also often due to lack of time for other writing. Perhaps this time factor is, again, one of the main difficulties in keeping records up to date; for in the present setting urgent matters often crop up, encroaching on such time as is set aside for this activity. It is interesting that, from this, comes a rule of thumb method of recording by means of which such cases are usually fully written up, while others of "lesser" importance or urgency tend to be summarized.

The dangers of too much summarization are clearly pointed out by Hollis, who states that this should vary directly with the complexity of the case, and maintains that "enough primary data should be included even in summaries to give direct evidence of the treatment process."[48] She adds that work can only be improved by studying the details of it, and that for this at least some detailed recording is necessary.[49] Hamilton, too, points up the facts

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46. Hamilton, G., op. cit., loc. cit.
47. Chapter II, pp. 20 and 21; and Appendix A, p.441.
48. Hollis, F.: "Contemporary Issues for Caseworkers," Smith Coll. Stud. in Social Work, Vol. XXX, No. 2, Feb. 1960; pp. 168 - 169.
49. Ibid., p. 169.

that, inter alia, oversimplification and the blurring of emotional overtones in the casework process may occur in summarization.[50] But it is interesting that Woodward reports, for the five psychiatric clinics which he studied in New York State, that several had dispensed with process recording entirely, and were presenting salient facts and significant movement in summary form only.[51] One of the benefits which he notes as resulting from this is that records were reduced by 50 - 80%.[52] The advantages of the concomitant reduction in time spent on this activity, in spite of the fact that good summaries may be difficult to draw up, are apparent in a department where time is at so great a premium, and, in addition, where all the recording that is done is typed or handwritten - and hence doubly time-consuming - by the worker, due to the complete lack of secretarial services for this purpose, including the absence of dictaphones, apparently so much a part of the American scene.

While these general remarks on social case recording apply to the hospital setting, there are in addition certain specifics which have to be considered here. The first of these is that pointed up by Bartlett, when she states that the social worker writes some records for her own use, and others for the use of the medical (or psychiatric)

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50. Hamilton, G., op. cit., pp. 64 - 65.
51. Woodward, L.E., op. cit., p. 80.
52. Ibid., loc. cit.

team.[53] Arising out of this latter come the particular principles relevant to recording for the use of another profession. In the first instance, clarity and conciseness are necessary, and the idiomatic language of social work should be avoided. Through the record, the social worker is (again) able to present the patient as an individual, in his own particular social environment and life, and this data, as well as any other content relevant to the medical situation, should be included in the record. Further, the social worker must make clear what she has done for the patient, and what responsibilities she has and is able to assume in relation to him.[54]

The integration of this "team" oriented record into the unit file is a further point of discussion. Some of the difficulties inherent in this are elucidated by Hamilton when she states that the medical record is about a single patient, whereas social work often deals with more than one patient, and, again, that doctors will not page through long records. Further, attaching social work records to the unit file introduces "the danger that in large institutions the confidential nature of the record may not be guaranteed."[55] Nevertheless, the unit medical record - developed in hospitals in the twenties and thirties[56] - has become widely used as a unified/....

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53. Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p. 253. Bracketed words included by present writer. It is of note that Hamilton (op. cit., p.111) points out that distinctive differences between hospital records in psychiatric and medical social work have not emerged
54. Based on Bartlett, H.M., op. cit., loc. cit.
55. Hamilton. G., op. cit., p. 108.
56. Bartlett, H.M., op. cit., p. 253.

a unified record of the activities and progress of patient and staff members. The method of inclusion of the social work record in it varies from hospital to hospital, in some a summary of progress being appended to the end of the "main" record, in others this being attached to the relevant part of the record, and, in still others, through the writing of notes in the body of the record, where information is immediately relevant to the medical treatment.[57]

All these forms necessitates the keeping of dual records by the social worker, for the records appended to the unit medical file are often different, at least in emphasis and terminology, to those kept in the social work department. Merrifield, et al, however, describe a recording system introduced at the University of Illinois College of Medicine, Chicago, whereby typical social work departmental records were completely given up for progress recording in the medical files, combined with more detailed records, and in which consultation sheets were also added to the medical files. Any additional records needed for social work supervisory purposes were drawn up separately, and then destroyed, though a library was at the same time being built up of special case records for teaching and demonstration purposes.[58]

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57. Based on Bartlett, H.M., op. cit., pp. 253 and 254, and Hamilton, G., op. cit., p. 109.
58. Merrifield, A.R., Fassler, L., Lane, H.J., and Lockhart, H.: "A New Recording System for Medical Settings," Social Casework, Vol. XLI, No. 5, May 1960; pp. 254 - 257.

In the psychiatric unit presently under discussion there is as yet no systematic method of team recording. The usual procedure is for special social work information to be noted, at the discretion of the social worker, in the daily progress section of the clinical file, and for social histories[59] to be routinely appended to the clinical file. Case summaries may or may not also be thus attached. The full social work record is kept in the Social Work Department, and is accessible to any team member who wishes to make use of it. Similarly, the medical record is available to the social worker, and it is interesting that psychological tests and results are almost invariably found in this. The inclusion of a similar social report from the social worker would complete the record. While this need not be a full process record, especially in view of the fact that much collaboration and consultation take place between the social worker and the psychaitrists, attaching a summary to the record, at least on closing of the case if not periodically, would ascertain that all the relevant features of the "social side" of the case were included in the patient's total record and, importantly, that these

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59. It should again be pointed out (as in Chapter II, p. 20) that such histories, letters, etc., form a part of the social work case record, and often save other writing up in the body of the record. Practice in the present Department is frequently simply to date an entry, and refer to the relevant history or letter for details of a happening. Thus: 21.5.63. - Letter written today to Mrs. C. to find out how she is keeping - see attached.

would be seen immediately on the patient's readmission, especially if new ward staff had been appointed, and the patient perhaps referred back to the social worker earlier than might otherwise be the case. The routine appending of a closing summary to the medical record would ensure that at least a carbon copy of this would appear on the social work record. As closing summaries are not a departmental routine, improvements to the social work record would occur concomitantly with those to the unit record.

Perhaps one of the reasons why such recording has to date not been started is, again, the lack of time available even for "normal" recording. The social worker's daily diary often is used as a source of information about activities, and the keeping up of this, together with departmental records, is virtually all the recording for which there is time at present. However, as the unit social work staff - hopefully - increases, the introduction of social work records to the general medical record will undoubtedly prove an added tool in facilitating the collaborative process between team members, and ensuring comprehensive care of patients.

(b) Supervision.

Because Berkman regards supervision as only "once removed" from the patient, and the remaining

facilitating services as farther away from him,[60] this topic will be discussed next. Further, an attempt will be made to relate the discussion only to the practice of supervision rather than to the theory underlying it, as it is the former which is really relevant to a practice-oriented study.

As Henry expresses it, "Traditionally, it has always been the practice in casework agencies for a caseworker to have a supervisor. As a practitioner, the caseworker has been supervized not only administratively, but also in the educational sense."[61] In addition, such supervision has, traditionally, taken place through and in the person-to-person interview between supervisor and caseworker. However, as practice developed, a school of thought began to emerge which pondered on the problems of the role of

supervision/.....

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60. Berkman, T.D., op. cit., p. 84.
It is interesting that this author brackets supervision and administration together. As administrative activities were engaged in by the writer only when the head of the Department was on leave, and she acting head, they did not form a regular or typical part of her duties and will not be described here. Similarly, as research is normally not engaged in by the department - the present study was extra-mural - such activities will also not be discussed here.

61. Henry. C.S.: "Criteria for Determining Readiness of Staff to Function without Supervision," in Administration, Supervision and Consultation, op. cit., p. 34.
Although the writer is aware of the different viewpoints on the topic of whether or not staff supervision is an administrative or separate teaching function of the supervisor, for purposes of this study this matter will not be further discussed, but Henry's viewpoint accepted.

supervision in perpetuating dependency in the worker,[62] and the different supervisory needs of workers at different stages of professional development,[63] particularly those of the experienced worker whom, in the word of Schour "we have continued to supervize.... .....too long."[64]

As an alternative to such supervision at least of experienced workers, the concept of consultation was introduced. Defined by Siegel as "a process of giving and taking help within an inter-personal relationship,"[65] the value of the service depends "upon the consultee's readiness to entertain new ideas and his ability to translate these ideas into skills appropriate to his function and role."[66] Most importantly, however, consultation, though being a

means/.....

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62. Stiles, E.: "Supervision in Perspective," Social Casework, Vol. XLIV, No. 1, Jan. 1963; p. 19; and Henry, op. cit., p. 45.
63. Henry, C.S., op. cit., pp. 38 - 40, passim.
64. Schour, E.: "Helping Social Workers Handle Work Stresses," Social Casework, Vol. XXXIV, No. 10, Dec. 1953, p. 427, as quoted by Henry, C.S., op. cit., p. 42.
65. Siegel, D.: "The Function of Consultation : Some Guiding Principles for Medical Social Workers," In Symposium Proceedings, 1953, Graduate School of Social Work, University of Pittsburgh, as quoted by Appelberg, E.: "Staff Consultation in an Israeli Organization for Immigrant Children," Social Casework, Vol. XLIV, No. 7, July 1963; p. 390. (Refer Chapter X, p. 289, footnote 70 , where a simple definition is given by the same author; it is here merely elaborated upon, and it should be noted that this meaning of the term, as opposed to the looser one used in the discussion of teamwork, is again indicated.)
66. Siklema, M.: "The School Social Worker Serves as Consultant," Casework Papers, 1955, F.S.A.A., N.Yk., 1955, p. 77, again as quoted by Appelberg, E., op. cit., loc. cit.

means of testing out conclusions against the experience of others,[67] carries no administrative responsibility, implying availability without control,[68] while the worker herself has responsibility for deciding when she needs such help, and what, if any, use she will make of it. However, as Henry points out, independent casework practice should never mean professional isolation.[69] Directly illustrative of these principles is a scheme of "time-limited supervision," reported by Wax, in operation at the Palo Alto Veterans' Administration Hospital, California, where supervision for professionally trained workers for a maximum of two years[70] has been introduced, with consultation taking its place thereafter. The scheme was begun in 1958, and found to influence positively both staff morale and independence.[71]

A further/.....

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67. Henry, C.S. op. cit., p. 40.
68. Aufricht, E.: "Control and Freedom in the Caseworker's Growth," in Administration, Supervision, and Consultation, op. cit., p. 48.
69. Henry, C.S., op. cit., loc. cit.
70. It is interesting that this time period coincides with that postulated by Henry, op. cit., p. 41, as an "internship" type period for the social worker, and also that considered by the Jewish Family Service of New York to be necessary for workers to understand their patterns and problems in treatment. (Leader, A.L.: "A New Program of Case Consultation," Social Casework, Vol. XLV, No. 2, Feb. 1964; p. 86). However, Jeanette Hanford ("Integration of Teaching and Administrative Aspects of Supervision" in Administration, Supervision and Consultation, op. cit., p. 55) feels that as many as seven years should elapse before a worker is regarded as professionally mature, and that even at this stage she should have some supervision.
71. Wax, J.: "Time-limited Supervision," Social Work (N.Yk.), Vol. 8, No. 3, July 1963; pp. 37 - 43, passim.

A further means of diluting the one-to-one relationship between supervisor and worker, and facilitating creative thinking by the worker, is that of group supervision.[72] This combines easily with individual supervision, and Leader describes this dual approach at the Jewish Family Service, New York, but states that it did not provide for sufficient transfer to the worker of the responsibility for improving his own practice.[73] As a result, this agency introduced, in 1963, a system of group supervision combined with consultation. A panel of consultants was assigned each worker, any one of whom the worker might approach for help, with, in addition, monthly meetings taking place between caseworker and an "administrative supervisor," who was also a member of the worker's panel of consultants.[74] This plan Leader describes as "perhaps an answer to 'formal' supervision."[75]

Whether or not the traditional type of supervision should be replaced or only supplemented by these other methods is perhaps a moot point. But it is necessary to describe these others in order to give some background to the type of supervision carried out in the Social Work Department of the hospital presently under consideration. For no formal individual supervisory conferences take place - or have ever done - within this department.[76]

Rather/.....

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72. Leader, A.L., op. cit., loc., cit.
73. Ibid., loc. cit.
74. Ibid., pp. 86 - 89, passim.
75. Ibid., p. 86.
76. The causes of this are beyond the bounds of this study, and cannot be discussed here.

Rather, development has been reversed, and consultation has been the order of the day. Further, only in 1961 were the weekly social work staff meetings - mentioned earlier in this chapter - introduced. However, this group is perhaps more in the nature of an administrative than a supervisory one, with departmental problems being discussed more than those of casework practice.

This lack in supervision of any real kind from the Social Work Department has, however, been overcome to some considerable extent, in the case of the psychiatric social worker, by a form of team supervision. This point raises with it the issue, however, of "dual" supervision of psychiatric social workers by a social work supervisor and a psychiatrist. Siporin, in a comprehensive article on the origins and complications of such supervision,[77] comes to the conclusion that social work, rather than medicine, is responsible for social work practice, and that social work has the supervisory responsibility for technical social work practice.[78] He continues, however, by saying that this conclusion recognizes that when medical practice includes social work, there is medical administrative responsibility for supervision to ensure that social work is used to achieve the medical objectives, and that this leads to the final

conclusion/.....

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77. Siporin, M.: "Dual Supervision of Psychiatric Social Workers," Social Work, (N.Yk.), Vol. I, No. 2, April 1956; pp. 32 - 42, passim.
78. Ibid., p. 40.

conclusion that the nature of the supervisory responsibilities involved are different.[79]

Nevertheless, such a statement does not alleviate the problems inherent in the actual practice of dual supervision, and Siporin states that new administrative organization of the lines of authority and supervisory responsibility need to be established within the psychiatric team. He proposes three such types of organization: (i) In which supervisory responsibility follows unit rather than developmental lines, and the psychiatric team is a tightly knit unit in which the psychiatrist takes administrative and medical responsibility in and for the team, and the social work supervisor acts as a staff consultant to the social worker. (ii) In which the social work supervisor assumes administrative and technical supervisory responsibility for the social worker, and the team is used for collaborative activity and consultation. Medical administrative responsibility is carried by the medical administrator, to whom the Social Work Department is accountable. (iii) In which a clear definition and allocation of administrative and technical supervisory responsibility - depending on the hospital or clinic setting - takes place between the Social Work Department, the psychiatrist in charge, and the team.[80]

Perhaps none of these types of organisation quite fits the procedures of the present unit, these being, rather,/.....

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79. Ibid., Loc. cit.
80. Ibid., p. 42.

rather, a mixture of all three, but with the exclusion of any great amount of technical social work supervision. While this may be an apparently inadequate method of supervision, and in some ways not in keeping with social work philosophy, the lack of "true" social work supervision is compensated for by her consultation and collaboration, in the team with other disciplines. For through this come added insights about patients and problems, and a demanding standard against which the social worker has to measure herself. Thus the deficits of the intra-departmental supervision are balanced to some extent by the advantages and opportunities of intra-unit and team consultation.[81]

(c) Student Supervision.

Just as staff supervision in general is not analogous to student supervision,[82] so in the present unit is this the case, and the methods employed in such supervision entirely different from those just described./.....

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81. It is interesting that Lewis (Lewis, K.M.: "Supervision, Education, and Social Casework : II," in The Boundaries of Casework, A.P.S.W., London, 1956; p. 59) points out the value, especially in the absence of social work supervision, of the team with which the social worker can share responsibility for difficult decisions and from which she has opportunities for continued learning.

82. Stiles, E., op. cit., p. 20. This author stresses the educational aspect of such supervision, untrammelled by administration, but, rather, including the teaching of this latter in it.

described. But, again, the administrative head of the department takes no responsibility for student training,[83] and students are assigned to individual workers. It is interesting that the psychiatric work of the hospital seems to attract students more than does that of the other sections, and one of the final year students assigned to the Social Work Department is hence always placed in the psychiatric unit.

Placement for field training varies for each year of the four-year course of the University, and, in the final year, two days a week (Thursday and Friday) are spent by the student in a selected agency. There is thus an opportunity for fairly intensive teaching, and for students to "carry" cases themselves. This again leads to a digression onto the time factor in the psychiatric unit, however. For, as was pointed out earlier in this chapter,[84] all facilitating services of the worker take place in the 17 hours per week available for service, of all kinds, to patients. Hence such teaching falls within this time. Unfortunately, supervision cannot, as was found by Berkman, be provided at the expense of other social work responsibilities[85] and this means that as much teaching as possible is done, but, at the same time,

the student/.....

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83. Yet it is through her that contact with the University, so important in the co-ordination of student training (see, e.g., Lewis, K.M., op. cit., passim, and Hunnybun, N.K.: Supervision, Education, and Social Casework : I," in The Boundaries of Casework, etc. pp. 44 - 49, passim), takes place.
84. Page 363 , Table XXXII, and surrounding text.
85. Berkman, T.D., op. cit., p. 77

the student carries cases as soon as she is able to do so, and therefore that time devoted to supervisory conferences is in part made up by the student's working with patients.

In spite of these difficulties, an attempt is made to give the student as much teaching time as possible, and, especially in the early weeks of her training, a vigorous orientation programme is initiated. She is shown round the wards, and introduced to staff, and the basic principles of the unit's running are explained to her. Records are used at first to form the basis of discussion around the types of patients and problems coming into the wards,[86] and she sits in on most interviews by the worker, which she then writes up for discussion. She accompanies her on her home visits, and also to ward rounds.[87]

As she begins to know staff and patients, she is assigned parts of cases,[88] or very short cases, and her activities discussed and considered with her.

As she/.....

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86. Lewis, K.M., op. cit., p. 54, points up the values of case records in teaching as being, inter alia, that cases can be chosen to teach just what is needed at each stage in the learning programmes, that the sequence of happenings can be traced, and the various forces in the case worked out as well as an hypothetical plan of help; but, above all - at least in the opinion of the present worker - the urgency of problems requiring immediate solution is removed and the tempo of work can thus be adjusted to the student's needs.

87. This observation takes place within limits, however, and at the discretion of the worker in the light of her knowledge of the patient, as well as with the consent of the patient.

88. E.g., contacting employers, seeing relatives where the patient is the main focus of concern or patients where the opposite is true, etc.

As she becomes more confident, correspondingly more difficult cases are assigned to her, until she is carrying a small case-load of her own. An attempt is made to hold a formal conference with her at least weekly, even if only for a short time, especially as the worker has to be able to step into the breach should any help be needed by one of the students, patients, in her absence; also she has to be able to report developments back to the team members.[89] In addition, the worker is available to the student for consultation at any time.

While this student supervision may appear orderly, it should be pointed out that in fact the above is the theme or trend of supervision, and that it would be more accurate to present it as a flexible and changing arrangement, one made up of snatches of conversation, of quick teabreaks together, and of a constant attampt at warmth, support, and guidance from the worker to the student, in a situation in which the student is thrown into a dynamic and fast-moving stream of activities. It is an effort to help her swim, rather than sink, to develop her own skills and independence, and an introduction to social work as a living and moving force with people who are people.

(d) Other Teaching Activities.

The teaching activities of the social worker are not limited only to those with students in her own

profession/....

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89. The final responsibility for patient care and carrying out of team recommendations still rests with the worker. Thus, although the conference may seem intended for the worker's benefit, this is not so, but merely a practical overlay.

profession, however, but where, with the social work student teaching is both formal and inherent, with the other disciplines such teaching is more often inherent. This dichotomy occurs because the formal teaching function in the department is carried out by the head,[90] and other workers lecture occasionally only on their specific work. But that inherent teaching which takes place is perhaps as important as the more formal kind, and is an associated part of the worker's daily activities, for "every service the social worker performs in a clinic or hospital, whether or not he consciously intends it, has a teaching aspect. Teaching, therefore, results from the performance of professional duties."[91]

Such teaching takes place to a large extent at the various interprofessional meetings, where students of other disciplines are present. Thus the social worker often is able to help not only the staff but their students to see the patient as a person, and

to see/.....

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90. Berkman, T.D., op. cit., p. 90 reports that in her study it was also most frequently the chief social worker who carried out the teaching of other professions.

91. Newcomb, M.L.: "The Educational Role of the Social Worker in the Collaborative Process," Jnl. of Psych. Social Work, Vol. XXI, 1952; p. 64.
The educational role of the social worker with the other professions is, of course, also of this nature. And just as the social worker learns from others, so teaching to other staff members takes place through joint activity on a case. This is thus a two-way type of activity. However, as Newcomb points out (loc. cit.) teaching is a secondary, though important activity, and the primary responsibility of helping the patient must always remain.

to see the full picture of him in relation to his environment. But, additionally, she is able to demonstrate what the social worker does for the patient, how she does it, and her attitudes and philosophy in the doing.

For some students, this is the only illustration they have of social work function, but for others, and more especially trainee nursing staff,[92] daily activities and day-to-day contacts in the wards provide additional examples of service to patients, and this is particularly so where these are supplemented by informal talks, and passing explanations. It is interesting how quickly orientations change and such learner members of staff begin to know when and how to make use of the social worker.

There is little direct contact with medical students, unfortunately, as their teaching rounds are purely medically (psychiatrically) oriented. However, at one stage an attempt was made to include the social worker and occupational therapist in a teaching "case conference" type group held each Monday morning. However, attendance of both social worker and occupational therapist had to be discontinued, for neither had time to devote a full morning (to the social worker one of the two available to her for working with patients) to such teaching. Nevertheless, its importance cannot be overestimated, and this scheme is one which, when time is less

scarce/.....

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92. As was explained in Chapter I, page 7. most members of nursing staff are in training.

scarce, could and should be introduced once more.

An additional teaching approach is that discussed by Bartlett, in the teaching of medical social work, whereby each medical student is assigned patients-and-families as cases for continued work over a period of several years, consultation being available to them, in their treatment and handling of these patients from a team of specialists, including medical social workers.[93] An adaptation of this programme to the short-term practice of the psychiatric unit under discussion might be instrumental in providing these future doctors with a broader and more socially-oriented approach to their patients.

(e) Community Relations and Interpretation of Service to the Community.

The effectiveness of much teaching, whether of a formal or an inherent nature, depends on the readiness of the learner to accept the new knowledge and insights which are being demonstrated. This is a principle which applies to interpretation of mental health services to the community as much as it does to the interpretation of social work services to students and staff members. However, in terms of Berkamn's definition of community relations and interpretation to the community as being organized programmes which "make the agency known, understood, liked, used, and supported," rather than interpretations around the

individual/.....

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93. Bartlett, H.M., op. cit., p. 257.

individual needs of patients,[94] no such work is carried out by the psychiatric social worker in the hospital.[95] Rather, the individually related type of interpretation takes place, and, again, an inherent type of community education hence follows through social work contacts with family members, employers, landladies, and with anyone to whom an attempt is made to impart the philosophy and practice of the unit.

Perhaps one of the main spheres of such influence is within the hospital community itself, of which, as was discussed in Chapter I,[96] the unit has slowly come to form an integral part. And as a wider group of individuals pass through its wards in training, or come to understand through demonstration, what it is doing, so it is hoped that these people will carry their newly acquired knowledge with them, and the hospital hence "extend its influence beyond its own

walls/.....

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94. Berkman, T.D., op. cit., p. 87. The quotation is taken by her from Scull, J.H.: "Public Relations in Social Work," in Social Work Year Book, 1951, Amer. Assocn. of Social Workers N.Yk., 1951; p. 400.

95. In fact, no programme of this kind is carried out at all. The opportunities of a general hospital for carrying out such functions are enormous, for, as pointed out so often in the text, that stigma which may attach to other organizations is often nullified or at least lessened by the non-specific and acceptable nature of a general hospital, and workers from such a base might well have wide opportunities for interpretive work. Again, however, the ever-present time factor operates, with its always constricting effects.

96. Chapter I, passim.

walls into the community."[97]

That so little community interpretation of an organized nature is carried out by the worker in the unit under discussion is not in keeping with Berkamn's finding that 34% of all hospital psychiatric social workers carried such responsibilities, and that, of all workers in psychiatric settings, more carried out such facilitating activities than any other type.[98] However, if viewed against the administrative aspects of this function as one of those of the departmental head, and in addition against the limited time available for and pressure of other work, this finding is not surprising.

C. SUMMARY.

The contents of this chapter has been geared to fill in gaps in the total account of function of the worker in the psychiatric unit under consideration, and, therefore, these last few sections, the so-called "facilitating services," have been described only briefly. But perhaps they have served their purpose, and, against the background of time and its scarcity, as prescribed in the earlier parts of the chapter, have served to present more fully the dynamics of such service, and the many facets of it. The threads of the whole dissertation will be drawn together finally in the next chapter.

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97. Bartlett, H.M.: "The Widening Scope of Hospital Social Work," Social Casework, Vol. XLIV, No. 1, Jan. 1963; p. 5.
98. Berkman, T.D., op. cit., p. 87.

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C H A P T E R XIII

SUMMARY, GENERAL RESULTS OF THE STUDY, AND CONCLUSIONS.

A. SUMMARY.

A brief review of the subject matter of a dissertation is perhaps helpful in drawing together its themes, and in leading up to its conclusions, and, besides, provides a perspective against which these conclusions may be viewed. It is therefore neither repetitive nor redundant to turn back, for a moment, to the beginnings of this thesis, where an outline was given of the development of thinking about mental illness, and the associated development of services for the mentally ill, in both Europe and America.

The concomitant development of such services in South Africa was also traced, and its culmination in the establishment of psychiatric in-patient units in general hosoitals illustrated by a description of the two such departments existing in the country at present. The history of the service at the Johannesburg Hospital was given in some detail, as the specific aim of the dissertation was "to clarify the newly-established position and functions" of the social worker in this unit,[1] and it seemed that these would be understood best against the background of the unit's development and integration into the hospital. It appeared, further, that an effective way of accomplishing this

aim/.....

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1. Chapter I, page 1.

aim would be through an analysis of the case records of patients admitted to the two wards of the unit during a specified period of time.

Once it had been established that (practice) case records could be regarded as forming an acceptable basis for research, a sample of 88 such records was drawn, these being those of patients admitted to the unit between 1st March and 31st August 1963. A classification system of social work function was designed whereby these records could be analyzed, and, in terms of this system, the social worker's functions were divided into several categories, these being:

(a) "Traditional" material assistance and environmental manipulative services;

(b) Environmental functions specifically psychiatrically oriented;

(c) "Indirect" services to patients, covering the collection of specific psychiatric information through home visiting and other means, and the social worker's role in diagnosis and treatment through the presentation of social data about patients, and her collaboration and consultation with her colleagues in the wards;

(d) Collaborative functions with (other) staff members;

(e) The functions of information-giving, advice-giving, and logical discussion; psychological support; and clarification, counselling and insight development; these being regarded both as functions and as methods of the social worker;

(f) Services involving families of patients;

(g) "Community".....

(g) "Community" social work functions to the patient through collaboration with community agencies, or direct follow-up and after-care of patients by the hospital-based worker.

(h) Miscellaneous functions.

(i) In addition, a system for assessing patient-worker relationship in each case was devised, as it was felt that this element was a basic part of all casework practice and that its assessment would form an interesting addition to the study. As well, it seemed that various types of patient-worker relationships might be found to be associated with different types of social work help.

The content analysis of the 88 records sampled was based on the above system, after the reliability of this had been determined by means of its application by an independent judge.[2] In addition, various social and psychiatric characteristics of the 88 patients in the group were noted, in order to present them as a group of dynamic and living people, and to provide a backdrop against which function could be seen as vital and a part of interaction, rather than as something static. In order to draw this picture more vividly, a major part of one chapter was devoted to discussion of the impacts of mental illness and associated hospitalization on the patient and his family.

The remaining chapters of the thesis were devoted to a discussion /.....

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2. Based on Macdonald, M.E.: "Some Essentials in the Evaluation of Social Casework," Jnl. of Psych. Social Work, Vol. XXII, No. 3, April 1953; p. 137.

discussion of those functions of the social worker and types of patient-worker relationship which emerged from the content analysis of the case records. Each function was not only described in detail, but the frequency of its performance in relation to the patients of the study discussed. Additionally, illustrative case histories were given for each, and the types of patient-worker relationship associated with each type of function considered. Attention was paid not only to work with patients, however, but also to that with families, and the proportion of such work done was discussed fully both in relation to each function as well as in relation to total functions carried out by the social worker with patients and their families. The collaborative process with other disciplines which underlies all function within the unit was elaborated, and finally, the pressures of limited time into which not only function to patients and families, but also "facilitating" services such as recording, supervision, teaching, and community relations, had to be compressed, were elucidated.

B. GENERAL RESULTS OF THE STUDY.

Detailed discussions of many aspects of social work in the psychiatric unit presently under consideration have been given throughout the text. The purpose of the present section of this final chapter is therefore not to interpret and speculate further on these functions but, rather, to bring them together, to compare their proportions to one another, and to review function in its totality.

(a) Types/.....

(a) Types and Proportion of Function Rendered.

Starting with a discussion of types of service given by the social worker, irrespective of whether to patient or family, it appears that of the total 605 functions rendered,[3] 186 are environmental functions of one kind or another (135 "traditional" type functions, 29 psychiatrically oriented functions, and 22 miscellaneous functions),[4] and 127 are advice-giving and supportive functions. (66 the former and 61 the latter).[5] The "indirect" services of home visiting and social history taking occur 24 and 32 times respectively,[6] while collaborative functions with staff total 119 (95 informal discussions, 24 formal meetings or ward rounds).[7] When work with community agencies is considered, 37 such functions appear,[8] while working with the family about the patient occurs in 52 instances.[9] Follow-up and after-care work occur in 28 instances.[10]

Expressed in tabular form, these figures can be given with their percentages of total function, and their proportions thus clearly be seen.

TABLE/.....

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3. Chapter VII, page 160.
4. Chapter VIII, passim, esp.190,216,218,222 and 225. Functions are here presented in the order in which they are discussed in the text, which differs from that of the classification system. The rationale of each grouping has been explained at the beginnings of the appropriate chapters.
5. Chapter IX, page 245.
6. Chapter X, pages 270 and 274.
7. Idem, page 299.
8. Chapter XI, page 317.
9. Idem, page 323.
10. Idem, page 346.

TABLE XXXIII - PROPORTIONS OF SOCIAL WORK FUNCTIONS RENDERED.

Functions	Number of times rendered		% in Total	
Environmental				
"Traditional" type[a]	135)		22.31)	
Psychiatrically oriented[b]	29)	186	4.80[c])	30.75
Miscellaneous	22)		3.64)	
Advice-giving and supportive				
Advice-giving, etc.	66)		10.91)	
Supportive	61)	127	10.08)	20.99
"Indirect" services.				
Home visiting	24)		3.97)	
Social history-taking	32)	56	5.29)	9.26
Collaboration with Staff members				
Informal	95)		15.70)	
Formal	24)	119	3.97)	21.67
"Community" oriented work				
Work with community agencies	37)		6.12)	
Work with families about patients	52)	117	8.60)	19.35
Follow-up and after-care	28)		4.63)	
Totals		605		100.02

a Financial ..... 46(7.61%)
Accommodation ..... 27(4.46%)
Employment ..... 23(3.80%)
"Hospital" help ..... 20(3.31%)
People in the environment..... 19(3.14%)

b. Placement under the Mental Disorders Act[11] ..... 26(4.30%)
Other psychiatric placements..... 3(0.50%)

c. 29 of 605 is actually 4.79%; however, the two sub-categories making up this section are 26 = 4.30% and 3 = 0.50% = a total of 4.80%, and inconsistency would thus have been introduced had this not been left as such. This accounts for the extra 0.01% - over and above the usual occurrence of this - relfected in the total.

This/.....

11. It is extremely interesting that 82 functions

were/.....

This table shows that by far the greatest amount of function was related to the material and environmental problems of patients - almost 10% more, in fact,/.....

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11. Cont. were related to certification of patients, being made up as follows:

26 - certifications
16 - advice to relatives about certification
13 - support to relatives around certification
3 - advice to patients about certification
6 - support to patients around certification
18 - involvement of family in certification

(Cat. 13)

82

This means that 13.55% of functions by the worker are related to certifications and associated problems. When it is considered that this type of function is only one among many, its often urgent and disrupting influence and frequency of occurrence adds another pressure to limited time, and often interferes with other function, and certainly with daily routines.
This finding seems to be in keeping with Bartlett's comment (Bartlett, H.M., Social Work Practice in the Health Field, N.A.S.W., N.Yk., 1961; p. 190) which, although referring to medical social work and the (physical) progress of disease, applies equally to work in the present setting, viz., that "the medical social worker has to learn to meet.....rapid changes. In fact it can be said that a certain attitude of readiness for surprize and ability to modify casework planning (and routines) quickly is an essential in this field of practice."
(Bracketed words those of the present writer.)

in fact, than in the next group, which is that of collaborative function. Thus, although Berkman and Goldman, in their respective studies, did not find this category the largest,[12] it was apparently so in the present study.

It is interesting that collaboration, that activity which permeates all work carried out in the unit, forms the next group, and is not the largest one, and that advice-giving and supportive help follow, with a difference of less than 1%. "Community" oriented work is next in line, and the smallest amount of function seems to be that relating to social histories and home visiting. It is strange that these, among the traditional and original functions of the social worker in a psychiatric setting,[13] should be so minimally represented in the present setting.

However, this brings up one of the faults in the classification system, viz., as mentioned in Chapter X,[14] that scoring of function was once only on the

scoring/.....

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12. Berkman, T.D., Practice of Social Workers in Psychiatric Hospitals and Clinics, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; and Goldman, F.: "What are Social Workers in General Hospitals doing for Long-Term Patients?" Social Work (N.Yk.), Vol. V, No. 4, Oct. 1960: as discussed in Chapter VIII page 225.
13. E.g., as in Timms, N., Psychiatric Social Work in Great Britain (1939-1962), Routledge and Kegan Paul, London, 1964; p. 114.
O'Keefe, D.E., "Psychiatric Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960, N.A.S.W., N.Yk., 1960; p. 451.
14. Chapter X, page 271, text and footnotes 20 - 22.

scoring sheet, and that in home visiting, though not other services, this proved a source of bias. Hence the amount of function reflected may not have been the "true" amount carried out. The same criticism applies, though to a lesser extent, to the obtaining of social histories, for although 32 is the total number of these written, this figure does not reflect the total activities taking place in obtaining information, or the additional sources consulted.[15] Then, too, the fact that time was not able to be assessed[16] was a limitation of the study, for these latter two functions each take up considerably more time than many of the other activities listed, and so each activity is not proportionally represented unless viewed in relation to this factor. Although the discussion and Table in Chapter XII[17] give some idea of the time available for various activities, and hence provide some answer to this problem, it appears that a more accurate way of showing type of function rendered by the social worker in the present psychiatric unit would be through a discussion of the number of patients assisted by various means. "Patients" would then be the common denominator against which function is viewed.

Thus, for instance, the 135 environmental functions were distributed among only 57

patients/.....

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15. Idem, page 275, footnote 29,b.
16. See Chapter III, page 52.
17. Chapter XII, pages 360,foll., and Table XXXII, page 363.

patients,[18] or 64.77% of patients, while collaboration took place in relation to 88 or 100% of patients. This approach therefore throws the results of the study into a somewhat different perspective, as illustrated by the following table.

TABLE XXXIV - PROPORTIONS OF PATIENTS RECEIVING DIFFERENT KINDS OF SOCIAL WORK HELP.

Function	Number of Patients		Percentage	
Environmental:				
"Traditional" type[a]	57)	75	64.77)	85.23
Psychiatrically oriented[b]	29)	75	32.96)	85.23
Miscellaneous	23)		26.14)	
Advice-giving and supportive:				
Advice-giving, etc.	61)	69	69.32)	78.41
Support	57)		64.77)	
"Indirect" services:				
Home visiting	24)	44	27.27)	50.00
Social history taking	32)		36.36)	
Collaboration with staff members:				
Informal	88)	88	100.00)	100.00
Formal	24)		27.27)	
"Community" oriented work:				
Work with community agencies	35)		42.05)	
Work with families about patients	52)	72	59.09)	81.82
Follow-up and after-care	28)		31.82)	

a. Financial ..... 30 patients (34.09%)
Accommodation ..... 27 patients (30.68%)
Employment ..... 23 patients (26.14%)
"Hospital" help ..... 20 patients (22.73%)
People in the environment .... 19 patients (21.59%)

b. Placement under the Mental Disorders Act ..... 26 patients (29.55%)
Other psychiatric placements. 3 patients (3.41%)

Several/.....

18. Patients and their families, in fact. This division will be made presently, however, in order to determine amount of social work function with patients and families separately. For the present, what is being discussed is type of function, rather than person to whom function was rendered.

Several interesting features emerge from this Table, the first and most significant being that collaboration took place about all patients, either formally or informally, and in over one-quarter of cases in both ways. This seems to indicate, indeed, that "consultation is the thread that runs through the entire process of treatment,"[19] and is perhaps a more adequate indication of the extent of this collaboration than is simply the total of such functions given in Table XXXIII. Further, viewing the proportions of patients receiving each type of help, rather than those figures indicating general groupings and amounts of function, it appears that advice is the function occurring next often - possibly its wide use is due to the nature of the hospital situation which makes it often not only useful, but necessary. This is an interesting finding in terms of the rather controversial views about advice-giving in the profession[20] and its possible conflict with the

philosophy/.....

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19. Lesser, W.: "The Team Concept - A Dynamic Factor in Treatment," Jnl. of Psych. Social Work, Vol. XXIV, No. 2, Jan. 1955; p. 125.
And a characteristic of the psychiatric setting, e.g., as also in: Proceedings of the Dartmouth Conference: Education for Psychiatric Social Work, Amer. Assocn. of Psych. Social Workers, N.Yk., 1953; p. 37.
Knee, R.: "The Open Question : Is There Anything Unique About Psychiatric Social Work?" Jnl. of Psych. Social Work, Vol. XXIII, No. 1, Oct. 1953, p. 45.

20. Thus, Schmidl, F.: "A Study of Techniques used in Supportive Treatment," Social Casework, Vol. XXXII, No. 10, Dec. 1951; p.418 appears to be against such help, though
Hollis, F.: "An Analysis of Casework Treatment Methods and their Relationship to Personality Change," Smith Coll. Stud. in Social Work, Vol. XXXII, No. 2, Feb. 1962; p. 115 clearly cites this as a technique of support, etc.

philosophy of "the client's right to self-determination." However, Thayer[21] reports consistent use of this technique among workers interviewed by her in a general hospital psychiatric unit, and this may be a specific of such social work or of social work within a large institution. Furthermore, it must be pointed out that it is not obligatory for the patient to take the advice given, and that this is not haphazardly given, as well as that all help within this category was at any rate not of an advisory nature, but included also the giving of explanations about various procedures and facets of treatment, as well as logical or reflective discussion about these.[22]

Support, occurring in 64.77%, or almost two-thirds of the cases, appears to have been given to the same number of patients as the "traditional" types of environmental or material help, and it is interesting that these two functions formed the second largest categories of service rendered "directly" to patients. Thus, again, the importance of environmental help to patients is stressed, and seems to fit in with Barkman's finding that more than half of the social workers employed in psychiatric hospitals were involved in such help.[23] However, only 22% of her workers

engaged/.....

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21. Thayer, A.A.: "Advice : A Casework Technique?" Abstract of thesis in Smith Coll. Stud. in Social Work, Vol. XXX, No. 1, Oct. 1959; p. 117.
22. This subject was fully elucidated in Chapter IX, pages 228 - 232.
23. Berkman, T.D., op. cit., p. 98. Though she does not report the extent of such services to patients.

engaged in supportive help to patients,[24] and in this respect the present study differs vastly.

It is striking that work with community agencies, i.e., knowledge about and use of community resources, often thought to be a characteristic of psychiatric social work,[25] as well as of work in the health field in general, should form a large part of social work function. It is also interesting, when proportion of patients served is taken, that that other characteristic, social history taking,[26] is carried out fairly frequently. However, again, if the total proportion of this function and home visiting are considered together, these form, as in Table XXXIII, the least often performed services, though if time is taken into consideration, Table XXXII[27] shows that five hours per week are devoted to home visiting, with at least two hours usually devoted to report-writing.[28]

Thus/.....

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24. Ibid., loc. cit.
25. O'Keefe, D., op. cit., pp. 455 and 456.
    Rice, E.P.: "Generic and Specific in Medical Social Work," Social Casework, Vol. XXX, No. 4 April 1949; p. 134.
    Knee, R., op. cit. (footnote 19), p. 48
26. This is discussed fully in Chapter X, pp. 273, foll., and regarded (page. 280), as part of the social worker's specific contribution to diagnosis and treatment.
27. Chapter XII, p. 363.
28. For, as was pointed out in Chapter XII, idem, footnote (c) to Table XXXII, additional report and history writing was done at other times.

Thus, seven hours per week are occupied in this way - more than one-third of the total time available for all other activities except collaborative ones.

Follow-up and after-care, also one of the earliest functions of the psychiatric social worker in a hospital setting,[29] although rendered to almost one-third of patients, formed only a small proportion of services.[30] But - turning back for a moment to function only - perhaps an interesting facet of the whole picture of social work function is that more than 50% of all services were psychiatric in nature, i.e., directly related to psychiatric problems rather than general problems, and/or involved the necessity for special (psychiatric) knowledge on the part of the worker, and/or are those listed above as considered characteristic of a psychiatric setting.

TABLE/.....

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29. See Introduction, pages (xiv); and (xv), and Timms, N., op. cit., loc. cit.; etc.
30. Chapter XI, p. 346.

TABLE XXXV - NUMBER OF SOCIAL WORK FUNCTIONS SPECIFICALLY PSYCHIATRIC IN NATURE.

Function	Number of Times Rendered.	Percentage in Total.
Relating to Certification	82[b]	13.55
Psychiatrically Oriented Environmental	3[c]	0.50
Social History taking[a]	44	7.27
Collaborative - Informal	95	15.70
Formal	24	3.97
Work with community agencies	37	6.12
Follow-up and after-care	28	4.63
Total	313	51.74

a. Home visiting was excluded, as not specific to a psychiatric setting, and those 12 visits made for social history purposes - and hence contributing to diagnosis and treatment - included in that section, making the number 44 instead of 32.

b. Obtained from footnote 11, p. 404 of this chapter.

c. The 26 certifications had already been included in the total of 82 above.

While this table may be somewhat controversial, particularly in that some of these functions are also parts of other fields, it is included for interest, and as it perhaps points up information of value in the discussion - to follow presently - on the generic and specific aspects of social work.

(b) Proportions of Function to Patients and Families.

It will be noted that no mention has been made in the preceding parts of the text of the functions carried out with patients' families, as distinct from those carried out with patients themselves, or the proportion of patients' families with whom contact was made.

This/.....

This is because, in fact, the 52 functions and 52 families noted in Tables XXXIII & XXXIV respectively, represent only a portion of such work. The reader is therefore referred back to Chapter XI, pages 332, foll., and Table XXXI , page 333 , where total involvement of, and help to, families during treatment of patients is discussed. Briefly summarised, it was found that 65 functions to families about their own problems, and 77 functions involving families in patient care, were registered, giving a total of 142 such functions. However, as was pointed out, this is in fact made up of 77 functions about patients, so that these 77 functions were scored also for patients. In other words, there is an overlap of 77 or 12.73% of functions. Expressed in tabular form, the following are thus the proportions of services rendered by the social worker in terms of amounts of these to patients and families.

TABLE XXXVI - PROPORTION OF FUNCTION TO PATIENTS AND FAMILIES.

To whom rendered	No.	%
To family only	65	(10.74
Through family to patient	77	(12.73)
To patient only	463	76.53)
Total	605	100.00

Perhaps an adequate way of indicating proportions of work involving contact with relatives and that with patients would be to add 77 to the total of 605.

In this/.....

In this way, a total of 682 would be reached, this being made up of 142 (65 + 77) functions of the former kind, and 540 (463 + 77) of the latter. The respective percentages of work with family and work with patients would then be 20.82% and 79.18%. Again, however, although this has been discussed fully in Chapter XI, it must be pointed out that, although only one-fifth of function concerned relatives, this was distributed among 56 or 71.79% of those families possible, and hence a considerable proportion of such service may be considered to have taken place.

(c) Relationship and Function.

Relationship between patient and worker has been a constant theme of the present text, and has been indicated for each type of function. A short summary pointing out general trends in this element is therefore appropriate at this point, and the first comment which must be made is that, in general, and unrelated to any specific type of function, a positive (very good, good, fair) patient-worker relationship seemed in the study, to be associated with more service and a negative (poor) one with less service to patients.[31] It would have been interesting to investigate whether time had any influence on this finding, i.e., whether greater amounts of time were spent with those patients receiving more help and lesser with those receiving less help; or, again, whether there was no connection of this sort, but that some relationships were more spontaneously developed than others, and needed less time to develop to the same depth. However, as has been/.....

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31. Chapter VII, page 175.

been pointed out already, this type of assessment was not possible.

Turning, therefore, to relationship and particular type of service, an association is found between environmental help in general and relationship similar to that between general function and relationship, viz., that positive relationships with patients were more usually associated with three or more services and negative ones with two or less services to patients. Whether or not the nature of relationship here was related to type or to amount of service could not be assessed, however, except for the sub-category of "Placement under the Mental Disorders Act," where it was found that the majority of patients had not been seen by the worker at all, and hence had no relationship with her (nil), or had been seen only briefly (X). The balance of this sub-group of patients all had positive relationships with the worker.[32]

In viewing advice and supportive functions of the social worker, it appears that not only were the majority of patient-worker relationships associated with such help positive, but they were strongly positive. On the other hand, relationships with those patients who themselves had not received such help, but whose families had, were primarily "nil" and "X", while where neither family nor patient had received such help, the tendency was for relationship to cluster towards the negative end of the scale/.....

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32. Chapter VIII, page 224.

scale. There thus seems to be a definite association of advice and support to patients with good patient-worker relationships; and for relatives frequently to receive these types of help around their own problems, these not necessarily involving work with the patient to any large extent.[33]

The "Indirect" services to patients showed no such distinct association with type of patient-worker relationship. Thus, the only trend of this nature appearing in home-visiting was where such visiting took place to patients themselves, and here relationship was, on the whole, good; but where visiting was about patients, nothing could be deduced about relationship.[34] In social history-taking, the main feature which emerged was that the majority of patients either had not seen the worker at all, or knew her only slightly.[35] Informal collaboration, having taken place in all cases, reflected the same types of relationship as were found in general, and formal collaboration yielded relationships proportional to those found in the group as a whole.[36]

Only in turning to services concerned with the patient and the community do any special trends again become apparent, and it is found that both referral to community agencies and follow-up and after-care are associated with strong positive patient-worker relationships.[37] In working with

relatives/.....

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33. Chapter IX, pages 247 - 249.
34. Chapter X, page 272.
35. Idem, page 277.
36. Idem, page 303.
37. Chapter XI, pages 319 - 320, and 348.

relatives about patients, a general, though less strong, trend for positive relationships to exist between patient and worker was also found.[38]

An overall review of trends in relationship seems to reveal, therefore, that the functions of advice and supportive help, as well as of follow-up and referral to community agencies, were associated most frequently with strong positive patient-worker relationships,[39] and that working with families of patients seemed to influence patient-worker relationships positively. If, further, the better relationships associated with environmental function can be attributed to type rather than to amount of function, it would appear that "direct" services to patients and services to patients which involved their families were associated in general with better patient-worker relationships than were "indirect" services or those directly to families.

C. CONCLUSIONS.

The aim of the present study has been defined as an attempt at definition of the functions of the social worker in the psychiatric unit of the Johannesburg General Hospital - "what exactly she does, and where the quality and type of service rendered could be altered or improved," and the study is not an effort to "prove or disprove any preconceived

suppositions,/.....

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38. Idem, page 326.
39. It is interesting that these may be functions associated with longer patient-worker contact, and hence that the element of time, as well as of type of function, may affect relationship.

suppositions."[40] Hence, what has gone before is intended to indicate precisely this, and does not represent the answers to any questions other than that one of "What does she do?"

Nevertheless, certain general conclusions about the nature of her work arise, as well as several questions about it. The first of these latter is whether or not the functions which she carries out constitute, specifically, psychiatric social work, or whether the work carried out could as well be termed generic social work? This question immediately introduces a subject of considerable controversy in the field of social work as a whole, and was first raised in America in 1929 when, as Bartlett expresses it, "the 'generic-specific concept' emerged out of the Milfoed Conference report."[41] This Conference, the fruit of discussions begun in 1923 by 39 leaders in casework,[42] concluded that there was a content generic to all casework, and that the equipment of the social worker was fundamentally the same for all fields.

The/.....

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40. Chapter I, pages 1 and 2.
41. Bartlett, H.M.: "Ways of Analyzing Social Work Practice," in The Social Welfare Forum, 1960, Proceedings of the National Conference on Social Welfare, Columbia University Press, N.Yk., 1960; p. 194.
42. Gregory, J.L.: "The Generic-Specific Aspects of a Family Casework Programme," Social Casework, Vol. XXXI, No. 1, July 1960; p. 285.

The specifics of casework arose from the adaptation of the various concepts, facts and methods of generic social casework to the requirements of the specific field.[43] Thus generic referred to casework content, and specific to setting.[44] This view was still in vogue when Marcus wrote, in 1939, that specific "refers to the form casework takes within the particular administrative setting: it is the manifest use to which the generic store of knowledge has been put in meeting the particular purposes, problems, and conditions of the agency and in dispensing its particular resources."[45]

However, because of lack of communication, the terms generic and specific were used differently by different groups of social workers,[46] and "the

distinction/.....

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43. Report of the Milford Conference: Social Casework, Generic and Specific," Amer. Assocn. of Social Workers, N.Yk., 1929; p. 11, 15 and 55, as quoted by Bartlett, H.M.: "The Generic-Specific Concept in Social Work Education and Practice," in Kahn, A.J., Issues in American Social Work, Columbia University Press, N.Yk., 1959; pp. 160 - 161.
44. Gregory, J.L., op. cit., loc. cit.
45. Marcus, G.F.: "The Generic and Specific in Social Casework - Recent Developments in Our Thinking," News Letter, Amer. Assocn. of Psych. Social Workers, VIII,? 1939, pp. 3 - 4; in Bartlett, H.M., op. cit. (footnote 43), p. 161.
46. As Bartlett points out (Ibid., p. 160), social work grew through practice in separate fields, unlike most other professions, where the process was reversed.
Among the first social work groups were the family service, child welfare, medical social work, and psychiatric social work associations.
(Hollis, F.: "The Generic and Specific in Social Casework Re-examined," Social Casework Vol. XXXVII, No. 5, 1956; pp. 211, foll.).

distinction between specialization in education (a concentration of courses) and specialization in practice (expertness in performance in a defined area) was not perceived."[47] There followed a period of confusion and "shifting emphases in use and interpretation of the concept (of generic - specific)",[48] resulting, in the 1940's, in formalization of a training course with a "generic" first year and a second year organised almost completely along "specialized" lines. In 1948, the Curriculum Committee of the American Association of Schools of Social Work pointed out that this arrangement in training led to the "erroneous assumption that generic content should be thought of as beginning casework, and specific as advanced,"[49] and it was suggested that generic content be included in the second year through the inclusion of "specific" content courses to be taken by all students.[50] As the second year became more generic in nature, however, it became impossible to cover "specialized sequences" within it, as previously, and in 1959 accreditation of specialized sequences in schools of social work was terminated.[51]

During/.....

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47. Bartlett, H.M., op. cit. (footnote 43), pp. 162 - 163.
48. Ibid., loc. cit.
49. Hollis, F., op. cit., p. 212.
50. Ibid., loc. cit.
51. Witte, E.F.: "Education for Social Work," in Kurtz, R.H. (Ed.), Social Work Year Book, 1960, N.A.S.W., N.Yk., 1960; p. 223. This has led to considerable discussion on how "specializations" will be taught - in the field, through supervision after graduation, or through advanced courses in the universities.

During this time, practice had seemed to move away from education, for while education considered the generic aspects of casework, the "specialized" professional organisations of social work were busy studying and publishing works directed mainly towards identifying appropriate function in each field, and no practical studies focused on the common elements of social work.[52] Many "special" sub-groups were started, and as they crystallized, appeared in two forms: as fields within casework, such as medical, psychiatric, and school social work, and as social work methods, such as casework, and group work.[53] In the fifties, however, the conviction regarding the existence of a common base for all social work permeated through to practice, and "thus many previously separate interests and efforts towards examination of social work practice were brought together, and.....it became possible to undertake consistent analysis and study, and to develop a cumulative programme....."[54] In 1955, the organisation of practice was accomplished through the formation of the National Association of Social

Workers/.....

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52. Bartlett, H.M., op. cit. (footnote 43), pp. 166 - 167.
53. Ibid., p. 170.
    This latter view of specialization was propounded particularly by Hollis, E.V., and Taylor, A.L., Social Work Education in the United States, Columbia University Press, N.Yk., 1951, as quoted by Lucas, L.: "Our Areas of Competence," Jnl. of Psych. Social Work, Vol. XXII, No. 2, Jan. 1953, p. 55.
54. Bartlett, H.M., op. cit., (footnote 41), p. 195.

Workers, in which all the groups and segments which had formerly been thought of as "specializations," whether by setting or by method, came together to form a single profession,[55] though the various sub-groups retained their identity within the larger organisation.

Does this mean that there are specializations or not? The general trend of thought in America seems to be that there is a common base to all social work, but that certain aspects and knowledge are specific to certain fields of social work. One of the most recent proposals on this subject has been that put forward by Bartlett, who suggests that there are certain common elements in all social work, but that in each segment of practice there will be differences in emphasis, extent, and use of these elements; thus, each field will embody the common elements, and the basic configuration of these will be found together in all aspects of practice which can be regarded as (professional) social work, but in differing proportions. These proportions and the specific balance of forces will identify the various fields,[56] and differences in the fields should arise from the social work practice itself, not from the environment in which it is carried on.[57] She elaborates this approach by stating that the basic values of social

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55. Bartlett, H.M., op. cit. (footnote 43), pp. 170 - 171.
56. Bartlett, H.M., op. cit. (footnote 43), pp. 181 - 182.
57. Bartlett, H.M., Analyzing Social Work Practice by Fields, N.A.S.W. N.Yk., 1961; p. 15.

work, its purposes and knowledge, sanction of it by the community, and its method (encompassing casework, group work and community organisation) form the base of all social work practice,[58] but that the characteristics of the particular fields are related to the problem or condition of central concern to the field, the system of organisational services of the field, the particular body of knowledge, values and methods which social work selects and makes its own in that field, socio-cultural attitudes in society toward the service, and the characteristic responses and behaviour of the persons served by the field.[59] The particular combination of these elements gives rise to the characteristics of the particular field.[60] One of the main advantages which Bartlett sees in this method of analysis of practice is that it enables progress from what was thought of as the generic to the specific without any sharp division or dichotomy, through the use of a single concept appropriate to practice.[61]

A review of comparable events in Britain during this time shows that there, too, social work began through practice in separate fields. However, it was only after the Second World War, that the "generic"

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58. Bartlett, H.M.: "Toward Clarification and Improvement of Social Work Practice," Social Work (N.Yk.), Vol. 3, No. 2, April 1958; pp. 5 - 8, passim.
59. Bartlett, H.M., op. cit. (footnote 57), p. 40.
60. Ibid., Diagram, p. 19.
61. Bartlett, H.M., op. cit. (footnote 43), p. 182.

issue began to evolve in that country, and that the first "generic" courses were established.[62] These were not courses designed to incorporate both "generic" and "specific" aspects of work, though, but, rather additional courses in social casework which were organised separately from the specialized ones of the various professional groups, almost in order to provide "special" generic workers. The various sub-groups held closely to their special identities, however,[63] and Snelling, writing in 1956, stated that it was only then "that we find talk of generic casework seeping in from all quarters,"[64] this "generic" having the same meaning as in the Unites States, i.e. referring to the "core of casework which is the same for all caseworkers."[65] But she pointed out clearly that the term applied only to a body of casework theory, not to a field of practice, which remained specific, for, she said, all practice is within a specific framework, at least in that it must limit its area of activity, and "all caseworkers concentrate upon <u>something</u>."[66]

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62. Timms, N., <u>Psychiatric Social Work in Great Britain (1939 - 1962)</u>, Routledge and Kegan Paul, London, 1964; p. 209.
63. Especially the Assocn. of Psych. Social Workers. (Timms, N., op. cit., pp. 209 - 210).
64. Snelling, J.M., "<u>Psychiatric Social Work and Social Casework in Other Fields : I</u>," in Goldberg, E.M., et al (Eds.), <u>The Boundaries of Casework</u>, A.P.S.W., London, 1959; p. 9.
65. Garrett, A., as quoted in Snelling, J.M., op. cit., pp. 9 - 10.
66. Snelling, J.M., op. cit., p. 10.

The "Younghusband" Report, published in 1959, showed that, in spite of the growing recognition of the "common core," training for social work in Britain at that time still took many and diverse forms,[67] covering general social science or social study degrees, diploma or certificate courses, full-time professional ('special') courses at University level and outside the Universities, and various in-service training schemes.[68] This report, while arousing much controversy among various of the "special" groups, precipitated much rethinking and some reorganisation in training for social work, but the first "real" move towards a professional organisation similar to the National Association of Social Workers in America was the establishment of the Standing Conference of Organisations of Social Workers, in February 1963.[69] The objective of this Organisation is to establish a unified and national Association of Social Workers, based on a minimum standard of qualification, and its

beginning/.....

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67. Ministry of Health, Department of Health for Scotland: Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services, Her Majesty's Stationery Office, London, 1959; p. 231.
68. Ibid., pp. 231 - 239, passim.
69. Standing Conference of Organisations of Social Workers, Notice in British Jnl. of Psych. Social Work, Vol. VII, No. 2, 1963; p. 119. The member associations of this organisation are The Associations of Child Care Officers, Family Caseworkers, Moral Welfare Workers, Psychiatric Social Workers, Social Workers, The Institute of Almoners, and the National Association of Probation Officers.

beginning is seen "as the rational outcome of many current trends today in social work, and, in particular, the increasing movement of social workers between specific fields of work, and the development of generic training."[70] Allowance is made for the continuation of sub-groups with special interests with within such an organisation. The trend in America has thus passed into Britain, but "specialization" courses have not been abandoned, as there, and strict sub-group membership provisions still apply, as, for instance, in the almoning and psychiatric social work fields.

As the different emphases in social work have varied, so have the specific-generic elements regarded as belonging to the fields of social work. Thus the issues, in "psychiatric" social work, have centred round whether or not there were distinctive elements in the training, setting, methods, clientele, or skill and knowledge of the psychiatric social worker.[71] Definitions of the field have varied from that specifying psychiatric social work as social work "practiced in direct and responsible relation with psychiatry,"[72] through definitions involving emphasis on process, function, setting, or all three,[73] as well as the/.....

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70. Ibid., loc. cit.
71. Knee, R., Review of "Psychiatric Social Work : A Transactional Case Book," by Grinker, R.R., et al, in Social Work (N.Yk.), Vol. VII, No. 4, Oct. 1962; p. 117.
72. Report of the Committee on Professional Education: "Essentials in Professional Education for Psychiatric Social Workers," Jnl. of Psych. Social Work, Vol. XXI, 1952; p. 55.
73. Lucas, L.: "Can we Reconcile Generic Education and Specialized Practice? - II", Jnl.of Psych.Social Work, Vol. XXIII, No. 4, June 1954; p. 216.

as the training and specific knowledge necessary in the particular field. In 1953, an Editorial in the Journal of Psychiatric Social Work outlined the essence of the psychiatric social work specialization as being, inter alia, that concern is with the psychiatric patient, that knowledge is needed of the problems with which the psychiatric setting deals, and that skill is needed in collaborative relationships.[74] But some of those aspects considered specific to psychiatric social work have come to be considered part of the generic content of all casework, so that, in 1960, O'Keefe wrote, of training, that "the content which was once offered primarily to the psychiatric social work student is now for the most part included in the curriculum for all social work students. The schools wishing to give more intensive preparation for this field of practice place special emphasis on the modification of social casework and social group work in the psychiatric setting; the working relationship with other members of the psychiatric team; the importance of the psychiatric diagnosis to the patient and his family; and a detailed knowledge of the community's provisions for the care and treatment of the mentally ill....."[75] Although these "specifics" have in general been withdrawn from courses or included in generic content, with the elimination of the accreditation system in America, they could perhaps remain considered as part of the "psychiatric"....

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74. Editorial Notes, Jnl. of Psych. Social Work, Vol. XXII, No. 2, Jan. 1953; p. 54.
75. O'Keefe, D.E., op. cit., p. 456.

"psychiatric" in social work. Ferard, in Britain, tends to confirm collaborative, team aspects of the work as specific to psychiatric social work, stating that, through these, further, professional knowledge becomes extended both in range and depth within the setting.[76]

Timms, in his oft-quoted work, propounds perhaps the same basic specifics of psychiatric social work, but in a slightly different way, when he states that "It is the institutional aspects of the work which provide the most fruitful way of examining the specialization of psychiatric social work. The main features of the settings[77] of psychiatric social work would seem to follow from the fact that the worker has been trained to work with psychiatrists in agencies carrying out community sponsored treatment of the maladjusted and mentally ill. In this work, familiarity with the changing world of psychiatry is essential, and has in fact proved the most important growing point for the clinical work of the psychiatric social worker. Thus, the psychiatric social worker has a place in specialized agencies, recognized by the

community/.....

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76. Ferard, M.: "Psychiatric Social Work and Social Casework in Other Fields : II," in Goldberg, E.M. et al (Eds.), op. cit., pp. 19 - 20. The sharing of responsibility, which is associated with this collaboration, is a further feature of the (hospital) psychiatric setting.

77. "Settings" now include the community health services as well as the psychiatric hospital and clinic. ("Working Together for Family Health," a Statement by the Royal College of Nursing, the Institute of Almoners, and the Association of Psychiatric Social Workers, British Jnl. of Psych. Social Work, Vol. VI, No. 3, 1962; p. 141). Further, the field has come to include the use not only of the case-work, but also of the group work and community organisation methods.

community for specific objectives (treatment) in relation to a defined class of people."[78] This definition, in turn, perhaps contains within it elements of Bartlett's concept of the generic and specific bases of social work.

It seems, from the above, that there is today a general trend in social work thinking which defines the old and controversial topic of "generic-specific" in terms of a broad base common to all social work, a base of values and belief, warmth and respect for the client, ethics and methods; but that, as well, there are special fields of practice, each with its own corner, its own particular skills and knowledge, and its own adaptations of elements in the common base.

This discourse has been related to the question, posed on page 418 of this chapter, of whether the social work carried out within the unit is psychiatric (specific) or generic. In answer, it would seem to the present writer that whichever of the criteria for determining this are applied, it could be termed psychiatric. For, turning back to the first concept of setting as determining the nature of the work, one finds that this criterion is met, for the setting is a psychiatric one. Again, the work is carried out in direct relation and responsibility to psychiatry, through a collaborative approach, and deals with persons defined as psychiatrically disturbed, and having problems related to this disturbance. It

involves/.....

78. Timms, N., op. cit., p. 216.

involves special knowledge on the part of the worker of community resources geared towards helping such patients, of the laws relating to mental illness, of the kinds of care available, of the "changing world of psychiatry" and psychiatric treatment, and, as illustrated in Chapter VII,[79] of the impact of mental illness on the patient and his family. While based on Bartlett's essential elements of social work practice,[80] it has also those certain characteristics which combine to make it a particular field.

The second question which arises from the findings of the study is whether or not the social worker in this psychiatric setting is being used fully and "correctly." The answer to this question is not simple; indeed, there possibly is no definite answer. For within this unit, which is always growing, changing, rushing, hurried, there has been no pause to consider "proper" function. Roles have evolved from practice, and each member of the unit has reacted from the fullness of his abilities, and has contributed what has been his to contribute. And, while there has been "no time to stop and stare," a working and complementary system of role expectations has developed.

In this context, the social worker's role has developed as one including perhaps too routine tasks, and perhaps not enough involving those special skills

which/.....

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79. Chapter VII, pages 164, foll.
80. As discussed earlier in this chapter, pages 422-423.

which she has to contribute. Thus, if the problems for which patients are referred to her are reviewed,[81] she is seen by those who refer cases to her as functioning mainly in the "traditional" history-taking role of the psychiatric social worker, and, apart from a very few instances, for the rest seen as able to assist with environmental and many practical problems. While some of these latter functions, particularly, may be considered as not requiring skilled social work help, in the interest of the patient, who is, after all, the reason for the unit's existence, they have to be carried by someone. And in terms of the present staffing of the unit, the social worker is the most appropriate person to carry them. Her role here could certainly be modified by the introduction of an untrained worker,[82] while the recommended appointment of an additional trained worker would enable each to carry cases more intensively, and reduce the problems of whether some service should be given to many - as is done - or much to some patients.

Yet this "limited" type of referral does not reflect her real role, or even, perhaps, how others see her as functioning. For, as has been pointed up by the main body of the text, and the tables in this chapter, she carries out much wider services to patients than those indicated by referral problems.

Nevertheless/.....

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81. See Chapter VI, page 149 , Table XXIV and relevant text.
82. As already discussed and recommended in Chapter XII, page 374 , and in terms of the limitations discussed previously both there and in Chapter VIII, pages 191 - 194.

Nevertheless, service could be improved in several areas, especially as a result of the addition of social work staff to the unit.

One of the most important changes this would bring with it would be that some kind of social work admission service could be instituted in the unit.[83] The lack of this, and attempt to substitute for it by sending out "admission letters" to patients[84] is possibly one of the greatest deficiencies of the social work service. For while, as pointed out previously, all service takes place at all times, the opinion of the present writer is that an admission service would be of great advantage generally, as admission is that time at which the fears and anxieties of both patient and family are at their height, and although help to patients and families at this stage is not, as pointed out by Knee, solely the responsibility of the social worker,[85] her part in allaying their fears and anxieties about the illness and hospitalization may be more effective at

the moment/.....

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83. A pre-admission service would not be feasible, however, because of the fact that most admissions are "direct" and with few exceptions, do not involve prior contact with the patient.

84. As mentioned in Chapter VI, page 145, footnote 44.
It is interesting, however, that Berkman (op. cit., p. 38) noted such a system in one hospital in her study.

85. Knee, R., op. cit., p. 48.

the moment of crisis, or close to it,[86] than at a later date.

A routine admission service of some kind[87] has certain other advantages, among them being that it provides an immediate source of contact with relatives accompanying the patient to hospital, and thus may extend service further in this direction. Although the proportion of families seen in the study is large, the amount of help rendered directly to them about their own problems was not great, and this is an area

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86. Thus Berkman, T.D., op. cit., p. 38, reports that most workers reporting reception interviews (admission interviews) in her study reported these as taking place within three days, and that such early contact was particularly helpful to the patient who needed an opportunity to release pent-up feelings.

87. Michaels, R.: "Centralized Intake in a Hospital Social Service Department," Social Casework, Vol. XXXVII, No. 7, July 1956; pp. 341 - 348, passim - discusses intake in a hospital Social Work Department by one or a central group of workers, with workers attached to units not carrying this function at all, and finds that this centralization of intake "provides the same advantages within the hospital as in other casework settings." (p. 345). The present writer, however, would be doubtful that any purpose would be served by this practice within the unit under discussion, for interference in patient-worker relationship might result - and especially the loss of the spontaneous "turning for help" associated so often with the beginning of hospitalization - and the balance within the team be upset.

which needs further attention.[88]

To the patient himself, certain advantages would accrue from such a service, the first of these being that that early referral so necessary to the (short-term) social work of such a setting[89] would take place. In addition, all patients would be seen, and hence, perhaps, more problems be uncovered than at present. Further, through being a part of ward routine, admission interviews by the social worker would retain the sanction of the doctor for social work services, and, through being "impartially" offered to all, perhaps lessen any feelings of embarrassment among patients "singled out" for such help. Even where initial resistance to her was encountered, the social worker would gain some indication of those patients to whom, at a later stage, social work help might be useful, and, conversely, patients would have an idea of the types of service offered to them by the social

worker/.....

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88. And one already indicated as valuable in terms not only of its meaning to the family, but to the patient, as evidenced by the better relationships between patient and worker where such contact took place than where it did not. It is interesting that Whitman and Young (Whitman, R.M., and Young, I.S.: "Psychiatric Social Work in a Brief Therapy Program of an Adult Out-Patient Clinic," Jnl. of Psych. Social Work, Vol. XXIV, No. 4, Sept. 1955; p. 210) point out that "It is.....a psychiatric rule of thumb that the significant relative or person is usually the one who accompanies the patient to the psychiatrist and to the out-patient clinic." This, again, emphasizes the importance of finding and seeing such relatives, and the influence of seeing them on treatment of the patient.

89. As discussed in Chapter VI, pages 145 - 147.

worker.[90]

Further, the social work member of the clinical team is the only person concerned with the patient's affairs in the community, or with linking him to the outside world, and hence "represents a channel to the outside community" for the patient,[91] whose admission may have left him feeling isolated and alone. As well, "although seeing a patient does not mean that there will be continuous social service activity throughout the patient's hospitalization,"[92] it provides the entreé into such activity as may later be needed, and into the social worker's contribution to "facilitating the transition of the patient from breakdown to recovery."[93]

If it were not possible to interview all patients admitted to hospital, in spite of the advantages inherent in this, a modification of this system might be useful. Thus, all patients in hospital for a certain period of time, e.g. two weeks,[94a,b] might be interviewed, though this, while ensuring fairly wide coverage, might not be appropriate to the short-term

nature/.....

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90. Especially in terms of the comments, made in Chapter VI, page 141 , that patients coming to hospital frequently are unaware of the existence of provisions for social work help.
91. Knee, R., op. cit., p. 48.
92. Ibid., loc. cit.
93. Ibid., loc. cit.
94a. Such a scheme is reported by Goldman, F., op. cit., p. 76.
b. In terms of the average length of hospital stay found for this sample of patients. (See Chapter VI, pages 139 - 140).

nature of the work.[95] Knee, on the other hand, suggests group meetings with patients as time-saving,[96] and Berkman points out the value of these not only in allaying anxiety in the patient, but through the therapeutic potentialities of the group experience.[97]

At the other end of treatment, viz., discharge and follow-up or after-care, additional services would also be appropriate. For, as has been pointed out,[98] not all patients are followed-up medically, and only some socially, while the basis on which this is done is haphazard and disorganized. Routine follow-up and after-care, similar to routine admission services, would not only be a logical continuation of treatment, but, in a community where insufficient resources for such services exist, would frequently be instrumental in helping patients to remain in the community; or, through serving as a last link with the hospital, help in their more efficient readmission, where necessary, and provide a continuity of service onto which the patient could hold, and from which he could be weaned at his own pace, rather than abruptly and hastily, on discharge. The advantages of full and effective after-care cannot be over-estimated, and perhaps should be considered before even the introduction of

full/.....

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95. E.g., with this time period as the criterion for "intake" interviewing, ± 25% of patients in the sample, unless referred specifically to the worker, would not have been seen by her. (See Chapter VI, loc. cit., Table XXII).
96. Knee, R., op. cit., pp. 48 - 49.
97. Berkman, T.D., op. cit., p. 39.
98. Chapter VI, page 157 , Table XXVII; Chapter XI, pages 340, foll., and 346, foll., and 350.

full admission services.

These suggestions are things of the future, however, and not practicable within the present system. While they should be worked towards, a return perhaps should be made to this present, and to what actually is done by the social worker in the unit. That there is room for improvement should not be doubted, for it is unlikely that sny service, and especially one so new, can be perfect. Its newness is perhaps an asset, however, for rigid patterns and role expectations have not yet been established, and hence the opportunity for change is great.

Perhaps one of the criticisms which might be levelled, by a reviewer, at the social work service as described here, is its lack of counselling and related services. However, it must be remembered that the psycho-therapeutic activities of the psychiatrists and clinical psychologist within the unit include such activities, and that, while the social worker must understand emotional problems and intra-psychic tensions, as well as their causes and expression, "as social work's representative on the clinic team, the psychiatric social worker can probably contribute less.....as a "proxy-therapist" than as a professional worker with special skills and knowledge of environmental factors combined with (such) an understanding of the unconscious implications of overt

behaviour/.....

behaviour."[99]

In general, however, it might be said that the social work service which has developed within the fairly short time of the unit's existence is a dynamic one which, in spite of the various pressures impinging on it, has a valuable contribution to make, both in helping the patient and in the team processes and progresses which are so vital a part of promoting his well-being.

Characterized by Berkman as carrying a supplemental[100] and by Lucas an adjunctive and complementary[101] role to that of the psychiatrist, the social worker nevertheless has a distinct and vital part to play in the unit. As the patient's link with the outside, she co-ordinates hospital and community services to him, and deals with his problems within and about the hospital, interweaving casework processes with the patient's ongoing illness and psychiatric care. Her dual orientation to the

patient/.....

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99. Forstenzer, H.M.: "Role and Responsibility of Social Work in Community Mental Health Programs," Paper presented at the Amer. Psychiatric Assocn. Meeting, May, 1958, and quoted in Woodward, L.E.: "Increasing Social Effectiveness in Meeting Mental Health Needs," Social Work (N.Yk.), Vol. V. No. 3, July 1960; p. 66. Brackets inserted by the present writer.

100. Berkamn, T.D., op. cit., pp. 35, 61 and 96.

101. Lucas, L.: "Our Areas of Competence," Jnl. of Psych. Social Work, Vol. XXII, No. 2, Jan. 1953; p. 58. This author raises the subject of the questionable value and degree of prestige with which such terminology and service are regarded by some, and the difficulties which "those accustomed to the independent functioning of social workers in social agencies" may have in accepting such a role, but points up its prevalence in many fields of social work activity.

patient-and-his-family and to the medical team characterizes her integrating role within the unit, while, possibly above all, that vivid picture which she brings to the team of the patient and his social environment, of the forces impinging on him from all directions, and her relating of his problems to this social reality, are among those special functions carried by her to which, perhaps, the "social" in social work refers.

A FINAL COMMENT.

The role of the psychiatric social worker develops in response to the individual demands of each particular institution,[102] and thus the findings of the present study are not necessarily representative of the social work functions in all general hospital psychiatric units, and should perhaps not be haphazardly generalized thereto. Nevertheless it is hoped that they may throw some light on the various aspects of such social work, and also lead to further understanding and improvement of a service which, developing as part of a unit of many parts, has shared with it the aim of returning psychiatrically disturbed patients to a state of mental health, that quality which is "the result of balanced and creative personal functioning that fulfils the best of man in social relations.....a quality of living, a process..... concerned not only with inner harmony, but also with

optimal/.....

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102. Timms, N., op. cit., p. 112.

optimal relatedness of person, family, and society... .....(and which) implies the capacity to grow, to learn, to live fully, to love, and to share with others the adventure of life."[103]

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103. Ackerman, N.W., The Psycho-dynamics of Family Life, Basic Books, Inc., N.Yk., 1958; p. 7.

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A P P E N D I X A

JOHANNESBURG GENERAL HOSPITAL.

ALGEMENE HOSPITAAL JOHANNESBURG.

SOCIAL WELFARE DEPARTMENT
DEPARTEMENT VAN MAATSKAPLIKE SAKE

DATE
DATUM

SURNAME/VAN: _____

CHRISTIAN NAMES/VOORNAME: _____

ADDRESS/ADRES: _____

AGE/OUDERDOM: _____ STATUS/STATUS: _____

DIAGNOSIS/DIAGNOSE: _____

PROBLEM/PROBLEEM: _____

REF. BY/VERW. DEUR: _____ RELIGION/GELOOF: _____

_____

OCCUPATION/WERK: _____

FAMILY COMPOSITION:
GESINSAMESTELLING: _____

_____

_____

_____

_____

FINANCIAL POSITION:
FINANSIëLE POSISIE: _____

_____

HEAD/HOOF: _____

WIFE/VROU: _____

CHILDREN/KINDERS: _____

CENTRAL REGISTER: _____
SENTRALE REGISTER:

GENERAL: _____

_____

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A P P E N D I X B

THE MENTAL DISORDERS ACT, NO. 38 of 1916, as amended in 1944, 1957, 1961, and 1963.[1]

The Mental Disorders Act, promulgated in 1916, came into effect on the 1st November of that year, "to consolidate and amend the laws in force in the several Provinces of the Union, relating to the detention and treatment of mentally disordered and defective persons, and to make further provision as to the institutions in which such persons may be received, detained, and treated."[2] The provisions contained in the Act are vast and comprehensive, and define, inter alia, who shall be regarded as a mentally disordered or defective person, regulations for the reception of patients to hospitals, and provisions for the administration of patients' affairs. For purposes of this Appendix, however, only a brief outline will be given of the first two topics, as they are those most intimately involved in the functionings of the present unit.

A. CLASSES OF MENTALLY DISORDERED OR DEFECTIVE PERSONS.

Section 3 of the Act defines six classes of mentally disordered or defective persons, viz.:

(i) A person suffering from mental disorder, that is to say a person who, owing to some form of mental disorder, is incapable of managing himself or his affairs.

(ii) A/.....

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1. Mr. H.E. Augustyn, of the Office of the Commissioner for Mental Health, very kindly assisted the writer with information and copies of the relevant amendments to the Act, for use in this section.
2. Union of South Africa : Mental Disorders Act, No. 38 of 1916, as amended, Government Printer, Pretoria, 1945; p. 2. Historical background to the Act appears in the Introduction, pp.

(ii) A person mentally infirm, that is to say, a person who through mental infirmity arising from age or the decay of his faculties, is incapable of managing himself or his affairs.

(iii), (iv), (v) Refer to idiots, imbeciles, and feeble-minded persons, i.e., those who, in the present study, would simply have been termed "mentally defective," but are so to the degree of being unable, from birth or an early age, to guard themselves against common physical dangers (idiot); incapable of managing their own affairs or of being taught to do so (imbecile); and who are incapable of competing on equal terms with their fellows, cannot manage their own affairs with ordinary prudence, require care, supervision and control for their own protection or the protection of others, and cannot benefit from training in a special school (feeble-minded).

(vi) An epileptic, that is to say, a person suffering from epilepsy who is a danger to himself or others or is incapable of managing himself or his affairs[3]

All these types of patient may be certified to mental hospitals, institutions for defective persons, or other licensed[4] institutions, and various methods of admission govern their entrance to these places.

B. METHODS/.....

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3. This class used to be class (vii) of the Act, class (vi) being one covering "socially, defective persons," i.e., those suffering from mental abnormality associated with anti-social conduct, and who by reason of such abnormality and conduct, required care, supervision and control for their own protection or in the public interest. (Mental Disorders Act, 1916, pp. 2 - 4).
However, this clause was removed from the Act by the Mental Disorders Amendment Act, No. 37 of 1957, and such persons are no longer certifiable.
4. In terms of the Act.

B. METHODS OF ADMISSION OF PATIENTS.

(i) Certified patients are admitted to such hospitals and institutions via the Courts, i.e. admission is statutory, on written and sworn application of a relative - or in the absence of such, a bona fide person with knowledge of the patient[5] - to a magistrate, supported by the written applications of two (registered) medical practitioners. In terms of such admission, patients lose all civil rights, and may be held at the hospital for treatment or custodially, i.e., indefinitely. Discharge is at the discretion of the medical superintendent[6] of the hospital, though appeals to the Court or Hospital Board for discharge are allowed. Neither the patient himself nor the person who applied for the patient's admission to hospital has authority to sign the patient out of hospital.[7]

(ii) Patients may be admitted to hospital on an "urgency order" which does not immediately have to go through the Courts, though it does so at a later date. This form of admission, as indicated by its name, provides for urgent cases, where it is impossible to utilize the routine channels of (i) for admission. Application has, again, to be made, however, but here it is to the officer-in-charge of the institution, not to the magistrate, and only one medical certificate need accompany the application. After the patient has entered hospital, the same conditions apply as in (i), and the legal machinery necessary for full certification is set in motion.[8]

(iii) Temporary patients are those patients admitted directly to the hospital, and who, it appears,

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5. E.g., social worker, ward sister.
6. This term replaced the older "physician-superintendent" in terms of the Mental Disorders Amendment Act, No. 78 of 1963.
7. Section 6 of the Act.
8. Section 9 of the Act.

are likely to recover from their illness within a period of up to one year. Application, again made by a relative or other bona fide person, is direct to the officer-in-charge of the institution, and accompanied by two medical statements.[9] This is the form of admission at present encouraged and is in keeping with the trend to shorter hospital stays, and the lessening of "enforced" admission and treatment. The patient does not lose his civil rights, and inter alia, may be signed out of the hospital by the person who applied for his admission.[10] The stigma of admission through the Courts is removed. This form of admission is often used in place of (ii), as it is usually as quick.

(iv) Provision is made in the Act for the admission to mental hospitals of Voluntary Boarders. Such patients may, at the discretion of the medical superintendent of the hospital,[11] apply in writing for admission to the hospital for a period of 6 months, this period being renewable. Civil rights are again retained, and a patient, on giving 7 days' written notice of his intention to do so, may leave the hospital. This is a method also currently gaining popularity.

(v) The/.....

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9. All these forms differ from those of (i) and (ii).
10. Section 49 of the Act.
11. In terms of the Act (Section 44)," any person who is desirous of voluntarily submitting to treatment, but whose mental condition is not such as to justify the issue of a certificate of mental disorder or defectiveness." (Page 26). In practice, patients must be aware of (i.e. have insight into) what they are doing, and the illness should in fact be one that has reasonable prognosis, or at least a chance of a remission. (E.g., a deteriorated epileptic or senile patient would not be accepted under this Section). Further, where a patient is grossly ill, or not well enough to be detained under this Section, or wishes to discharge himself but is, in the opinion of the physician - superintendent, unfit to do so, application may be made to hold him in the hospital under (i) or (iii).

(v) The Act also makes provision for the admission of inebriates (i.e., persons who habitually drink or use alcohol or any narcotic to excess) to mental hospitals.[12] Such persons sign themselves into the hospital for a period of not less than 6 months, and may not sign themselves out. Discharge takes place at the discretion of the medical officer caring for the patient, and/or the medical superintendent of the institution, or on expiry of the 6-month period.

C. GENERAL.

The above outline of types of patient admitted to mental hospitals in terms of the Mental Disorders Act and modes of such admission is very brief. Details have not been given of the time periods relating to the issuing of certificates, etc., or to the legal and administrative details of the Act, for the intention of this Appendix is merely to give some background to the Mental Disorders Act, and to the practical aspects of this which are of daily importance in the unit, especially as these relate to the discussion, in the text, of the Act. Hence the nuances of each section and the wider provisions of the Act have not been given.

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12. Section 52, p. 32.

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G L O S S A R Y

DEFINITIONS OF PSYCHIATRIC ILLNESSES, AS USED IN THE TEXT[1a,b.]

Affective Illnesses may be regarded as those illnesses characterized primarily by an exaggeration of "normal" emotions, i.e., by disturbed and exaggerated affect, either positive (elation) or negative (depression), from which all other symptoms seem directly or indirectly derived. - See under depression, manic-depressive psychosis.

Alcoholism is used in the present text to denote primarily those conditions associated with the intake of alcohol "in such quantities and with such frequency as to lead to loss of efficiency in working and earning, to disturbance of family and social life, or to damage the drinker's physical and mental health."[2] However, also included within this category are

acute/.....

1a. Based on discussions with Professor L.A. Hurst, to whom I am deeply indebted for this help, and the following texts:
Ewen, J.H., Mental Health, Edward Arnold & Co., London, 1947;
Henderson, D., and Gillespie, R.D., A Textbook of Psychiatry, 8th Ed., Oxford University Press, London, 1956;
Henderson, D., and Batchelor, I.R.C., Henderson and Gillespie's Textbook of Psychiatry, 9th Ed., Oxford University Press, London, 1962.
Hinsie, L.E., and Shatzky, J., Psychiatric Dictionary, Oxford University Press, New York, 1954.
Mayer-Gross, W., Slater E., and Roth, M., Clinical Psychiatry.
Cassell & Co., Ltd., London, 1954.

b. Self-evident terms, e.g., attempted suicide, are not defined here; nor in general are those terms not used in the text. The list of definitions therefore does not purport to be a full list of psychiatric illnesses, and is one giving the meanings of terms only as used in the present text.

2. Mayer-Gross, W., et al., op. cit., pp. 332 - 333.

acute intoxication, pathological drunkenness (abnormal reactions to small amounts of alcohol), and the alcoholic psychoses, i.e., those diseases which are the end result of chronic alcoholism, viz., Korsakow's psychosis and alcoholic dementia (both of which are dementing conditions associated with deterioration of the cognitive, emotional, and "conduct" aspects of behaviour), and delirium tremens and alcoholic hallucinosis (characterized by hallucinations and delusions, these occurring in the former during a state of clouded consciousness, and in the latter in a state of clear consciousness).[3]

Amnesia is defined as an inability by the patient to recall past events. It may be circumscribed (i.e., the area of memory loss is delineated and specific) or global, global amnesia in turn being of two kinds - reterograde and anterograde. The former is an amnesia for retention and recall, running backward in time, and due to a failure of retention and recall of impressions, while the latter is an amnesia of fixation of impressions, running forward in time from the onset of the amnesia; this type of amnesia is based on the mechanism of non-registration of new impressions or stimuli, so that although such impressions are not retained, memory for remote events is relatively well retained. Psychoneurotic, usually hysterical, amnesias are circumscribed, while the chronic and acute organic reaction amnesias are normally global.

Anxiety, characterized by an element of anticipation and an element of fear, is a normal reaction, and should be differentiated from an immediate fear

reaction/.....

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3. These psychoses are normally separately listed under "toxic" or "organic" psychoses, but the present division was preferred here, in terms of the classification of illnesses given in Chapter VI, pages 131, foll.

reaction, which is also normal. Anxiety becomes pathological, however, when, on clinical assessment, it is of a degree greater than is elicited generally by the situation precipitating it, and is incapacitating. Such anxiety is usually associated with autonomic disturbances, and may become generalized to situations beyond the one originally evoking it. The psycho-analysts, further, define as "free-floating" anxiety that anxiety in which the stimulus or situation evoking the reaction is not apparent to the subject; this type of anxiety may also generalize to other situations. For purposes of the present study, anxiety is regarded as a psychoneurotic illness (discussed below) though it may also be a symptom of other illnesses.

Depression, an affective illness characterized by varying degrees of sadness in the patient, may be of several kinds:

(a) Endogenous depression is that depression which arises from within the patient, i.e., without any apparent precipitating cause(s). It may be present as mild or acute depression, or as depressive stupor, with associated psychomotor retardation and difficulty in thinking; some forms present with increased or "agitated" psychomotor activity. But all are characterized by sadness and despair beyond the norm.

(b) Reactive depression is a pathological depression precipitated by external events. It should be distinguished from "normal" depression, which is sadness or grief appropriate to a given situation or event, for it is disproportionate to such an event. Such depressions are often termed psycho-neurotic, as opposed to the psychotic nature of (a).

(c) Mixed depressions are those depressions in which both endogenous and precipitating causes are evident. These depressions are sometimes termed endo-reactive.

(d) Involutional/.....

(d) Involutional Melancholia is a form of endogenous depression occurring at the "involutional" or "menopausal" stage of life,[4] in persons with no previous history of such illness. It is characterized by depression without retardation, anxiety, a feeling of unreality, and by delusions of an extravagant or bizarre nature, often hypochondriacal, nihilistic, and persecutory.[5]

Drug Addiction refers to the habitual use of drugs by a patient, leading to that patient's "loss of efficiency in working and earning,.....etc."[6] A characteristic of the addict is that he may become ethically deteriorated, due to the effects of the and the need to obtain it secretly.[7] Sudden cessation or deprivation of the drug may lead to withdrawal symptoms, which may include delirium with hallucinations.

Epilepsy is a tendency to recurring seizures in a patient, these seizures being motor (major or minor) sensory, psychomotor and/or visceral in nature, and produced by an abnormal, excessive electrical discharge within the central nervous system. Associated with epilepsy there may be psychotic manifestations of either a transient (confusion, etc.) or permanent (dementia) nature, or mental defect.

General Paralysis of the Insane (G.P.I.). This is a form of mental illness resulting from syphilitic infection, and is regarded as the fourth, or a variant of the third, stage of the infection. It is a dementing condition associated with memory failure, especially for recent events, and intellectual and emotional deterioration. Ideas of grandeur develop, often in conjunction with a state of heightened excitement. Agitation may

occur/.....

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4. Women : 40 - 55 yrs.; men : 50 - 65 yrs. (Henderson D., and Gillespie, R.D., op. cit. p. 277).
5. Ibid., p. 278.
6. See under Alcoholism.
7. Mayer-Gross, W., et al., op. cit., p. 354.

occur, as well as a depressive form of the illness accompanied by delusions of sin and unworthiness.

Homosexuality is an anomoly of sexual conduct manifesting through a sexual attraction between members of the same sex. It may be latent, or overt, in the latter case resulting in sexual relations between the persons concerned. The term may be used inclusively for both men and women, although the designation "Lesbianism" refers specifically to such manifestations in women.

Hysteria is a condition in which mental processes, originating from unconscious or semi-conscious motives, produce abnormal mental and physical symptoms, the motivation of which is to provide relief from some life situation.[8] It may be characterized by dissociation and by histrionic behaviour.

Involutional Melancholia - see under Depression.

Lesbianism - see Homosexuality.

Manic-Depressive Psychosis is one of the affective illnesses, and is characterized by (excessive) elevation or depression of mood, neither of which are based in reality or justified by external circumstances, or seem (realistically) related to a precipitating cause. This illness may present only in its depressive or only in its manic form, or in a "combined" form, involving both types of phase, though at different times. It is characterized by periodicity, and may be interspaced with (long) periods of normality.

Mental Deficiency, as used in the text, is not divided into the three groups of feebleminded, imbeciles, and idiots, but merely indicates " a condition of subnormal mental development at birth or in early childhood, and characterized mainly by limited intelligence."[9]

Organic/.....

8. Ewen, J.H., op. cit., p. 75.
9. Mayer-Gross, W., et al., op. cit., p. 53.

Organic (psychiatric) Illnesses[10] include, in the present text, those illnesses associated with a demonstrable cerebral (brain) lesion which produces psychological disturbances in the patient,[11] and those illnesses which are associated with brain tissue changes or degeneration. The acute, toxic conditions resulting from toxic effects of various kinds on the brain-substance (e.g., the alcoholic-psychoses) are not here included. See G.P.I., senile psychoses.

Paranoia.[12] This disease is a chronic, progressive disorder occurring in later life (after 45 years of age) in which fixed, systematized delusions of persecution, and later also of grandeur, are the prominent features. The personality is well-preserved, however, and memory and general intellectual faculties remain intact. There is usually clear thinking on subjects unrelated to the delusional system, and no hallucinations occur.

Paranoid Schizophrenia. This disorder is one occurring earlier in life (before 40 years), and is characterized by delusions only moderately well systematized. Hallucinations are present and occur early in the disease. The personality deteriorates, and in its developed state the disease shows the thought disorder, affectations and indifference typical of the schizophrenias. (see below).

Paraphrenia is a term introduced by Kraepelin[13] to indicate a disorder intermediate to paranoia and

paranoid/.....

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10. Or the organic reaction types of the Meyerian School.
11. Mayer-Gross, W., et al., op. cit., p. 392.
12. Paranoia, paranoid schizophrenia, and paraphrenia are included under the heading "Paranoid States" in the present study. (See Chapter VI, page This division is based on the Meyerian approach in psychiatry; Kraepelin included paranoid schizophrenia with the schizophrenias, and this has been indicated later by a bracketed insertion of this illness under that head.
13. Although this is a Kraepelinian term, it fits into the Myerian concept of "paranoid states."

paranoid schizophrenia. Developing at the intermediary ages of 35-45 years, it leaves the personality relatively well-preserved, and it is associated with comparatively little thought disorder. Delusions are not as well systematized as in paranoia, but are more so than in paranoid schizophrenia. Hallucinations, though present, develop later and are less prominent, being preceeded by 2 - 3 years by the delusions. This category is often regarded as only a provisional one for diagnosis, and as really describing a late paranoid schizophrenia.

Psychoneurotic Illnesses. Ewen defines a psychoneurosis as a type of reaction that implies a failure of adaptation to social conditions and a want of adjustment to inner mental trends.[14] The patient's personality remains essentially unchanged, however, and his grasp of reality is preserved; his social participation is maintained, and insight is usually present. Psychogenic factors are extremely important (see, e.g. hysteria, anxiety, reactive depression). Such illnesses differ from the psychoses in that they involve total or considerable personality change, a distorted grasp of reality, alterations in or loss of social participation, and lack (complete or partial) of insight into the condition. Psychogenic factors are relatively unimportant in the causation of the psychoses, and a genetic or organic factor is often prominent (see, e.g., endogenous depression, manic-depressive psychosis, the alcoholic psychoses, organic illnesses, schizophrenia, paranoia, etc.).

Psychopathic States. The choice of the contentious term "psychopathic," in place of "personality disorder," is based on Henderson & Batchelor,[15] and Henderson & Gillespie,[16] and refers to those persons in the/.....

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14. Ewen, J.H., op. cit., p. 68.
15. Henderson, D., & Batchelor, I.R.C., op. cit., Chapter XIII, pp. 318 - 333.
16. Henderson, D., & Gillespie, R.D., op. cit., Chapter XII, pp. 384 - 402.

in the past called moral imbeciles, morally insane, or sociopathic personalities. In terms of the Mental Health Act (Eng. & Wales) 1959, psychopathic states are defined as "persistent disorders of mind (whether or not accompanied by subnormality of intelligence) which result in abnormally aggressive or seriously irresponsible conduct on the part of the patients, and require or are susceptible to medical treatment."[17] Henderson & Batchelor regard this definition as a valuable working base, but specify, further, that such persons are those who have been, from childhood or early youth, habitually abnormal in their emotional reactions and conduct, but who do not reach, except episodically, a degree of abnormality requiring compulsory detention; who are not sufficiently well-balanced mentally to be at large, and not sufficiently involved to be suitable for mental hospital care; who fail to fit into their social milieu, and whose emotional instability is largely determined by a state of psychological immaturity which prevents them from adapting to reality and profiting from experience; who lack judgement, foresight and ordinary prudence.[18] These persons may be divided into three groups:

(a) Predominantly aggressive;
(b) Predominantly inadequate or passive;
(c) Predominantly creative.[19]

Psychosis. See with Psychoneurotic Illnesses.

Schizophrenia, originally termed dementia praecox, is a psychosis which, "in its most typical form, consists of a slow deterioration of the entire personality, which often manifests itself at the period of adolescence. It involves a great part of the mental life, and expresses itself in disorder of feelings,

conduct/.....

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17. Henderson, D., & Batchelor, I.R.C., op. cit., p. 318.
18. Ibid., loc. cit.
19. Ibid., loc. cit.

conduct, and of thought, and in an increasing withdrawal of interest from the environment."[20] It is characterized by the splitting of the harmonious functioning between affect, cognition, and conation, with selective deterioration of affect occurring first, so that the emotions are no longer in harmony with cognition and conation; formal thought disorder occurs next. The primary symptoms of the illness are affective blunting, disturbed associations, ambivalence, and autism (withdrawal and fantasy), while the secondary ones are delusions and hallucinations.[21]

Schizophrenia may be divided into the following sub-types:

(a) Simple Schizophrenia. Here, there is an absence of any definite trend, and the symptoms described above occur, being slow and insidious in onset, with shallowness of affect a prominent characteristic. One of the features distinguishing this form from the other sub-types is the absence of hallucinations and delusions in the patient.

(b) Hebephrenic Schizophrenia. Onset of this form is moderately rapid, and the illness is characterized by the general "silliness" of the patient. Intellectual aspects of the personality are markedly affected, and great incoherence manifests in the train of thought. Delusions, as well as auditory and other hallucinations, usually bizarre, unsystematized, and disconnected, are present; conduct is strange, impulsive and restless.

(c) Catatonic Schizophrenia. Onset is usually acute, and the illness is characterized by states of stupor and excitement which recur and may alternate with one

another/.....

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20. Ibid., p. 250.
21. After Bleuler, as discussed with Professor L.A. Hurst.

another. In both phases, automatic release phenomena, such as stereotopy of movement and posture occur; automatic obedience, negativism, resistiveness and impulsive behaviour may also occur, and delusions and hallucinations may be present.

((d) Paranoid Schizophrenia - see above.)

Senelity. The senile psychoses are a group of mental disorders related to old age and characterized by mental deterioration and degenerative brain changes. Onset is at 65 - 75 years, and is gradual, with loss of intellectual power and some change in the personality. Perception and comprehension become impaired, and conduct shows a retrogression to the instinctive level characteristic of infancy.

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BIBLIOGRAPHICAL ABBREVIATIONS USED IN THE TEXT.[1]

Amer. Assocn. of Med. Social Workers = American Association of Medical Social Workers.

Amer. Assocn. of Psych. Social Workers = American Association of Psychiatric Social Workers.

Amer. Jnl. of Nursing = American Journal of Nursing.

Amer. Jnl. Psychiat. = American Journal of Psychiatry.

Amer. Jnl. Sociol. = American Journal of Sociology.

Arch. Gen. Psychiat. = Archives of General Psychiatry.

A.P.S.W. = Association of Psychiatric Social Workers (Great Britain.)

British Jnl. of Psych. Social Work = British Journal of Psychiatric Social Work.

Dis. Nerv. System = Diseases of the Nervous System.

F.S.A.A. = Family Service Association of America.

Jnl. Abn. and Social Psychol. = Journal of Abnormal and Social Psychology.

Jnl. Amer. Statistical Assocn. = Journal of the American Statistical Association.

Jnl. of Psych. Social Work = Journal of Psychiatric Social Work.

Jnl. Nerv. Ment. Dis. = Journal of Nervous and Mental Diseases.

Jnl. Soc. Issues = Journal of Social Issues.

Marr. Fam. Living = Marriage and Family Living.

N.A.S.W. = National Association of Social Workers (America).

Phil. Science = Philosophy of Science.

S.A.M.J. = South African Medical Journal.

Smith Coll. Stud. in Social Work = Smith College Studies in Social Work.

Soc. Serv. Rev. = Social Service Review.

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1. The International System of Abbreviations was not used, as discussion with Miss E. Lucas, Librarian, Medical School, University of the Witwatersrand, confirmed that a consistent scheme, even if not based on this System, was adequate.

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ERRATA

When the text was already in production, the following errata were noticed:

(i) Chapter V - p. 114 was inadvertently omitted in the numbering of pages, and what forms p. 115 of the text should be p. 114, etc., throughout.

(ii) Footnote 26, Chapter XII (p. 369, and 371) was inadvertently duplicated.

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