1959

Patients' attitudes towards and use of the social worker during the early phase of hospitalization for mental illness

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Boston University
PATIENTS' ATTITUDES TOWARDS AND USE OF THE SOCIAL WORKER DURING THE EARLY PHASE OF HOSPITALIZATION FOR MENTAL ILLNESS

A thesis

Submitted by
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(A.B., Radcliffe College, 1957)

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1959
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CHAPTER I
INTRODUCTION

Social work has been described by a noted authority in the field as "a response to the inadequacies of organized social institutions or to people's inability to use their services." Social casework emphasizes, through its activities, assistance to individuals with regard to obstacles encountered in their use of the services of other institutions, or to difficulties in their interpersonal relations within such "primary" groups as the family. Concrete expression is given to the former approach when "secondary" institutions such as hospitals, schools and correctional agencies make use of the special contributions of social work in carrying out their prime function. In such instances, social service departments are located within the larger institution as an auxiliary branch.

Broadly, the purpose of this study is to examine some aspects of the relationship between the practice of social casework and the treatment of mental illness in the mental hospital setting. It has long been acknowledged that the social worker has a recognized role in the treatment of the mentally ill, since mental illness reflects some failure in social as well as personal adaptation. Social work in mental hospital settings, however, has expanded the concept of

its role and undergone modifications. This evolution has been the result of new knowledge and new experiences. "The truth is that casework concepts are dynamic--they change, grow and develop..."2 This statement applies as well to casework oriented to a specific setting as to the generic casework processes.

Historically, social workers were primarily concerned with the readjustment to community living after hospitalization--social services occupying a role only at the chronological end of the treatment program. Later in the development of psychiatric treatment, however, it became clear that the maintenance of the interest of the patient's family during hospitalization would facilitate recovery, and that this was an appropriate and necessary job for the social worker. As interest and concern for relatives increased, it was seen as important to provide for the patient's family some support and relief from their own anxieties during the crisis of hospitalization, freeing them to be more helpful to the patient himself. Another function, more recently seen as valid, is to modify, through intensive casework, the key relationships in the patient's life. This stems from increased awareness of the nature of mental illness, based on theory and clinical observation that there are pathological interpersonal processes at work in the patient's life which led to his illness. Thus, the application of the social worker's particu-

lar skills and traditional concerns with the reestablishment and reinforcement of family equilibrium, finds a happy union with modern psychiatric theory, and concrete expression in the activities discussed above.

These functions so far mentioned as legitimate and accepted by the social work profession and by other hospital personnel are primarily related to work with relatives. Social workers also, however, provide other indirect services to patients, serving as a link between the patient and the community at large, as well as various direct services. Direct services to patients are focused predominantly upon the accomplishment of a smooth adjustment to the hospital. The social worker is, thus, in the paradoxical position of working towards the maintenance of the patient's relations with the outside world, while helping him to separate from it temporarily. The social worker may make "friendly visits" to the patient, to reassure him and to relieve some of his initial discomfort; she may offer a continuous and reality-focused supportive relationship in addition to the psychotherapy provided by the doctor, or she may undertake the sole therapeutic responsibility for the patient under psychiatric supervision and administration.3,4,5,6


It can be seen from the preceding discussion that social work in a mental hospital includes a wide range of activities. Others, not mentioned, may be performed, depending upon the unique administrative organization and theoretical orientation of both the hospital at large and the social work department and the interaction between the two.

...The practice of social work is influenced not only by the medical or psychiatric setting but also by the way the social service unit is organized and by the responsibility it accepts as primary. The structure of the parent agency and the structure of the social service unit comprise the two components...of the matrix in which social work is practiced...7

Decisions as to which activities are to be performed in serving each patient are customarily made on the basis of a "team" evaluation of the patient's needs, and service is rendered on the basis of these. This implies that the patient is the passive recipient of services selected for him by the social work staff, with suggestions from the medical personnel.

The Patient as Initiator

Current trends in both psychiatric and social work thinking, however, tend to view the mental patient and the hospital setting in broader terms. The patient-client is not seen merely as a syndrome of clinical symptoms and pathology; he is considered rather as a personality who brings with him to the hospital a system of values, goals, attitudes.

and habitual responses which will determine to a large extent the course of his hospitalization. The hospital is not merely a place where he can get "treatments"; but instead it is a highly complex social community of which the patient is a member and in which he interacts with the other members in terms of status, role, values and other group characteristics. These interactions within the hospital "milieu" will influence the patient's recovery.

There are a wealth of studies in both psychiatric and social work literature which reflect upon the relationship between socio-cultural factors in both the etiology and treatment of mental illness. Class and ethnic factors and conflicts often determine the forms of mental breakdown the illness takes.\(^9\), \(^10\) In addition, social and cultural characteristics of mentally ill people frequently determine the kind of treatment selected by the helping person. The patient's motivation and capacity for certain kinds of help are deduced on the basis of these social characteristics.\(^11\) These factors have been found to apply to the selection and use of casework services as well.


the more dynamic attributes of emotional orientation towards
the hospital and experiences in his total life situation,
will influence the course of his progress in the hospital.
Also relevant to the patient's adaptation in the hospital are
his attitudes towards his illness, and expectations of hos-
pitalization.

...the social attitudes which the patient formed
outside the hospital persist. His conception of
hospitalization is assimilated with varying degrees
of realistic and distorted application to these at-
titudes. 12

That such attitudes which the client brings with him are also
considered important determinants of his perception and use
of casework help is attested to by the statement:

The social worker must accept the possibility that
she is identified in the client's mind with other so-
cial workers or inquiring persons who in the past rep-
resented authority, hostility, beneficence, acceptance,
etc. 13

Thus, the patient is not merely the object of staff de-
cision regarding his future in the hospital. He exerts a
very powerful influence upon the staff by virtue of his so-
cial characteristics, past and current life experiences in
his total life situation, and his predominant social and per-
sonal attitudes. He demonstrates his motivation and capacity
for shared participation in both the hospital milieu and the

11. Hollingshead, and Redlich, Social Class Factors and


13. Feder, Leah,"Early Interviews as a Basis for Treat-
ment Plans," in Readings in Social Casework, Columbia Univ.
Press, N.Y., 1940, p. 208.
specific opportunities for treatment.

Patients become active consumers of what the hospital has to offer. They develop different involvement in different members of the staff and different hospital activities, selected in part from their own initiative... 14

It is evident then that the patient is involved in a complex interaction with other members of the hospital community and that in a broad sense he is the stimulus which evokes responses from the staff. His behavior, values, attitudes, needs, and expectations to a large extent determine his use of the diverse opportunities with which he is confronted in the hospital.

The purpose of this study is to investigate some of the patient's relevant attitudes and perceptions of social workers in the mental hospital, which bear upon his use (or disuse) of this avenue of service. It is more specifically aimed at an exploration of the patient's own felt needs early in hospitalization, his awareness of the availability of social service help and his knowledge of which needs the social worker could attend; his attitudes towards social workers based on previous experience and more general attitudes towards authority and accepting help, and his motivation to participate in the services offered. The validity of early social service contacts with patients on the basis of these findings will be discussed in the light of some "principles" used generically in the casework process.

Methodology

Statement of Research Questions. The problem as formulated is to investigate the perceptions of mental hospital patients with regard to social workers; these findings will be related to the present and future use by these patients of social work services located within the hospital. For reasons which will be discussed later, it was decided to focus attention upon the patients' perceptions and felt needs during the earliest phase of hospitalization—that of the two week period immediately subsequent to admission. The purpose of the study may be stated in three parts:

To determine

1. some of the sources of the patient's current perceptions of the social worker, in his life situation, past experiences, and general attitudes.

2. the awareness on the part of the patient of needs to which he feels the social worker could attend, and

3. the degree of the patient's motivation during the acute stage of mental illness to make use of these services, and the nature of his participation.

These findings will be related to the expanding concept of the role of the social worker, both generic and specific to the process of rehabilitation in the mental hospital setting.

Design of the Study

Sample. The sample is composed of thirteen patients admitted to the Massachusetts Mental Health Center during the month of March, 1959. The group consists only of those pa-
tients who according to their records have never been hospi-
talized before for mental illness, and excludes all those ad-
mitted to the hospital directly from the court. The first
criterion was used on the basis of our desire to gain a fresh
view of the patient's perceptions of social workers in a men-
tal hospital, uncolored by previous experience in such a set-
ting, and to learn something about the effect of the hospital
admission procedure upon his perceptions and its success in
communicating to the patient the role of social service in the
hospital.

Court admissions were excluded from the study, since
these patients are often discharged after ten days observa-
tion. The factor of court referral would have been such a
weighty influence upon the patients' attitudes and percep-
tions, that it would have separated them as a group from the
other patients. It was decided then, due to limitations of
time, to exclude this group and to reserve the study of the
perceptions and patterns of use of the social worker of court-
admitted patients for a future investigation.

An attempt was made to maintain an equal number of males
and females, and equal numbers of patients who came to the
hospital voluntarily or via a doctor's recommendation and com-
mittment. Due to the predetermined nature of admission pro-
cedures, however, decided upon and influenced by other depart-
ments in the hospital, this was impossible to arrange without
severely limiting the sample. Also, as will be substantiated
by the findings of this study, the formality of the legal authority under which the patient was admitted, is often not indicative of the real pressures which led him to the hospital. Family members, it was expected, play a key role in arranging for hospitalization of both voluntary and doctor-referred patients. "The decision for hospitalization is usually a difficult one because it is dependent upon a complex interaction of social and personal factors."15

Data Collection

The interview schedule (see Appendix A) was the organizing medium of the interviews conducted with each subject during the second week of hospitalization. Although the interview was focused to elicit information covered in the schedule, it was rather loosely structured in order to allow the respondent to answer in his own terms and according to his own frame of reference. In general, the order of topics in the schedule was maintained, but the interviewer utilized many of the same techniques of casework interviewing in the interest of obtaining more complete responses to the issues that were raised. Where the material seemed too threatening, or the question unclear to the patient, an attempt was made to rephrase the question or to return to the topic at a later time during the interview. Thus, although the interviews were quite different for each patient, it was felt material

gained in this manner would be fundamentally more valid than material gained via a highly structured instrument. That authorities consider the use of such interviews as valid is reflected by the statement, "The research interview itself... can also profit from the researcher's bringing to bear upon it his casework principles and techniques." 16

The interviewer introduced herself to the subject by name only, not identifying herself as a social worker. She gave a brief description of the nature of the study and invited the patient's participation. The explanation given embodied the idea that the purpose of the study was to learn about the patient's initial reactions to the hospital, what their present concerns were, and how the hospital might better help them. The interviewer thus, did broadly identify herself with the hospital and the findings must be considered in the light of the interpersonal factors resulting from this. The subject was promised, however, full confidentiality of any information or opinions he might choose to reveal in the course of the interview. One subject, mute since admission, refused to participate in the study.

The interview schedule covered four main categories: Identifying information, Attitudes surrounding hospitalization, Attitudes specific to the perception of social workers, and Motivation to participate in casework services. The ver-

batim process of the interview was recorded immediately afterwards and the data was extracted from them. Items included in the schedule were drawn from theoretical and clinical material and previous research endeavors already discussed.

The Research Setting

This study was conducted at the Massachusetts Mental Health Center, a small psychiatric hospital providing about one hundred fifty beds for the treatment of the mentally ill. It is affiliated with Harvard Medical School, for purposes of psychiatric training and research into the nature of mental illness. Administratively and philosophically, it is oriented and committed to the provision of intensive treatment and rehabilitation of the patients. In setting out to attain these objectives, various forms of psychiatric treatments are employed, ranging from psychotherapeutic to somatic therapies.

In addition, the "milieu", designating both the social and emotional climate of the hospital and the various activities provided by the adjunctive services, are seen as important influences upon the course of the patient's recovery. A high proportion of hospital personnel to patients produces a great number of staff-patient interactions, offering to the patient much external stimulation and few opportunities for withdrawal. Although acute, rather than chronic illnesses comprise the majority of the patient population, expectations for patient behavior on the wards are high. Restrictions and limits are at a minimum and are employed for purposes of con-
trol and reassurance rather than punishment. The high number of staff personnel, however, and the essentially "democratic" atmosphere and organization of the hospital along administrative lines, allows for a great many ambiguities and distortions in the formal and informal systems of communication between staff members as well as between the patients and staff.

The Admissions Procedure.

The newly reorganized admissions procedure reflects both the increasingly humane treatment of mental patients in general, and the recognition of the importance of the initial impact of hospitalization on his future progress. At one time, patients were admitted to the hospital through the rear of the building, often with the aid of physical restraints, and rushed to the ward for disinfectant baths. Desperate relatives and friends, who accompanied the patient, were almost ignored.

The admissions procedure is no longer a secretive and hurried affair, fraught with potential trauma for the patient. The admissions office, bright and attractive, is located in the front of the hospital, and patients are brought in through the front door. Essentially non-medical tasks, such as relief of fears of both relatives and patients, and interpretation of the hospital, were transferred to the jurisdiction of the social worker, who could now provide continuous service to patients from admission, through hospitalization, to di-
charge.

...with the integration and unification of social service functions of the Hospital through the social worker a great improvement in morale was noted. Relatives began to see hospitalization as a temporary procedure and patients as possessing potentialities for recovery. With hope aroused, relatives began to show eagerness to contribute to the therapeutic process. 17

Thus, we can see that the social worker as leader of the "team" at the time of admission, coordinating the functions of the doctor and the nurse, occupies a strategic position in influencing the initial impact of the hospital upon the patient and his family. Impressions gained at this time will affect both the patient's total adjustment to the hospital, and, specifically, his use of the opportunities for social work service.

Scope and Limitations

It is felt that to a large extent the findings of this study can be generalized to apply to the entire patient population of the Massachusetts Mental Health Center, meeting the same criteria. Nothing extraordinary occurred during the month of March to influence a change in the rate or character of admissions. Thus, we conclude that this sample is typical of the population from which it was chosen. In addition, there is no reason to believe that this group is significantly different from the entire population of patients admitted to similar hospitals--where rehabilitation rather than custodial

17. Greenblatt, Hork, and Brown, From Custodial to Therapeutic Care in Mental Hospitals, (Russell Sage Foundation, N.Y. 1945) p. 51.
care is the chief goal, and admission policies are determined by this underlying philosophy. Also, some of the areas of investigation (such as attitudes towards accepting help), though considered specifically in this study, can be applied broadly to all mental hospital patients, and, indeed, to all "clients."

Some of the aims of the study, however, particularly the attempt to investigate the effects of specific hospital procedures, constitute limits in extent of generalizability. Other limitations exist in the manner of data collection, which relies on the interviewer as a standard instrument, combined with difficulties inherent in interviewing psychotic patients, early in hospitalization, and with regard to material which might be "emotionally laden". It is important to note, in addition, that the extent to which the patients' current perceptions are based on previous experiences or upon social and personal attitudes is difficult to evaluate in one interview. The interview could only hope to elicit some rather superficial impressions of the nature of the patient's current perceptions and some of their sources. This study, however, might serve as an exploratory base, providing certain "leads" for future investigations of more intensive nature.

Impetus for the Present Study

The present study is an outgrowth of a broader project being carried out at the Massachusetts Mental Health Center.
As stated in the unpublished progress report,\textsuperscript{16}

...The project has aimed not only at exploring the possibilities for smoothing the rehabilitation process through its various stages and integrating its diverse aspects, but also in amalgamating project and hospital personnel into a coordinated effort towards common rehabilitation goals.

Inherent in the broad and exploratory nature of the project, were many diverse avenues of investigation. An example of these diversities, relevant to this study, was both the emphasis on the establishment of a special "rehabilitation team" to provide special services, and the tendency to regard members of existing services as already performing rehabilitation functions.

Despite some resistance to the establishment of a rehabilitation team to provide special services to patients with special problems, these attempts led to the improvement of many parts of the treatment process as a whole, and introduced many innovations which have become an integral part of the hospital organization. In addition, there has been increased communication between the traditional services such as nursing and social service, and the rehabilitation services such as the work program.

As an offshoot of the tendency to regard members of the traditional services as already performing important rehabilitation functions, an investigation of the specific roles of these services was conducted. Those studied from the point

of view of "role in psychiatric rehabilitation" were social service, occupational therapy, vocational placement, etc. An attempt was also made to examine the patient's attitudes and perceptions of treatment and their view of the "interpersonal aspects of hospital life". Some questions were asked which bear directly upon the patient's view of various categories of personnel, such as; "if you had any troubles, to whom would you talk?" The physician was reported most frequently as the person to whom the patient would turn, and nurses and attendants were second. Social workers were mentioned third. The sharp difference between the frequency with which doctors, nurses, and social workers were mentioned was striking, in terms of to what extent the patient sees these categories of personnel as helpful to him. Doctors were mentioned sixty-seven times, nurses and attendants sixteen times, and social workers nine times. It is also striking in terms of the present study that only two of the forty-seven patients on the acute wards mentioned social workers as the person to whom they would go with a problem.19

These findings suggest that patients especially in the early phases of hospitalization did not perceive social workers as important members of the "rehabilitation team" and would rarely take the initiative in making use of social work services available in the hospital. It is unclear, however, what the "dynamics" of this situation may be. It is the aim

19. Ibid., p. 39
of this investigation to examine more closely some of the specific attitudes towards social workers influencing use of social services particularly in the early stage of hospitalization. If these "dynamics" are better understood, perhaps better communication between patients and staff can be achieved, thus leading to more effective service. It has been found in an earlier study by Caudill,

The lack of communication increased the mutual isolation of patients and staff. Both patients and staff structured their actions in accordance with a set of values and beliefs, but because the values and beliefs were only incompletely known by the other, the two groups viewed one another in terms of stereotypes which impeded an accurate evaluation of social reality.

It must be kept in mind, however, that there are many channels through which the needs of patients are made known to social workers. Decisions as to which needs the social worker can best attend are frequently made by nurses, doctors and relatives. Thus, patients' perceptions and attitudes towards social workers is but one factor in the complex interaction which eventually leads to the utilization of social work services by the patient. Nevertheless, his attitudes, phantasies, and general orientation to the hospital and expectations from it will undoubtedly influence others in making referrals to social service department. In instances when social work contacts are initiated by other persons, the patient's acceptance of these services will be colored by his attitudes, even if the service consists only of help extended

to his relatives. The extent to which he sees these indirect services as related to his own recovery, is an important concern for all those engaged in psychiatric rehabilitation. If the patient does not see these services as helpful to him, or even as destructive or threatening, he will have less confidence in the ability of the hospital as a whole to help him.

If such negative attitudes exist, it would be important to know to what factors they might be attributed; unpleasant past experiences, transfer of negative attitudes from other persons to the social worker, or due to inadequate interpretation by the social worker of her role. It would also be instructive to gain some greater awareness of some of the influences associated with positive attitudes towards social workers.

It should also be noted that the patient's perceptions and attitudes towards his illness (including his evaluation of its severity and the degree to which he is incapacitated) will also bear upon his initiative in asking for help and his acceptance of services preferred. Some mention should be made too, of the influence of the patient's pathology upon his awareness and evaluation of his own needs and strengths. We must remember, however, that although regression, distortions of reality, turmoil, and other aspects of illness will undoubtedly affect his perceptions, he reacts to the hospital in terms of his total personality. It is with his current per-

ceptions of social worker, inspired by pathological attitudes or not, that we are concerned here. "Those who are attempting to bring about the rehabilitation of the patient must determine the existing ability of the patient and develop experiences which fit his existent functioning capacity." 22

It is a basic assumption of this study that social workers do perform services, direct and indirect, in the early phases of hospitalization and that these services are accepted by the profession and other hospital personnel as a legitimate and necessary part of their role. This is consistent with the concept of rehabilitation, as "a process... which starts immediately after the patient's admission to the hospital, is concurrent with, and part of treatment." 23 It is also the case however, that "there are obvious differences in social work responsibility among hospitals with different programs and different uses of social work during the early period of hospitalization." 24 Some programs are quite routinized and others are informal. The present study takes place in a setting where social work functions in relation to admission are routine, including reception of the patients and securing of social history (part of the total diagnostic procedure). Further contacts, however, with either patients or relatives are elected on the basis of individual

23. Schwartz, op. cit., p. 2
case considerations, and are often dependent upon the "grapevine" system of communication of needs for service.

Although differences in programs exist, the literature on psychiatric rehabilitation reflects the belief on the part of most mental hospitals that there are needs for social service in the early period of hospitalization. "The best treatment can be given to the patient when social service has been an integral part of the treatment plan throughout hospitalization."25 This study is directed towards the end of better understanding of the patient's relevant attitudes and perceptions of social workers, leading to more effective service during this phase of hospitalization.

25. Ibid, p. 41
CHAPTER II
DESCRIPTION OF THE SAMPLE

As discussed in the Introduction, it is known from both clinical experience and research investigations that social characteristics influence the patient-client's use of psychiatric and casework services. Socio-cultural traits are operative in the choice of treatment by the helping person; the values, norms, and behavior patterns will influence the nature of participation in these various forms of help.1,2 This chapter will present some of the social characteristics of the patients in this study which may be related to his perceptions and use of casework in this hospital.

Age and Sex Distribution

It can be seen from the following table that the sample chosen for this study was a youthful one. This appears to be representative of the hospital population as a whole, which most of the time tends to be composed of patients middle-aged or younger. This fact is to a large extent the result of the philosophy surrounding admission procedures, which in turn is influenced by the philosophy of the hospital. Being a "therapeutically oriented" hospital, admissions tend to be of the

acute type, not of long-standing duration, and which are thus believed to be better prognostic risks. Table I shows the exact distribution of age and sex of the sample.

**TABLE I**

**DISTRIBUTION OF AGE AND SEX**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>16-25 years</td>
<td>4</td>
</tr>
<tr>
<td>26-35 years</td>
<td>1</td>
</tr>
<tr>
<td>36-45 years</td>
<td>1</td>
</tr>
<tr>
<td>46-55 years</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>4</td>
</tr>
</tbody>
</table>

It must be noted that extreme concentration of ages below thirty five may greatly influence the kind of material which is obtained. It will undoubtedly affect the social data (such as employment, family constellation, and living arrangements.). This factor may also, however, influence more subtly the kinds of attitudes and perceptions which the interview aims at eliciting, since attitudes frequently change according to maturity and experience. (For instance, in this particular study, material pertaining to attitudes towards authority or independence-dependence will be colored by the fact that these are some of the central problems of this stage in life.)
**Occupation**

Table 2 shows that nine of the sample were "unemployed" immediately prior to hospitalization and four were hospitalized while still engaged in their respective occupations. ("Occupation" is used here to include that of student and housewife.) The fact that the majority of the sample were not actively working at their usual occupations is indicative of the probability that mental illness often leads to hospitalization only after several months of severe incapacitation. The large number of patients who were students is related to the concentration of ages between sixteen and twenty-five.

**TABLE 2**

**OCCUPATION PRIOR TO HOSPITALIZATION**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White collar</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Laborer</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Housewife</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
</tbody>
</table>

The fact that such a large percentage of the group was unable to work (or attend school, as the case may be) might conceiva-
bly affect the kinds of concerns patients have and might thus affect the services requested of social workers (i.e. assistance with the reestablishment of employment or substitute arrangements, such as financial assistance, homemaker services for housewives, or special academic arrangements.)

significant social relationships

"The first function of the social worker is to represent the hospital to the family of the patient...she helps the family solve the problems generated by the hospitalization."3 It would follow from this, a statement which is substantiated by the findings which will be presented later, that the social worker often becomes very quickly identified in the patient's mind with the relatives or other significant figures in his life who are instrumental in his hospitalization or who maintain close contact with him while he remains in the hospital. It is then valuable to know whom the patient considers his most important ties. Table 3 indicates the nature of the relationships the patients in this sample cited as most meaningful to them. These are tabulated according to the age of the patients.

This distribution is what we would predict; the younger the patient, the more likely it is that parents will be the key figures socially and emotionally, and with the older patients, spouses, siblings, and friends become more significant.

These differences will tend to be reflected in the member of the family constellation whom the social worker chooses to have contacts with and also the inter-familial conflicts in which she may become involved. (Parent-child conflicts, marital tensions, or sibling rivalries.) These factors will then influence the perceptions the patient may have of the social worker.

**TABLE 3**

**PERSONS MENTIONED AS CLOSEST RELATIONSHIPS BY AGE OF PATIENT**

<table>
<thead>
<tr>
<th>Relationship</th>
<th>16-25</th>
<th>26-35</th>
<th>36-55</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Father</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Spouse</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Friend</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

**Living Arrangements**

Prior to hospitalization three members of the group had been living alone, three were living with friends, three were living with their spouses, and four were living with parents. Since a large proportion of the group had been living with other people, it is less likely that they will feel the need to rely on social service for assistance in this area. The following table compares this data with that of table 3
(Persons Mentioned as Closest Relative).

TABLE 4
LIVING ARRANGEMENTS AND PERSONS MENTIONED AS CLOSEST RELATIVE

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Living Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alone</td>
</tr>
<tr>
<td>Mother</td>
<td>1</td>
</tr>
<tr>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>3</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>5</td>
</tr>
</tbody>
</table>

The table shows that the patients who were living alone felt closest to friends or siblings, those who were closest to spouses were living with them (one patient was living with her husband and mother), and the five patients who were living with their parents mentioned their mothers (and sibling) as closest relative. Seven patients were married (two were divorced and remarried) and six were single. Two of the married patients were separated from their spouses.

Education

Four patients finished from one to two years of high school, and six were high school graduates. Three patients were attending college and graduate school. This distribution is typical of the wide range of social and economic groups.
represented by the patients in this hospital. Although it is a state hospital, its world-wide reputation as a center for training and research and its stress on the treatment of acute illness tends to bring to the hospital a high population of students of upper middle class origin. Three of the four patients who had finished one or two years of high school were presently attending high school and had plans for college.
CHAPTER III
ATTITUDES SURROUNDING HOSPITALIZATION

We discussed in the Introduction the likelihood that patients may easily transfer attitudes associated with the hospitalization experience as a whole (inclusive of the events and pressures which preceded it) to the various categories of personnel within the hospital including the social worker. These "displacements" of attitude will influence the image the patient formulates of the members of the treatment "team" and will to a great extent determine the use he makes of these opportunities for help. This is particularly true in the case of the social worker, whose role it is to be the link between the patient and the outside world, and who plays a key part in the admission procedure. (The effects of the social worker's role at the time of admission upon the patient's image of the social worker will be presented in Chapter V.)

Perception of Reason for Hospitalization

The reasons patients gave for their hospitalization fell into five groups. Some patients gave more than one reason for their need to be hospitalized, so that the frequency with which each of these were mentioned will be tabulated, rather than one reason given by each patient. The five general groups of reasons were as follows: 1. Relief of symptoms causing personal discomfort, 2. Relief of symptoms causing
difficulties in social adjustment, 3. Help with personality problems of long-standing nature and less concern with acute symptoms, 4. Family unable to tolerate behavior of patient, and 5. Other outside pressures with patient taking little responsibility for decision. The first category was cited most frequently (six times) as cause for hospitalization. Illustrative of this category are the following statements:

"I didn't feel good; I felt nervous, tense, and mixed up."

"Myself is my biggest worry. I am obsessed with certain thoughts and it is exhausting to think every minute."

The second category was mentioned five times by these patients. Remarks which illustrate this category are as follows:

"I knew I couldn't continue to function every day."

"I couldn't seem to get down to work at school."

"I can't seem to get along with kids my age."

The third category was mentioned twice. One patient said:

"I feel that I have always been indecisive, afraid of changes, and of people leaving me. I want help with these problems."

Another stated:

"I feel incapable of getting married, running a home and family. My boy friend wants to get married and I get very frightened."

Two patients gave as reasons for their hospitalization statements which are representative of the fourth category. One patient commented:
"Everyone in my family thought it was a good idea for me to come."

Another said:

"I wanted to get out of everyone's way. I was causing them too much trouble to stay home."

The fifth category of statements was characterized by the fact that patient attributed reasons wholly to outside pressures and took no responsibility at all for the decision. They presented themselves as wholly without control in the situation, with little understanding of the outside pressures which were brought to bear and which were arbitrary and incomprehensible. One patient said:

"I came to the hospital because my doctor put my name on the waiting list."

Another said:

"My doctor thought I needed some pills and shock treatments."

It is clear that patients have varying degrees of insight into the reason for their hospitalization, that they assume varying degrees of responsibility for participation in the decision, that they perceive their problems differently and have very different expectations of the hospital. All these factors relate to the patient's perception and use of the social worker in the hospital.

Key Agent of Hospitalization as Perceived by the Patient

The person whom patient perceives as most instrumental in arranging for hospitalization is not always reflected by
the legal authority under which he comes to the hospital.
In this sample, the patients were either admitted under Section 79, the ten-day commitment by a doctor for observation, or Section 86, a voluntary commitment. Table 4, however, shows who the patient saw as primarily responsible for his hospitalization.

TABLE 4

<table>
<thead>
<tr>
<th>Legal Authority</th>
<th>Patient's Perception</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr. Family Self Friend Agency</td>
</tr>
<tr>
<td>Section 79</td>
<td>4 2 1 1</td>
</tr>
<tr>
<td>Section 86</td>
<td>2 2 1 1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6 4 1 1 1</td>
</tr>
</tbody>
</table>

Half of the patients admitted under Section 79 saw persons other than the doctor as the significant person in planning for hospitalization. None of the patients who came on "voluntary commitments" (Section 86) saw themselves as the primary source of incentive for hospitalization. Eight of these patients expressed some negative attitudes towards the persons they cited as responsible for hospitalization. For instance, one boy said:

"A friend of mine (a girl, she's older) thought I needed some help. She took me to the Mass. General and they sent me here. I guess I can't trust my
friends anymore."

or as stated by another patient:

"My husband was most in favor of my coming here. The doctor agreed, but I think my husband persuaded him. I don't need to be here."

Three patients expressed positive feelings towards the person whom they regarded as most instrumental in effecting hospitalization, and saw their interest as helpful and in their best interests. For example,

"A social worker from the X Hospital suggested I come here—she thought it would help to relax my nerves, and I think she was right."

One person expressed some mixed feelings:

"I didn't want to come at first when my doctor said I should, but then I saw it was for the best."

The one patient who felt that she had taken the most initiative in arranging for hospitalization expressed some disagreement with her family about hospitalization:

"I thought I should come and get my problems straightened out. My family doesn't understand mental illness, they don't think I'm really sick."

Thus, we can see that patients are often in great disagreement with persons responsible for them about the decision to be hospitalized. It is well known from clinical experience that the motivation of the patient for help and the image he has of the helping person is often at the start affected to a large extent by the path he has traveled in arriving for help. If his experiences have been negative he will often be less accessible and part of this will be due to phantasies he has of the helping person. We could predict, then, that since
so many of these patients appear to have had many conflicts surrounding the issue of hospitalization, that their whole attitude towards and expectations of the hospital would be colored by this.

Perception of Severity of Illness and Expectation of Length of Hospitalization

If a patient feels himself to be very ill and in need of a long period of hospitalization, it is more likely that he will expect to employ the services of various hospital personnel. Some patients, however, for many reasons, expect to be in the hospital for only a brief time and do not perceive themselves to be severely ill and therefore in need of much outside help.

In this group nine of the thirteen patients interviewed saw themselves as what we will call "moderately ill". Statements from which this category was formulated were:

"I feel that I have some problems, but I am not as bad as some of the others."

"I am not as sick as some people here, but I do agree with the doctor that there is something wrong."

The four remaining patients regarded themselves as not very ill at all, as compared with most of the other patients. However, some members who fell into this category expressed their anxiety that they would become ill if made to stay in the hospital.

Four patients had no idea of how long they expected to be hospitalized, and stated in most cases that "The doctors
will decide." Three patient expected to be in the hospital one month or less, and six patients expected to be hospital-ized from one to six months. According to these findings, it appears that most patients tend to expect some rather lengthy period of hospitalization.

**Initial Reaction to the Hospital**

The patients' initial impressions of the hospital environment as a whole were elicited during the interview. Six patients expressed a considerable degree of dissatisfaction based on specific complaints about the hospital procedures and/or physical facilities. Some patients were rather vague and merely expressed general dislike of being in a mental hospital. Some of these comments were:

"I'm not getting any treatment here." (meaning somatic treatments)

"I'm frightened of being in the hospital, especially the staff meetings. There seems to be so much confusion and people always trying to make me go to the different activities. The attendant follows me all over."

"I find there is almost no privacy in the hospital. Also, I feel kind of lost among all these people who are strangers to me."

Four patients expressed some mixed feelings about the hospital. These comments tended to be based on some ambivalence towards the idea of being in a position which the patient regards as dependent. Other statements regarded as "mixed" reflected both positive and negative feelings towards the limits set by the hospital, which the patients found both re-
assuring and restricting. Some of these remarks were as follows:

"I am getting used to the hospital because I have to. The trouble is you get too used to it—I don't like to feel too comfortable here."

"I like the hospital—but the rules are too strict. I don't think I should have to go to bed so early." (This patient is an adolescent boy who, during the interview, responded in a negative way towards all the limits imposed by the hospital.)

Three of the patients expressed quite positive feelings towards the hospital. They felt comfortable and certain they could be helped here. They had already begun to establish relationships with other patients and with some staff members, particularly the student nurses. They found the hospital a generally warm and accepting place and a relief from the pressures many of them had been experiencing at home and in the community. One patient said:

"I have confidence in the type of treatment I am getting here and in the doctors. The staff allows you to think about your problems and doesn't punish or scold you for the things you do."

Another said:

"I like the hospital. It's much better than it was at home. There I just sat watching the clock. Here there are lots of things to do."

These patients seemed to find the hospital most satisfactory and seemed to be able to make use of the various therapeutic opportunities offered within the hospital community most quickly. They were much less bothered by some of the realistically difficult aspects of hospital life (i.e. disturbances of other patients, being presented at staff conferences, etc.)
than the other patients.

We would expect that patients who were able to relate more positively at first to the hospital community as a whole, would also be more prone to utilize the services of various categories of personnel in the first weeks of hospitalization and that their generally positive attitudes towards the hospital would contribute to a positive image of the social worker as a member of that community.
We have discussed previously the notion that patients' more generalized attitudes towards their relatives and towards authority will influence their perceptions of the social worker. In addition, past contacts with social workers, and the patient's ideas about the functions of the social worker are central to the purposes of the present study. Material related to these factors will be presented in this section.

Attitudes Towards Relatives

Since it is the unique function of the social worker in the hospital to deal with the relatives of the patients, it is relevant to ascertain the nature of the patients' attitudes towards their relatives. These attitudes may easily influence the patient's attitudes towards the social worker, as the social worker quickly becomes identified with them in the patient's mind. If the patient is resentful towards the relative who had him committed, these feelings are likely to contribute to his image of the social worker.

Comments made concerning relatives fell into three general categories; positive, negative, and ambivalent. Eight of the patients expressed very mixed feelings towards their close relatives. Characteristic of these remarks were the following statements;
"I think that I am closest to my mother, but I fight with my father a good deal. He is ashamed of my being in the hospital and won't let me tell any of my friends."

"Sometimes I feel close to my sister and sometimes I don't want to have anything to do with her."

Only three patients expressed predominantly negative attitudes towards relatives, indicating no desire to maintain contacts with them. These comments were:

"I feel uncomfortable with my relatives. They are like strangers to me and I have no desire for them to visit me."

"I don't like to go home to my parents'. It's dreary there and they argue all the time."

Two patients verbalized primarily positive feelings towards their relatives. In both cases, relatives visited often and were very supportive, according to the patients. Both were anxious to return home and to reestablish the relationship just as it had been.

The fact that such a large percentage of the group expressed rather ambivalent attitudes towards the significant relatives in their lives is probably indicative of the fact that many of the patients were engaged in serious interpersonal conflicts with close relatives. The illness probably developed within the context of these conflicts.

**Attitudes Towards Doctors as Authority Figures in the Hospital**

It is known from clinical experience that clients often invest the social worker with the authority of the agency.
In this case, the authority of the hospital is invested by the patient in the image of the social worker. Since the doctors in this hospital are generally considered by both patients and the staff to be the prime authority figures, questions during the interview designed to elicit attitudes in this area were phrased in terms of doctors rather than the staff in general. Patients' attitudes again fell into three general groups. Five patients expressed predominantly positive feelings towards the hospital medical staff, three were primarily negative, and five patients expressed mixed feelings. Patients who spoke positively said:

"The doctors seem very human; I don't feel any great separation between them and me, they give me the feeling that we are all human."

Those who commented in a negative vein said things like:

"The doctors are stuffy, accusing, and cross. I don't find them helpful."

"I'm frightened of the doctors and won't really talk to them. It's like when I was working--I couldn't ever speak up to my boss."

Patients who expressed ambivalence towards the doctors made remarks such as this:

"The doctors are quite reserved (not warm--but distant). With them it's all business--but I suppose that's really for the best."

It is clear that the patients who had the most positive attitudes towards the hospital authorities (perceived by all as the doctors) viewed the hospital as a very democratic community with little separation between the staff and the patients. On the other hand, patients who saw the authority figure in
the hospital in a negative light saw them as punitive, distant, and threatening.

Previous Contacts with Social Workers

The great majority of the sample (nine) had had no contacts previously with social work services. One patient had a brief contact through the Community Extension Service of this hospital which is a service provided in order to work with families towards preventing the hospitalization of those patients on the waiting list. Three of the patients had had contacts of a more lengthy and intense nature with social workers. In one case this involved regular and frequent contacts with medical social worker at a local hospital for a period of about six months. This patient was a forty-two year old single woman with few close emotional ties and no material resources. Hospitalized in a general hospital for what appear to be severe anxiety symptoms, she was helped by the social worker in a supportive relationship to leave the hospital and find a new job. In the patient's words:

"The social worker helped me a lot while I was looking for a new job. We talked over my feelings and she gave me more confidence in myself."

Another patient who had had previous contacts with social workers was a thirty year old man badly crippled with arthritis who had up to this time been inaccessible to programs of rehabilitation. Unable to work, and leading a rather lonely and isolated life at home most of the time with his mother,
he was able to make use of a group work activities program at a near-by settlement house. He found this group of other young adults helpful and established a very positive relationship with the group leader. In addition, this patient had had brief contacts in the past with caseworkers who helped him in obtaining part-time work and with whom he talked over some of his feelings. It was one of these workers who suggested to him that he be hospitalized. With regard to these experiences he said:

"I liked the group because it gave me something to do during the day and people I could talk to who had problems too. The group leader was very nice.

The social worker at the Blank Hospital talked to me and thought I should come here for my nerves."

It appears that these previous contacts helped him to be more accessible for help with his emotional problems which prevented him from utilizing opportunities for physical and social rehabilitation.

The third patient who had had direct contacts with social workers over a long period of time was a twenty-nine-year-old woman, who since the age of fifteen had had contacts with two different child guidance clinics and other social agencies. Her anger and rebelliousness towards all figures of authority were reflected in her remarks about the social workers whom she had known in the past. It is hard to evaluate, however, whether her very negative attitude towards social workers was based on realistically poor experiences in the past, or whether her anger at having been hospitalized was the
predominant factor. The fact is, however, that for whatever reason, this patient evaluates her past experiences with social workers at the present time as having been decidedly unpleasant and useless to her in helping her to solve her problems. She said of the social workers she has known:

"Social workers are all cut out of the same mold. They make pretty speeches and appear to be understanding but they really aren't. They all make simple things very complicated."

Such an attitude will undoubtedly influence this patient's use of the social service facilities within the hospital.

Perception of the Function of the Social Worker

Patients had many different ideas concerning the function of the social worker both in general and inside the hospital. Most patients did not make a distinction between social work performed within the hospital and in the community, but many did cite one important function of the social worker as "helping with the outside". This seems to indicate an awareness of the unique aspects of the social worker's role in an institutional setting. Patients' perceptions of what social workers do were mostly phrased in terms of various activities. (This is interesting in that this method of defining the role of the social worker is found frequently in social work literature. Only in the past few years have writers in the field begun to conceptualize about the role of the social worker in broader and more abstract terms.)

The comments made by patients fell into four general
groups. Three patients saw the social worker's prime function as dealing with relatives. Mrs. P. made the following remarks:

"The social worker is the go between with patients and relatives. They help with the outside world. You can tell what they do from the word 'social'. If I had no relatives, she would visit me."

Miss M. stated her impressions of what the social worker does in this way:

"The social worker helps with problems inside the hospital and outside. They act as a buffer between patients and relatives."

Mr. P. said:

"Social workers try to be helpful. They contact relatives."

The second group of patients saw social workers as helping primarily with reality problems and providing tangible services. The following statements were made:

Miss M.: "Social workers help in many ways. They help with problems, not nerves. (Patient makes distinction between inner and outer problems.) They help with things like jobs, money, etc."

Mr. E.: "The social worker helps with things like school, money and apartments."

Mr. S.: "The social worker gives out money. I get this idea from the Depression--maybe they do other things now."

Three patients saw social workers as helping with both reality problems and with relatives. For instance:

Miss C.: "Social workers help with problems such as children from broken homes, retarded children. They also talk to relatives about things that might be bothering the patient at home."
Two patients saw social workers as helping primarily with one's inner feelings. (It should be noted that these patients were of the group who had had previous contact with social workers of a long term and supportive nature.) Mr. E., who also perceived the social worker as helping with reality problems said:

"The social worker is there to help you with your nerves too. I think it's good to have someone to talk to."

Four patients had either no idea or only very vague notions of what the social worker is expected to do. Three of these patients, however, although they could not define clearly what they meant, perceived the social worker as a "helping person."

Mrs. A.: "The social worker makes it easy for patients. They take care of anything that is needed."

Mrs. B.: "I have no idea what the social worker does. Maybe you can tell me." (Patient's predominant attitude of anger at the hospital prompted a rather belligerent response.)

Mr. C.: "Social workers take notes. They help out."

Mr. D.: "The social worker is someone who gets reports. She helps with the outside."

It is clear that most of the patients perceived the social worker's role as that of a helping person who deals with the reality and familial problems of the patient predominantly "on the outside". A sizable number of the sample, however, had only vague ideas of ways in which the social worker could be helpful. The fact that so many patients saw accurately the social worker's role in relation to relatives, a function
unique to the social worker in this kind of setting where the doctor is primarily responsible for the patient, must be at least in part attributed to experiences within the hospital. (It should be noted that the basic family-centered approach of all social work is a fairly sophisticated concept and probably not too well comprehended by the public.) For these reasons, the patients were asked to evaluate and comment upon the experiences already had during this hospitalization with the social service department and their plans for future use of this service. This attempt to evaluate the nature of the formal and informal communications between the social worker and the patient which had so far taken place will be covered in the next chapter.
CHAPTER V
MOTIVATION TO PARTICIPATE IN CASEWORK SERVICES

Awareness of Contacts at Admission and Resulting Impressions and Expectations of Future Service

All patients but one recollected the social worker's presence at the time of admission. Despite this awareness, however, seven of the thirteen patients interviewed had no memory of having had defined for them the social worker's role, and thus, they had no clear-cut expectations of future service from the social worker. Remarks such as these that follow were made:

"I think the social worker, the nurse and the doctor were all there when I was admitted to the hospital. I don't remember anything the social worker said."

"I knew the social worker was there when I came here but I don't remember her name or if she said she would see me again."

Four patients not only remembered the social worker's presence at admission, but came away with a notion of what the social worker could do for them and with definite expectations of future service. Remarks such as these were made:

"Miss P. talked to me the day of admission and told me that she could help with any problems I had in the hospital and with a job when I get out."

"Miss N. was there when I came to the hospital. I thought she would be talking to my relatives because she asked for their address."
The one patient who had no awareness of the social worker at the time of admission said:

"I was very confused. I have no memory of talking to Miss L. at the time, but I know she has talked to my wife since."

Although most of these patients had definite recollections of the social worker at the time of admission, it is evident that at this time the social workers in general did not succeed in communicating to the patients what their role would be in their recovery. It is not possible to evaluate whether this was due to the social worker's failure to clarify this for the patient, or due to the anxiety or confusion of the patient at this time, which was so great as to prevent his comprehension of the explanation. In any case, in a majority of the group, this communication between the worker and patient did not successfully take place at the admission. Perceptions of the social worker's role must have been based on experiences or attitudes formulated before hospitalization or upon communications between the patient and the worker between the time of admission and the research interview.

**Direct Contacts with the Social Worker Since Admission**

Six of the patients had had no direct contacts with the social worker since the time of admission. Five patients had had contacts which were initiated by the worker. All of these contacts as described by the patients consisted of the social worker "dropping by" for a social chat, to see "how the patient was getting along" in the hospital. Most of
these patients expressed some discomfort at the informality and unpredictability of these visits. One patient said:

"The social worker never makes definite appointments and I never knew when I'm going to bump into her. I don't think she's really interested in me."

(Patient interprets social worker's behavior as rejection.)

Another patient in this group perceived the informality of the social worker's visits as a kind of attempt to catch him unawares and to "investigate him". Two patients in this group found that there were problems with which the social worker could help them, which they would not have consulted her about had she not initiated the contact.

Two patients actually initiated contacts with the social worker on their own. One of these patients wanted help with changing his job in the hospital, and the other patient's problem concerned asking the worker to procure some clothing from his family. Problems brought to the social worker were requests for help with reality problems both inside and outside the hospital. Both of these patients who initiated contacts on their own had had previous experience with social workers prior to hospitalization. (One of these patients was the one who described her experience in such negative terms.)

Knowledge and Evaluation of Indirect Services

An attempt was made to investigate the patient's awareness of indirect services performed by social workers in his behalf, and his evaluation of their relationship to his own
rehabilitation. In all but two of the thirteen cases, the patients were aware of social workers' contacts with relatives and other community agencies. In only four of these cases did the social worker, according to what the patient said, ask permission or inform the patient directly of these contacts. In the other four cases, the patient subsequently found out about this from the relative. (In one of the four instances where the patient's consent was requested, it was refused, but the relatives were contacted regardless.) In the other cases, permission was obtained.

Five patients saw these contacts as related in some advantageous way to their treatment program. Characteristic of these responses are the following:

"Miss L. has been talking with my husband and brother. At first I resented it, but I can see that it is for the patient's own good. The patient might be hiding something that the relative could tell."

"Miss N. talked to my friend who brought me here. I was glad because it is difficult for me to talk about myself."

Three of these five patients were those whose consent to contact relatives had been requested. On the other hand, eight of the patients expressed negative feelings towards social service contacts with relatives. These remarks reflected suspiciousness, fears of disclosure of "personal" matters, and denial of the significance of his relatives. There was also resentment regarding the failure of the social worker to include the patient by asking his consent to talk with the
relative. These comments were made:

"Now that you mention it, I wondered what the social worker and my mother have been saying about me."

"The social worker asks my parents about problems at home that might be upsetting me. I don't see how this helps as I have no problems at home."

"After the social worker called my sister, she asked if I'd mind. I thought that was pretty stupid."

It is evident that the patient whose participation was encouraged by asking his consent to talk with relatives had more positive attitudes towards this aspect of service and saw it as a helpful and integral part of his treatment program.

**Prime Concerns of the Patient Currently**

The needs of the patient as he sees them will undoubtedly influence the nature of his use of the existing opportunities for help within the hospital. The concerns which patients had fell into four broad categories. The first, included needs which the patients felt were specifically related to the hospital setting, such as changes in room arrangements, work program, money for personal supplies, telephoning, etc. This type of concern was mentioned seven times.

The second category of needs which the patients felt were problems related to their separation from the community. These included relationships with employers, landlords, and schools, support of families during hospitalization, securing new jobs, and the like. These sorts of concerns were men
tioned ten times. (Many of these were concerns that patients felt in relation to leaving the hospital, even though it was found that most patients expected to be hospitalized for a substantial duration of time.) This would indicate that even early in hospitalization, patients have concerns about the future and seem to indicate a wish to begin planning. It should also be mentioned that both groups of patients who were employed up until hospitalization and unable to work prior to hospitalization had concerns in this area.

The third category of concerns mentioned by patients were problems related to their families, specifically in relation to hospitalization. These worries included such matters as provision of temporary placements for children or homemaker services, difficulties in working out visiting schedule mutually satisfactory to patients and relatives (some felt relatives visited too often, others not frequently enough), and lack of understanding on the part of relatives of the patient's distress. In relation to families, concerns ranged from the need for the provision of tangible resources to improvements in the relatives' attitudes towards the patients' illness. Such concerns were mentioned seven times by patients. The last grouping of concerns which the patients described as upper-most in their minds referred primarily to a preoccupation with their own inner problems, anxieties, and symptoms. Seven patients described such difficulties as these.
Patient's Plans for Coping with These Problems

Four patients felt that they were capable of resolving these difficulties on their own. All four patients were in the sixteen to twenty-five age range, and expressed some typical adolescent concerns about independence. They related their desires to "stand on their own two feet" to the inner problems which had necessitated their hospitalization and for which they had stated they wanted help, (a reflection of ambivalence around this issue). Typical of these remarks were:

"I want to learn how to make my own decisions and solve my own problems. I don't need any help with them."

"I think it's undignified to take help from others."

"I don't like the idea of having to go out of the hospital with a social worker or a nurse. I'd rather wait and go alone to fix up my apartment."

Three of these patients were of the group who did not judge themselves to be really ill.

Five patients stated that with the help of their relatives they could straighten out most of the reality problems and that they could also work out on their own some of their interpersonal difficulties.

"My parents have taken care of everything."

"The social worker can't lead you by the hand. My husband and I can work things out on our own."

Four patients stated that they felt overwhelmed by all these troubles and felt that they were in need of help. (Two
of these patients had actually initiated contacts with the social worker already, and the other two, as the result of this research interview, felt that some of these problems were appropriate to bring to the social workers. In addition, three other patients who previously felt no need of outside help with these concerns now felt that they would make use of social work services.

"You gave me the idea that Miss L. could help me to arrange with my family when they should come to the hospital and when I could go home for the weekend."

"Maybe the social worker would help my wife understand what I am going through and why I have to stay in the hospital for awhile."

At the end of the interview almost all the patients asked the interviewer to define for them the social worker's role. Seven patients indicated their plan to make use of social service help (as opposed to two patients who originally planned to request social service help during the future course of their hospitalization.) Six patients maintained their former plans to cope with their problems on their own or with the help of families or other social contacts. However, each patient in the sample expressed in his own terms the feeling that his understanding of what the social worker could do for him had been vague, that the interview had clarified this in his mind, and that he could now see the social worker as performing functions which were important to him or to other patients and which he would or might utilize in the future.
CHAPTER VI
DISCUSSION AND CONCLUSIONS

Social Characteristics

We saw in Chapter II that this group of patients were characterized by youthfulness, ten of the thirteen members of the group being younger than thirty-five. Three patients were white collar workers, only two patients were employed as laborers, six were students, and two were housewives. Nine of the patients had been unable to function at their respective jobs for some time prior to hospitalization. Five patients saw either one or both parent as their most significant social relationship, four mentioned their spouses, and four stated they were closest to siblings and friends. The younger the patient, the more likely it was that he felt closest to his parents; the older he was, to a spouse, sibling, or friend. By and large, the patients were living with the person whom they described as their closest relationship, and those who were living alone were closest to married siblings or friends. Five patients were married, two divorced, and six were single, and two of the married ones were separated. One patient had finished two years of high school, three were high school students planning to go to college, three patients had terminated their education after graduating from high school, and three were presently attending college or graduate school.
First let us consider the factors of age, occupation, and education. From the sociologists, we have learned that these three attributes are important determinants of a person's social position in the community at large. The recent trend in research towards an application of sociological concepts and knowledge to the "mental hospital community", indicate that, not only is there a clearly defined social structure within the hospital, but also that a person's social position in the larger community will influence his position within the hospital social structure. In a study, by Eugene Gallagher, of patients' adaptation to the hospital community, in which he investigated some of the same areas as were examined in this study, it was found that youth, high social class background, and education were highly correlated with the receipt of psychotherapy by the patient.

Thus, we see that attributes to which high prestige was attached outside the hospital, also were highly valued within the hospital social structure. Patients possessing these characteristics were also found to participate more actively in the hospital milieu as a whole, despite the severity of their illness. It should also be noted that social class factors were interwoven with associated class values and personality traits (such as authoritarianism) which are known to characterize the lower classes. Lower class patients were more submissive towards hospital authorities. We might also

Note another suggestive finding, which bears on the present study; "the elder the patient is, the more likely he is to like the hospital and the less ready he is to criticize it."²

These findings have important implications for our own. In relation to age, we would not be surprised to discover much dissatisfaction with the hospital expressed by the many younger patients in the sample; we would expect the patients who come from the lower class groups occupationally and educationally to be more submissive in relation to hospital authority. There appears to be one important distinction, however, with relation to social class status. While high social standing in the community, greater educational opportunity may make a patient more likely to be selected for and accept psychotherapy as a form of treatment, social work has traditionally been associated with meeting the needs of the lower classes. Not only might there be a tendency for a large proportion of this sample to view the services of the social worker in terms of class stereotypes and social stigmas, but persons higher on the status hierarchy usually possess greater means and resources for coping with reality problems dealt with traditionally by social workers. Values of independence and individual initiative are ascribed more prestige than in the lower classes.

Perhaps other factors, however, override these negative attitudes stemming from social origins. The social disfunction of all mental patients, regardless of social class char-

²
acteristics, merely by virtue of their hospitalization, and
also reflected by unemployment, may be an important factor in
contributing to the utilization of social work services. In-
creased educational opportunities may have brought the patient
into contact with some of the more modern and sophisticated
concepts of the social worker's role.

Factors related to the key social relationships of the
patient showed that most of the families of these patients
were at least physically intact--only two of the married pa-
tients were separated. Many of the other patients said that
they were living with their closest relative or relatives.
Evidently, the interpersonal conflicts which many of the pa-
tients described were contained within the family and were not
sufficient to result in gross disorganization. This finding
undoubtedly has implications for the social worker. Her most
important function is related to the reestablishment of fam-
ily equilibrium and the improvement of inter-familial rela-
tionships which are related to the patient's illness. It is
clear that with these patients, familial problems will be
associated more with emotional and interpersonal conflicts,
rather than with the necessity for the provision of prac-
tical services due to massive family breakdown.

Attitudes Surrounding Hospitalization

In Chapter III, we learned that patients gave five dif-
f erent kinds of reasons for their hospitalization; relief of
symptoms causing personal discomfort, relief of symptoms causing social disfunction, help with personality problems of long standing nature, family pressures, and other outside pressures. These categories were presented in order of frequency with which they were mentioned, the first mentioned most often. The last two categories of reasons reflected the least degree of understanding, participation in the decision, and assumption of responsibility for recovery. From these findings, we can see that these patients seemed to see the factors which brought them to the hospital as related mostly to their personal problems, and could recognize clearly the relation between their own behavior and hospitalization.

This is not inconsistent, as it might seem, with the material pertaining to the person the patients saw as most instrumental in arranging for hospitalization. We saw that despite the formality of the legal authority under which the patient came to the hospital, all patients but one saw persons other than themselves as instrumental in the plan for hospitalization and had some negative attitudes toward them. Despite these factors, patients still seemed able emotionally and intellectually to acknowledge a high degree of personal responsibility.

These findings are not disparate either, as might seem at first glance, with the findings of an earlier study by Whitmer and Conover, which found that "behavior and circum-

stance played a major role in precipitating hospitalization... rather than recognition of psychopathology. Our patients, in acknowledging a relationship between hospitalization and their behavior, indicate that they see, as a part of the necessity for hospitalization, the intolerability of their behavior to themselves as well as to their families.

This does not necessarily indicate that patients recognize the existence of psychopathology in themselves. Material gathered in relation to patients' perceptions of their illness shows this. Although nine patients did recognize some degree of illness, there was a marked tendency to regard other patients as much sicker. In many of these cases, these patients saw themselves as having "some problems" but emphasized the bizarre, "crazy" behavior of other patients as different from themselves. Four patients did not see themselves as ill in any sense but expressed fears that continued association with other patients would make them ill.

There is no doubt but that the patients' tendency to regard themselves as not severely ill will influence their participation in the various therapeutic facilities available in the hospital, including social work. If a patient does not see himself as too incapacitated, he will be less anxious to ask for or accept outside help. "The whole question of the patient's attitudes towards his illness, of which the acknowledgment and denial are but one facet, is a hugely important but complex factor in the adaptation of the indivi-
dual to the hospital, treatment, and to other patients."\(^4\)
(This is perhaps somewhat more complicated by the fact that
the healthiest patients are able to acknowledge illness.)

The fact that quite a number of patients revealed their
fears about being made sick by association with other pa-
tients reflects some of the negative aspects of life in the
hospital community. The preponderance of research efforts
in the past decade directed towards the recognition of the in-
fluence upon the patient of the entire hospital milieu, in-
cluding the negative as well as the therapeutic aspects of
life in such a community,\(^5\) has led to the concept that hospi-
talization should be made as temporary as solution as possible.
With such emphasis on speedy rehabilitation of the patient
and his quick return to the community, we can see the impor-
tance of social work planning towards this goal beginning dur-
ing the early period of hospitalization.

Although there are admittedly many negative and discom-
forting facets of hospital life for the patient, Gallagher
states,

"Since the hospital has a fairly standard way of hand-
ling patients...patients who have a need to feel es-
tranged manage to get themselves into situations
which do in fact, estrange them; correspondingly, pa-
tients who have a need to feel positive emotional

\(^4\) Gallagher, E., \textit{op. cit.}, p. 218

\(^5\) Greenblatt, York and Brown, \textit{From Custodial to Ther-
peutic Patient Care in Mental Hospitals}, Russell Sage Founda-
bonds with the hospital may seek...experiences which engender these feelings."6

We have seen from our own findings related to the patient's reaction to the hospital environment, that different patients will select varying facets of the hospital, positive and negative, to which they respond. This "emotional orientation" to the hospital has its sources within the patient--his personality, experiences in his past or current life situation, and also undoubtedly his illness. Many of our patients expressed negative or mixed feelings towards the hospital environment as a whole. (This may be related to Gallagher's finding that youth of the patient is associated with a greater willingness to criticize the hospital.) The dissatisfactions also reflected fears of dependency and helplessness, hostility towards controls imposed by the hospital, etc. Positive feelings were related to confidence in the hospital, a sense of trust and warmth in the hospital climate. It should be noted here that the three patients who expressed solely positive feelings towards the hospital were people with few social or emotional resources outside the hospital--reflective of Gallagher's contention that "...the varying need state of the individual patient, determines his degree of alienation or trust in the hospital."7

The degree of "alienation" or "trust" in the hospital

7. Ibid., p. 146
as a whole will indeed be reflected in the image the patient has of the social worker, as part of that community. Probably the same "need states" of the patient will affect his drive to secure a positive relationship with the social worker as influence his emotional orientation to the hospital.

**Attitudes Related Specifically to Patient's Perceptions of Social Workers**

Eight of the thirteen patients expressed very mixed feelings towards relatives, suggestive of the interpersonal conflicts which were the context in which the illness may have developed. None of these patients, however, indicated a wish to terminate relations with their relatives, but rather to improve them. Two patients regarded their relatives as supportive, with respect to hospitalization, and desired no changes or improvements. Three patients excluded their relatives as objects of significance to them during hospitalization, indicative of very negative feelings towards them.

If such ambivalence towards relatives exists, as it seems to for most of these patients, some of these emotions will undoubtedly be displaced onto the social worker who may seem to the patient to "be siding with the relative". Thus, we see the importance of the careful interpretation to the patient of her role by the social worker, in order to reduce the possibility of such distortions.

The tendency of clients to invest the social worker with the authority of the agency is a phenomenon of which a case-
worker is often aware. Likewise, the patient reacts to the social worker in the hospital as to a representative of the hospital's authority. Much has been written on the "power structure" of the hospital in the recent sociological studies of mental institutions, with consideration of its effect upon patient care. These factors apply equally to its effects upon social work services to patients.

In order to get at some of the patient's attitudes towards this aspect of hospital life, questions were phrased in terms of doctors as the prime figures of authority. That most members of the hospital community see doctors at the top of the power hierarchy is a hypothesis substantiated by other studies. Even in a hospital such as this one, which is organized along very democratic and flexible lines, this fact appears to the investigator to be the case. Again, eight patients expressed either negative or mixed feelings towards this aspect of the hospital environment. Doctors seemed accusing, distant, punitive. Five patients emphasized the apparent lack of separation between staff and patients. Some patients who expressed ambivalence towards the doctors enjoyed the freedom of the hospital but also expressed some feelings of anxiety with regard to the pressures for many interpersonal contacts with doctors and other staff. With regard to

the present study, we should note that these pressures are not so great with reference to the social worker who is not a member of the ward staff per se. "The doctor is the hospital to the patient; the social worker is the outside community."10

Only four patients had had any previous contacts with social workers prior to hospitalization. This is an interesting finding, since it is so often the case with clients who arrive at other kinds of social agencies that they have had contacts with many other social services. These previous experiences with social workers are weighed heavily by the caseworker in assessing the client's capacity to use help. This data which the caseworker frequently utilizes in her initial evaluation of the client was apparently not available to the social workers assigned to the patients in this study.

Patients' perceptions of the function of the social worker were accurate, but fragmented and somewhat vague. Most patients saw social workers as helping with problems related to the "outside"—with regard to relatives and reality problems. An important finding was the fact that only these patients who had previous casework contacts saw the social worker as helping with inner feelings. This has implications with regard to the patient's use of social service, since most of these patients stated they had come to the hospital for relief of problems causing personal discomfort. However, the patients' perceptions of the reasons for hospitalization may be different from their present concerns.

10. Ibid., p. 199.
Motivation to Participate in Casework Services

In Chapter V, we learned that all but one of the patients in this group had some awareness of the social worker's presence at the time of their admission to the hospital. The one remaining described himself as too confused at that time to recall the identities of any of those who were present. Of the patients who did recall the social worker, only four felt that, as a result of that contact, did they gain a more clear-cut and meaningful understanding of the social worker's role nor did they have any special expectations for future service. We concluded that, either due to the psychological turmoil of the patient, or to the failure of the social worker to do so, successful communication between the patient and the social worker did not take place with regard to what the patient might expect from the social worker in the future.

It should be noted, however, that this finding does not mean the social worker and the patient did not "communicate" at all. If we consider that the social worker's function at the time of admission is to represent the hospital to the patient and his family, making the initial impact of the hospital as untraumatic as possible, then the central task of the social worker is to do just that. She may convey to the patient in a "non-verbal" way, a sense of "trust"; or she might give a brief explanation to the patient of what he can expect to happen to him in the next few days.
"Reception is the process of helping the patient to accept his hospitalization, of relieving his fears, and threats inherent in the experience of compulsion..." 11

Although we still maintain that the social worker's role in the admissions procedure is crucial in its influence upon the total effects of the hospitalization experience, and may bear upon his later use of social service, it appears that any attempts to define to the patient her specific usefulness were in vain. This leads us to the idea that perhaps it is inappropriate for the social worker to do so at this time—that any formal explanations are superfluous and incomprehensible to the patient, whose mind is undoubtedly occupied with other thoughts, fears, and phantasies of the hospital. This seems to reflect upon some aspects of social work carried on within another institution; at times the social worker merges with the organization at large, and her unique professional identity becomes secondary. This does not exclude the fact, however, that she utilizes her special skills in carrying out the over-all goals of the hospital and the immediate goals of the admissions procedure.

With respect to contacts between patients and social workers since the admission, only seven patients had seen the social worker. Of these, only two patients had initiated the contact. Both of these patients had had previous experience of a fairly intensive nature with social workers, but one evaluated this contact in a negative way. This finding, though it

is rather inconclusive, might suggest the thesis that familiar-
ity with social workers, rather than positive or negative
attitudes towards them, is the more significant factor in
leading patients to initiate social work services. In addi-
tion, the comments made by patients whose experience in the
hospital with the social worker were initiated by the social
worker, were regarded as infringements of privacy, expressive
of discomfort with the informality and unpredictability of
the visits. This seems to reflect upon some of the meanings
to patients of the freedom and easy interchange between pa-
tients and staff, characteristic of this hospital. These pa-
tients felt the lack of "security which comes from compliance
with a clearly defined institutional regime, with little pres-
sure for interaction with the staff on a personal, informal
level." It was clear that these patients felt distinctly
uncomfortable about the ambiguity of the purposes of the
social worker's visits.

We also found that in only four instances was the pa-
tient's consent obtained, or was he informed, of social work-
ers' contacts with his family. (In eleven cases, the pa-
tient discovered this later from the relative himself.) This
finding appears to strike a discordant note with the state-
ments found in social work literature to the effect that

"collaboration between several members of a team, nec-
essary for a therapeutic result should always be as-
sented to by the patient..."13

12. Gallagher, op.cit., p. 142
and the other more general but inclusive remarks insisting upon the principle of "client participation". This omission on the part of the social worker not only excludes an opportunity for participation by the client, but also serves to elicit many negative reactions. This is an extension of what Goffman describes as the "betrayal funnel"—the coalition between the relatives and hospital authorities which operates in getting the patient to the hospital in the first place.

"The moral experience of being the third man in such a coalition can only embitter the patient, especially since his troubles have already probably led to some estrangement from his next-of-relations." This, it would seem, is an important area for interpretation by the social worker of her role.

Many different kinds of concerns and needs were mentioned by patients, most of which were relevant to areas of concern for the social worker: problems with adjustment to the hospital, problems related to the patient's separation from the community and from his family, concerns with relatives' attitudes towards their illness, and inner worries and disturbing feelings.

Nine patients stated that by themselves, or with the help of relatives, or friends, they could work out most of their problems on their own, and the remaining four felt that they would need some outside help in doing so. As a result of

the research interview itself, five more patients felt that their problems were appropriate to bring to the social worker and felt more positive towards the idea of utilizing social work help. Six patients maintained their plans not to make use of social work help in solving their current problems, but all the patients indicated that the research interview itself had increased their understanding of what the social worker does, and expressed more interest in utilizing these services now or in the future.

There are several factors operative here. One important finding was that many more patients than would appear from the number of contacts, have concerns and needs with which the social worker could appropriately assist the patient, according to her role as defined by the profession. This failure in communication between patients and social workers might be attributed to three factors: one, the difficulty of many patients in expressing their needs. This is a difficulty not limited to patients in the mental hospital but is found in all of casework practice. We find reference in social work literature to

"the wide variation in the ability of clients to express their needs..., some find it easy to express their wants... others give a picture of passivity... in their indifference to the acceptance of help."16

The second reason appears to be the inadequate interpretation by the social worker of her role, at a time when this would be meaningful and comprehensible to the patient. Both these ob-

Obstacles in the way of communication could be greatly reduced by early and routine interviews with patients, directed towards an evaluation of future treatment plans. This would include an assessment of his strengths and problems which he might handle without outside help, as well as the needs he reveals for outside assistance.

The third, but no less important factor in the complex interaction between the patient and the social worker has already been mentioned above. It is the very real capacity of many patients, even in the early days of hospitalization, to deal effectively with their problems on their own.

"Caseworkers find it hard to believe that clients, in an unjust economic order, or depriving individual circumstances, can do anything to solve their practical situations. Likewise, if clients have a serious disability due to illness, social workers feel they can do nothing."17

Self-help is one of the more significant beliefs of the social work profession; yet the above statement is at times applicable. Self-help is but an extension of the commitment to client participation in the helping process and the right of the client to "self-determination". There is another casework "principle", however, which is relevant here, particularly in discussing the validity of casework services to patients during the early phases of hospitalization. It is the phrase, well known to social workers, "meeting the client where he is". Perhaps social workers tend to make the assumption that during the early period of hospitalization, the patient-client is too

17. Hamilton, G., Readings in Social Casework, p. 159
ill to participate in any way—either in his own behalf or in collaboration with the social worker.

We have seen, however, that even during the most acute stage of hospitalization, patients have a great willingness and need to participate (to varying degrees) in the treatment program, expressing a considerable measure of independence and personal initiative. Perhaps the social worker's "identification with the forward-moving, healthy parts of the client's personality" should be an incentive to increased social work activity during the early period of hospitalization. But such activity should focus upon the assessment of the patient's strengths, as well as aiding him in making known his needs and accepting outside help.

"...services are designed to meet practical needs, but casework enters in by sensitivity to human beings; by leaving people so far as possible to manage their own affairs, by making services available; by consistently using the principle of client participation and client consent..."18

Early casework interviews with all patients, aimed towards bringing into clear focus the patient's own personal and social resources, as well as his needs for outside assistance, would be truly "meeting the client where he is". Such casework would be an extension of the hospital's recent efforts to understand and utilize the patient's total personality in the process of psychological and social rehabilitation.

18. Ibid., p. 167
APPENDIX A: INTERVIEW SCHEDULE

I. Identifying Information
- name
- sex
- age
- occupation
- key family relationships
- living arrangements

II. Attitudes Surrounding Hospitalization
- patients perception of reason for hospitalization
  - key agent of hospitalization
    - doctor
    - family
    - self
    - other community resource

III. Attitudes Specific to Perception of Social Workers
- attitudes towards key relatives
- attitudes towards hospital authorities
- previous contacts with social workers
  - nature
  - frequency
  - evaluation of helpfulness
- perception of function of the social worker
  - in general
  - in the hospital

IV. Motivation to Participate in Casework Service
- awareness of contact with social worker at Admission
  - expectations of future service
  - impressions
- contacts with social worker in the hospital since admission
  - direct
    - initiation of contacts
    - nature of contacts
  - indirect
    - awareness of contacts with relatives or other community agencies
    - consent of patient for these contacts
    - evaluation of helpfulness to him
- prime concerns of the patient currently
  - related to hospitalization
  - related to separation from the community
  - related to his family
- perception of his ability to cope with these problems
  - by himself
  - with help of family
- plans for future contacts with the social worker
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