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Dependency, rejection and stigma in the rehabilitation of mental patients

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DEPENDENCY, REJECTION, AND STIGMA, IN THE
REHABILITATION OF MENTAL PATIENTS

A Thesis

Submitted by
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(A.B., Western Maryland College, 1953)
In Partial Fulfillment of Requirements for
the Degree of Master Of Science in Social Service

1955
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II  Degree of Rejection In Sample of Twenty Cases

III Degree of Stigma in Sample of Twenty Cases

IV Summary Scale of Cases According To Degree of Intensity of Each Factor Studied
CHAPTER I

INTRODUCTION

The general area of this thesis concerns mental patients and their problems and needs, as they may be hampering their social and emotional rehabilitation. Because this is a subject of such magnitude, the writer will attempt to focus specifically on three factors which he feels to be of paramount importance to the mental patient's satisfactory readjustment to society, and in which the social worker is trained and experienced to function as a helping person.

These three factors are:

1) Dependency on the part of the patient, with emphasis on the protective environment of the hospital and the supporting and accepting caseworker.

2) Rejection of the patient by his family and relatives.

3) The stigma of mental illness and its effect upon the patient and his family.

An attempt will be made to isolate these factors as they are confined to the casework process, define and understand these factors, determine their significance, and determine how the caseworker might recognize and treat them.

Some Specific Questions

1) What are these factors and how are they manifested?

2) How significant must these factors be to require treatment in the
casework process?

3) How might these factors be recognized during the casework interview?

4) What are some casework techniques which have been utilized to treat these factors?

Plan of the Study

The writer has devoted a chapter to each of the three factors mentioned, discussed and attempted to define each factor by using available material such as literature and other resources on the subject, and made a statistical study of a sampling of twenty cases. The statistical study consists of a scale for each factor and the plotting of the sample according to the degree of intensity to which each factor is apparent in each of the case records. The writer then discussed how each factor asserted itself in the casework process and how it may be recognized by the caseworker. Then there is a general discussion of treatment preceding the brief presentation of each case in the sample, a statement of the degree of intensity of each factor in each case, and treatment techniques utilized in each case, will be indicated. The final chapter will be devoted to summary and conclusions.

Basis for Scaling

The criteria which the writer has used as a basis for scaling have been confined to those which appear in the case recordings. The primary concern is in the casework process and what the worker can accomplish from his contacts with his clients. Therefore, our criteria will be based upon
symptoms and manifestations of each factor as they become apparent in the interview. In accordance with these principles, the writer considered the following questions in scaling each of the three factors.

Dependency:
1) Does the patient verbalize a desire to remain in the hospital?
2) Does he verbalize on how difficult it is to leave the hospital?
3) Does he speak excessively in favor of the hospital?
4) Does he appear to be content to remain in the hospital?
5) Does he reject discharge planning on an unrealistic basis, such as waiting for an unlikely, or even impossible, placement?
6) Does he request help?
7) Does he accept help?
8) Does he indicate dependency in a discussion of his adjustment to the hospital?
9) Does he indicate a fear of the community?
10) Does he resist visits to his home?
11) Does he request the worker to accompany him on job interviews?

Rejection of the patient by his relatives:
1) Is there any indication of overt rejection, such as a refusal to have anything to do with the patient or to be helpful to him in any way?
2) Is there any indication of lack of interest in the patient?
3) Do they deny any responsibility for the patient?
4) Do they over-emphasize his faults or complain continuously about his negative attitudes and behavior?
5) Do they constantly nag him?
6) Are they over-protective or over-solicitous of him?
7) Does he appear to be a social embarrassment to them?
8) Are they unwilling to accept his financial expenses?
9) Do they fail to visit him whenever possible?

Stigma:
1) Is the patient afraid of returning to the community?
2) How does he feel about facing and meeting new people, such as potential employers?
3) Does he verbalize any feelings of stigma?
4) Does he express feelings of insecurity or inadequacy?
5) Does he initiate discussions about stigma?
6) What are his reactions to a discussion of public acceptance?
7) How does he relate to people with whom he comes into contact?
8) What are his feelings about coming into contact with these people?

These questions, listed under the respective factors, were considered in determining the degree of intensity of each factor in each case of the sample. These were the things the writer looked for in the recordings, and if they were found to have a severe, or even crippling, effect upon the patient and his social and emotional rehabilitation, the writer judged the factor to be of a high degree. If they appeared to be no more, or less, than a matter of concern, or anxiety provoking, they were judged to be of a moderate degree. If they were present but offered no major difficulty which could not be handled without help, they were scaled as low. If there were no indications of the factor in the record, it was scaled as none.
Methods of Collecting Data and Selecting Sample

The writer utilized the following methods to collect the material and data for this thesis:

1) Survey of the literature on each factor.
2) Collection of resource material.
3) Analysis of each case record in the sample for statistical data in determining the degree to which each factor was apparent in each case.
4) Analysis of case material for theoretical consideration of each factor.
5) Analysis of case material to present case examples of how each factor was recognized and treated.

The sample was chosen from the case files of the Metropolitan State Hospital in Waltham, Massachusetts. The case records are necessarily cases in which intensive casework was done and process recorded so sufficient material would be available for this study. The writer chose the cases on the recommendation of his supervisor that the records were process recorded, indicated a continuous casework relationship in process, were concerned with rehabilitation and the social and personal adjustment of the patient, and would be available for study.

Limitations

The writer recognizes the following limitations in this study:

1) The sample may not be a representative one since the cases were chosen on the subjective basis mentioned above.

2) The subjectivity of the recording must be taken into account and
the recognition that the cases were not recorded for research purposes.

3) The degree scaling of each factor in each case was done solely by the writer and based upon his judgement in consideration of the questions posed for each factor in each case.

Findings Anticipated

The writer anticipated finding the appearance of each of these factors in each of the cases, to some degree. He anticipated finding adequate examples of appearance and treatment of each factor. He also planned on making an adequate analysis of each factor in terms of understanding it and working with it, and hoped to introduce a better understanding of these factors, the dynamics involved, and how they relate to the casework process, thereby stimulating interest and further research and study of these and similar factors in the casework process.

Justification of the Study

Mental health, mental illness, and the rehabilitation of the mentally ill are problems of growing concern in the United States. Each year more attention is being given to these problems and every profession dealing with these problems is advocating the need for research and study of all phases of these problems. The writer regards this as an accepted truism and feels it indicated in the following Act, which appears prior to the table of contents in every issue of Patients in Mental Institutions, which is published by the United States Government for the National Institute of Mental Health.
Declaration of Purpose
National Mental Health Act

"The Purpose of this act is the improvement of the mental health of the people of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; assisting and fostering such research activities by public and private agencies, and promoting the coordination of all such researches and activities and the useful application of their results; training personnel in matters relating to mental health; and developing, and assisting States in the use of the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders."

---Public Law 487---79th Congress

By thumbing through such literature as that mentioned above and taking into account that "about 1 of every 7 drafted men who passed the physical tests had to be rejected for mental reasons; about 1 person in 13 in this country is insane or in need of psychiatric help; and 1 in 19 will eventually be committed to a state asylum"; one can readily realize the scope of the above mentioned problems and the need for research and improvement of services rendered to those directly and indirectly afflicted. The writer can further see this need by observing the number of admissions and readmissions in his field work placement. To thumb through a patient's record and see that he has a long history of mental illness and several admissions is far from unusual.

Every state mental hospital has a social service which is an integral part of its functioning staff. The social worker is directly concerned with the discharge planning and rehabilitation of the patient. Francis J.

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Braceland says, "It is the man as a feeling person who will recover from the illness, and the man as a person of sensibilities who will wear the orthopedic appliance, about whom psychiatry is concerned. It is the person as a whole who should be treated, not merely the diseased part."

This is, and must be, the attitude and philosophy of social work. "The special expertness that the social worker contributes is knowledge of how to effect adjustments between individuals and their environments and skill in bringing about such adjustments." Along with environmental manipulation, job placement, etc., the psychiatric social worker in the mental hospital deals with the attitudes and feelings of the patients and their relatives. He also deals with the relationships of each towards another and the way in which these attitudes and feelings affect these relationships. The writer feels these attitudes and feelings, and behavioral reactions to them, are factors which are most important and significant in the rehabilitation of the mental patient. Therefore, he plans to isolate and study the three of these factors which he has previously mentioned.

The writer planned this study on the tentative hypothesis that some, if not all, of these factors are universal, to some degree, in all cases of psychotic patients (whether recognized and worked with or not) and are fertile areas to which the casework process needs to be applied for the satisfactory social and emotional rehabilitation of these patients.

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2 Reprinted from United States Naval Medical Bulletin, Vol. 43, No. 4, Oct. 1944.

CHAPTER II

DEPENDENCY

The writer understands a dependent person to be one who relies on others for support. There are various areas in which one may be dependent, such as economic dependency which requires financial support, but the writer confines this study to emotional dependency and the need for emotional support. In conjunction with this definition, the writer believes that no human being is completely independent. Some persons may say "I don't need anybody for anything," but this is not true! The manifestations of what the writer will call emotional dependence are inherent in all human beings, whether they be on a conscious or unconscious level. The following passage appears to bear out this premise in a logical and simple manner.

"Everyone carries a large quantity of dependence within him into adult life, long after the establishment of an independent social, economic and family existence. It may well be disguised, sublimated or overcompensated. There are many ways in which the normal adult gratifies his dependence, in secret, even without his own knowledge. He may become an altruistic supporting figure for others, doing unto them as he would wish for himself, thereby obtaining gratification by identification with the recipient. On the other hand, he may overcompensate against his dependent needs by becoming an aggressive, sometimes hostile, figure in his community, or may indulge his unconscious trends through the use of alcohol."

Granted that in order for any human being to make a successful adaptation to society, he is naturally emotionally dependent. Since our consideration is focused on the mental patient and his relationship with

1 Roy R. Grinker and John F. Spiegel, Men Under Stress, p. 226.
the psychiatric social worker in the casework process, it is noted that a dependency situation is created whenever a person requests help, and a dependency situation is indicated where the person maintains the relationships and accepts this help.

The following is a scale in which the writer has plotted each of the cases used for the sample in this study. Each patient has been placed in the category to which his or her dependency situation relates, depending on its degree as indicated in the patient's case record.

TABLE I

DEGREE OF DEPENDENCY IN SAMPLE OF TWENTY CASES

<table>
<thead>
<tr>
<th>Degree</th>
<th>Total Cases</th>
<th>Per Cent</th>
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<tbody>
<tr>
<td>High</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Low</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>05</td>
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</table>

Wherever people are grouped together on a semi-permanent or permanent basis, their social needs must be fulfilled by each other, for they are removed from a society that is familiar to them, in which they had previously found varying degrees of fulfillment of these social needs.

Low Dependency With Denial of Illness

Adjusting to a hospital environment is harder for some than for others,
but all patients experience the struggle for readjustment in some measure (See Table I). Not everyone is able to adjust completely to the hospital environment and some patients keep their relationships with staff and other patients at a minimum and to the smallest degree possible under the prevailing circumstances. They are either emotionally unable to relate more intensely due to the manifestations of their illness, or restrain themselves from relating due to a denial of their illness in one form or another.

This denial of illness and refusal to relate to other patients and staff make discharge a most desirable goal of such a patient. This pattern continues throughout the entire period of hospitalization and when discharge planning is under consideration, it would appear to the lay person that no dependency is evident. However, in consideration of our definition of dependency, the writer feels this is not so. Without losing sight of the focus of this thesis, which is discharge planning, the writer discusses the adjustment of patients to the hospital as a preliminary manifestation of the degree to which dependency exists, and such conditions as these would be apparent in the following case summary.

**R.C.: A Case of Low Dependency**

This is a sixty-one-year-old, single woman who is a retired school teacher. The informant, an older sister with whom the patient has always resided since their parents' death, considered the patient's intellectual endowment, judgement, and common sense just average. The sister described the patient to be dogmatic, stubborn, lacking in tolerance, and quite argumentative. She was also inclined to be jealous and suspicious. She was always full of ambition and her ethical standards were high and very rigid both for herself and others.
The onset of her mental illness was gradual. About two years prior to her hospitalization, her sister felt that she became more stubborn, more intolerant, and more introverted than ever before. She told people that a certain man, whom she did not know, and his cohorts were following her wherever she went, and she would deliberately go out of her way to avoid them. She said they were watching her house and she would draw the blinds for fear "this man might see me." She stated this man was a Roman Catholic and was spying on her for the Catholic Church. She openly denounced the Church and said they were infiltrating all organizations and then blamed them for every little, everyday, inconvenience which she experienced. Her sister felt that she could no longer tolerate this behavior and after coming to the hospital for observation, the patient was regularly committed and diagnosed as "Paranoid State".

Five months after her commitment, her case was referred to social service as her sister was anxious to have her placed in a private nursing home. The worker made several unsuccessful attempts to contact the patient, who had ground privileges, and after finally contacting her rather spontaneously and by chance, the patient regarded him with suspicion but agreed to have an interview with him. The patient did not keep her appointment, and when later seen by the worker, she said that since he had wanted to see her, she thought it was his place to come to her ward, which he did. She continued to be hostile and resisting, and said "I don't want a social worker interfering in my life." She insisted she was not ill, certainly did not need a social worker, and insisted that she be released from the hospital immediately. This attitude prevailed for many weeks. After the worker conferred with one of the staff psychiatrists, it was agreed that this patient was still very paranoid and had no insight whatsoever into her illness and socially unacceptable behavior.

A positive relationship between the patient and the worker gradually developed as the worker demonstrated his interest in the patient and a desire to help her. The patient gradually accepted this relationship as the worker gained her confidence. She confided in him and after considerable testing, the results of which enabled her to trust the worker, a casework relationship was established. This process enabled the patient to control her paranoid behavior and ideas which resulted in the situation reaching a point where discharge planning was considered to be a most desirable activity by the worker and the psychiatric staff. The patient accepted the worker as a helping person and throughout discharge planning, an
atmosphere of mutual trust and confidence prevailed. As this process progressed, the patient readily asked for help in such areas as finding a job and locating a place to reside. She also requested help on such matters as how to conduct herself during the job interview, as well as advice in other areas.

Discussion:

This case summary shows us a patient who might very well be labeled an "independent human being". At the initiation of social service contact, she resisted any efforts to help her and totally denied any need for help. However, the social worker persisted in his efforts to establish a relationship, and this gradually evolved. The worker recognized and accepted the dependency of the patient even though the patient totally denied it, and this would appear to be the first step in working with dependency. The factor was handled by the worker as he concentrated on accepting the patient's resistance, focused on establishing a relationship, accepted the patient at her level, and eventually moved at her pace. This enabled the establishment of a casework relationship which resulted in the patient's movement and growth to the point where she could accept the worker and her dependency. Any degree of dependency appeared to be lacking at the time of initial contact, but the worker's patient efforts made this more apparent as the case progressed, until the point where these needs were obviously apparent and verbally admitted.

In the absence of the usual symptoms of overt dependency, which will be discussed later in this chapter, this factor gradually asserted itself and became more apparent. Total denial blocked any usual recognition of the factor to the untrained eye, so to speak, but assuming its presence
strengthened the worker's awareness until it was obviously apparent. When this point was reached, the worker adequately treated the factor in consideration of its degree of intensity.

A Case of High Dependency

The writer will now focus upon a situation in which this factor of dependency is much more obvious by the appearance of the usual symptoms, which will be discussed following the presentation of the case material. The case of R.C. unveiled a patient who had a rather low degree of dependency. At the other extreme, we have a patient who feels secure in the protective environment of the hospital and who strongly resists, or even rejects, any attempts at discharge planning. Through the following case summary, the writer hopes to indicate such an extreme situation.

R.M.:

This is a forty-four year-old, single, male who had a history of mental illness since he was twelve years old. He has had four admissions to mental hospitals resulting in his having spent a total of sixteen years in hospitalization. He was diagnosed as "Dementia Praecox, Paranoid Type" during his first hospitalization, but this diagnosis was changed and he has been diagnosed as "Manic-Depressive, Manic" since 1932. There is no available information about the patient's birth and infancy, but he is described as having grown and developed at a normal rate. He is said to have had temper tantrums and would kick out at parents, siblings, and the few friends that he occasionally played with. For the most part, he had no friends and his brother had little to do with him because he "acted more like a little girl, played with dolls, and engaged in no boy's sports." He did poorly in school, although he was considered to be "bright," because he refused to do anything asked of him. Though he always had poor grades, he was considered to be more intelligent than his contemporaries. He never got along well with children or adults and he either avoided his peers or fought with them. In his adult adjustment
he is known to have had many jobs, lasting for very few short periods of time as he was unable to get along with his employers or fellow employees. It is believed that he did not belong to any clubs, nor did he have any friends or outstanding interests.

Since he lived alone in a boarding house, the circumstances of the onset of his present illness is not known. Immediately prior to his hospitalization, he locked himself in his room, screamed and yelled that he was being persecuted and "they" were after him, and "they" were going to kill him. His landlady called the police and he was found to be untidy, denuded, confused, excited, and deluded. He was also said to be extremely destructive to furniture and clothing.

One year after his commitment, his psychosis was felt to be in remission and he was referred to social service for discharge planning, with the focus on job placement, residence, and general readjustment to the community. There was some indication of passive resistance as the patient broke the first two appointments with the worker, saying he had a cold and was not feeling too well. The worker finally saw him on the ward and said he was going to help him prepare to leave the hospital. The patient said he was happy to hear this and would appreciate any help the worker could give him. In the very first interview, he vaguely mentioned his own insecurity about leaving the hospital and then voluntarily related the story of his mother's death and commented that his brothers were not too severely affected by her death because they weren't as dependent upon the mother as the patient was. The patient expressed a good deal of insecurity and lack of confidence in himself as he asked the worker if something wasn't true after he expressed it as a fact. He made statements of a positive nature and then added "---, isn't that so?" or "---, don't you think?" As the case progressed, the patient projected his insecurity upon other patients and somewhat denied that he shared these feelings. He expressed a good deal of ambivalence about leaving the hospital and many times he would say he was anxious to leave, get a job, and live a normal life, but he also quickly added that he was not quite ready for this yet.

His general dependency was further indicated in his relationship with his brother. He was perfectly willing to have his brother make arrangements for him and he would never question his brother and his actions. Whenever discharge planning was discussed, the patient stressed the fact that he wanted to take things slowly. The worker accepted these dependency needs, giving the patient reassurance and support wherever possible. At first the patient projected his feelings and commented on how other patients felt
about the things discussed during the interviews. This defense was found to be adequate until it was slowly replaced by the patient's intellectualizing on this factor and discussing it in such terms with the worker. When discussing potential employment possibilities, the patient's dependency was overtly expressed in his making no comment other than asking the worker "what do you think?"

On a few occasions, the patient was a few minutes late for his appointments with the worker. At such times, he would apologize very extensively for his tardiness and appeared to regard it as an unforgivable sin. The patient's insecurity and a lack of confidence in himself tended to strengthen, intensify, and increase his dependency needs. He continually found excuses for hesitating and delaying concrete steps which would result in his leaving the hospital. At first he insisted that he had no clothing to wear, then he said he thought it was too close to Thanksgiving, then he insisted that it would be best to wait until after Christmas as everyone in the community was hurrying and rushing around, and finally he returned to his problem of inadequate clothing, which was actually more than adequate. The worker accepted all of these defenses as the prospect of discharge was still too threatening to the patient. The projection and intellectualizing continued and the worker made no direct attempt to break these defenses down. Through intensive casework and by keeping at the patient's pace without threatening him too much or too directly, he gained a better understanding of himself and his relationships with others.

After a considerable amount of time, the patient reached the point where he asked the worker to arrange an interview appointment for him pertaining to a potential place of employment. His extreme dependency was still obviously apparent as the patient requested the worker to accompany him into the interview and later commented that he could never have done it if the worker had not gone with him and given him the necessary support. The patient felt he had jumped a big hurdle by doing this and he felt "it wasn't as bad as he thought it would be." The patient expressed a good deal of increased confidence in himself, and as the case progressed, one noticed the patient's dependency transferred from the hospital to the worker, and gradually the degree of dependency was considerably reduced as the patient gained self-confidence and self-assurance. At the conclusion of the record, the patient expressed his gratitude and appreciation for the worker's not rushing him and allowing him to move at his own pace.

Discussion:

Here we see a case of extreme, overt dependency which is easily recog-
ized by the worker. Some of these indications are worthy of noting. It was immediately indicated and expressed by the patient in the very first interview and it also came out, so to speak, in many other manifestations. This factor is also recognized in the area of relationships. In this case, it was apparent in the patient's relationships with his mother, brother, and the worker. The patient continually asked the worker for advice and further asked to be told what to do. The passivity in which he related to his brother is another area in which dependency is indicated. His ambivalence and expressed insecurity also make the factor apparent. Generally, the writer feels that this factor and the degree of its intensity can be assessed by being aware of the patient's history of performance, past and present relationships, and present attitudes and behavior.

In the area of recognition, experience has shown us that the longer the hospitalization, the more difficult it becomes for the patient to accept discharge and plan effectively, or participate effectively, in discharge planning. This seems to be substantiated by Koos, when he says, "The degree and length of illness is important for the personality, too, because the more serious the illness, the more likely is the patient to become dependent upon others and to demand that he be sheltered and protected." 2 These comments are not confined to the area of mental illness only, but the writer feels such assumptions to be applicable to mental illness, since such illness is of long duration and is considered to be one of the chronic

or long-term illnesses. Koos further observes that the patient regresses to a lower level of social adaptation with an increased dependence and need for emotional security. He goes on to say that if the illness is too prolonged or too severe, there is often difficulty in getting the patient back to a stage of "normal" independence. In accordance with this observation, the writer believes that any patient who has a prolonged illness and lengthy period of hospitalization may be suspected of having a relatively high degree of dependency, but this remains to be demonstrated as a real correlation.

"Discouragement, fear of recurrence, defeat of plans and hopes for the future, economic insecurity, lowering of standards, exhaustion of savings, mounting debts, the recognition of the ever diminishing hope for the future are frequent concomitants of prolonged illness." These are further areas in which dependency may be recognized. They indicate the patient's problems and matters in which any person would be expected to have extreme feelings of intensity, problems and matters in which a social worker could be of extreme help.

The writer believes all of these areas, pertaining to attitudes, feelings, behavior, etc., to be of extreme significance in recognizing this factor in the people with whom we work. These areas are of a rather broad and various nature, but their importance cannot be overlooked or disregarded, since it is within these areas that dependency exists and must be

3 Ibid p. 181.
4 Minna Field, Patients are People, p. 42.
effectively handled by the person who is attempting to help the patient make a satisfactory social and emotional adaptation to the community.

In conclusion, the writer feels, as indicated in the case presentations and the discussion of these cases along with their manifested dynamics, the degree of dependency will vary from one individual to another and it's expression or appearance may be admitted and apparent or it may be denied and much less apparent. In any case, these dependency needs may be manifested in the following areas, within which the social worker is trained and experienced.

1) information concerning the hospital and / or the community
2) counseling on personal or family problems
3) financial assistance
4) medical assistance
5) follow-up care and referrals
6) vocational rehabilitation
7) job training
8) employment service
9) education
10) help with reassembling the family
11) guardianship service
12) other types of planning

The writer recognizes the broadness of this range of problems and the intricacies involved in each and every one of them. It is also evident that these problems are the usual stimuli for patients requesting social work services and are the basis for many referrals from other hospital staff. The psychiatric social worker, as we shall discuss in Chapter V, with his keen sensitivity and awareness of the needs of individuals, should be able to recognize and treat these and similar problems where they are not overtly obvious.
CHAPTER III

REJECTION

Rejection of a mental patient by his relatives and family may be manifested in many ways. It may be on a conscious or unconscious level of the relative's awareness. It may be overt, hostile and admitted, or it may be hidden, passive and denied. It may or may not be recognized by the patient, relative, and / or the worker. This factor can be extremely nebulous and have many intricacies. In this chapter, attempts to clarify some of these matters are made. The factor's various manifestations, the degree of its intensity and therefore its significance as a problem for social casework, and some methods and techniques for its recognition are also discussed.

It has been said that a family finds it very difficult to have a mental patient in its midst. This is certainly true in terms of demands made upon the family in relation to communication with the patient and his changing attitudes. However, rejection of the patient and the basis for this rejection does not always have its beginnings at the time of discharge planning, nor at the time of hospitalization, nor, in many cases, even at the time of the onset of the illness. The seeds of rejection are frequently planted many years prior to the patient's hospitalization. In some instances of parent-child relationships, these seeds may have been planted prior to the patient's conception, as in the case of an unwanted child.
Before continuing the discussion of this factor, it is necessary to clarify what is meant by rejection and elucidate this by arriving at some operational definition of rejection. Maslow and Mittelmann define rejection as "such attitudes and behavior, partly unconscious, toward another person as lead him to believe that he is not loved and valued as an individual."\(^1\) Newell, in a study of maternal rejection, defines rejection as when the behavior of the parent is hostile, neglecting, indifferent, irritated by the child, punishing severely and nagging.\(^2\) Another definition is offered by Symonds, who states the following:

By rejection we mean the child who is unwanted either by mother or father. Either mother or father or both fail to give the child adequate care, protection or affection, or they may make invidious contrasts with other children in the family, or with children outside of the family, and in general the child is neglected in one or more ways. Sometimes the mother compensates for the guilt which they may feel for this rejection by lavishing affection on the child and overprotecting it.\(^3\)

The writer does not feel that any one of these definitions which he has encountered would serve to provide an adequate understanding of this factor. In consideration of the above mentioned definitions and other material he would anticipate an operational definition of rejection as a refusal on the part of the relatives to accept and/or respect the patient as an individual human being who is worthy of such acceptance and respect.

\(^{1}\) A. H. Maslow and Bela Mittelmann, Principles of Abnormal Psychology, p. 608.


Also, the writer would incorporate some symptomatic manifestations of rejection. Some of these symptoms would be; denial of any responsibility for the patient, refusal to help him in areas where they possibly could, failure to visit as frequently as possible, over-protection and being over-solicitous as an unconscious form of rejection, neglect and harshness towards the patient, indifference, nagging, and lack of interest in the patient and his welfare. 4

TABLE II

DEGREE OF REJECTION IN SAMPLE OF TWENTY CASES

<table>
<thead>
<tr>
<th>Degree</th>
<th>Total Cases</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>Moderate</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Low</td>
<td>1</td>
<td>05</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>05</td>
</tr>
</tbody>
</table>

Table II gives us some indication of the extent of rejection in these patients.

It was indicated in the preceding chapter that a dependent person was

4 See p. 3 Ch. I for further symptoms of rejection.
in need of supportive therapy, mainly because of his lack of self-confidence and insecurity. This insecurity is a basic problem which is immersed in the very core of the casework process with mental patients. Many primary causes of this insecurity are bred in family relationships. "People who are starved of love when they are children usually grow up to be what we call 'insecure personalities'." This lack of love is a conscious or unconscious form or symptom of rejection. Many relatives who reject the patient have rejected him in the past, usually in his childhood, and many times since his conception. Rejecting him when he is psychotic may not necessarily be a new attitude. This can be illustrated in the following, which is a brief case summary.

D.H.

This is a seventeen-year-old, single, male who is blind due to a congenital gonorrheal condition and whose entire family rejected him from the time of his birth. Because of this, he spent most of his life in various institutions. He was starved of love and frequently asked to be placed in a foster home so he could know what a home, love, and affection were. He was extremely dependent upon the hospital as his reaction to a life of rejection, and he became seclusive and untrusting of everyone. He was very cautious and hesitant to form intensive relationships, as it appeared as though he could never show any affection to anyone since no one ever showed him love or affection. The worker spent many months demonstrating that he was concerned about the patient, and it was quite some time before the patient was convinced that the worker was interested and concerned about him.

This brief summary would show us that emotional hurts and scars are not

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5 See Chapter II and Chapter V.


7 See p. 56 for a more detailed analysis of this case.
easily healed. The effect of one person upon another, via their relationship, can certainly be long-lasting and intensive. Maslow indicates this by writing "... any individual can be a real force which creates maladjustment in others, e.g., by rejecting, hating, humiliating, or scorning others. Or else he can be a real psychotherapeutic force, e.g., by respecting others and being kind, affectionate, loving, and accepting."\(^8\) Certainly this intensity is increased and magnified in a family relationship which has been of long duration and extreme closeness.

Since rejection is a factor which, of necessity, would affect two people, the one who rejects and the one who is rejected, we must consider the relative who rejects and the patient who is rejected. The writer will now focus upon the former, the relative who rejects.

"It is not only the hated one, the rejected one, who is affected psychologically. The hater, the rejector, is also affected. Even though they may be different, the effects of hating are quite as serious as the effects of being hated. The hater's lot is to project into others, through his own strong feelings of guilt and his unconscious loss of self-esteem or self-respect, the hatred which he feels; hence he soon comes to think that he himself is hated, and therefore he becomes insecure. The fact that the degrading and brutalizing effects of hating are largely unconscious does not make them any less effective."\(^9\)

This would seem to indicate the importance of rejection and its effect upon the relative of our patient and its significance for the social worker.\(^10\)

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In some instances, this rejection would be of such a nature that it could not be adequately handled or treated due to its intensity and necessary limitations. When such circumstances prevail, the rejection necessitates environmental manipulation.11 The writer avoids such instances at present as they will be discussed in a later chapter under treatment.12

Where the family environment is a good one and the rejection can be adequately handled, there are many considerations to which the caseworker must give thought. Family relationships play an important part in the social and emotional rehabilitation of the patient. In order for the worker to help the patient achieve the optimum re-adaptation once he returns to the community, the worker needs to understand these relationships so he may enable the family to understand the effects of these relationships upon the patient, as well as themselves.

There is a strong need for casework services to relatives of patients. This need is apparent in many areas, but paramountly with a factor such as rejection. From the moment of initial contact with a patient and/or his family, there should be an alertness to family attitudes and problems, that have influenced, and have been influenced by, the patient. In the interest of ultimate rehabilitation, social treatment is often instituted in attempts to modify family difficulties where indicated, beginning sometimes with the history-taking process.13

11 See case presentation of F.B., p. 30 and p. 46.

12 See Chapter V.

13 Margaret G. Muller, "Casework Aid to Patient and Family Following Hospitalization for Mental Illness", The Family, December 1941, 22:256.
Rejection can be recognized if the worker is aware of the symptoms from the very beginning of his contact with the patient and/or his relatives. In our discussion and definitions of rejection, we have stated the areas in which such symptoms of this factor can be seen. In order to further exemplify this, the writer will now present the case of V.F., to illustrate an example of unconscious rejection of a patient by her mother. The illustration will show some of the dynamics in a relationship in which the rejection affects the rejector, as Maslow points out.14

V.F.15 Case of a Rejected Daughter

This case was referred to social service for casework assistance and discharge planning. It was found that a very unfavorable relationship existed between the patient and her mother. Because of an extreme conflict between these two people, it was deemed advisable for both parties to be seen by separate workers.

In the initial interview with the patient's mother, it was noticed that she was on the verge of an anxiety state and extremely tense. During this interview, she talked continuously relating the story of the patient's life since the onset of her illness. It was noted in the record that "the worker could not get a word in edgewise, and the client talked on as if something was driving her, and she could, and would, not stop until she was finished." The mother told the worker in this interview that the patient had struck her in the head and she expressed extreme fear that the patient would harm her in a physical manner. After expressing a good deal of hate for the patient, it was noticed that the client felt guilty about this and appeared to recognize what she had been saying. She then went on to say how much she loved the patient, and how much each of them had enjoyed their visits together at the hospital.

It is a policy at the hospital for relatives to leave a certain amount of money at the treasurer's office for the patients to spend in the canteen. Although the F. family is

14 See quotation #9, p. 24.

15 This case is not part of the sample but is used for illustrative purposes.
of a middle class income level and certainly with adequate financial resources, it was noticed that Mrs. F. had made no attempt to leave some money for her daughter, and she frequently spoke of the "tremendous expense" of caring for the patient during the many years of her illness.

The client expressed a good deal of ambivalence throughout the casework contacts. She showered phrases of sweetness, love, and kindness upon the patient and then, many times during the same interview, suggested the patient be hospitalized indefinitely, said it was not fair to the community to have mental patients "running around loose", and occasionally she suggested that the hospital perform a lobotomy on the patient.

When Mrs. F. was told that the patient's psychosis was in remission and she was capable of leaving the hospital, Mrs. F. said it was fine the patient was well at the hospital, but she felt she would have a relapse if allowed to return to the community. She also expressed a good deal of fear and anxiety over her own physical well-being, in connection with the patient coming home and staying with her at her apartment. She verbalized her fears of staying alone with the patient and was afraid the patient would attack her and possibly even kill her.

As the case progressed, it became apparent that the client was having an anxiety-provoking conflict concerning her attitudes towards, and feelings about, the patient. She frequently regarded her daughter as a failure, her failure, since all of her other four daughters were happily and successfully married. This comparison of the patient to her siblings increased the client's hate for her and stimulated her rejection of the patient. This rejection and hate on the one hand, and the recognition of her duty and responsibility on the other hand, caused much ambivalence which resulted in guilt feelings and caused her much anxiety and tension.

The thought of the patient's discharge was a very real and threatening eventuality which added considerably to the client's anxiety. Also, it was further indicated that this ill daughter was a real embarrassment to this middle-class family which enjoyed a good deal of status in their community.

Discussion:

Here we see the case of a relative who was socially embarrassed by her daughter's illness, was afraid that the patient might physically harm her,
regarded her daughter as her own failure, was ambivalent towards her because of these feelings which conflicted with her sense of motherly duty and responsibility, and was threatened by the eventual prospect of her daughter being released from the hospital. All of these feelings and conflicts inherent in their relationship caused a good deal of tension and anxiety in the mother, which tended to accentuate their problem and magnify it to very threatening and further anxiety-provoking proportions. This seemed to evolve into a vicious circle which moved the mother closer to an anxiety state and prevented her from dealing adequately with her problem.

The worker recognized her neurotic needs and it appeared as though the client was saying "I should love her, she is my daughter, but I am ashamed of her. She may harm me, I hate her, she is my failure, my daughter is crazy, what will people say, she must not be released from the hospital, but she is my daughter, what can I do?"

These feelings were recognized by the worker as he saw the client's rejection of the patient and the effect this rejection was having on Mrs. F. The rejection can be seen in the client's neglect to provide spending money for the patient, her unrealistic insistence that the patient was not well enough, first mentally and then physically, to leave the hospital, her suggestion of a lobotomy when there was absolutely no medical indication, or even suggestion, of its necessity, her inadequate comparison of the patient to her siblings, and her pessimistic attitude concerning the patient's future as well as her complete denial that the patient would ever be well.

A case of rejection follows in which there are many indications of
sibling rivalry and jealousy.

**R.C.16  Case of a Rejected Sibling**

Rejection of this patient was indicated from the moment of initial contact with the patient's sister. During a home interview, when the medical-social history was obtained, the sister expressed fear that the patient would be examined and found to be "non-psychotic", and would therefore be returned home. She frankly admitted how difficult it was to have the patient at home and then went into a discussion of her own anxieties and how upsetting the patient's presence was to her. She also said she preferred to have the patient hospitalized so she would be free to take her usual summer job and would be free of any duties or responsibilities. It was apparent that the sister found the patient to be quite an inconvenience. She demanded "some reassurance from the worker that the patient would remain in the hospital," and insisted that "she did not want her in the home."

After expressing much hostility towards the patient, the sister became rather anxious and expressed a good many guilt feelings about the fact that if the patient was hospitalized, there would be nobody to visit her during the summer. The worker attempted to allay some of the sister's anxieties and guilt feelings, which appeared to have been a manipulation of the worker by the sister to insure the patient's hospitalization. This was further carried through as the sister requested the worker to do whatever he could to insure the patient's commitment. The worker consulted with the doctor and recommended hospitalization in conclusion of what the sister told him.

The patient was committed and the next contact with social service was five months later when placement was under consideration for this patient. The case was continued by another worker at that time and the sister was found to be still highly rejecting of the patient. It was agreed that return to the home would be the most desirable placement and the sister was seen rather intensively on a weekly basis so she might gain a better understanding of her feelings towards the patient and perhaps become more accepting of her.

At the time of contact, the sister expressed a continued fear of the patient and expressed the feeling that it was very embarrassing, socially, to have the patient at home. She made many excuses of why she could not have the patient at home. As the casework process continued, the sister expressed much hostility towards the patient. These feelings and jealousies

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16 See p.48 for further analysis of this case.
appeared to stem from the time they were both children. This hostility and rivalry became latent and remained as such for the past forty years, but came to the surface when the patient was hospitalized. Through intensive casework, the sister became more aware of this on a conscious level and increased her understanding of her relationship with the patient and the involved dynamics.

Discussion:

Here we see an illustration of sibling rivalry and social inconvenience as a basis of rejection. It would appear that this rejection was either unrecognized or felt to be unimportant by the first worker. However, it was recognized by the second worker as it was extremely overt and apparently obvious. It made placement difficult and certainly endangered the rehabilitation of the patient.

A final case presentation to illustrate rejection is that of F.B., who is a female patient rejected by her husband.

F.B.17 Case of a Rejected Wife

It was decided that this patient was ready to leave the hospital and a social worker was sent to her home to evaluate the environment and determine the advisability of returning the patient there. The patient expressed a desire to return to her home and husband but frequently verbalized that his maltreatment of her was the cause of her illness. Upon visiting the home, the worker found it to be in a filthy condition with the husband being highly intoxicated.

It was agreed that this would not be a satisfactory environment to which the patient should be returned and the husband, who said that he would not mind having the patient home, showed no interest or desire for this to happen. In addition, he did not appear to be an adequate provider. The worker asked him what the patient might do all day long if she returned to him. His only reply was "stay in her room."

The patient was finally placed in a position at a private

17 See p.146 for a further analysis of this case.
hospital, working in the cafeteria. She was able to accept the fact that it would not be advisable for her to return to her husband. It appeared that the patient only expressed a desire to return because she felt it to be her duty. Whereas, in reality she despised her husband and basically did not wish to return to him. Her placement worked out very happily for her and she showed no remorse when she was notified of her husband's accidental death the following year.

Discussion:

Here is a case of overt rejection in which there was an obvious situation of an undesirable environment for the patient. The rejection can be recognized in the husband's total lack of interest or concern about her welfare. His past and present behavior, as well as his comment on the future, she could "stay in her room," all indicated rejection of the patient.

In this chapter, we have seen a case of long-standing rejection (D.H.), unconscious rejection (V.F.), rejection due to sibling rivalry (R.C.), and a case of a husband rejecting his wife (F.B.). There are many other relationships in which rejection could be manifested, but the writer is unable in this thesis, to explore them.

The writer has discussed rejection and indicated by resource material and case presentations some means and/or techniques for recognizing this factor. Relatives' ignorance of mental conditions appears to be a frequent cause of such destructive attitudes as rejection. In many instances, this rejection is born out of fear -- fear of the patient, fear he would never be the same, fear he would regress, fear he would always be an economic drain and never economically independent, and fear of what others in the social group might think. Fear usually exists in conjunction with ignorance and sometimes yields to the social workers' tools of explanation, reassurance, interpretation, and clarification.
CHAPTER IV

STIGMA

Formerly, a stigma was a brand burned upon a slave or criminal and from the days of its origin, the word has been a sign of disgrace. Today it is a blot on one's honor and reputation. It is applied to defects, scars, blemishes, and the like, as well as being the mark or sign of a diseased condition. When we stigmatize a fellow human being, we are denouncing him and applying terms of disgrace to him. The writer applies this term to the social disgrace of having been "an inmate of an insane asylum," or much too commonly as "a crazy maniac in the bughouse," or more verily "a patient in a mental hospital." Our operational definition of stigma is confined to the negative attitudes of the general public towards the mental patient.

We will concern ourselves, in this chapter, with the disgrace of being, or having been, a mental patient, the public's misunderstanding and/or misconception of mental illness and the mental patient, how important a matter this is for the patient's rehabilitation, the patient's and relative's feelings concerning this factor, and, finally, the social worker's role in recognizing this stigma.

There is much the social worker can do about this factor via his professional organizations, contacts with the community, public relations, and social action, but of necessity, we confine our discussion to the case-work process with the patient and his family and how the above mentioned
areas can be treated, after being recognized, in this process.

"Mental hygiene requires something more than a body of theory and a group of practitioners. It requires, in addition, an informed and sympathetic public that will provide the supporting values and institutions and, in part, will participate in the work."¹ These words would appear to express a broad understanding of our problem, "an informed and sympathetic public that will provide the supporting values." The returning patient usually meets many obstacles when he returns to the community, which significantly affect his readjustment. Perhaps more significant is the patient's reactions to these obstacles and his feelings about them.

"Frequently individuals returning from a mental hospital find themselves the center of suspicious anxiety ..... They are put to numerous tests, little and big, to prove that they are not still 'crazy.' Even when they are not avoided outright, they find those about them frequently overquick to interpret their human variations as signs of returning illness."²

In an attempt to determine the intensity of this factor, and therefore its significance for the social worker, the writer presents a scale in Table III as a means of determining the degree of intensity and significance of this factor in his sample.

In the preceding chapter, the writer endeavored to show that acceptance of mental patients by their relatives does not come naturally

¹ Helen Leland Witmer, Psychiatric Clinics for Children, p. 28.

and is often a difficult matter. The above scale and preliminary discussion of this factor also indicates a lack of acceptance of the patient, only this time on the part of the community and the public in general. The personal and social fears of the mental patient and his illness certainly do not implement their understanding and tolerance. Communal education would be helpful in eradicating the public's fears and misconceptions but, without minimizing its value and importance, the writer only mentions it briefly.

There is a hesitancy aroused from hopelessness to provide funds for the care and treatment of the patient, but pity motivates some contributions for care. However, this hopelessness does not anticipate much value in treatment and it inhibits contributions and appropriations,

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See Chapter III, REJECTION.
maintaining that the patient belongs in an institution and not in society. These attitudes are derived from fear, and fear is bred in misunderstanding and ignorance.

The study will now focus on the reactions of the patient and his family, their feelings concerning this stigma, and how the social worker might recognize this factor.

In attempting to find employment for the patient when he is ready to leave the hospital, in interviews with potential employers, and in interviewing patients and relatives, one can hardly deny that such a factor exists. We have seen that a patient's return to the community causes social embarrassment for many relatives and intensifies the rejection of the patient.4 The scale on stigma has also indicated the intensity and significance of this problem. How does the patient feel about it? How does he react to this problem?

He may deny its existence and rationalize, as in the case of R.M.5, "the public now understands that mental illness is like any other illness," and tells himself and others that there no longer is a stigma. He may intellectualize and say he recognizes the problem but he is going to face it. This was apparent in the case of R.C.6 when she said "I feel it is a blot upon my name but there is not much I can do except be frank about it and try to live with it." There may be a deep concern and worry on the part of the patient, as indicated in the following case summary.

4 Ibid.

5 See case presentations on p.p. 114 and 141.

6 See case presentations on p.p. 11 and 18.
S.M. 7: Case of Intense Stigma

This is a twenty-year-old, single, female who entered the hospital in June 1953 and whose diagnosis was established as Schizophrenic Reaction, Schizo-Affective Type. She was referred to social service because it was felt that her family situation had contributed to her present illness, social service could help the patient with her feelings regarding her family, and also could help her with her readjustment to the community when she left the hospital.

This factor appeared to manifest itself in the second interview with the patient when she raised some questions concerning her ability to obtain a driver's license and said "she feels people talk about her being in a mental hospital and she wonders what they are saying and thinking of her." She said she was not ashamed of having been in the hospital and asked the worker how she would feel if she were in the same situation. The worker gave her an intellectual interpretation of the comparability of mental illness to physical illness and the need for hospital care in both instances. The patient made no apparent response or comment, and after a long pause, she diverted the discussion to her family.

In a later interview, the patient initiated a discussion of employment by informing the worker that she had been offered an opportunity to train for an airlines job. She said she had previously been interested in this type of work, but now she was not sure. She went on to say that she had an appointment with the man who interviews applicants, but she did not go. "She wondered if she would be able to get a job because she had been in a mental hospital."

Other employment opportunities were explored with the patient and she made up her mind that she wanted to return to her former place of employment. When the worker explored her feelings and asked how she felt about this, she expressed a good deal of concern and feeling about her stigma. She thought her friends would ask many questions and look at her queerly. She also commented that some of her so-called "friends" have made the remark that she is "crazy" and has been in a "crazy house." The worker commented that it was difficult to have people make these remarks and the patient said she is not going to do what she had done in the past, i.e., keep her feelings to herself. She said she now talks more freely about her feelings and believed the stigma did not bother her as much as it did in the past.

See p. 57 for a further analysis of this case.
As the case progressed, the patient informed the worker of her boyfriend who had been wonderful to her, but she expressed feelings of inferiority saying she felt she is no longer good enough for this boy, since she has been mentally ill. She felt very tense and uncomfortable when out in a crowd and especially when someone remarked about another person being "nuts" or "crazy."

Discussion:

Here was a case of intense feelings of stigma as the patient faced the realization of her leaving the hospital. Her feelings were neither hidden nor denied as she readily expressed them in the second interview, after a relationship had been established and she felt she could confide in the worker. It is easily recognized as she expressed her feelings so vividly in areas pertaining to employment, her boyfriend, and social gatherings.

The preceding case was an illustration of feelings of stigma on the part of the patient and not her family, manifesting itself in areas of employment and social interaction. An illustration of feelings of stigma on the part of the relative, the result of which is rejection of the patient because of her illness, can be seen in the case of R.C.8

It can also be seen in these preceding cases that the social worker has an opportunity to educate some of the public via his contacts with potential employers and other citizens. He can play a part in the task of erasing the public's misconception of mental illness and for some patients, he can reduce some of the existing stigma, as well as help the patient with his feelings about the stigma.

8 See p. 29.
We have been discussing stigma, what it means, how it is manifested, how it affects the individual patient, and the worker's role of recognizing it with some mention of it's implications for the family and their reaction to it.

"Illness, as much as any other single factor, has a profound effect on family equilibrium. It frequently necessitates drastic changes in roles both of the ill person and other members of the family. When the significant persons in the family constellation react to the illness with guilt, anxiety, over-protectiveness, rejection, or just plain resentment, these are vital factors which certainly may affect the patient's recovery and planning for his rehabilitation."9

The implications for the family can be seen to some extent in the case of V.F.10. This mother's rejection, partially based upon social embarrassment and feelings of stigma, necessitated a good deal of intensive casework help. The feelings of stigma were expressed by the mother and as she received help with them and came to understand her feelings, she was able to be much more accepting of the patient and play an active and positive role in her rehabilitation.

In the case of R.C., we also see a relative rejecting the patient because of social embarrassment. In that case, the worker emphasized the sister's potential role in the patient's rehabilitation and made her more comfortable with her feelings of stigma so she could accept the patient on a more positive basis.11

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10 See Chapter III, REJECTION, p. 20.

11 Ibid, p. 29.
Now let us turn our attention to treatment as the writer interprets the degree of each factor and how it was treated in each of the twenty cases of the sample.
Our basic considerations have been in the realm of the casework process, maintained largely in the casework interview. The writer considers these interviews to be psychotherapeutic in nature, giving a broad definition of psychotherapy as: a verbal interchange between therapist (worker) and patient (or client), the purpose of which is to increase the patient's (or client's) understanding of himself and his psychological motivation, reactions and behavior.

In actuality, treatment may begin at the initial interview and may be manifested in the basic acceptance of the patient or client, or even prior to this, as therapeutic elements may be present in just the thought of seeing a helping person. Hinsie writes, "The psychotherapist who understands his patient well and who knows how to use psychological stimulation succeeds with any method that he cares to use." The writer feels this to be true in consideration of our discussion and, in fact, recognizes a therapeutic value in discussing one's problems with an interested and understanding person.

"---- the critical moments in psychiatric social work come in the face to face contacts of the worker with the persons who are a part of the case problem. A well-trained social worker brings to these contacts a knowledge of the subject matter of human personality and human behavior, of the social environment of human beings and the effects of interplay between the two. If any bit of social treatment is analyzed, however, it

will be seen that its success lies not only in the use of the facts and concepts of psychiatric and social science, but quite as much in an ingenious and imaginative use of a multitude of minor devices, emphases, suggestions, etc., which collectively have furnished the basis of an effective relationship between the worker, the patient, his family, and others.\footnote{2}

Ideally, the worker helps the patient accept his illness and the most effective discharge plan, through the utilization of casework techniques and skills. He may arrange for care in the community, referrals for financial assistance, occupational therapy, further casework services, etc. The illness may have very different meanings for different people, and it is the social worker's job to help these people understand and accept the illness and the problems it arouses. He works with the internal as well as the external environment and utilizes manipulation, supportive therapy, clarification, interpretation, and insight therapy under psychiatric supervision. He brings important casework skills with him in the form of a knowledge of human behavior and an understanding of the emotional and social implications of illness to the patient and his family, as well as a knowledge and understanding of community resources.

Social casework treatment has been, and still is, traditionally classified under the following four major headings:

1) \underline{Psychological Support} (as acceptance, support by encouragement and reassurance, etc.).

2) \underline{Environmental Manipulation} (as placing a patient in a nursing home, finding him employment, etc.).

\footnote{2} Porter R. Lee and Marion E. Kenworthy, \textit{Mental Hygiene and Social Work}, p. 133.
3) Clarification (as interpretation, giving information, structuring positive thinking from confused ideas, etc.).

4) Insight (as helping the patient or client become more aware of his unconscious or preconscious motivation and attitudes, with the presence of elements of transference, etc.).

We shall briefly present each of the twenty cases as a means of indicating which one, or combination, of the above mentioned techniques were utilized in the sample.

**J.F.** High Dependency, High Rejection, High Stigma

This is a forty-five-year-old, single, male who was totally rejected by his only living relative, a sister, who said she could not be of any help in finding him a job or a place to live, and had not visited or written to him for quite some time. He was afraid to face the community, verbalizing that he could not bear to account for himself and his illness. Because of this, he turned down many employment opportunities. He was not anxious to leave the hospital and asked the worker not to spend too much time looking for a placement for him as he would be willing to remain in the hospital until a job came along.

Diagnostically, it appeared as though the sister rejected the patient because of the stigma attached to him and his illness. This rejection made the patient feel very inferior and further stigmatized, which seemed to result in his complete dependency upon the accepting and protective environment of the hospital.

Following the establishment of a sound relationship, in which the patient was totally accepted and encouraged to express his feelings, the worker gave him a good deal of support and reassured him that he was well and capable of returning to the community.

After much psychological support, in which the worker gave the patient encouragement and reassurance, environmental manipulation was utilized, wherein the worker located a supporting placement and an understanding and accepting employer. The supportive relationship and reassurance from the worker enabled the patient to leave the hospital, and the worker's interpretation to the employer strengthened the supportive elements in the environment, in which the patient was able to make a happy and successful readjustment.
G.E.M.: Low Dependency, High Rejection, No Stigma

This is a sixty-four-year-old, married and separated female who had not been visited by her relatives for quite some time and who expressed a good deal of worry and concern for their welfare. The initial referral to social service was for purposes of contacting relatives. Letters were sent to them, requesting that they visit or communicate with the patient, as in previous instances, but there was no response whatsoever. This was in 1934 and the patient was again referred to social service for placement in 1950. Her parents had passed on and neither her husband nor her siblings had any contact with her during these years.

After this final referral, the only relative who could be contacted was a brother who wished to have as little as possible, and preferably nothing, to do with her. He said he could be of no assistance and would be contented with whatever the hospital decided.

There appeared to be no indication of feelings of stigma on the part of the patient and her only dependency was upon the worker to locate a satisfactory placement for her. She appeared to be very willing to leave the hospital, but needed clarification and support in adjusting to her new environment.

Since this rejection was of such a long duration, the patient appeared to have accepted it and resolved any negative feelings. It appeared to present no problem and environmental manipulation was utilized to locate a nursing home where the patient was to live in and be employed. It seemed to work out well as the patient appeared to be satisfactorily readjusted at the conclusion of the record.

H.D.: No Dependency, High Rejection, Moderate Stigma

This is a single, forty-six-year-old, female who had been hospitalized for a period of twenty-six years. Her family steadily took her home for visits during the first ten years of her hospitalization, but had stopped entirely for the last sixteen years. Suddenly, they resumed this practice and it was because of this that the patient was referred to social service. The patient expressed a good deal of anxiousness to return home. The patient's parents also appeared to suddenly want the patient home. Ensuing contacts with the parents indicated that they had been stimulated into this sudden surge of love for their
daughter by extreme guilt feelings for their previous neglect.

The father was very insistent that she come home immediately but the mother became a little hesitant about wanting the patient at home, as she expressed the feelings that she did not want to assume the responsibility of having to support this sick daughter. Stimulated by guilt, they wanted the daughter out of the hospital and would have preferred to have her placed in a nursing or boarding home. However, the expense would be too difficult for them to manage and the only solution to their guilt was to have the patient return to their home.

The patient was placed in the home, but this rejection still manifested itself. The guilt seemed to be resolved as the parents accepted the patient in the home, even if only on a physical basis. Emotionally and socially she was totally rejected. Her most entertaining activities were taking walks and going shopping, but her parents refused to accompany her at any time. The worker felt this was due to a social embarrassment for their "crazy daughter". The patient maintained many of her schizophrenic symptoms, especially in her appearance and behavior, and it was felt this resulted in the parents feeling socially embarrassed and stigmatized, which seemed to account for the rejection.

Most of the treatment was done with the parents, in the form of support and encouragement to make the patient happy and their endeavors to accomplish this. Their guilt was not explored at all, as it was felt to be a positive force on behalf of the patient. However, the guilt was manipulated somewhat, as a means of increasing its intensity as a positive force and stimulating the parent's acceptance of the patient, emotionally and socially as well as physically. There were no indications of treatment with the patient in regard to the three factors under our consideration.

R.M. High Dependency, Moderate Rejection, High Stigma

This is a single, forty-four-year-old, male who had spent many years of his life in mental hospitals. There were moderate indications of his being rejected by his only living relative, a married brother who lived ten miles from the hospital. The brother rejected the patient somewhat because he had no understanding of the patient and judged

3 See p. 11 for additional analysis of this case.
him by his own standards, which were very rigid. The brother made fairly frequent visits to the patient, but nagged him at these times, told him he should leave the hospital, become a man, and make his own way in the world. Although the patient's psychosis was in remission and he indicated a very good prognosis, his brother's attitude and behavior became very threatening to him. He was afraid to leave the hospital, afraid to face the world alone, and felt stigmatized and very much inferior to others in the community. He turned down many employment opportunities and said he could not leave the hospital until he regained his self-confidence, remaining week after week, and month after month, waiting until he felt secure enough to return to the community.

Treatment in this case was focused on the patient's feelings of stigma and the resulting intensive dependency. The worker saw the patient's brother on many occasions, with the purpose of reducing the rejection and its threatening effect upon the patient. Through interpretation and clarification, the brother came to understand and accept the patient and his problems. With this increased understanding, the brother was not as rejecting of, nor as threatening to, the patient. The worker had many discussions with the patient about the stigma of mental illness, interpreting and clarifying the reality situation to him, as a means of diminishing his fears of returning to the community. This meant a reduction of feelings of stigma and dependency upon the protective and secure environment of the hospital.

These techniques and a tremendous amount of supportive therapy were the underlying therapeutic themes. The worker took advantage of every opportunity to support and reassure the patient that he was well, could return to the community, and make a satisfactory re-adjustment. Timing was very important and the worker had to be aware of the high degree of dependency as a reaction to the stigma, so as to avoid "pushing" the patient and becoming a threat to him.

**M.G.: High Dependency, High Rejection, High Stigma**

This is a divorced, fifty-six-year-old, female, who is a deaf-mute. Nine years after her admission, it was felt that she was ready for placement in the community. The worker communicated with the patient by utilizing the writing method. Her parents had passed away and the only known living relatives were two sisters, who were found to be a little
skeptical about the patient leaving the hospital since she had been so sick and hospitalized for such a long period of time. They said they would not object to her being discharged, but insisted that they did not want to take on any responsibility other than perhaps visiting now and then. The patient reacted to this rejection with the rationalization that her sisters were quite busy and believed they would take care of her if they possibly could. She seemed to have no hostile feelings towards her family and appeared comfortable with her defense.

She became rather dependent upon the worker, partly due to her being a deaf-mute, and the worker gave her a good deal of reassurance and encouragement which helped her accept a placement where she could live and work. The worker interpreted the patient's emotional needs to the employer and he appeared to be very accepting of the patient. Satisfying experiences with the employer, the worker's support, and the supportive nature of the environment, provided by environmental manipulation, appeared to relieve the high degree of dependency and feelings of stigma, and it further appeared as though the patient's own defenses made her comfortable with the rejection.

Dynamically, it would seem that the patient's illness and physical condition motivated the sisters to reject her, and both of these stimulated her to feel stigmatized, thereby resulting in her dependency. The main treatment techniques which were utilized were psychological support and environmental manipulation.

F.B.4: Moderate Dependency, High Rejection, Low Stigma

This is a married, fifty-nine-year-old, female who had a long history of marital maladjustment and who blamed her husband, her only known living relative, as being the primary cause of her illness. He was visited by the worker when it was felt that the patient was ready to return to the community. He was found to be very rejecting of the patient and was only willing to accept her as a housekeeper and maid. She reacted with a good deal of hostility towards the husband. The worker accepted and encouraged the expression of these feelings, as it was felt they were justified and placement with the husband was not desirable as he could neither provide a decent home nor environment for the patient.

4 See p. 30 for an additional analysis of this case.
Feeling that she was alone, she became somewhat dependent upon the accepting hospital and worker. This dependency was met with a good deal of encouragement and reassurance from the worker, and similar supportive techniques were utilized for her almost negligible feelings of stigma.

Environmental manipulation provided a supportive placement in terms of a job in a private mental hospital where she could receive room and board. This seemed to satisfy her dependency needs and feelings of rejection, although she realistically looked forward to the possible eventuality of her maintaining her own home once again.

Therapeutically, there was clarification of her justified feelings towards her husband because of his rejecting attitude. Psychological support and environmental manipulation were utilized in treating her dependency and minor feelings of stigma.

**G.R.G.:** Moderate Dependency, Moderate Rejection, Low Stigma

This is a single, forty-three-year-old, female who was referred to social service for placement after seven years hospitalization. Her only known living relative, her father, had remarried since the death of his wife and was residing in Connecticut, where he was a Methodist minister. He visited the patient frequently and expressed much interest and concern for her, but stated he could do nothing for her financially. The patient was an invalid due to chronic arthritis. The worker sensed a moderate degree of inward rejection which was not overtly expressed. It appeared as though the father visited the patient out of feelings of duty and obligation rather than love or affection. He said he could not accept the patient in his home because of financial reasons and it was also partly suspected to be due to his wife's attitude toward the patient, whom she never met.

The patient seemed to have adequate defenses to meet this rejection, although she seemed to react with moderate dependency upon the worker, who gave the patient a considerable amount of psychological support in these areas as well as with the patient's slight feelings of stigma.

The worker utilized community resources in obtaining finances from the Department of Public Welfare, which enabled the utilization of environmental manipulation. The patient was placed in a nursing home where she had more freedom, had the continuing visits from her father and apparently was able to
make a happy and satisfactory re-adjustment.

Although the three factors did not present major difficulties, they were problems which necessitated casework help. Treatment in this case can be classified under the two techniques of psychological support and environmental manipulation.

**R.C.5: Low Dependency, Moderate Rejection, High Stigma**

This is a single, sixty-one-year-old, female who had rather strong feelings of stigma. The problem of rejection was relatively moderate, although very intensive, but not to such a degree as to be considered high. The patient's dependency was so minimal that it only required the meeting of her requests for finding employment. Other than this request, there were no other indications of dependency, and as the case progressed, she made her own attempts to locate employment as she was relieved of her feelings of stigma. This stigma seemed to be her biggest difficulty and the worker treated it with interpretation and clarification of mental illness and increased public understanding and acceptance.

Support and encouragement also seemed to be helpful, as the reduction of feelings of stigma resulted from the utilization of these techniques and the experiencing of satisfactory experiences in the community. She still felt stigmatized, but much relieved of the previous concern and anxiety as she felt she could live comfortably with the stigma.

Since her parents' death forty-years ago, she had been residing with her only sister, who was also single. The sister expressed a good deal of ambivalence towards the patient, which seemed to result from a long-standing sibling rivalry. It was because of this rivalry that the sister appeared to receive some satisfaction in the patient's illness and hospitalization. However, she had a real sense of responsibility and love for the patient, but the negative aspects of the ambivalence seemed to outweigh the positive aspects, and she refused to have the patient at home. She based this decision on her feeling that the patient caused her too much anxiety and tension, was a social embarrassment, and she wished to be free of the responsibility required in constant supervision.

The worker saw the sister many times and supported the more positive aspects of her ambivalence. He gave her a good deal

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5 See P. 11 and 29 for an additional analyses of this case.
of reassurance and support, and encouraged her to fulfill the wonderful role she could play in the patient's rehabilitation. These techniques appear to have been fairly successful as the positive factors of the ambivalence begin to become stronger than the negative factors, allowing the sister to accept the patient at home once again. The worker actually manipulated the factors in the sister's ambivalence, stressing the positive aspects, and gave her support, encouragement, and reassurance through clarification.

S.W.: High Dependency, High Rejection, High Stigma

This is a single, thirty-six-year-old, male who requested help in seeking employment and getting discharged from the hospital. The father expressed indications of rejection as he found many faults with the patient, was angry about his "flying off the handle, getting mad, and flaring up." He said he did not want the patient loafing around. He complained about his health being poor and "his abilities to work for the patient's best interests depends upon his health." He continued to complain about the "inconveniences of coming to and from the hospital." He seemed very ambivalent about taking the patient home, and he finally decided he would, but only after the worker clarified and interpreted the patient's illness and personality to him. The worker also supported the positive side of the father's ambivalence, telling him how helpful he could be to the patient and what a wonderful thing he would be doing for the patient's rehabilitation. This seemed to satisfy the father's narcissistic needs, and he resolved his ambivalence by taking the patient home for a visit.

There were many short visits in the following two years, but the father could not be persuaded to take the patient home on indefinite visit, in spite of all the worker's efforts. The father continued the brief visits as though he was doing his duty, but none of the worker's attempts to reduce rejection were successful.

Other relatives were contacted, but total rejection was the reaction from each of them. The patient reacted to this rejection by feeling inferior and stigmatized because of his illness. This, in turn, resulted in his becoming very dependent upon the hospital, as it appeared to be the only place where he was accepted.

It became necessary for the worker to give the patient a tremendous amount of psychological support, which finally enabled the patient to consider discharge planning and find employment where he could live in and also work. Employment
was obtained for him but he turned it down, giving the excuse that his teeth needed attention and he could not leave the hospital. After much acceptance and support, he expressed his true feelings by verbalizing how afraid he was to face the world. Clarification and interpretation of his feelings and abilities, along with encouragement and reassurance, finally enabled him to leave the hospital and make an adequate readjustment.

It is interesting to note that there were no indications of high dependency until the patient realized he was being rejected. He feared facing a strange world when his own family would not accept him. This greatly increased his dependency and feelings of stigma. These were treated as the worker helped the patient clarify and interpret his family situation and his feelings about it. This was combined with much supportive therapy.

_H.M._: Low Dependency, No Rejection, Low Stigma

This is a single, thirty-five-year-old, female who had been employed as a laboratory technician in a general hospital. There were some indications of feelings of stigma as the patient initiated a discussion of stigma with the worker. She desired to get back her old job, only if for a short period of time, so in applying for another job, so she could say she was working in that hospital rather than applying from here and saying she was a mental patient. She wanted to be frank and honest about her illness, but she felt she would not be hired if she told people during employment interviews.

There was very little indication of dependency as she appeared very anxious to leave the hospital, preferring to find her own employment and requesting very little assistance from the worker. This minor degree of stigma was further indicated as the patient convinced herself that her former employers would not have her back. Her defense for this was a rationalization that there was too much tension there and she would prefer not to return.

Her minor dependency indicated itself in her requesting help from the worker in supplying employment leads which she would follow-up by actually arranging for and going to the interviews herself. She also asked the worker to contact her former employers to ask them if they would take her for the previously mentioned purposes. The worker did this and found the employers to be very accepting and understanding of the patient, and they
even suggested that the patient work for them once again, on a permanent basis. When the patient was informed of this acceptance, there was a marked change in her attitudes and feelings.

When told of her former employers' attitude, she put aside her previous plans and accepted the position, made an adequate readjustment, and remained happily employed until discharged. The primary treatment technique utilized was environmental manipulation, with some clarification via interpretation to an accepting and understanding employer. There was also a limited amount of supportive therapy through encouragement and reassurance that she was well and capable of functioning in the community. Her employer proved this to her by offering her the position and demonstrating their confidence and acceptance.

There was no mention of the patient's family in the record and therefore no indication of any apparent rejection.

I.M.: High Dependency, High Rejection, Moderate Stigma

This is a single, twenty-five-year-old, female who seemed to have been rejected all of her life. She has a sister of whom she was very jealous and towards whom she expressed much hostility. It seemed that sister was always mother's favorite and mother was too anxious about disguising this favoritism. The patient said she had always felt unwanted at home and her family never showed her any love or affection. She was never happy at home and always felt inferior to her sister because of the mother's favoritism. The entire family, except for a brother of the patient, showed no interest in the patient and could never find the time to see the worker to discuss the patient and her discharge plans. The worker felt the family desired to have the patient finish her life out in the hospital, and they were not at all concerned with her welfare. The patient expressed the feeling that the hospital was her home and acted as though she were perfectly contented to remain there.

Her brother appeared very much interested in her, but he expressed concern over the patient's being "reluctant to make plans to leave." The patient frequently said she was not well enough to leave the hospital and the worker and brother felt this was not true, but only her reaction to a life of rejection. The worker and brother agreed that it would be wise to have the patient start making visits to the brother's home. These visits would be short ones at first and then gradually increased, as the brother and worker would give the patient a good deal of
reassurance that she was well, in hopes of building up her self-confidence. The worker also gave a good deal of psychological support to implement these visits.

It was planned that this acceptance and support, coupled with satisfying visits, would, in time, decrease the patient's dependency upon the hospital. This plan gradually became successful as the patient left the hospital to live with her brother and his family.

Her moderate feelings of stigma were indicated as she expressed inferiority feelings because she was an ex-patient, and she avoided meeting people for fear of what they would think. The supportive therapy by the worker and the acceptance of the patient by her brother and his family appeared to resolve the difficulties produced by the stigma and dependency. The accepting environment and the absence of "pushing" the patient also seemed to help in reducing the feelings of stigma as the patient became more secure and was able to accept a job and engage in social activities.

D.A.: High Dependency, Moderate Rejection, High Stigma

This is a single, twenty-two-year-old, male who had been hospitalized for three years. It is a most interesting case in which the interrelatedness between dependency and stigma can clearly be seen. There are extreme feelings of stigma as the patient is very suspicious of everyone, including the worker, and he is very unhappy in the community. He felt he was being watched by everyone, wherever he went, and this suspiciousness resulted in his losing one job after another. He blamed all of this on his having been a mental patient as he expressed the feeling that everyone avoided him and looked down on him.

There was a moderate degree of rejection as the mother complained to the hospital about the patient, nagged him at home, and continually found fault with him, although she never once refused to have the patient at home. It seemed the patient was unhappy at home but the mother would never suggest he return to the hospital. It was the worker who suggested that he return as he was making a very unsatisfactory readjustment. The worker asked the patient if he wanted to return to the hospital until a job could be obtained for him. He was very happy to accept this and so was the mother since she was not the one who had suggested it. When the patient returned to the hospital, he seemed to be very pleased to, once again, be within it's protection. He said he felt very comfortable in returning and added that he wished
to remain there until he could be placed in a job where he could also reside. The mother also expressed satisfaction about the rehospitalization. The patient spent a month at the hospital and refused many employment opportunities which were brought to his attention during that time. His dependency increased as he remained in the hospital, requiring the worker to give him a tremendous amount of constant reassurance and psychological support, which finally enabled him to accept a job in an institution where he could live as well as work.

Being in this setting protected him from being stigmatized, which seemed to reduce his dependency upon the hospital and the worker, and satisfactorily reduced any feelings of rejection. This was the result of his being removed from the rejecting environment produced from his being at home, and his mother was much more accepting of him as she only saw him on his day off and was not burdened with the expense of his room and board.

A.T.O.: Moderate Dependency, High Rejection, High Stigma

This is a single, thirty-four-year-old female who had been in the hospital for a period of less than three years when it was felt she was ready to leave. She said she was anxious to leave the hospital and planned to live with her sister, who was single and had an apartment in a local community. The patient said she planned to take things easy for a while before she would think about looking for a job and felt it would be better to get settled first. This and her insecurity about how well she really was indicated some degree of dependency as she wanted to make sure she was going to be all right.

The rejection seemed to manifest itself as the sister refused to have the patient live with her, saying she travelled a lot and was never home, and her extreme resistance to seeing the worker or even speaking with her over the telephone. The sister was very hesitant and avoided the issue each of the many times the worker attempted to discuss the patient with her. At first, the patient reacted to this rejection by denying it and rationalizing that her sister was very busy. As the rejection became more apparent and the worker encouraged the patient to make constructive plans, the patient said it would be better for her to get an institutional job where she could live as well as work. The rejection became more pronounced as the sister refused to send any money to the patient, visit her, or speak with the worker. The patient's reaction was increased dependency upon the worker. The worker accepted these dependency needs and at the
same time encouraged the patient to become more independent, by attempting to build up her self-confidence and making her feel more secure with herself.

The matter of stigma came up when the patient was considering the possibility of returning to her former job. She was afraid of what people would think of her having been ill and thought they would always be watching her and suspicious. She was very ambivalent about this and the worker explored the matter with her, supporting and strengthening her ego and the part of her which wanted to go out and face the world.

There was a good deal of clarification and supportive therapy as the patient came to realize that she had to lead her own life, which was what her sister was doing. The treatment appeared to be effective as the patient attempted experiences in finding a job and a place to live. The relationship enabled the patient to accept the clarification of, and the support in, the reality situation. This helped the patient make the move to leave the hospital and participate in satisfying experiences, which tended to reduce the dependency and feelings of stigma. The clarification of her relationship with her sister and her satisfying experiences seemed to resolve any difficulties caused by the rejection.

C.C.: High Dependency, High Rejection, Low Stigma

This is a single, thirty-six-year-old female whose only known relative was a married sister. There was no difficulty in establishing a relationship, which was one in which the patient became extremely dependent upon the worker.

Diagnostically, it appeared as though the patient did not want to leave the hospital and engaged in unrealistic planning to give the impression that she did want to leave but was unable to. The patient's sister had visited very infrequently and had said she could not have the patient live with her, but as if motivated by extreme guilt, the sister suddenly said the patient could live with her family if she wished. This seemed to resolve her dependency as she anxiously accepted the invitation and, immediately after going there on visit, she obtained a job and was placed on indefinite visit. This would seem to indicate that her dependency was a direct result of the rejection. However, within a few weeks, the rejection got the better of the sister's guilt feelings and the patient was returned to the hospital with the sister saying the patient was acting queerly and they could not have her in the home. On her return to the hospital, the patient was examined by the physicians and it was determined that there was no apparent
regression on the part of the patient.

The patient's reaction to this rejection was verbal hostility and the resolution that she wanted nothing more to do with her sister. This appeared to be an adequate defense in response to this rejection. The patient seemed to have had a very satisfactory experience in her job while on visit, and she was anxious to return if the worker could help her locate a room where she could live. This experience appeared to be instrumental in reducing the patient's dependency and the worker encouraged the patient by helping her locate residence. The dependency was resolved by her satisfactory employment experiences and her defenses appeared to reduce the anxiety resulting from the rejection. The environment was manipulated in helping the patient find a room and engaging in social activities, and the worker evidently felt this was adequate as there were no indications of any further treatment.

J.H.: Moderate Dependency, Low Rejection, High Stigma

This is a single, thirty-four-year-old, male who had been in the hospital for only a few months before it was felt that he might make good use of social service. He was very accepting of the worker and expressed a strong desire to have someone "help him out." He had always resided in the home of his father, who was rather accepting of the patient, apparently because of a vow he had made to his dying wife, but there were indications of minor rejection as the father expressed impatience with the patient and verbalized the burden of having to care for him.

The major difficulty throughout the record appears to be one of extreme feelings of stigma on the part of the patient. He was very insecure, expressed doubts of his ability to make progress, imagined that people looked at him and knew that he was a mental patient, and he became very suspicious of everyone he met. The patient seemed to be rather intelligent and benefited from intellectual discussions about mental illness. There was a good deal of clarification and interpretation with him about his feelings of inadequacy, sensitivity, and feelings of inferiority. The patient gradually verbalized on how much it helped to hear mental illness spoken of in this way.

Utilization of the relationship, clarification and interpretation helped the patient feel more adequate and less suspicious of the world, which tended to reduce his feelings of stigma.
This evolved into a reduction of his dependency, as he was able to function more adequately in terms of finding employment and resuming his social life. These satisfying experiences helped him prove to himself that he was less stigmatized than he had previously thought.

Diagnostically, it appeared as though the patient's dependency resulted from his feelings of stigma, and as the latter was treated with psychological support and clarification through interpretation, it's reduction appeared to reduce the dependency. The patient's self-confidence increased and he became more secure in his environment. There were no indications of treatment for the rejection and it proved to present no major difficulty.

D.H.6: High Dependency, High Rejection, No Stigma

This is a single, seventeen-year-old, male who was blind due to a congenital gonorrheal condition and his entire family rejected him from the time of his birth. As a result of this rejection, he has lived in institutions practically the whole of his life and has never had a home. It appeared that this total rejection resulted in his extreme dependency. His visual impairment also contributed to his dependency. The patient continuously expressed a great deal of resentment and hostility towards the world in general, obviously suffering from a life barren of love and affection.

The worker saw the patient very intensively, sometimes two and three times a week, over a period of many months. There was a considerable amount of difficulty in establishing a relationship as the patient was very distrustful of everyone. There were many, many weeks of testing before the patient was able to trust the worker and accept him in a casework relationship. This seemed to be the focus of treatment as progress was very gradually made. Through this relationship, the patient transferred his dependency from the hospital to the worker, and, in time, he was able to accept the support, encouragement and reassurance the worker offered. This increased his self-confidence and the desire to improve himself until he was able to plan, with the worker, his enrollment in a school for the blind. Community resources were utilized as funds were obtained from the state division for the blind. Other funds were secured from a sectarian guild for the blind, and these finances enabled the patient to secure a wardrobe which he sorely needed. This appeared to have some therapeutic value for the patient as he began to feel more secure and confident in his worth as a human being.

6 See p. 23 for additional analysis of this case.
The patient felt very strongly that he had missed a lot in life and he expressed a sincere desire to be placed in a foster home so he might be able to experience what it was like to be part of a family. Since it was felt this was something the patient really needed, school planning was terminated and the patient was placed in a home with affectionate and loving people. The worker utilized his relationship with the patient to support and reassure him that he would be accepted in this home. This proved to be effective as the patient left the hospital and appeared very happy in his placement. There were no indications of stigma in the record.

S.M.7: Low Dependency, High Rejection, High Stigma

This is a single, twenty-year-old, female who had only spent a few months in the hospital before she was referred to social service. It was felt that her family situation had contributed to her illness, and social service could help her with her feelings concerning her family, as well as her readjustment when she returned to the community. She immediately expressed a good deal of hostility towards her father, said he frequently beat her, and insisted that she could no longer stand to live with him. When she was home, her father avoided her and did not speak to her, and she related a lifetime of parental rejection. There were also indications and expressions of internal feelings of stigma which the patient did not verbalize during initial contacts. It was noticed that she could not apply for jobs or face her friends because of these feelings. The worker encouraged and accepted the expression of her feelings, and coupled this with reassurance, totaling a great deal of supportive therapy. Discussing, clarifying, and interpreting some of her feelings and self-understanding of these matters with her enabled her to attempt situations which proved to be emotionally rewarding and self-satisfying.

With these tried and true experiences, she gained a better self-understanding and increased her self-confidence, which enabled her to make a happy adjustment, residing with a sister and her husband and obtaining employment for herself. With her increased self-understanding and defenses, she was able to participate in more positive relationships with her family, especially her parents, and her ambivalence was resolved as she decided to live away from them. The treatment utilized resulted in the patient's

7 See p. 36 for further analysis of this case.
increased confidence in herself and she became more secure as she maintained herself financially, made her home with her accepting sister, and engaged in satisfying social and recreational experiences.

This case illustrates the utilization of all four treatment techniques; psychological support, environmental manipulation, clarification, and some insight.

**M.F.M.**: Low Dependency, Moderate Rejection, Low Stigma

This is a single, twenty-four-year-old, female. Her parents were dead and her only sibling was married and residing in a distant state. She had made her home with an uncle who verbalized his rejection of the patient and said "he would like to have no responsibility for her and wishes that her sister would have her live with her." The uncle said he had had a lot of trouble with the patient, had to watch over her, and was always afraid she would be getting into trouble. He continued to complain of the patient's temper tantrums and her being lazy and her unwilling to assume any responsibility or do any work around the house. In spite of all of these negative feelings, he did express a feeling of warmth for her and a great deal of interest in her.

The uncle was ambivalent towards the patient and he requested the worker to help him understand the patient and supervise her in a more effective and satisfactory manner.

Some rather intensive interviews were held with the uncle, in which the worker encouraged him to express his hostile feelings as a means of release, and supported the positive aspects of the ambivalence, which focused on his affectionate and interested attitude towards the patient.

The worker also interpreted the patient's illness and emotional needs to the uncle, who was able to make use of the worker's clarification so he could be more accepting of the patient and have her live with him once again.

This change of attitude on the part of the uncle tended to support the patient and thereby reduce her minor feelings of stigma and her dependency. Other than the intensive casework with the uncle, there were no indications of treatment.
S.S.: High Dependency, High Rejection, High Stigma

This is a married, thirty-eight-year-old female who was at the hospital for less than one year when she was referred to social service for casework help in regard to her family and discharge planning. Her husband was contacted, but he totally rejected the patient and expressed no understanding of the patient, her illness, or any obligation to help her get well. Evidently, the husband has been unfaithful and there appeared to be a great deal of marital friction. Her reaction was one of extreme hostility and she verbalized the wish to kill him. The husband became afraid of the patient, and coupled with previous marital problems, he wished to have nothing to do with her. After the establishment of a sound relationship, the patient became very dependent upon the worker and was perfectly willing to do whatever the worker thought was best. She recognized her dependency, and, with this and other strengths, the worker was able to encourage her to participate more actively in discharge planning. She was able to do this, comfortably, with the worker's support.

The patient was placed on indefinite visit in the home of her father, who appeared to be an accepting and understanding person. The worker helped her to accept and understand her feelings towards her husband and his rejection of her. The patient gradually came to accept this in a more comfortable manner, as the reality situation.

This rejection, coupled with extreme shame and feelings of stigma, appeared to motivate the patient's dependence upon the worker. A good deal of supportive therapy was utilized as the worker helped the patient encounter new experiences which were not as anxiety provoking as the patient had feared they would be. They were extremely satisfying and increased the patient's security and self-confidence. This treatment enabled the patient to get a job, engage in social activities, comfortably accept her husband's total rejection, and make a satisfactory and adequate readjustment to a new environment.

V.P.: High Dependency, Moderate Rejection, Low Stigma

This is a single, thirty-seven-year-old female who is the mother of an illegitimate child, and who was hospitalized for less than a year when she asked to see a social worker. The patient's mother died when the patient was quite young and she spent most of her life in various foster homes, which resulted in her extreme feelings of insecurity. She admitted this insecurity and the feeling that it resulted from her
never having a home. Her father kept in moderate contact with her throughout her years and occasionally visited her at the hospital, but was unable to do anything for her.

The patient reacted with a little hostility, but this appeared to present no difficulties, possibly since this moderate rejection was of such long duration and the patient had enough strengths to live comfortably with it.

When she was informed that the doctors agreed she could return to the community, she became rather upset, said they were unfair, she was not well, could not leave, and had no place to go since her father lived in a single room. She continued to express a great deal of feeling about being insecure and afraid of failing.

A very supportive relationship was established, and gradually the worker was able to interpret to the patient that she feared leaving the hospital because she was afraid of failing in the community. She was reassured by the worker and was encouraged to be as active as possible in discharge planning. This became rather threatening to her and she regressed to her previous high dependency and rejected any discharge planning. The worker accepted this and maintained treatment at the patient's level of progress. This strengthened the relationship and it was noted that the patient accounted for her dependency in the fact that her family showed very little interest in her and she had never had a home. The worker was able to clarify for the patient that she was happy and felt secure when she was with friendly people who were interested in her, and therefore felt happy and secure in the hospital. Because of their relationship, the patient was able to accept this clarification, reassurance, and support.

After the patient understood and accepted her feelings, the treatment was focused on giving the patient a tremendous amount of psychological support, which enabled her to leave the hospital and accept a job in a private nursing home, where she also resided. However, she was still very insecure and was referred to a family service agency in her community.

There was a great deal of psychological support in almost every case in the sample, clarification and environmental manipulation were used to a considerable extent, and there were two cases in which there were indications of insight. Along with the four traditional classifications of
casework treatment, there were many instances in which the seemingly "little" techniques and skills were utilized with very positive and effective results. These case presentations should help to increase the reader's understanding of how significant these factors are and also how they may be recognized as well as treated.

It is realized, in a consideration of treatment, that many patients have no need to cling to their illness as a form of life adaptation and they require much less help from the social worker. "Others, whose illness is bound up with immature or neurotic attitudes, can often be helped to increase their ego strengths and powers of self-direction by understanding support on the part of the caseworker."8 Efforts for enforcing the patient's ego strengths should be maintained and the "patient's capacities for planning and taking measures in his own behalf should be encouraged."9

A final word on treatment comes out of this quotation: "Return to health is fostered by the existence of a favorable social climate."10 One's social environment and the security it provides, economic, social, and emotional, all provide assets that support the patient in his effort to make a satisfactory readaptation to his community. Most of these case presentations illustrate ways in which the social worker can strengthen these supportive elements in the community.

8 Frances Upham, A Dynamic Approach To Illness, p. 43.
9 Ibid, p. 44.
CHAPTER VI
SUMMARY AND CONCLUSIONS

The purpose of this thesis has been to study three factors, dependency, rejection, and stigma, in the emotional and social rehabilitation of mental patients. These three factors were isolated, defined, and discussed, so we may have a better understanding of them and their manifestation in the casework process. By the utilization of scales, we have determined their incidence and intensity and through the presentation and discussion of the twenty cases in the sample, the writer has attempted to determine how these three factors may be recognized and treated.

In scaling the cases in the sample, the writer judged each factor to be apparent in the case record to a high degree, if it appeared to have a crippling, or semi-crippling, effect upon the patient's readjustment; moderate if it produced some problems and difficulties which would tend to hamper or endanger the patient's readjustment; and low if it was apparent but presented no major problem or difficulty. If there were no apparent indications of the factor in the record, it was scaled as none.

Table IV on page 63 would suggest that each of the three factors is significant in the social and emotional rehabilitation of mental patients. They would appear to be problem areas in which the patient and his family are in need of assistance; assistance which the social worker is skilled and adept in providing, via the casework process and the utilization of his skills and training.
TABLE IV
SUMMARY SCALE OF CASES ACCORDING TO DEGREE OF INTENSITY OF EACH FACTOR STUDIED

<table>
<thead>
<tr>
<th>Degree</th>
<th>Dependency</th>
<th>Rejection</th>
<th>Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Per cent</td>
<td>No.</td>
</tr>
<tr>
<td>High</td>
<td>10</td>
<td>50</td>
<td>12</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Low</td>
<td>5</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>05</td>
<td>1</td>
</tr>
</tbody>
</table>

The writer has enumerated the many various ways in which each of these three factors can be recognized by the worker during the casework interview. The general areas which are worthy of analysis in dependency are; the patient's attitudes and feelings about leaving the hospital, whether they be conscious or not and verbalized or not, his present functioning and behavior regarding discharge planning, such as hesitancy to accept employment in the community, etc. In the area of rejection, we would want to be aware of overt rejection as refusal to accept the patient or be of any assistance to him, as well as unconscious or camouflaged rejection, indicated when the relative nags the patient, continuously finds fault with him, etc. Stigma is usually manifested in discussions of mental illness, feelings about returning to the community, facing people, meeting old friends and new acquaintances, etc.

The chapter on treatment suggests that anything which is utilized that
has a positive effect upon reaching the treatment goal, has therapeutic value, but for purposes of clarity, we have viewed treatment primarily in consideration of the four traditional classifications; psychological support, environmental manipulation, clarification, and insight therapy.

The presentation and analysis of case material suggested that psychological support was utilized in each of the twenty cases in the sample. It was concluded that this is a primary technique which helps satisfy the patient's needs for support, encouragement, and reassurance, as they arise from his basic insecurity and feelings of inferiority. It was also found to be effective with relatives who were ambivalent towards the patient, in strengthening and supporting the more positive aspects of the ambivalence.

Clarification, through interpretation, suggestion, and discussion, and environmental manipulation were also used extensively in the sample, but not in each and every case, as was psychological support. Clarification was used with relatives, as well as patients, to interpret and clarify reality situations, feelings, and attitudes. Environmental manipulation was helpful in preparing and strengthening supportive elements in the patient's environment when he was either returned to his former environment or when placed in a new environment.

Insight therapy was found to be present in only two of the cases, both of which indicated a spontaneous realization of previously unconscious or subconscious feelings and attitudes. The writer recognizes that it may have been utilized in other cases, but there were no indications of such in the recordings.
The case presentations also indicated that most of these four techniques were frequently used in collaboration with each other. There were many instances in which psychological support was used with clarification and environmental manipulation, and in both cases of insight, there were clarification and psychological support.

Another conclusion suggestion is that each of the three factors is interrelated with the others. There were many cases in which a patient's family rejected him because of the social embarrassment and stigma resulting from his illness. This rejection, in turn, increased the patient's awareness, and therefore his feelings, of stigma, resulting in his becoming increasingly dependent upon the protective environment of the hospital and/or the worker. A resolution of rejection and/or feelings of stigma tended considerably to reduce the degree of dependency. Whenever a patient is rejected by his family, whatever the cause, it will be increasingly difficult for him to leave the hospital, where he is accepted, and return to society, where it is difficult for him to believe he will be accepted if his own "flesh and blood" does not accept him.

The importance of intensive casework with relatives, as well as patients, is further suggested as an important and necessary part of the rehabilitation process with mental patients. We have found the attitudes and feelings of relatives to have a significant effect upon the patient and his readjustment, and many times these attitudes and feelings can be manipulated by the caseworker so as to produce an optimum prognosis for the patient's emotional and social recovery.

By isolating and studying these three factors, one hopes to have
indicated their significance and the ways in which the social worker may perform his professional services, in these and similar areas. Finally, one must be aware of the need for providing casework assistance to families as well as the patients. Ideally, the social worker's objective and focus should be that of keeping the patient and his family in constant contact. This would develop for the patient closer community ties which would facilitate his discharge, and for the relatives insight into the progress and development of the patient's illness, so that when and if the patient does recover and his return to the community is recommended, he will find the bridges still standing and the road considerably shortened.

Approved,

[Signature]
Research Instructor
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