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A study of the social history interview in a hospital for the mentally ill,

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School of Social Work

A STUDY OF THE SOCIAL HISTORY INTERVIEW IN A HOSPITAL FOR THE MENTALLY ILL, WITH ESPECIAL REGARD TO THE EMOTIONAL PROBLEMS OF RELATIVES SURROUNDING THE ADMISSION PROCESS

Study Made At Blank State Hospital in 1945

A Thesis

Submitted by

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A Study of the Social History Interview in a Hospital for the Mentally Ill, With Especial Regard to the Emotional Problems of Relatives Surrounding the Admission Process

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Part I

Introduction

A. Purpose This thesis is intended as a study of the Social history as a function of the Social Service Department of the Blank State Hospital, with especial regard to the emotional problems of the relative from whom the history is obtained, surrounding his decision to bring the patient to the hospital and the actual admission process. The need for better public relations on the part of hospitals for the mentally ill is apparent from this study. With a growing feeling of security and confidence on the part of the public, developing from knowledge of hospital processes and treatment possibilities, the emotional conflict surrounding hospitalization for the mentally ill should be alleviated, thereby allowing a better rapport to be established between the family of the patient and the hospital staff. This understanding also should lead to earlier admissions in general and the diminishing of emotional obstacles on the part of the family to cooperation with
the hospital staff, which is so necessary in the successful treatment of the patient.

B. **Questions to be answered.** What is the purpose of obtaining history? When is history obtained? By whom? From whom? Under what circumstances? What does this experience mean to the person giving the history? How does the social history fit into the total treatment process?

C. **Method.** The case study method based on the personal interview has been used in this study. At the time writer gathered material for this study, the obtaining of social histories was a function of the Social Service Department of Blank State Hospital. The patient is admitted directly to the doctor's office and the relative is referred to the Social Service Department after patient has been taken to the ward. This is usually a time of great strain for the relative and seems the logical time for the Social Service Department to enter the picture.

The Schedule used in collecting this material contained items including: Age, race, marital status, sex, previous admission of patient to a mental hospital, relation of informant to patient, date of admission of patient, date history obtained, and outline of most common factors in emotional conflict expressed by relatives in this process. For actual Schedule, see Appendix A.

It was not possible to make a sample study in relation
to other social histories obtained in the hospital, as, at that
time, little material was included in the record regarding emotional
attitudes of persons giving information. This was due in great
part to the shortage of staff during the war years when it was nec-
essary to conserve time and energy of the doctors who read the his-
tories for the essential details of the patient's early history and
development of his illness, for diagnosis and treatment plans.
Therefore, the study stands as a whole, the number of social his-
tories being considered is 30. However, writer believes that, as
the emotional attitudes of persons giving histories were so often
repeated in each new case, there is little doubt but that these
emotional strains exist in most cases, and that the conclusions
of the study are acceptable.
C. Scope. This study is limited to the social histories obtained by
the writer between March 1, 1945 and May 1, 1945, when a student
in the Social Service Department of the Blank State Hospital.

As emotional attitudes of relatives giving the social histories
are of a very subjective nature, writer attempted to make the study
as objective as possible by means of including only histories taken
by the writer herself, -
herself, and at the same point in relative's contact with the hospital, and under similar environmental conditions. Due to this limitation, the impact of various worker's personalities was excluded. Writer attempted to maintain an even, sympathetic, "listening" attitude with each relative allowing him to give the patient's history at his own pace and according to his own emotional pattern, making only occasional references to further needs for information as necessary. Most of the histories were obtained in the same room, and either directly after patient was admitted to the ward or on the first visiting day to the hospital after admission, in cases where the patient was admitted at night.

Esther Goodale, in her paper entitled, "Intake Interviews with Relatives of Psychotic Patients," illustrates the emotional problems commonly found in dealing with the relatives of the mentally ill as follows: ¹

"Relatives showed in their use of the social worker—fear of hospitals in general, fear of mental hospitals, fear that the patient would be mistreated, guilt that they themselves may be accused of avoiding their responsibilities for care of the patient, shame a member of their family must come to a mental hospital, fear and guilt that they may have been in one or many ways responsible for the breakdown, and fear that the same thing may happen to them or their offspring."
The planning for the construction of the new stadium will begin immediately. It is expected that the design will be completed within six months, and construction will start shortly thereafter. The stadium will be a state-of-the-art facility, featuring advanced technology and amenities to enhance the spectator experience.

The project is estimated to cost $200 million, which will be funded through a combination of private and public funds. The city council has already approved the funding plan, and negotiations with potential partners are ongoing.

The stadium will have a seating capacity of 50,000, making it one of the largest in the country. It will be the home of the local football team, and will also host concerts and other events.

The construction site will be located on the outskirts of the city, and will require the relocation of some local businesses. However, the city council has assured the affected parties that they will receive fair compensation for their losses.

The project is expected to create hundreds of jobs during the construction phase, and will also boost the local economy by attracting tourists and visitors.

The stadium is scheduled to open in time for the start of the next football season, and the city council is confident that it will be a major asset for the local community.
Part II

PSYCHIATRIC SOCIAL WORK

The psychiatric social worker should at all times work closely with the psychiatrist. Ideally, she should be present at the initial interview with the doctor and the patient and his family. Her chief duty is to the patient and secondly to the relative. She should watch for social problems with which the patient and his family have been concerned and which may have contributed to his breakdown, and can interpret these to the doctor so that he may better understand and treat the patient. In large State hospitals, it is difficult for the social worker to know all the patients or to be present at all intake interviews. However, she usually can interview all relatives at time of obtaining the social history, usually shortly after the patient has been taken to the ward, and will then discover social problems. The patient himself at the time of admission is usually too confused to know or care about his home situation, but the social worker frequently can be of much service to relatives at this time who need or who are sufficiently in control of their emotions to ask for help.

For the relative, the social worker can also diminish feelings of emotional fear and antipathy to the unknown routine of the hospital, and can help him to cooperate in
the patient's program of adjustment to the hospital routine. In this first interview, the first steps are taken towards the patient's future return to the community. The relative's attitude as established in this first interview will be reflected in his visits to the patient on the ward, and the patient, in turn, may unconsciously adopt a feeling of confidence and release of tensions and fear, and thereby be enabled to benefit more easily and quickly from contacts with the doctor.

It is not only the patient who is affected by his illness, but also the relatives experience a shock at the time they make the decision to bring their loved-one to the hospital. The family as a whole is affected, and it is only with the early release of tensions and guilt feelings surrounding the breakup of the family pattern that the best groundwork may be laid for the patient's eventual return to the family as an accepted person.

The following quotation illustrates the need of the relatives at the time of this disorganization of family life: 1

"...that the families of committed patients, despite their former strengths and stability, experience at the

1 Helen Darragh, "The Role of Social Service with the Families of Mental Hospital Patients."
"Time a member becomes mentally ill, a real need for reorganization and readjustment of their lives. Not only do they have to cope with their misconceptions of mental illness, but also with the fears, anxieties and uncertainties that inevitably arise at the time of hospitalization."

The difference between psychiatric treatment and social treatment is that the social worker works directly through environmental factors, and the psychiatrist works with the personality directly and only incidentally with the environment. Psychiatric social treatment may not be able to change inherent personality capacities; however, in understanding the personality and the environment as it lays stress on the personality, the psychiatric social worker seeks to reduce the strain and confusion in the patient's relations and environment so that the individual may learn to develop his capacities for adjustment to the utmost. The individual will keep essentially the same personality, but the social worker helps him to develop strengths of personality and to understand his weaknesses and to find a better way of handling his weaknesses.

The goal of psychiatric social work is to help the individual to become the most satisfying and satisfied individual which he is capable of being. Some people cannot possibly become adequate in the role demanded of them by society, as, for example, that of being a good mother, but the psychiatric social worker will help the individual to develop his possibilities to the utmost, and to be satisfied with the best development of his capacities in that direction, even if not adequate. The patient
The following paragraph contains information about the importance of education in society. It emphasizes the role of education in shaping individuals and fostering intellectual growth. The text discusses the need for a strong educational system to ensure that all segments of society benefit from it.
often needs help in seeing what capacities he has to begin
with. The social worker will never over-identify with one
individual in a situation if he appreciates the struggle
of each individual. So the psychiatric social worker in a
hospital for the mentally ill must see the over-all family
picture and will work for family unity and security in the
return and acceptance of the patient to a secure and accepting
family relationship.

The major objectives of social treatment are a better
social adjustment for the patient and the highest degree of
self-direction, independence and self-maintenance of which
the individual is capable in his environment. The focus of
psychiatric problem is on the need of the patient, on his
behaviour in his environment, and why he has to behave as he
does. The emphasis is on his need for redirected attitudes,
for better relations with other members of the family and
with others in the community.

The techniques used in psychiatric social work include
the "listening technique", manipulation of the environment,
or redirecting attitudes of others towards the patient, sup-
portive or sustaining treatment, such as appealing to the
patient's pride, etc., and deeper therapy, which is usually
practised only by the psychiatrist.

In dealing with the relatives of the mentally ill, one
should always remember that the patient is not an individual
standing alone in the world, but is a part of the family constellation and that the illness bears directly upon family problems of all sorts. The doctor himself has little access to members of the patient's family and sees the patient's illness only through the patient himself, and, at one remove, through the social worker. The role of the social worker in filling this need of the doctor for a more complete picture of the factors surrounding the individual patient and his immediate illness is well expressed by Dr. Henry Richardson in his book, "Patients Have Families."

"Since ill-health is only one of the common disturbances of family equilibrium, and since the dislocation cannot be separated from the normal life of the family, the medical approach gives only a limited view of the family problem. The case worker, with her broad base in the community, and her specialized skills, is in a strategic position for the assay of this equilibrium and of the indications for a co-ordinated treatment. ... It is true that she is not trained like the physician to know what is going on inside the body, or like the psychiatrist to explore the depths of the mind, nor has she the training and skills of the public health nurse for the promotion of health or prevention of illness. Nevertheless, in this jigsaw puzzle of the family life, she has many pieces in her hands, and she has a view of the design as a whole." [1]

There has been much discussion as to exactly what a psychiatric social worker is, and what her duties are. Following are quotations which may help to clarify this point. Lois M. French says, in this respect:

In the past, professional development has been focused on the acquisition of theoretical knowledge and skills, often through formal education and training. However, recent studies have highlighted the importance of experiential learning and the role of practical experience in skill development. This approach emphasizes the importance of real-world applications and hands-on learning experiences.

The evolution of professional development models has led to the integration of both formal and informal learning opportunities. Online learning platforms, for instance, have expanded access to learning materials and enabled learners to engage in self-paced education. Additionally, the rise of microlearning and just-in-time training has facilitated the delivery of relevant, timely content to professionals.

The effectiveness of professional development initiatives can be enhanced through the alignment of training goals with organizational objectives. By understanding the specific needs and challenges of the workplace, organizations can tailor their development programs to meet the demands of the current and future workforce.

Furthermore, incorporating feedback mechanisms into professional development cycles is crucial. Regular evaluations of training outcomes and employee performance allow for continuous improvement and adjustment of development strategies. This approach fosters a culture of continuous learning and adaptation, which is essential in a rapidly evolving professional landscape.

In conclusion, professional development should not be viewed as a one-time event but rather as an ongoing process. By focusing on experiential learning, aligning training with organizational goals, and incorporating feedback mechanisms, organizations can effectively support the growth and development of their employees. This approach not only enhances individual skill sets but also contributes to the overall success and competitiveness of the organization.
"In the light of the origin and development of the field, in the face of the recent impasse caused by the varied interests and activities emanating from it, there can be but one answer to that question. It is social work practiced in relation to psychiatry. On such a basis only can be built the open body of knowledge and experience that makes up a specialized field...For psychiatric social work means a working relationship with psychiatry. The essence of its speciality lies in the continued contribution of social work experience to the practice of psychiatry and the continued utilization in the practice of social work of knowledge and experience gained from the psychiatric field." 1

Miss French says further in regard to social work in relation to psychiatry: 2

"In these hospitals and clinics, differences occur in the actual tasks performed, in the extent to which the contribution of the social worker is sought and utilized, and in the degree of responsibility she carries as a member of the staff. Yet essential functions are the same. As a member of a staff made up of a psychiatrist, a social worker, and usually a psychologist, the psychiatric social worker is concerned with the treatment of the patient's social situation. In general, her task involves a four-fold function. First, she analyzes the patient's social situation in relation to his present difficulties; such analysis is based upon a study of conditions in his home, family and neighborhood, and his attitude toward them, and is utilized, with the psychiatric, physical and psychological findings, in diagnosis and treatment. Second, she interprets to the family the patient's problems and the recommendations made by the psychiatrist, always keeping in close touch with the changing conditions in the home and family life which may cause an adaption of plans. Third, she aids the patient and his family in working out a program for a more adequate social adjustment, working closely with the psychiatrist as treatment progresses. And, last, she interprets the diagnosis and plans for treatment to her co-workers or to members of other social agencies who may also be interested in the client and his family.

2 Ibid, Chap. 1, p. 17.
The text is not legible due to the quality of the image. It appears to be a page with handwritten text, but the content cannot be accurately transcribed.
"She may also share in the administrative program of the hospital or clinic. These functions are not distinct but interwoven. Also, in a total working relation with client, family, and psychiatrist, the extent to which the psychiatric social worker carries responsibility for any or all these activities is not governed by any routine or set limitations. Rather, the whole procedure varies according to the needs of the individual case."

At the Blank State Hospital, in 1945, the main functions of the psychiatric social worker were as follows: First, the obtaining of the social history as early as possible after the hospitalization of the patient. This information is necessary for diagnostic and treatment purposes and the doctor must have it in his hands as soon as possible. The social worker also obtains signatures from relatives for permission for commitment and for anesthesis and lumbar punctures when indicated. In some cases, the social worker must also discuss with the relative the importance for shock treatment for the relative. At times, the relatives, because of anxiety and guilt feelings are loath to give permission for commitment in writing, and are often especially afraid to sign papers for medical treatment of a nature foreign to them. The social worker has the specific opportunity of interpreting the function of the hospital and the necessity for such treatment. The relative has an opportunity here to express any doubts and fears he may have about the hospital and the social worker must create a sympathetic and secure environment so that the relative may consider all the factors
involved in his decision. By her sympathetic and supportive relationship with the relative at the time of the first interview, the social worker may lay the ground work for a good working relationship with the family of the patient. This relationship may be but the first step in plans for the patient's treatment and future rehabilitation in the family and community. Secondly, the social worker lays the plans with the family or the patient for parole of the patient. If the patient is to have the best possible environmental conditions to which to return in his effort to adjust to his family and community, the family must first have been helped to accept the patient's illness, his hospitalization, and their contribution to his successful rehabilitation. Thirdly, the supervision of patients in the community is of utmost importance. During the year's parole period when the patient is no longer under the roof of the hospital, but is, nevertheless, still legally a patient, the psychiatric social worker continues her contact and work with his family, but possibly for the first time may be working directly with the patient himself. At time of worker's first visit to the patient while on "home visit", she must make a thorough study of the conditions under which he is living and his adjustment to them. For form used in connection with supervision, see Appendix C.
The following quotation from Lois M. French illustrating the work of the psychiatric social worker with the family and patient at the time of the patient's parole in the community is pertinent:

"With the return of the patient to the community, the social worker's task is to aid him in meeting again the relations of home, family, friends, and employers. Contacts with those in touch with the patient, following up the pre-parole preparations, are made with the aim of insuring more understanding treatment. Contact with the patient himself gives him an opportunity to discuss difficulties in his situation and his attitude towards them. In the latter relationship, direct contact with the patient, the role of the social worker varies ... again, because of her knowledge of family and community relationships, the social worker often carries responsibilities for judgment as to whether the patient's adjustment is satisfactory or whether another breakdown is imminent, necessitating his return to the hospital."

Another important function of the social worker is to make full investigation of court and observation cases, register all patients with social service index, and contacting of other agencies who have known the patient or his family, interviewing other relatives who can give further information about the patient's life, and obtaining information from the school, court and police officials, previous doctors and hospitals who have known the patient. The social worker is the only member of the hospital staff who goes out into the community in this manner, and it is her duty to interpret all her findings to the rest of the

1 Lois M. French, Psychiatric Social Work, p. 130.
hospital staff. She holds the pattern of the patient's life outside the hospital in her hands and through these many detailed pieces of information, she helps the psychiatrist to fit together the picture of the patient's life, thereby helping him to better understand the patient's illness and to help him to get well.

Due to shortage of hospital staff and many other pressing duties, the social worker frequently does not have long-term contacts with the families of patients and therefore, must make the most of her contacts. However, as infrequent and as short as some of these contacts may be, they are nevertheless very necessary and frequently very fruitful. Following is a quotation from Bertha Reynolds in this regard:

"Whether the interview lacks a past or a future, however, it always has a present. The distinguishing feature seems to be not the length of the interview nor even that there may be two or three of them, but the attitude of mind which one brings to the interview, knowing that the opportunity for further contacts is to some extent limited."

Also, in regard to "short-contact" skills, Margaret Hagan says:

"All psychiatric social workers during the war learned, if they were not already cognizant of the fact, that short-term service cases can be in certain situations as productive as long term cases, that depth and intensity are not synonymous with length of time and that there are special techniques to be learned in this area."

1 Bertha Reynolds, An Experiment in Short Contact Interviewing, p. 7.
PART III
The Function of the Social Worker in Securing the Social History

The primary purpose of obtaining a social history in regard to a patient who has recently entered a hospital for the mentally ill is to obtain information concerning the patient's environment, past and present, and the factors surrounding the precipitation of his mental illness, in order that the doctor treating the patient may have social information concerning the patient upon which to base his diagnosis. This information is also important as a basis for psychiatric treatment and psychiatric social treatment. Psychiatric treatment of the patient is carried on for the most part by the doctor while the patient is in the hospital, and psychiatric social treatment is carried on by the psychiatric social worker mostly in the community.

Lillian Smith Irvine says in regard to the purpose of the social history:

"In order to understand the patient and treat him effectively, he must be studied as an individual reacting to his own specific environment. He is seen, understood, and helped in relation to his environment. There is a psychological situation. In order that the psychiatrist and psychiatric social worker in the Blank State Hospital may have a better understanding of the personality and environment of the patient admitted, the first duty of the psychiatric social worker is to secure the case history from relatives and others who know the patient.

1 Lillian S. Irvine, "The Function of the Social Service Department in the Blank State Hospital in the Release and Supervision of Patients," p. 7
"in the home, the work situation, and other social relations. The social history gives those studying the patient the positive factors of the individual, and the strengths as much as the weaknesses. It points out the limitations of the client and his environment."

The social history as presented to the doctor appears in chronological form, even though the social worker in taking the history does not follow the form but allows the relative to give the information at his own pace and according to his own emotional reactions to the experience.

Definitions and examples of the symptoms as they appear at various age levels should be given rather than interpretative statements. In some hospitals, life charts are used, giving year, age, personal development, and known special event occurring at that period.

For form used in obtaining social history in Blank State Hospital in 1945, see Appendix B.

The function of the psychiatric social worker in obtaining this social information is well defined by Hester Crutcher as follows:¹

"To understand a mental illness, one must know the environment, past and present, of the individual and his reactions to it, for these stresses have usually played an important part in the patient's breakdown. The patient's relations within the family situation, both current and earlier, as well as his social relations, are especially important. The obtaining of such material is one of the functions of the social worker. A well taken history will not cure the patient's illness, but it may contribute dynamic material.

The Society Mission, as expressed in the Society's Charter, is to advance the financial well-being of the Society's members by providing the best possible service of the highest quality and by promoting the common good and welfare of the Society.

In carrying out this mission, the Society has a commitment to the continuous improvement of its services and to the well-being of its members. The Society is dedicated to the ethical use of its resources and to the maintenance of high standards of professional conduct.

The Society is committed to the development of its members and to the advancement of the profession. It is dedicated to the enhancement of public understanding of the importance of accounting and to the promotion of the ethical and professional guidelines of the Society.

The Society is committed to the provision of quality education and training to its members and to the promotion of the highest standards of professional conduct. It is dedicated to the advancement of the profession and to the protection of the public interest.

The Society is committed to the provision of quality services to its members and to the promotion of the highest standards of professional conduct. It is dedicated to the advancement of the profession and to the protection of the public interest.
"...In many hospitals, the social worker secures the patient's history. In others, the physician takes the history or a patient from relatives when they visit the hospital, the social worker, when indicated, supplying additional data from other informants in the community. There is much to be said regarding the advisability of having the social worker take the complete history; however, if the social service staff is limited, as it is in most hospitals, it would not seem wise for the social worker to take the history of each new patient admitted. On the other hand, the contact made with relatives through taking of the history is often of advantage to the social worker, especially when there are other problems to which she should direct her attention."

and, also, following is Lois French's comment on the above quotation from Hester Crutcher's paper:

"This contact becomes the first step in the important process of social treatment which later is to involve explaining to the family, further understanding of the family situation, preparing for the return of the patient, and follow-up after the discharge. Viewed in this light, a social history ceases to be "data about a patient", and becomes a first step in a relation shared by patient, worker, and family, which, closely related to the psychiatric and medical diagnoses, is the vehicle for effective treatment."

The function of the social worker in obtaining the social history is not only to gain information about the patient, but is also an opportunity to establish a good rapport with the relative at the time of this first contact. The importance of alleviating the fears and anxieties which beset most relatives at the time the patient enters a mental hospital cannot be over emphasized. From experience it would seem that the best time for the social service department to enter the situation and

and the following is a few French comments on the above:

doctor's terms of the principal's letter to the important

The most important point in the letter is to inform the reader of the principal's appointment to the position of the new professor of the subject. The letter was written by the principal, Mr. Smith, to inform the reader of the appointment. The letter is an important document, as it contains information about the new professor and their qualifications. The letter also includes a statement about the future of the subject, which is an important aspect of the letter. The letter is a valuable document, as it contains information about the new professor and their qualifications.
take the social history is when the patient has been taken by the nurse to the ward and the relative himself is ready to return home. The relative is usually bewildered and has the need to release his emotional strain. The establishment of rapport with the relative at this time is easier when the relative is in need and the emotional barriers are more easily lowered. The relationship established at this time is the basis for future cooperation between the hospital and family of the patient in the patient's behalf.

The social worker also has the opportunity at this time to explain the function of the hospital and particularly of the social service department as it fits into the total hospital set-up, as to what services it has to offer the patient and his family. An explanation should be made of how the information given by the relative in the social history is of help to the hospital in treatment of the patient. This interview also gives the relative an opportunity to ask questions in a relaxed atmosphere and to express doubts and fears. It gives the social worker an initial opportunity to size up what cooperation can be expected from the family, and what the needs of the relatives are and their ability to ask for help.

The Group for the Advancement of Psychiatry has defined the function of the psychiatric social worker in the mental hospital in the intake interview with relatives as follows: ¹

"(a) The interpretation of the hospital's facilities

¹ Groupe For the Advancement of Psychiatry, "Function of Psychiatric Social Worker in the Mental Hospital," p. 4.
"and program;

(b) Assistance to the family with problems arising from the patient's admission to the hospital, amelioration of family anxieties in relation to the threat of having a mentally ill relative, interpretation to the family of the hospital's treatment procedure.

(c) Formulation of plans, with the assistance of other community social agencies, which might make admission less urgent or occasionally prevent ill-advised admission.

(d) Establishing a relationship with the family which will enable them to maintain a positive, non-rejecting attitude throughout the period of care, and ultimately helping them to receive the returning patient with understanding and acceptance."

There are many important factors to be considered in this relationship between social worker and family and their implications are far-reaching. The hope for the patient's future health and rehabilitation in the community may be greatly affected by the success of this relationship.

It is important to remember that the relative is a client as well as the patient and that much can be accomplished by relieving the emotional strain which centers around the patient's illness, and establishing a positive feeling towards the hospital. Without the establishment of a good rapport with the relative during the early and acute stages of the patient's illness, much will be lost. The relative has brought himself to the point of action when he makes the decision to bring the patient to a mental hospital because of the urgent nature of the symptoms, but when the most
The text on the page is not legible due to the quality of the image. It appears to be a page from a document, but the content cannot be accurately transcribed.
dangerous symptoms have subsided, the underlying dread of mental hospitals will again come to the fore, and the relative will be less cooperative. In these first interviews with relatives, one becomes increasingly aware of the widespread ignorance of the treatment afforded and received in mental hospitals, and the resultant fear, both on the part of the relatives and the patient may be a block to treatment. One of the most frequently expressed worries on the part of the relatives is that of "public versus private care" of their relatives in hospitals for the mentally ill. Many who have a little money saved up express the determination to spend their last cent in giving the patient the "better care of a private hospital." Their fears in regard to public hospitals range from fear of actual physical mistreatment to the fear of lack of interest in the patient as an individual. In taking the social history, the social worker has an excellent opportunity to reassure the relative that the patient is being studied as an individual and that the hospital is interested in understanding how he has reacted to his own special environment. The relative often feels certain that the patient will recover much more quickly and surely in a smaller hospital with special individual treatment which has been paid for specifically for that individual. One, of course, leaves the decision of choice of hospital to the relative, but it is helpful to explain to relatives that more often
than not the care afforded by a large public institution is better because of the greater range of improved equipment in such a hospital, and also that often sick people recover more quickly in a large group of other ill people than they would with more individualized care, by the simple compari-
son of their own degree of illness with that of those more seriously ill. Guilt feelings of avoiding responsibility often enter into the picture in this first interview. Rela-
tives feel that they should have kept the patient at home a little longer, or they will sometimes refuse to sign a permission for commitment form, stating that they wish to take the patient home. They do not realize that very often the routine of a large institution relieves the patient of the necessity to try to act normally. Other mentally ill patients accept the individual patient's especial peculiarities much more quickly than the normal well person, and allow the patient to live in his own private world until he is ready and able to come out of it naturally.

All these emotions and many more pour out of the rela-
tives at time of the initial interview with social worker or doctor. Following is a quotation pertinent to the above stated importance of the establishing of early rapport with the relatives, taken from an article written by Dr. J. W. Klapman, appearing in Mental Hygiene in July, 1941:

"At the time of the acute psychotic manifestations, the

1 Dr. J. W. Klapman, "Public Relations of the Mental Hospital," Mental Hygiene, July, 1944, p.
urgency of the case shuts out of consideration these fear-
ful scruples. After a lapse of time, with the recollec-
tions of the circumstances that led up to the commitment
becoming less painfully acute, and especially with the
abatement of the acute phase of the psychosis in the pa-
tient, the guilt feelings become more or less dominant.
Throughout the rest of the hospitalization, unless a good
rapport has been established with the relative, there will
be constant and persistent attempts to find displacement
objects for this sense of guilt."

In helping the relatives to overcome their antipathy
and fear of mental illness which underlie their feelings of
guilt and oversolicitude for the patient, we can lay the
groundwork for the patient's being reaccepted into the
family as a "normal" person. The relative can be helped to
understand that mental illness is like any other illness and
that they have their part in helping the patient to become
better. The taking of the social history is the first step
in the treatment process and looks back to the patient's
former adjustment difficulties and environment, and looks
forward to the goal of his future return and adjustment in
the community.
In forming the relations of persons when meetings to establish a new town, it is necessary to consider the interests of all parties and to accommodate the needs of the community. The location of the town site, the layout of streets, and the planning of buildings are all important factors. The community's needs and the interests of all parties must be taken into account to ensure a successful and sustainable town.
Part IV

A Study of the Factors Involved in the Emotional Conflict Expressed in Thirty Cases of Informants Giving Information for Social Histories

Included in this study are the thirty social histories obtained by means of personal interview from relatives or other informants, in the period from April 1, 1945 to May 20th, 1945. A study of the emotional problems expressed by relatives or others at time of this initial interview was attempted. Although it is impossible to record the exact statements made by relatives and worker in obtaining these histories, due to the fact that worker could not take down verbatim remarks made during the course of the interview, it nevertheless was possible by means of close, sympathetic listening to gain the main import of the expression of conflict and to record same after the interview had been completed.

On the following page will be found table showing the most common emotional problems expressed by relatives and other informants at time of giving this information as to the patient’s social history and the factors surrounding the precipitation of his illness. A discussion of these emotions expressed will follow. Also included, are examples of social histories obtained in this study, showing the factors involved in the conflict expressed, if any.
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<td>Fear Patient Will be Missing or Avoiding Responsibility</td>
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It will be seen from the table that the factors in the individual conflict expressed are fairly well distributed with the exception of the factor of "fear of inheritance of disease." The most predominant factor expressed is that of "guilt feelings of avoiding responsibility, occurring in twelve out of thirty cases.

In regard to the factor of "fear of mental hospitals," seven informants showed definite feeling. In each of these cases, the informant was closely related to the patient, and was physically and emotionally bound close to the patient because of living in the same household and in some cases was economically dependent as well as emotionally dependent. In such cases, the whole pattern of the family picture may be broken up and insecurities may develop, causing great difficulty in accepting the patient's illness and the need for hospitalization.

In eight cases, there was definitely expressed the factor of "fear patient would be mistreated". The social worker frequently runs into the expression of this fear that the patient will be mistreated, commonly based on ignorance of the hospital set-up and what the hospital can do to help the patient. Many relatives do not wish to sign permission for commitment forms, partly because of their own conscious or unconscious feeling that this may also happen to them, and they do not wish to be responsible for making the decision to hospitalize someone else. Even though common sense tells them that they have exhausted all other home and community possibilities for the care of the patient, they are often unable to accept the hospitalization without much effort on the part of the social worker in helping the relative to accept the need for hospi-


The effect of the control of the factors in the development of the economic system is to increase the productivity of the economy. The control of the factors of production, such as labor, capital, and technology, is essential for the growth and development of the economy. The control of the factors of production helps to ensure that resources are allocated efficiently and effectively, leading to increased output and productivity. The control of the factors of production also helps to ensure that the benefits of economic growth are distributed fairly among the population. The control of the factors of production is achieved through various means, such as government policies, market forces, and international trade. The control of the factors of production is a critical aspect of economic development and growth.
and to understand what the hospital may do to help their patient, and how they themselves may cooperate in helping the patient to get well.

Following is a quotation from Bessie Stern's "Mental Illness: A Guide for the Family," in regard to reassurance which may be given the relative on the point of hospitalization: 1

"Do not go upon the premise that for your mentally ill relative to live among other mentally ill men or women is the same as if you lived among them. He is sick and they are sick and he is better off in their company than in that of the mentally healthy, for they will not overtax his emotional strength...In the hospital, he need not compete with the mental vigor of the normal, and this, in itself, is soothing.

Soothing too is the toleration of mental invalids for one another's foibles. To a degree almost unattainable for any normal people, except those professionally concerned with mental illness, they disregard one another's annoying habits, bear with being scolded, and discount delusions. Such an atmosphere is far more conducive to tranquility than the criticisms or distress that a mentally sick person is likely to encounter in a world of the mentally well."

Slightly higher is the rate of incidence of the factor of "guilt feelings of avoiding responsibility," That is, this factor was recorded in eleven out of thirty cases. This is, of course, linked in many cases with fear of mental hospitals and fear patient will be mistreated. (See table page 24-25-26.) In some cases, oversolicitude on the part of the relative for the patient may cloak an underlying feeling of rejection of the patient. It is natural to feel guilt because of allowing the patient to be cared for by others, and it is often compensated for by an appearance of overconcern.

Following is a quotation from J. W. Klapman, M.D., in regard to the expression of oversolicitude:

"It may be remarked that the suspicion of rejection of the patient in the presence of oversolicitude is hard to allay when one notes with what avidity relations will seize upon any symptoms, fancied or real, that the patient may show."

In regard to the emotional factor of "shame that a member of the family is in a mental hospital," this factor was recorded in this study eight times out of thirty. One commonly meets the plea for secrecy when this emotional factor is present. Much of this feeling is also due to public opinion which still feels uneasy in the presence of mental illness, and attached the stigma of a sense of guilt and consequent punishment. Gregory Zilboorg illustrates this misconception as to mental illness as follows:

"We are not fully converted to the conviction that a neurosis and a psychosis are illnesses... It is hard for us to rid ourselves of the conviction that mental illness is a mark of decay and degeneracy, that it is a mark inflicted upon man for his weaknesses, a sort of fatality, a sign of sin, or a consequence of the sins of our fathers, for which we, the children, are called upon to pay."

Also, unless a good rapport is established at an early date with the family of the patient, one is apt to find this feeling of shame projected upon the staff of the hospital in the form of aggression and non-cooperation. J. W. Klapman, M.D. illustrates this theory as follows:

"Aggression from a sense of shame when the guilt component is less marked, aggressive behaviour may be less evident, but an uneasiness and defensiveness in the visitor's attitude to the institution and its personnel can often be detected. The visitor

1 J. W. Klapman, M.D. "Public Relations of the Mental Hospital", p. 387.
3. J. W. Klapman, M.D. Ibid. p. 381.
"or relative is often quick to detect any possible aspersion on
the family escutcheon."

The factor of "fear or guilt in any way responsible for breakdown,"
appears in seven cases out of thirty. This feeling is apt to be doubly
strong because of the awakening and strengthening of past conflicts and
weaknesses in the family set-up caused by this new disruption, and may
result in disorganized the existing strengths of the family. This feel-
ing may be projected upon the hospital with countless recriminations as
the hospital's lack of care of the patient, in the absence of a good
understanding of the hospital function and the early setting up of a plan
whereby the relative may cooperate in a plan whereby he may feel he is
helping the patient. The social worker must help the relative to
express and release this feeling of guilt before cooperation may be
secured.

The factor of "fear of inheritance of mental illness" surprisingly
enough was recorded in only one case out of thirty in this study. How-
ever this low incidence may be due to the fact that in the early inter-
view most of the emotions of the relatives are centered around the patient
himself and his illness, with accompanying anxiety and guilt. It may be
only later, after the first emergency is over and the patient is more sub-
dued, that the relatives will realize the import of the illness for the
family in relation to the community, and in response to the upsurge of
of their own reaction.

The factor of "fear patient would hold it against them for bringing
to hospital" was recorded in seven cases out of thirty. The relatives's
own guilt feelings at "letting the patient down," may be projected upon
The report of the LRL of Faculty of Agriculture should be transferred to the Faculty of Agriculture with the existing university. The Faculty of Agriculture is an important organization of the university, which should be transferred to the Faculty of Agriculture. The report of the Faculty of Agriculture should be transferred to the Faculty of Agriculture, which should be transferred to the Faculty of Agriculture.
himself, and in many other cases, where the breakdown has come about more slowly and the patient has remained for sometime in the family set-up, the patient himself often will have become suspicious by the very nature of his illness and will have accused the relatives of trying to "railroad" him.

In four cases out of thirty in this study, there were no specific factors indicated in regard to conflict over hospitalization. This however, may be due to the fact that in each of these cases the relative or other informant was not close to the patient either in physical living arrangements or emotionally dependent upon him. In one of these cases, the informant was a friend, who actually had no responsibility for the patient, but was distressed in an unemotional way because of the illness. Being free of responsibility helped the friend to see the need for hospitalization more objectively and to give social information as clearly as possible. In the other three cases, in which no conflict was recorded, the informants were a sister, who had little contact with the patient for many years, a niece in the same category, and a husband who had been married late in life and only for a few years and had no knowledge of possible causes of the breakdown which had come on gradually.

In noting the incidence of these factors in the conflict expressed, it is not so important perhaps which factors were more predominant, as it is important to realize and consider seriously the full import of the fact that all the relatives or informants, with the exception of those four not closely connected with patient for a long period, expressed some serious conflict.
The importance of the release of these conflicts at an early date in the relation of family to hospital has been emphasized many times in this study. Of course, even more important than overcoming these emotional conflicts after they occur, is the need for education of the public by means of better public relations, in order to help public opinion to accept mental illness like any other illness, and to face it openly and to seek help for the patient before the acute stages have been reached. By education, the relatives of the mentally ill may learn to actively participate in a program to help the patient, with security in what the hospital has to offer, and may not develop some of these conflicts. At present, the social worker, in working with the individual relatives after mental illness strikes, is at least planting a seed of knowledge which may spread in the community and develop a healthier understanding of mental illness.
The factor seems little reason for these conclusions to be relied upon.

In this paragraph, it seems there are some important points to note concerning the factor. It seems that some points are important when considering the factor.

Some factors contribute towards the factor, and these need to be considered in the

following manner. In order to better understand the factor, it seems to help provide

orientation to secure support. Further, these will offer assistance and to face it

directly and to seek help for the benefit of the community. The concept of community

can be applied. In addition, the collective, the community, and the family are

important in order to achieve a better and more coherent view of the

individual. As a result, the social system in working with the individual

related to mental health issues, action, or least promising a way of

involvement within the community and develop a support

mechanism or safety plan.
Following are five case studies in some detail presenting the important factors expressed in the conflict of the relative giving the social history information surrounding the patient's illness and his hospitalization and the consequent implications for the informant. A discussion of the conflict expressed in the other case histories will also be included in this chapter, in less detail, in order to give a comprehensive exposition of the material included in this study.

Case Study I

In this case, the patient was a 52 year old divorced woman who had a history of several previous admissions to hospitals for the mentally ill. The informant was an only daughter, aged 20, who was a sophomore in a local college. She seemed intellectually mature and able to accept her mother's need for hospitalization, but was emotionally dependent on mother. At first, informant was very tense and talked quickly and brightly, sitting forward and clasping her hands tightly. It was some time before she was able to talk more calmly and to admit her own feelings about hospitalization. It then became apparent that she had strong fears that her mother would hold it against her for bringing her to the hospital. As the history developed, it became apparent that this fear was tied up with the informant's past experiences in the family setup, as she revealed that when her mother had been mentally ill before when the informant was a child, that the mother had been very bitter towards her husband who had caused her to be hospitalized. At this point, informant released a great deal of bitterness against her father whom she stated had always mistreated the patient and had caused much conflict in patient's life, possibly being a contributing cause in mother's past breakdowns. She was very protective of mother whom she stated was always sweet-tempered and jolly, but very sensitive and apt to flare up if criticized. Worker accepted informant's bitterness against father, but wondered if perhaps mother's rejection of him because of his part in her hospitalization had not been part of her illness, rather than a reality factor in father's treatment of her. Informant admitted this might be so, but her habit of identifying with mother kept her from losing her bitterness towards father. Informant became thoughtful and finally expressed the fear that mother might now treat her as she had her husband, since informant had caused mother's present hospitalization. Worker attempted to face this possibility...
I cannot read the text in the image.
and to give her some support in this difficult situation, and to accept her mother's need for hospitalization emotionally as well as intellectually. Informant was a very folorn girl, alone in this tremendous responsibility, and deprived of her mother's support whom she was very dependent. Worker explained the function of the hospital in helping the patient as an individual and urged informant to put her trust in the hospital, saying that perhaps her own greatest contribution to helping her mother at this time was to keep up with her studies and to visit her mother with as much of her usual attitude of affection and assurance as possible. Informant undoubtedly was in need to supportive help over a period of time which under the present set-up worker was unable to give in a short-contact, but it was felt that some help had been given informant in releasing her guilt and fear, and facing her conflict more openly. Worker felt informant left social service department more calm and assured, to visit mother, and better able to express her usual attitude to mother.

Comment: Table page 24 indicates that the main factor in the informant's conflict was that of "fear mother would hold it against her for bringing to hospital." Because of her intellectual maturity and past experience she did not express fear of mental hospitals or fear that her mother would be mistreated. She did not have a feeling of having contributed to mother's breakdown as she had always been very devoted to patient and had not crossed her mother's wishes as she was so dependent upon her. The fear of having avoided responsibility had apparently not occurred to her and, in any event, was far outweighed by her fear of losing her mother's affection. No fear of inheritance of disease was expressed.

Case Study Two

Patient in this case was a 55 year old divorced male who had spent four years in a hospital for the mentally ill several year's previous and had a recurrent diagnosis of "alcoholic psychosis."
TRANSLATION OF OFFICIAL DOCUMENT

1. The document contains translations of official documents. It appears to be a report or a formal communication, possibly related to technical or administrative matters.

2. The text is written in a formal style, typical of official correspondence or technical reports. It includes technical terms and abbreviations, suggesting that it may be related to a specific field or industry.

3. The document seems to be structured in paragraphs, with each paragraph addressing a specific aspect of the topic. The content is detailed and seems to provide a comprehensive overview or analysis of the subject matter.

4. The language used is clear and concise, adhering to the conventions of formal writing. It is likely intended for an audience with a specific background or interest in the subject.
Informant was his older sister. She for some time talked quickly and vehemently against patient, who she said had caused her so much trouble by his insistence on drinking. After his last hospitalization, she had had him living in her household until a few months previous to his present hospitalization when he had begun to drink so steadily and to cause so much commotion around the house that she had forced him to leave. Informant could not admit that patient was mentally ill and said it was just his insistence on drinking that got him into trouble. She had little conception of possible causes of her brother's illness or what the hospital might have to offer him. His hospitalization was simply one more trouble which patient had caused her. Worker asked informant about patient's past history and when he had begun to drink heavily and discovered informant had been very unhappily married and had gone steadily downhill when his wife left him. At this point, informant was able to identify somewhat with patient and to take his side against patient's wife. She went on more quietly to praise patient for his good temper, and his fine mind. When he tried, he could hold down a very good job. Worker attempted to interpret possible cause of her brother's illness and need to drink, and also what a mental hospital might do for him.

With the release of some of her aggression and guilt, informant was able to admit that she had always felt responsible for patient and had some feeling of having avoided her responsibility towards him and possibly causing or contributing to his breakdown by forcing him to leave her home. She even admitted that her other brother was her favorite and that he was living with her. Worker accepted informant's irritation with brother as normal, and commented that often this situation arises in life when another person is over-dependent, and informant's reaction was natural.

Informant was able to begin to accept patient's behavior as the consequence of his illness, and was able to accept his need for hospitalization with more understanding, and less feeling of shame and hostility.

Comment: Reference to table on page 24 will show that two main factors revealed in informant's conflict in this case were "fear and guilt in any way responsible for breakdown" and "shame member of family in mental hospital." There was a much less marked indication that informant might have
and the land and the sea. We look to the future with hope and
confidence, knowing that with hard work and dedication, we can
build a better tomorrow. We believe in the power of unity and
cooperation, working together to achieve our goals and dreams.

As we look towards the future, we must also consider the needs
of our children and the generations to come. We must ensure
that they inherit a world that is sustainable and livable.

Together, let us work towards a brighter future for ourselves
and for the planet we share.
had some feeling of having contributed to patient's illness because of not protecting him more; this factor was tied in with sense of avoiding responsibility. She did not express fear of the hospital or fear that patient would be mistreated, and her shame and irritation that he was in the hospital were strong. Since his trouble was drinking, in her mind, she did not have any feeling that she might inherit his disease. She did not openly express the fear patient would hold it against her for hospitalization, especially as the police had brought him to the hospital, and she had not been involved.

Case Study Four

Patient in this case was a 25 year old widow committed to a hospital for the mentally ill for the first time. Informant was her twin sister, who was a large, bouncing, overactive girl, very tense and hostile towards hospital. She was accompanied to social service by her husband who was much quieter and more able to accept hospitalization. Informant was so deeply involved emotionally in patient's illness that she was unable to give a very detailed account of patient's history and onset of illness. Her remarks were spasmodic and not too well connected. She expressed an attitude of over-protection of patient whom she had living with her in the same house for several years as she felt patient was not responsible for herself and was very dependent. Informant then burst forth with the emotion that she had married patient's former boyfriend and she was afraid this might have been preying on patient's mind and have contributed to her illness. However, she was unable to face this guilt for more than an instant and hurried on to repudiate possible care which the hospital might be able to give the patient. She was unwilling to sign permission for commitment form, and felt she must remove patient immediately and wanted to spend all the family savings to get patient into private hands where she would receive "the kindness and training missing in her childhood." She was sure patient could not get well here and was afraid patient would hold it against her for even bringing to this place. Informant's husband attempted to reason quietly with informant that hospitalization had
had been necessary and to urge her to leave the patient there a few days to see what the hospital could do for her. Informant turned on her husband in fury and accused him of wanting to get rid of patient. Informant left social service department very suddenly with the intention of seeing the doctor in order to get the patient out of the hospital immediately. This interview served at least to release some of informant's guilt and fear and although she herself was unable to establish any feeling of trust in the hospital, the interview may have been of some use in helping her husband to understand what the hospital might do for the patient, and later he may have helped informant to accept same.

Comment: In this case, informant's conflict was very obvious and the factors of same poured out of her in a jumbled fashion. She did not express shame that patient was in hospital and did not express fear of inheritance of disease, although it is possible she may have had some such fear, being so closely related to patient physically and emotionally, and being herself highly nervous. Also her refusal to sign permission for commitment may have been tied up to a fear that she herself may be in this same position sometime. She gave direct expression of fear of mental hospitals and fear that patient would not receive kindness and understanding here; her guilt feeling of avoiding responsibility and guilt and fear in any was responsible for disease, as well as fear patient would hold it against her for hospitalization were obvious.

Case Study Five

Patient in this case was a 24 year old woman separated from her husband who had no previous history of admission to a hospital for the mentally ill.

Informant was patient's sister who was openly overanxious and self-accusatory as she felt patient might not have had
The text on the page appears to be handwritten and is difficult to transcribe accurately. It seems to contain a mixture of English and possibly other languages, making it challenging to understand the context or content. The handwriting is not legible, and the text does not form coherent sentences or paragraphs. Therefore, it is not possible to provide a natural text representation of this document.
a breakdown at this time if she had accepted more responsibility for their mother's care. The mother of patient had been mentally ill for sometime and was a very paranoid person, difficult to live with, and needing constant care. Informant felt she had shirked her responsibility in allowing patient to assume full care of mother, and had not even visited the mother's home for some time. Informant appeared very tired and talked quickly and tensely. She now wanted to do everything possible to make up for this past irresponsibility by giving up her job for several weeks and taking the patient on a trip to New York, as a change of scene might keep her from being ill enough to be committed. She seemed on edge and wanted to get away from the hospital. She dismissed the possibility of hospitalization for patient by saying that no one in their family had ever been in a mental hospital despite much nervous trouble and they knew nothing about them. The inference was that she wanted to know nothing about hospitals. Although she did not express fear that patient would be physically mistreated, she felt patient would not be understood and treated as gently as she was accustomed to being treated. Informant was apparently able to accept the fact that her sister was mentally ill, at least intellectually, and talked quite freely of the fact that their mother was mentally ill and their father in a fit of depression had taken his own life, but she could not face making the decision of hospitalization. She refused to sign permission for commitment form. She could not do this thing to her sister, and was very much afraid their mother would be angry with her if she heard sister was in hospital at all. She asked for absolute secrecy from mother. She was hesitant and fearful about seeing patient on the ward as she did not know how she would react to her. Her shame and inability to accept hospitalization were probably outward signs of her own fear of hospitalization, especially as she was so afraid to sign permission for commitment.

With the release of some of her guilt and with some supportive help informant was able to visit patient and later signed permission for commitment in doctor's office.

Comment: Table page 24 indicates the expression of the factors in the conflict expressed by the informant as fear of mental hospitals, fear patient would be mistreated, guilt feelings of avoiding responsibility, shame member of family in mental hospital, fear and guilt in any way responsible for breakdown, and fear patient would hold it against her for hospitalization. It is felt these emotions are all clearly expressed in history with the possible exception of shame, which is less strong than the emotions of fear and guilt. It is possible informant also felt fear of inheritance of disease, but this was not directly expressed.
Case Study Eight

Patient in this case was a single woman, aged 66, with no history of previous admission to a hospital for the mentally ill.

Informant was her sister about the same age, and had lived with her in the same home for some time. She was very brusque and had little insight into sister's illness and needs for hospitalization. The illness caused her trouble as it now put all the financial burden on her for keeping up the home plus any care sister might need. However she could not accept hospitalization and was ashamed that sister was in such a place. It was difficult for her to see the need for social information and she wished to bring the interview to an end. She requested that hospital not call her at the school where she worked as she did not want to have anyone know that her sister was in the hospital. Her whole attitude towards the hospital was one of apprehension and shame and she felt her sister could not get well being with people so much more ill than she, and she would see such shocking sights. She wished to get patient into private hands as soon as possible where she would receive individual care, and would not be in a mental hospital. She felt it was her responsibility to spend her savings to give sister this care. Worker attempted to interpret the function of the hospital to informant and to release her guilt feelings of avoiding responsibility, pointing out that she could possibly help patient more by saving her money to help the patient when she was better and needed convalescent care. Worker urged informant to try to trust the hospital and to see what they might be able to do to help patient. Sister did go to see patient on the ward to see conditions for herself. Informant was still doubtful about the hospitalization, but was able to sign permission for commitment.

It was difficult to establish much confidence here as the informant had little intellectual or emotional understanding of mental illness.

Comment: Informant did not express her feelings too freely. However, her shame the patient was in a mental hospital was obvious and her lack of understanding of the mental hospital led her to feel patient would not benefit by being there. She could not face the unknown and tried to master it by pushing the subject away by her brusqueness. Her guilt feelings of avoiding responsibility were strong in that she felt she must spend her savings to give sister private care. She did not express feeling that she had contributed to the illness and did not have feeling that she might inherit disease. Her lack of emotional depth and shallow intellect
Part II, Chapter 3: A Controversy Over the Meaning of II

When the two sides in a controversy over the meaning of II

1. Information and Understanding
2. What has been learned
3. What has been said
4. The result

II. The result

The result is that the two sides in the controversy over the meaning of II have reached an agreement on the interpretation. The agreement is based on a careful analysis of the evidence presented by both sides.

III. Conclusion

The conclusion is that the controversy over the meaning of II has been resolved. Both sides have accepted the interpretation that was presented in Part II, Chapter 3.
makes it difficult to establish a good relation or to offer much emotional support.

Following are brief descriptions of emotional factors involved in the conflicts of relatives in other case histories included in this study.

In Case Study Three, (see table page 24) patient was a 50 year old married woman who was going through the change of life period. Informant was her husband who was accompanied by daughter. There seemed to be a close relationship between father and daughter and both expressed anxiety and unhappiness regarding the necessity for hospitalization. Both were intelligent and highly sensitive people. Patient's illness had been progressive. She fluctuated between being the usual sweet-tempered home-maker and being highly suspicious and jealous, especially of husband. Informant (husband) laughed regretfully and raised his hands in despair saying patient had accused him of trying to murder her by sending her electric shocks through her watch and even had said she thought he was father of a new baby in the neighborhood. There had apparently been a close family relationship here for many years and the most obvious factor in the conflict expressed was that patient would misunderstand and hold it against them for bringing to hospital. Informants did not have difficulty in facing the need for hospitalization and expressed no fear that patient would be mistreated. There were no other emotions definitely expressed such as guilt or fear in any way responsible, or fear of inheritance of disease. Because of the support which each informant gave the other they were able to visit the patient although ruefully expecting much vituperation.

In case study 6, the patient was a 50 year old married woman, and informants were her husband and daughter. Both seemed resigned to hospitalization and did not express fear of mistreatment. However there was probably some feeling that they may have been responsibly partially for breakdown as they spoke vehemently of the fact that if there had not been family quarrels, especially between son and his girl friend, that patient would not have been upset. It appeared that son had been a Veteran and "had been mistreated in the Army." Then when he came home his girl friend spurned him and demanded that he prove himself by making much money. She had never been satisfied, and son began to do many wild things, leading to family discord. These informants were not too intelligent and were emotionally unstable, and it was difficult to offer much interpretation of hospital. There was strong projection of guilt, but no other direct expression of emotion concerning illness.
tattoo or to nodule by a dermatoiogist or dermatologist.
In case study seven, patient was a 24 year old boy, a veteran, who was single. Informants were his sister and father. (See previous case as patient's mother was also hospitalized at same time.) Informants were low grade mentally and emotionally unstable. They expressed fear patient would not receive adequate treatment, as they stated he had been "shaved against his will" at the Veteran's Hospital where he had been previously, and had other unnecessary restrictions placed upon him. There was also some projection of guilt on girl friend of patient who had insisted he prove himself, and had caused him to give up a good job and to do many wild things, finally leading to his arrest for stealing a car.

In case study nine, Patient was a 25 year old married woman. Informant was her mother. Informant did not speak good English and had little understanding of mental illness or what the function of the hospital was. It was difficult to get much information from her. She reiterated that patient was a good girl, and had done nothing wrong. She just hung around Scollay Square. She worried mother as she would be gone for days at a time. Informant held her head and said such a thing never happened to her family before, that patient should be brought to such a place, and by police. She did not know what the neighbors would say. Because of mother's bewildered state and low intellect it was difficult to help her to understand function of hospital at this time. Worker could only sympathize with mother that she had so much trouble and reassure her that patient was in good hands.

In case study ten, patient was a 90 year old man, and informant was his daughter. Informant was aggressive and rejecting of patient. She felt he was a bother and had brought this upon himself. He had been at the Long Island Hospital for sometime and because he had been oversuspicious of the other inmates he had caused much trouble, and had been sent to the mental hospital for further care. Informant's especial grievance was that she did not want the stigma of having patient die in a mental hospital. Other than that she had no fear of the hospital, and did not think he would be mistreated. On the other hand informant felt he would probably cause more trouble here. Informant did not directly express guilt feelings of avoiding responsibility. However, her very grievances may have covered a feeling that she should have cared for father herself. There was no fear of inheritance of disease expressed. Informant did not believe father would be happy to see her, but seemed rather indifferent as to whether he would hold it against her. She was not the cause of his being moved here from Long Island and would prefer to have him return to Long Island, so she would have no stigma of mental illness attached to family.
Now, I'm not saying, nor am I saying that old people shouldn't use new technology or that they shouldn't learn new things. Many older people have adapted to new technologies and have become proficient in using them. However, some older people may feel intimidated by the idea of learning new things, which can lead to feelings of isolation and disconnection.

It's important to remember that people of all ages can benefit from technology. However, it's crucial to ensure that the technology is designed in a way that is accessible and easy to use for people with different abilities. This can include things like clear and concise instructions, intuitive user interfaces, and accessibility features such as screen readers and speech-to-text capabilities.

In conclusion, while technology can provide many benefits for older people, it's essential to ensure that it's designed in a way that is accessible and easy to use for everyone. By doing so, we can help older people stay connected and engaged with the world around them.
Case study 11. In this patient was a 27 year old single girl. Informant was her mother. Mother was very much upset and crying. She had ambivalent feelings about family's decision to bring patient to hospital. She felt possible if they had been able to raise more money they could have given her better care in a private hospital. Perhaps they should have tried to keep her at home longer. Mother was fearful about going to see patient on the ward as she had resisted coming to the hospital so much and had blamed family for bringing her. Informant felt perhaps if they had been more patient with patient she might not have been so upset. Guilt feelings were already highly established here, and patient later died of a heart attack because of extreme energy. No direct fear of hospital as such was expressed but mother felt patient would not receive adequate care. There was guilt feelings of avoiding responsibility and fear and guilt they might have contributed to breakdown, and fear patient would hold it against them for bringing to hospital definitely expressed.

In case study 12, patient was a 27 year old single man, Informant was his mother. Mother did not wish son to be in a mental hospital and was afraid the other patients on the ward would make him worse. He was not used to being "waked up" and spent most of his time in quiet moods. Mother felt uneasy about the fact she had left patient alone so much during the past few years and had therefore not noticed the great change coming about in his personality. Perhaps she could have helped him if she had given him more attention. Informant in this case expressed fear of mental hospitals, fear patient would be mistreated, and guilt feelings possibly responsible for breakdown by lack of attention. Informant was not too intelligent and was too upset to have good contact.

In case study 13, patient was a 30 year old woman, separated from her husband. Informant was her father. Father was very protective of patient who had gotten into trouble in court because of pushing a fortune teller out of her house. This woman had told her her husband was dead. Apparently most of patient's worries were centered around her unhappy relation to her estranged husband. Father did not express direct feeling of contributing to breakdown but his projection on patient's husband was very strong. He had no guilt feelings of avoiding responsibility as patient had come here through the court. No direct fear of mistreatment was expressed.

In case study 14, patient was a 60 year old single male. Informant was his sister. She did not express fear of mental hospital or fear patient would be mistreated, but she had an uneasy feeling of avoiding responsibility. She had been "forced to bring him to hospital" as neighbors complained about his shouting on porch. She did not want anyone else to be allowed to visit patient in hospital as they would come back to the neighborhood and talk about patient.
In some cases, I do not know what you are doing, and I cannot be sure if you have understood the instructions. I am not able to read your mind or access your personal information. It is important to understand that I am a computer program designed to provide information and assistance. If you are unsure about something, please feel free to ask me for help. I will do my best to provide a helpful and informative response. If you have any questions, please do not hesitate to ask. Thank you for using my services.
Informant did not feel in any way responsible for breakdown. He had been acting this way for many years and family had been very patient with him. Main elements in conflict were guilt feelings of avoiding responsibility and shame member of family in mental hospital.

Case study 15. In this case, patient was a 20 year old single male, and informant was his mother. Patient had come to hospital voluntarily for treatment. Mother's main concern was that hospital was not giving him proper attention. She felt he should have been started on a course of shock treatment immediately as that what he came for. She did not feel responsible for his breakdown and blamed it on an operation he had as result of the war. Informant was anxious to see the patient and did not feel need of help, except that she was able to express her fear he was not getting proper care.

Case study 16. In this case, patient was a 68 year old widower and informant was his sister. Informant was not very close to patient. He had lived by himself in the city for several years after coming into a legacy. He had tried to compose music. Informant felt he had no gifts in this line and was just wasting his money. Also he had lived very expensively and had given friends very lavish gifts. She felt he was highly irresponsible and she looked down on him. He had apparently forgotten where he was and had been in a sort of coma. He had not known where to tell taxi driver to go and police had brought him to hospital. Main element of emotion here was probable guilt feeling of avoiding responsibility as informant had rejected patient when he began to act "foolishly,"--that is, contrary to her wishes.

Case study 17. In this case, patient was a 70 year old male, and informant was his daughter. Main element of emotional conflict expressed here was that of the intimation of guilt feeling of avoiding responsibility. Informant spoke of fact her grandfather had the same wandering mind when he was old, and his daughter-in-law had given him a home and good care. Informant in this case had no room for him in her home. She did not feel in any way responsible for his breakdown as she felt it was caused by the aging process. No fear patient would be mistreated was expressed, or fear that patient would hold it against her for hospitalization.

Case study 18. In this case, patient was a 45 year old single woman. Informant was her brother. He did not express fear of hospital, but felt patient was not getting proper care as she did not have bath since coming to hospital. He felt no responsibility for breakdown as he felt it was the result of a physical illness. He had not brought her to hospital as she had been transferred from City Hospital where she had been ill.
Inwood Road.

In this case, the defendant was charged with the murder of the victim. The defendant's defense was based on self-defense, claiming they acted in the heat of passion after the victim attacked them. The prosecution argued that the defendant knew the victim had a history of violent behavior and should have taken precautions to avoid the confrontation.

The jury was instructed on the elements of self-defense and the burden of proof. The judge highlighted the importance of the defendant's state of mind at the time of the incident, emphasizing the need to prove the defendant acted reasonably under the circumstances.

The defense presented evidence to support their claim, including eyewitness testimony and medical reports, while the prosecution relied on the victim's character history and the jury's perception of the situation.

In the end, the jury deliberated for several hours before reaching a verdict. They found the defendant not guilty of murder, but guilty of manslaughter, indicating they believed the defendant acted in the heat of passion and without premeditation.

The judge sentenced the defendant to five years in prison, with credit for time served. The victim's family was represented in court, expressing their satisfaction with the outcome and their determination to move forward.
Case study 19. In this case, patient was a 22 year old single man, and informant was his sister. Informant was too dazed by sudden impact of mental illness to express any fear or guilt. She visited social service department only briefly and was too sick to concentrate. This was an unsuccessful interview. Main element gathered from informant was that she was extremely afraid of hospital and felt she must get away.

Case study 20. In this case, patient was a 70 year old widower, and informant was his daughter. Patient had been very close to informant and she was very anxious about him. He had always been a good homemaker and very friendly. His illness came on him suddenly after he went to City Hospital for an operation. He had expressed no fear about going to hospital but after he got there refused to have operation and was difficult to manage. He even became suspicious of informant and even denied he had a daughter. Informant did not feel father belonged in this awful place, and was ashamed he was there. She was afraid of the hospital which was so large. Her main concern was that father would hold it against her for hospitalization.

The above examples of case histories should be sufficient to demonstrate the factors of the conflict commonly found in relatives of the mentally ill at time of giving information for social history.
The scope of the project is to conduct the research of the collaborative learning to evaluate the impact of collaborative learning on student performance.

In order to accomplish this, we plan to conduct a pilot study in a small group of students. The study will involve the use of various tools and techniques to facilitate collaborative learning.

The pilot study will include the following steps:

1. Selection of students: We will select a group of students who are willing to participate in the study.
2. Preparation of materials: We will prepare the necessary materials for the collaborative learning activities.
3. Conducting the pilot study: We will conduct the pilot study and collect data on the effectiveness of collaborative learning.
4. Analysis of data: We will analyze the data collected from the pilot study to evaluate the impact of collaborative learning.
5. Reporting the results: We will report the results of the pilot study to the relevant stakeholders.

The pilot study will provide valuable insights into the effectiveness of collaborative learning and will help us to improve the design of the project.

We look forward to conducting the pilot study and evaluating the impact of collaborative learning on student performance.
Part Five

Conclusions

In this study, attempt has been made to show the function of the social history interview, not only as a basis for obtaining social information concerning the patient's background and factors surrounding the precipitation of his illness as a basis for diagnosis and future treatment plans, but also, and most important for the purposes of this study, as it reveals the emotional factors in the conflict of the relative or other informant giving the social history.

It has been pointed out that the early establishment of rapport and confidence in the hospital staff on the part of the relatives of the patient is essential as a basis for future cooperation in plans for the patient's treatment and eventual rehabilitation in the community.

It is impossible to establish this rapport without first releasing the relatives' conflicts surrounding mental illness and the need for hospitalization. This release of conflict and the accompanying interpretation of hospital function is an important function of the psychiatric social worker in obtaining the social history.

The obtaining of the social history is not an isolated service performed by the psychiatric social worker, but is the first and important step in the overall treatment plan for the patient.
It is true that the patient is first and last the chief interest of the mental hospital, but the relative must also be considered as a client, indirectly for the good of the patient, and directly in helping him to release his conflicts surrounding mental illness. It is a great shock to almost any family to have a member become mentally ill and may cause reappearance and strengthening of old conflicts and weaknesses in the family structure, and the family must be helped to face these problems and to reorganize their strengths to meet this emergency.

The actual factors of the individual conflicts in the order of their numerical incidence is as follows:

The factor having the highest incidence is that of "guilt feelings of avoiding responsibility," occurring in 12 cases out of 30.

The factors of "fear patient would be mistreated" and "shame member of family in mental hospital" appear in the next highest incidence, namely, in 8 cases out of 30.

Following closely, are the factors of "fear of mental hospitals" and "fear and guilt in any way responsible for breakdown," appearing in seven cases out of 30.

Also occurring 7 times out of 30 is the factor of "fear patient would hold it against them for hospitalization."

The factor of "fear of inheritance of disease" occurs in only one case out of 30, but, as has been pointed out above, the relatives' conflicts are usually centered in this early
interview on the patient himself, and it is only later, with
the subsiding of the emergency, that the relative has a fuller
conception of what the illness means for him.

In four cases out of 30, there were no definite factors
of conflict expressed by the informants, but as has also been
pointed out above, in each of these cases the informant was
not too close to the patient either emotionally or physically.

It is perhaps not so important which factors occurred
most often as that in all but four cases, the relatives were
bothered by some deep conflict surrounding mental illness and
the need for hospitalization.

The very existence of these conflicts points to the
obvious misconceptions and fantasies surrounding mental illness,
misconceptions as to the cause of mental illness, and the
treatment possible in hospitals for the mentally ill. The
public has access to many popular articles which usually em-
phasize unfortunate instances of mistreatment of the mentally
ill, and people are quick to seize upon these examples as being
representative of the general state of care in mental hospitals.

Dr. J. W. Klapman, in his article on "Public Relations of
the Mental Hospital" tells of some of the misconceptions which
block the obtaining of cooperation and understanding from the
relatives of the mentally ill: 1

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1 J. W. Klapman, M.D., "Public Relations of the Mental Hospital" p. 381.
The problem of public relations is a more or less acute one for the mental hospital, for it is an especial target of public animosity, and despite the genuine and marked progress achieved by the modern mental hospital in the last few decades, there is relatively little reduction in the animosity and suspicion with which the public regards these institutions... To know the origin of some of these hostile attitudes is at least to have acquired a prerequisite for their correction.

The attitude of the public toward the mental hospital has a unique basis. One's first assumption would be that it is due to concern for the alleged mistreatment of inmates, but such possible concern is inconsistent with the stigma and the disability heaped upon any individual with a record of mental institution hospitalization.... but the point need not be labored. Freud has shown that such attitudes are in reality displacements of guilt feelings, a displacement, in this instance, on the mental hospital itself first, and secondly, on its personnel.

On the basis of the results of this study, it would appear obvious that there is a great need indicated for a good educational program for the strengthening of the public relations of the mental hospitals, and also, most important, the legislation which will provide for more adequate care of the mentally ill, better trained and better paid staffs to carry out the treatment indicated by the overworked psychiatrists.

Approved by:

[Signature]
Richard K. Conant, Dean
### Appendix A

#### SUPPLEMENT

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Date of Admission</th>
<th>Date of Return</th>
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**Previous Admission:**

<table>
<thead>
<tr>
<th>Relation of Informant to Patient</th>
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</table>

#### Problems Encountered:

1. Fear of patient being mistreated
2. Guilt feelings of belonging responsible
3. Close number of family in mental hospital
4. Fear and guilt in any way responsible for situation
5. Fear of family inheritance of illness
6. Fear patient would resist it against doctor's treatment or hospital.
Appendix A

SCHEDULE

Case Name:

Case No:        Date of Admission:     Date of History:

Age:            Race:              Marital Status:       Sex:

Previous Admission:       Relation of Informant to Patient:

Living in same household:

Problems Presented:

a. Fear of Mental Hospitals

b. Fear of patient being mistreated

c. Guilt feelings of avoiding responsibility

d. Shame member of family in mental hospital.

e. Fear and guilt in any way responsible for breakdown.

f. Fear of family inheritance of disease.

g. Fear patient would hold it against them for bringing to hospital.
Appendix

Case Name:

Date of Accident:

Age:

Relation of Insurer to Policy:

Living in Same Household:

Policy Preceded:

Part of Home Policy:

Policy Preceded:

State of Accident

City:

County:

Year:

Place of Accident

Street:

City:

County:

Year:

Part of Home Policy:

Facts of Accident:

Dear

Place of Accident:

Street:

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Appendix B

Social History Form

Blank State Hospital - 1945

Name of Informant, Address, Relation to Patient

Be specific as to names and address, relationship to patient and telephone number. If the informant does not have a telephone, ask for a number at which he may be reached. Make a note as to the intelligence and apparent reliability of the informant.

Residence, Citizenship, etc. of the Patient

Birthplace, date of birth, if foreign born, date of the arrival to the United States, naturalized or alien, if naturalized, place and date. Military service, army, navy or marine, with details, benefit organizations, insurance carried, in what company, name of the beneficiary. Patient's present address and previous addresses. Time in Boston.

Family History

It is not sufficient to ask the general question: 'Has any member of the family ever been insane or nervous?' A detailed inquiry will often bring out a number of nervous or mental troubles. Specific inquiry must be made concerning the persons of the direct ancestral lines as follows:

(a) Paternal grandparents - Names, birthplace, cause of death.
(b) Maternal grandparents - Names, birthplace, cause of death.
(c) Father: Birthplace, date of birth, occupation, address, alcoholism? If dead, age at death and cause of death.
(d) Mother: Date and place of birth, occupation, alcoholism? Address, if dead age at death and cause of death.
(e) Names and addresses of all children in the family, living or dead. Date and place of birth. Civil state, number of children, occupation, alcoholism? Collateral branches. Mention any known cases of nervous diseases in any uncles, aunts, cousins.

Inquire if there has been epilepsy, cancer, tuberculosis, in any member of the family. If there are cases of nervous or mental diseases, get the full name of the person, the relation to the patient, and the date and place of treatment.
Appendix A

Social History Form

Date of Report: 1958

Name of Investigator, Inc., Institution or Facility

Psycho-Social Factors and Family

Relevant, Relevant, Medical or Other Factors

Review of Patient's past medical history with the patient's family

Family History

If it is not sufficient to say the patient's previous medical history, a detailed inquiry will be made. Specific areas which may be noted are:

- Parental Background - Race, religion, occupation of parents
- Mental Health History - Presence, character, intelligence, brain
- Incest: If yes, give details and cause of death
- Adoption: If yes, date and place of birth
- Manner: If yes, date and cause of death
- Marital: If yes, date and place of birth
- Genetic: If yes, date and cause of death
- Occupation: If yes, date and place of birth
- Other: If yes, date and cause of death

Important: If the patient was born in another country, information to say:
Social History Form - page 2

PERSONAL HISTORY OF THE PATIENT

Early Development

Birthplace and age, unusual incidence attending birth, retardation in talking or walking, infantile convulsions, night terrors, fits of temper, etc., severe illnesses or infections, diseases in infancy or childhood, sequella? Frights, shocks, injuries?

Education, Intellectual and Moral Development

Names of schools and years attended. Educational opportunities, time spent in school, interest in studies, progress, behaviour, truancy, etc.

As an adult, regarded as bright, intelligent, or dull-minded? Well-informed or ignorant? Reading, memory, judgment? Moral responsibility, reliability, religious interest? Church affiliation? Criminal traits, tramp life, police record?

Sexual Life

Married, single, widowed, or divorced? If married, date and place of marriage, by whom married, names of all children, beginning with the oldest, date and place of birth, occupation, civil state, addresses, if the patient has been married more than once, give the information about all marriages. Masturbation, or abnormal sex practices. In women, unusual symptoms at menstrual periods; age at menopause. Nervous symptoms accompanying climacterium? Treatment of partner and children.

Diseases and Injuries

Any previous nervous affection of symptoms, such as headaches, nervous prostration, chorea, epilepsy, hysterical attacks, etc? Mention severe infectious diseases and sequella, if any. Inquire concerning tuberculosis, rheumatism, heart disease, neuritis, etc. Venereal disease, syphilis and gonorrhea, full account, if possible, of how acquired, age, and treatment and after affect. Severe injuries, particularly head trauma, should be described as regards to their immediate and subsequent effects. Name and description of all diseases. Place and date of treatment.

Occupation

Kinds of work undertaken, ambition, efficiency, wates, etc.
Social History Form - page 3

Length of time in different positions, reason for changes, etc. Name of employers and dates when employed in chronological order.

Alcoholism, and other Toxic Influences

Intemperate, moderate or total abstainer. If intemperate, age at which drinking began, apparent cause of same, kind of beverage consumed and approximate amount. Periodic or steady drinker? Unusual reaction to alcohol?

Inquire about attacks of neuritis, delirium, hallucinations and suspicions, idea of jealousy.

Other toxic influences: Drug habits, occupational poisons, lead, arsenic, phosphorus, mercury, etc. Illuminating gas, poisoning nicotine intoxication.

Make-up and Type of Personality

Very important because certain of the non-organix psychoses appear to be a further development of mental traits or tendencies early recognizable as personal peculiarities or deviations from the normal. In addition to the points already covered under the preceding headings, the following important types should always be borne in mind and appropriate inquiries made:

Open or manic make-up: Lively, active, sociable, pushing, talkative, cheerful, optimistic; may be domineering, irritable and inclined to cruelty; sometimes not very efficient; may be noted as changeable, lacking in persistence, concentration and application. May show transient blue spells or lowering of spirits.

Depressive make-up: Gloomy, worrisome, blue natures who feel continually inhibited or restrained and unable to make decisions, easily discouraged.

Cyclothomic make-up: Emotionally unstable, either up or down, have blue spells or are unduly cheerful and care-free.

Shut-in Make-up: Shy, retiring, self-conscious, bashful, quiet, secretive, and unsociable. Lack of interest in opposite sex or definite aversions; often prudish and over-particular. Unusual religious interest frequent. Inclined to day-dreaming, show fondness for the abstract and mystical. Odd habits, hobbies, or crabby pursuits and common.

Paranoid make-up: Mistrustful, suspicious, tend to misunderstand, unduly sensitive, feel discriminated against and have feelings of self-importance. (These traits may be related to shut-in
טווחית תהליך הסברה

指导下への意志形成、感じの発見、感情の表現

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Institutional meaning of material, moral, emperical

Institutional meaning of material, moral, emperical

بناء סדר וארגון: איזון, ר.loadData, תפקוד, שליטה, מרכזי

Institutional meaning of material, moral, emperical

On the same scale:_INTENSIVE, INTENSIVE, INTENSIVE, INTENSIVE, INTENSIVE

Institutional meaning of material, moral, emperical

Institutional meaning of material, moral, emperical

Institutional meaning of material, moral, emperical

Institutional meaning of material, moral, emperical
tendencies)

Other types of make-up include the psychasthenic, neurasthenom and hysterical; also the mentally retarded or undeveloped (Feeble-minded).

If the patient is under 60, ask for a lumbar puncture permit. If he is on Section 79, ask for a request for commitment.

**Previous Attacks of Mental Disorder**

Get dates, places where treated, apparent cause, duration of attacks, and general character of symptoms.

**Precipitating Cause of Present Psychosis**

Try to determine what occurrence or situation appeared to bring about the mental breakdown. Emotional strains, excitement, quarrels, worries, griefs, disappointments, sexual episodes, separation, deaths, childbirth, etc., financial loss, overwork, physical disease, etc.

**Onset and Symptoms of the Psychosis**

Take as far as possible a spontaneous account beginning with date when first symptoms were noticed in the patient. In this connection, particular attention should be given to the changes in behaviour in mood, in manner or speech, in attitude towards others, and towards work.

Appearance of suspicion, unusual interests, peculiar ideas and delusions.

Hallucinations in various fields and reaction to them. Obtain as much as possible regarding trend of patient's ideas, topics, of conversation and content of hallucinations. What did the voices say?? What was seen in visions?

Forgetfulness, impairment of memory, loss of orientation, and clouding of sensorium. Always inquire regarding suicidal tendencies or attempts, threat of violence, assaults or homicidal tendencies. Compare informant's statement with those given in the commitment certificate.

What treatment was given at home? Name of physician in attendance. Date on which patient was taken to the hospital.
Appendix C.

Supervision of Patients On Home Visit

(Form used at Blank State Hospital for reports of Supervision in the Community in 1945)

Date of visit

I Present Situation: (Brief statement covering hospital record and home situation at outset.)

II Environment: Home and neighborhood
   Occupation
   Recreation and church activity
   Economic status

III Condition of Patient:

   Physical health
   Mental health (Significant remarks of patient)
   Insight of patient towards health, home and elsewhere.
   Adjustment of patient: Successes, failures.
   Discussion of problems: psychiatric, domestic, social.

IV Nature of Interview:

   Plans for solving problems
   Advice of any nature
   Reaction of patient to plans.

V Social Summary:

   Outstanding social factors in situation and their interpretation.
   Social plans for whole situation
   Progress of or alteration in plans.
Appendix C

Supervision of Patients on Home Visit

(A UNO T) or (B C O L

I. Present Situation:

II. Environment:

(a) Home and neighborhood

(b) Community

(c) Support and access to activity

II. Conditions or Needed

III. Nutritional Needs

(a) Nutritional losses or potential

(b) Insight of patient's current nutritional state

(c) Measurement of intakes: preparation, consumption, balance

IV. Wards of Interest:

(a) Areas for solving problems

(b) Areas of need and caring

(c) Areas of learning to plan

V. Social Comment:

(a) Occupational social factors and training plan

(b) Performance

(c) Plan for social interaction

(d) Process of social adaptation
Bibliography


6. Group for the Advancement of Psychiatry, "Function of Psychiatric Social Worker in the Mental Hospital," p. 4


M platform

M platform

3. Location, Nature of a public transport terminal, including

2. Facilities. Include "The Role of Public Transport in the Urban Area."

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