Services to Families of Patients Hospitalized in the Psychiatric Section of Veterans Administration Hospital, Hines, Illinois

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SERVICES TO FAMILIES OF PATIENTS HOSPITALIZED IN THE
PSYCHIATRIC SECTION OF VETERANS ADMINISTRATION
HOSPITAL, HINES, ILLINOIS

IX
Clara C. Alexander

A Thesis Submitted to the Faculty of the School of Social Work
of Loyola University in Partial Fulfillment of
the Requirements for the Degree of
Master of Social Work

June
1954
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Presented with the permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions nor the conclusions deduced by the writer.*

* In compliance with Section 3, Veterans Administration Circular 214, 1946.
CHAPTER 1

INTRODUCTION

This study was made in the Psychiatric Service of Veterans Administration Hospital, Hines, Illinois. Social Service records were reviewed for the purpose of identifying, for evaluation, the services which the social worker offers to families of patients hospitalized because of a mental disorder. The focus was to discover what types of help are available to relatives. It was anticipated that this study would also show the kinds of problems confronting families when a relative is confined to a psychiatric hospital. Furthermore, this study demonstrates the method used by Social Service in communicating to other disciplines information about the family situation, pertinent to the patient's condition and treatment planning. It was hoped that findings from this thesis would aid in future planning for the Social Service program in this setting.

The goal in treatment in mental hospitals is to return the patient to community-living with the fullest utilization of all resources within the hospital for personal, social, and
vocational rehabilitation. The Social Service Department as one of the resources within the hospital, contributes toward this goal:

1) by helping the patient to clarify and understand his feelings which obstruct treatment,

2) by helping the patient to understand his situation better,

3) by helping other people significant in his environment.

The psychiatric social worker has knowledge of community resources and skill in using them for the benefit of the patient. She understands the patient's total situation and possesses the ability to manipulate various aspects of the situation. Not only is she in the best position to know resources to help the patient, but, of equal importance, she contributes toward alleviation of the stresses and strains that arise from the family's reaction to the illness.

Previously, during the development of an improved program for the care of the mentally disturbed, little emphasis

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3 Ibid.
was placed on the importance of families as a potential resource in the patient's treatment. Relatives were useful as a source of social data, but were otherwise ignored, or considered a necessary evil. Social workers are becoming more aware of the need to establish a continuing relationship with the relatives. This practice provides an opportunity to encourage them to maintain positive, non-rejecting attitudes toward the patient throughout hospitalization. The family can also be helped to receive the returning patient with understanding and acceptance. By interpretation of hospital facilities and program, and by assisting the relatives with problems arising from the patient's hospitalization, the social worker alleviates their anxiety in relation to the mentally ill relative.

The greatest majority of psychiatric social workers in mental hospitals practice within the framework of Psychiatry. They must have an awareness of their function and contribution, in terms of the over-all function of the hospital. Their focus is designed to influence the patient's attitudes and to alleviate his cares which affect his ability to cooperate in treatment. Therefore, contacts with the patient's family to help them deal

4 *Psychiatric Social Worker.* Report #2, 3.
with their problem are not seen as ends in themselves.

Furthermore, the existence of a Social Service Department within a mental institution indicates the recognition that social, environmental, and emotional problems affect the patient and, consequently, his recovery and maintenance of health. It is also indicative of the fact that the social worker is best trained to serve the special needs of the family members, both as individuals and as group. In addition, she is able to use her knowledge in a collaborative process toward a common goal.

Following World War II there was an expansion of the Veterans Administration program for emotionally disturbed veterans. Hospitals and staff were provided for psychiatric treatment. The V.A. hospitals are among the best staffed hospitals in the country due to their extensive training programs and the funds available. In addition, their close alignment with schools of the country, and the personnel standards which the agency has developed, aid them in attracting more adequate personnel. In the development of its programs the Veterans Administration has recognized the

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6 Dartmouth Conference, June 1950, 61.
value of social workers in psychiatric hospital settings. As of 1952 they employed 210 workers in psychiatric hospitals with an average of six social workers in each setting.

Setting. The Veterans Administration Hospital, Hines, Illinois, is a general medicine and surgery hospital with a bed capacity of 2630. The Psychiatric Section of the hospital has a bed capacity of 136, with a staff of 139 persons including:

- Chief of Psychiatric Service
- Asst. Chief of Psychiatric Service
- 5 Staff Psychiatrists (includes chief and assistant)
- 13 Psychiatric Residents (7 currently assigned)
- 5 Clinical Psychologists
- 15 Clinical Psychology Trainees
- 3 Social Workers
- 2 Social Work Students
- 24 Nurses
- 78 Aides

Services to the patients are organized on a team basis. Staff and resident psychiatrists, Clinical Psychologists, Social workers, and Nurses are represented on the team in addition to an attending psychiatrist or consultant. The team service facilitates discussing and determining diagnosis, treatment-planning, and also reviewing of reports of patients assigned to the team. The resident psychiatrist is responsible for the operation of the team, and coordinates the various

disciplines toward effective treatment during hospitalization aiming toward effective rehabilitation.

The Psychiatric Section has facilities for various types of treatment. Among them are the somatic therapies of which the most widely used are insulin and electro-shock. Personnel is available for psychological testing, group and individual therapy. Also considered an integral part of treatment and rehabilitation are the adjunct services as manual arts, corrective, physical, educational, and occupational therapy.

Limitations and Considerations of the Study. In collecting sufficient data to be employed in making this study, it was necessary to review closed Social Service records for a one year period. There was a realization of the value of using recent data and consideration of the bi-monthly method of reporting statistics in the Department. Therefore, this study includes cases closed during the period of December 24, 1952 to December 24, 1953.

In reading the social service records two basic criteria were used for limitations. The first criterion resulted in the elimination of cases indicating no services offered to families beyond the history taking process. In this setting, for diagnostic purposes, and as an aid in continuing treatment, it is

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almost routine to secure social history information for each patient. The social history attempts to present the current social situation, a description of the onset of the illness and a selected developmental history. The social worker attempts to assess the immediate social situation and potential obstacles in treatment. During this process it was recognized that relatives are helped by interpretation, by an opportunity to ventilate, and by the anxiety-reducing techniques of the social worker. These individual services represent an essential part of the history taking process; however, it was recognized that they are not always reflected in the social service record or the formal social history.

The second criterion used in this study excluded records which did not reflect planned contact with the family. In many instances there was an indication of short unplanned contacts with relatives beyond the history taking process. The recording of these contacts was brief and in summary form which would not lend itself to this evaluative study. It is necessary to give recognition to these services, because undoubtedly, the relatives were helped by these brief contacts. However, the limitation of recording made it impossible to assess the benefits. After applying the above criteria, sixty cases were chosen to be used in this study.

A schedule was used in obtaining the data presented here.
The following areas are covered:

1) identifying information of the patients and families,

2) nature and sources of referral to the Social Service Department and the lapse of time between admission to the hospital and the referral,

3) enumeration of the services offered to the families and who received the services, and the number of contacts;

4) utilization of additional information secured, by other disciplines, and

5) evaluation of services and their benefits to the patient and the family.

The material obtained by the use of a schedule was tabulated and the results constitute the major body of this thesis. The following chapters contain a presentation of the findings with interpretations and evaluations.
CHAPTER 11

IDENTIFYING INFORMATION OF THE GROUP STUDIED

There are several prominent similarities in the sixty veterans included in this study. Some are accredited to the method and limitations of case selection, while others indicate areas that would give clues to the type of veterans likely to need services.

The following table represents the distribution of the veterans according to their diagnosis. The diagnosis selected in this table was found in the discharge summary. It was felt that the admitting diagnosis was tentative and less inclusive.
TABLE 1
DISTRIBUTION OF VETERANS ACCORDING TO DIAGNOSES

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>33</td>
</tr>
<tr>
<td>Depression</td>
<td>10</td>
</tr>
<tr>
<td>Acute Brain Syndrome</td>
<td>4</td>
</tr>
<tr>
<td>Involutional Psychosis</td>
<td>5</td>
</tr>
<tr>
<td>Manic Depressive</td>
<td>2</td>
</tr>
<tr>
<td>Anxiety Reaction</td>
<td>1</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>2</td>
</tr>
<tr>
<td>Passive Aggressive Personality</td>
<td>2</td>
</tr>
<tr>
<td>Hysterical Disassociative State</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

It was recognized that diagnosis is only a label used because the patient presents similar symptoms found to be common in one particular group. The diagnosis does not indicate standard procedure to follow. Each patient is an individual and the most important part of the process of diagnosis is the evaluation of his background as a means of learning.
the reason for the difficulty. We realize that the end might be the same, but the means are different. Adding to the tenuous nature of diagnosis is the fact that it is often dependent upon the particular doctor, because of the continued lack of agreement regarding categories.

According to Table 1, the largest percentage of veterans were diagnosed as schizophrenic, in this study. This finding is not unusual, because the incidence of schizophrenia is the highest of all psychiatric disorder among hospitalized patients. They constitute one-half of the total. The schizophrenic process is due to the individual's interpersonal experiences. He lacks the ability to relate to other persons because of childhood rejection, and develops resentment and distrust.

The small percentage of alcoholics in this study does not represent the proportion of alcoholics in the total intake. In studies containing a larger percentage of single, unattached men, the percentage was usually higher. The veterans in this study had strong family ties.


Only five of the sixty veterans were Negroes. Although statistics were not available, it seemed, from observations, that Negroes represent a larger percentage of the total hospital intake, than this study indicates. In the process of screening the cases, it was noted that many Negro families were not willing to accept help beyond the history taking process. In some cases a verbal referral was made to another agency for financial assistance. It has been an observation, that Negroes are reluctant to request or receive intangible services. This could be attributed to a lack of knowledge and understanding of casework services within the community, as well as within this hospital setting. Since statistics were not available to make a comparison, and the cases in this study represent only a small portion of the total intake, the findings would not be significant to make any valid conclusions.

The religious factor was also insignificant in this study. There was almost equal distribution between Catholic and Protestant veterans.

The following table represents the age distribution and marital status of the patients included in this study.
The above table indicates the large concentration of patients within the age group of 25-45. This age distribution is obviously affected by the necessity for veteran status as an eligibility requirement for hospitalization in this setting. In addition, the proximity of two wars would cause an increase within this age group. Many of the patients were veterans of the Korean War as well as World War II.

The majority of the veterans were married, which could be related to the age distribution. In the general population a large percentage of men between the ages of 25 and 45 are married. The method of case selection also influenced the percentage of married veterans. This study was limited to veterans whose families received services from Social Service.

Table III indicates the household composition of the veterans' families.
TABLE III

HOUSEHOLD COMPOSITION OF VETERANS

<table>
<thead>
<tr>
<th>Persons in Household</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife only</td>
<td>13</td>
</tr>
<tr>
<td>Wife and children</td>
<td>23</td>
</tr>
<tr>
<td>Wife, children and parents</td>
<td>2</td>
</tr>
<tr>
<td>Wife, children, parents and siblings</td>
<td>2</td>
</tr>
<tr>
<td>Children only</td>
<td>3</td>
</tr>
<tr>
<td>Parents only</td>
<td>5</td>
</tr>
<tr>
<td>Parents and siblings</td>
<td>7</td>
</tr>
<tr>
<td>Siblings and other</td>
<td>3</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

The above table indicates the relative size of the veterans' families. As indicated previously there was a predominance of married veterans. Table III indicates that all of the wives were in the home except one. One-half of the households included from one to eight children, with an average of two children in each home. In families containing children, the problems encountered because of hospitalization were increased. The absence of a father and wage earner creates difficulty in management and disrupts the family interrelationships. The wife is usually presented with the problem of providing for the family and of rearing the children alone for a pro-
longed period of time. These families would, therefore, need more help in dealing with their problems. In cases where the veteran resided with his parents, or other relatives, such as siblings, aunts, uncles, or grandparents, there would be less financial pressure due to hospitalization, but the emotional aspects remain the same, however less intense.
CHAPTER III

REFERRALS TO SOCIAL SERVICE

There are many means by which a patient can be referred to Social Service in a mental institution. The doctor, the patient, or the patient's family are the most common sources of referrals in this setting. However, other disciplines within the hospital, such as a nurse, an aide, or an interested social agency, may recognize the need of a patient for social services. Although patients may be referred to Social Service on an individual basis, for a specific problem, the service attempts to attain complete coverage. Social Service is asked to see every newly admitted patient on a program basis because the service is seen as such an integral part of the total hospital program.

Social Service is informed of all newly admitted patients within a few days after their entry into the hospital. The patients are assigned to social workers according to team services. Each social worker is assigned to a team and she is responsible for intake of the team. The patient is contacted if a request is made by himself or by the hospital personnel.
Only a small percentage of patients enter and leave the hospital without some contact with a social worker.

Team meetings are held weekly, at which time the intake is reviewed and plans are made for procedure of investigation of each patient. It is usually at these team meetings that the doctor refers for a social history. Other recommendations are made in preparation for presentation in order to discuss diagnosis and treatment plans.

The following table is a graphic picture of the relationship between the source of the referral and the request.

**TABLE IV**

**SOURCE AND TYPE OF REFERRAL**

<table>
<thead>
<tr>
<th>Source</th>
<th>Total</th>
<th>Social History</th>
<th>Communication</th>
<th>Discharge Plan</th>
<th>Consent for Somatic Therapies</th>
<th>Interpretation of Illness</th>
<th>Other or Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>20</td>
<td>22</td>
<td>--</td>
<td>2</td>
<td>4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Wife</td>
<td>18</td>
<td>1</td>
<td>1</td>
<td>--</td>
<td>14</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Patient</td>
<td>5</td>
<td>--</td>
<td>4</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>Relative</td>
<td>5</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Parent</td>
<td>2</td>
<td>--</td>
<td>2</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>23</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>18</td>
<td>6</td>
</tr>
</tbody>
</table>

As indicated in Table IV, the doctor initiates the ma-
The majority of referrals for social history information. The doctor seems to have a clear understanding of the function of social service and the importance of obtaining social data about the patient. Since this study is concerned with the services given beyond history taking process, referrals for a social history present the principal opportunity of becoming aware of the family need for these services.

One of the most important requirements of a good referral is preparation. However, current practice in this hospital does not permit the doctor to prepare the family for a referral to Social Service. It is assumed that the social worker is able to discuss the social history taking process with the patient before contacting the family. Often patients are opposed to having their families interviewed, but interpretation of the need for the information usually results in their willingness to cooperate. In some cases he prepares the family for the referral.

Social workers recognize the limitations in preparing the family for the referral; therefore, permissive attitude is essential in the initial contact. The relatives may resent being questioned about their family background and are sometimes defensive. The social worker exhibits skill in handling their feelings, and by acceptance and reassurance, she is able to establish a relationship which will facilitate a discussion
of their problems caused by the hospitalization.

Initial referrals by the doctor requesting discharge planning with the family are very few in this study. It is usually assumed that discharge-planning is a continuing process which begins when the patient enters the hospital. It is interesting to note that these referrals were made within a week of hospitalization. However, after an evaluation of the patient's home situation, prolonged hospitalization was recommended.

Securing consent from the next of kin for any unusual treatment or somatic therapy is a policy in treating psychiatric patients, if the patient is incompetent. The function involved here is the responsibility of the social worker in this hospital. The basic principle in assigning such responsibility indicates a recognition of the importance of interpretation as a means of securing cooperation in treatment. Families are often ill-informed and lack knowledge of factual implications of different types of treatment. The social worker reassures and attempts to relieve anxiety by explaining and recognizing their fears. When the social worker is successful in her attempt the family is aided in fully evaluating the treatment. It is usually necessary early in hospitalization to obtain consent in order to prevent delays.

One positive indication of a person's willingness to utilize services is exhibited by his initiation of the request
or referral. According to Table IV, the wives and relatives, including parents, siblings, aunts, uncles, and grandparents initiate a large portion of the referrals, requesting interpretation of the implications of mental illness, as it affects them and the patient. Family interest is an indication of their willingness to cooperate in treatment and to utilize the services available through the Social Service Department.

In most cases the hospitalization of the husband presents problems resulting from his absence from the home and from his unemployment. Financial pressures motivate many wives to contact the hospital in order to learn of the length of hospitalization, and the availability of financial benefits. The wives also raise questions about hereditary factors, community attitudes, problems in handling the patient during visiting hours together with problems concerning their own personal feelings about the illness. In the cases where the veteran lived with parents, other persons were in the home also. Therefore, the patient probably was not the only wage earner.

The concern of patients is usually related to communication. He requests contacts made to his family or employer to inform them of his whereabouts. This may be an entre into discussing the family situation and the making of plans for future contact with relatives, in cases where the social worker recognizes a need for services.

The following table illustrates the relationship of the
request and the lapse of time between entry into the hospital, and the referral.

TABLE V

LAPSE OF TIME BETWEEN HOSPITAL ADMISSION AND THE REFERRAL

BY TYPE

<table>
<thead>
<tr>
<th>Time</th>
<th>Total</th>
<th>Social History</th>
<th>Communication</th>
<th>Discharge Plan</th>
<th>Consent for Somatic Therapies</th>
<th>Interpretation of illness</th>
<th>Other or Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 week</td>
<td>34</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>--</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>1-2 weeks</td>
<td>13</td>
<td>9</td>
<td>2</td>
<td>--</td>
<td>2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2-4 weeks</td>
<td>4</td>
<td>2</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>over a month</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>--</td>
<td>1</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>unknown</td>
<td>4</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>22</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

Table V indicates that the greatest portion of referrals are made within the first two weeks of hospitalization. The promptness with which requests are made for social histories can be related to the frequency of team meetings and the recognition of the need for background information before discussing diagnosis and treatment-planning. Early referrals facilitate promptness in beginning treatment.
Because the veteran resides with a family their concern regarding his care would motivate early contacts with the hospital. Wives, especially, attempted to secure some information about the illness within a week because the husband's absence from the home created immediate repercussions with which they needed help. The patient's parents, or other relatives, waited for several weeks before contacting the hospital. This fact is probably not an indication of lack of concern but is due to the absence of immediate pressures.

Promptness of referrals permits establishing a relationship with the family members in which services can be offered more effectively to them during hospitalization. Wives presented the problem of providing financially for the family, and rearing the children alone. These families would need more help with management and support during the hospitalization. In the case where a veteran resided with parents or other relatives, the family's concern about hospitalization would cause them to seek some information regarding the illness. Such instances permit the worker to understand the family and to provide service.

These findings imply that the closer the patient, emotionally and physically, is to his family, the more apt the family is to request and secure services from the Social Service Department.
CHAPTER IV

DESCRIPTION OF THE SERVICES

Mental illness results in additional strains and tensions within the family group. They are sometimes expressed overtly, but more often are smoldering in unexpressed fears, doubts and irritations. The way that relatives handle these feelings and respond to the increased pressures during hospitalization, affects the patient's ability to cooperate with and use treatment. It is important for Social Service to have an awareness of the types of problems encountered by families, problems which are due to the patient's hospitalization. With such awareness the social worker can help them by means of a sensitive use of knowledge of the hospital, community resources, and the progress of the patient from admission to discharge.

The results of this study indicated eight types of services offered to families in order to help them with their problems. In some cases there was overlapping, as one service seemed to evolve from another. However, the following is a

1 Harry M. Moore, "Hospitalization As a Dynamic for Use of Casework With Relatives in a Veterans Administration Mental Hospital", Journal of Psychiatric Social Work, Volume XI, #4, Spring 1950, 141
description by means of illustration of the services found to be most significant. This will help to clarify the criteria employed in placing the cases within the eight categories. Also added is the number of cases in which each type of service was given.

Referral to an Agency for Casework Services: 5 cases

During the history taking process and the continued contacts with relatives, the social worker often recognizes the need for casework services beyond the limitations of the immediate setting and is cognizant of the need for continuing casework services after the patient's discharge. For instance, a wife might realize that one of the factors contributing to the patient's illness is her feeling toward her father. This feeling reflects itself in the relationship with her husband. She desires help in understanding her difficulty in making a successful marital adjustment. The social worker realized the need for long-term intensive treatment which was not within the function of the setting and therefore, suggested a referral to another agency.

In another case, the patient died during hospitalization. There was a recognition of the widow's need for a long-term supportive relationship, and she was referred to a community agency. The social worker, with her knowledge of community resources and a sensitivity to the needs of the individual, is often in a position to initiate a referral to another agency. In addition, she prepares the relative, in order that the most effective use of the resource can be made.
Referral to an Agency for Financial Assistance: 6 cases

Because this setting offers treatment to male veterans, financial problems resulting from hospitalization would be increased. Hospitalization for a psychiatric illness is usually prolonged and families are often faced with no income, or with a notable decrease in the former income. An example of this type of situation, is the case of a wife who is unable to seek employment because of her three small children. She recognizes the need for financial assistance, but is reticent in applying for public aid. She is threatened by the stigma attached to public agencies along with the necessity of reducing her standard of living. These feelings are reflected in a pessimistic and rejecting attitude about the family's eligibility for assistance.

With an understanding of the underlying reason for the wife's resistance, the social worker was able to help her move forward and accept the resources available to her family. By using knowledge of the needs of the family and the eligibility requirements of the other agency, the social worker was able to make an appropriate referral. A letter was sent promptly to the agency verifying hospitalization, as well as giving available information about the family and the wife's attitude toward accepting public aid. This type of service resulted in reduced anxiety in the initial contact of the wife with the agency, and promptness in her securing assistance.
Interpretation of the Patient's Illness: 20 cases

Relatives bring to the hospital their fears about mental illness, with the frequent result of their denial of the illness and explaining the patient's behavior by projecting it upon somatic difficulties. The social worker discusses with the family their feeling and then attempts to answer their questions regarding hereditary factors, locked wards, and hospital routine. It is an educational process which is scaled to meet the individual needs of the family members, and is incorporated in a continued interpretation of the patient's progress during hospitalization. The veteran's behavior during visiting hours often motivates questions by the relative. A case in illustration is that of a mother, who is concerned because of her son's inconsistent attitude toward her. She had difficulty appropriately responding to the patient's expressions. The social worker attempted to explain the patient's behavior in terms of his illness, and give some suggestions as to ways of responding in the situation. The following instance also illustrates this service. A wife was concerned about the children's susceptibility to mental disease. Her concern caused her to interpret any unusual behavior as a symptom of possible difficulty. After securing information regarding the hereditary factors and the nature of mental illness, the wife was able to recognize the impracticality of her attitude.
Interpretation of Treatment and Hospital Recommendations
30 cases

Although most relatives recognize the patient's need for treatment, many of them unknowingly present obstacles which prevent effective use of hospitalization. The social worker attempts to interpret to the family the type of treatment being given and the hospital recommendations which would bring about the patient's effective use of the treatment. In every phase of hospitalization there should be communication with the family, with an awareness of their continuing responsible investment in hospital treatment for the patient. An interpretation of the implications of various types of treatment helps the family to understand, prepares them for any noticeable reactions, and prevents unnecessary anxiety.

An example from this study is that of a family's inability to accept commitment of the patient. When the recommendation was made, the family initiated their own plans for returning the patient home. They felt confident that he could not benefit from further hospitalization because he seemed to have improved, according to their observation. Their actions indicated little awareness or acceptance of the seriousness of the illness. Continued interpretation helped the family to accept commitment. The social worker was aware of the temporary nature of the patient's state, and recognized the family's guilt regarding commitment.

In another instance, a wife refused to consent for electro-shock treatment because the patient informed her that it
resulted in loss of memory and, in some cases, patients were fatally harmed. The wife had accepted the patient's reasoning and thus refused to cooperate. After establishing a relationship, the social worker was able to explain the nature of the treatment and some of the temporary after-effects. The interpretation helped to dispel the wife's fears and indirectly to elicit cooperation from the patient. Thus the social worker employs knowledge of the hospital and of human behavior in interpretation of treatment methods to the family.

**Psychological Support:** 29 cases

Florence Hollis defines psychological support as treatment done through the process of the client-case worker relationship in which there are techniques employed to relieve anxiety and feelings of guilt; to promote the client's confidence in his ability to handle his situation adequately. Hospitalization of a family member provokes many anxiety producing situations which the members feel inadequate to handle. For example, a young wife was suddenly the sole supporter of herself and two small children, as a result of her husband's confinement. The pressures of employment, caring for the children, and other added responsibilities seemed almost unbearable. By discussing her situation with the

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social worker, she was able to relieve some of the accumulated anxiety and tension, and secured reassurance and praise for her management of the situation.

Again, there was the case of the father who had been cruel and neglectful of the patient in childhood. The patient reacted by rejecting his father during visiting hours. He also expressed his rejection, in his abrupt manner and, sometimes, refusal to see the father. Here is an illustration of the use of support as a means of activating potentials in the family situation which were helpful in discharge planning. It was necessary to interpret the patient's feeling and to permit the father to express his guilt regarding his own behavior, with support, the father was able to continue to visit, regardless of the patient's attitude. After completion of somatic therapy, the patient was able to accept his father. The social worker, by encouraging the father to visit, was able to promote a good relationship which was helpful in making effective discharge plans.

Modification of Attitudes: 14 cases

Families often possess attitudes which present an obstacle in treatment, or hamper effective planning around the patient's discharge. Therefore, some type of modification seems necessary in order to permit the patient full utilization of the treatment. The social worker attains this goal
by helping the relatives to develop insight into their feeling and emotions which have resulted in a disturbing aspect in the patient's environment. For example, a domineering, over-protective mother had little understanding of her behavior as it perpetuated dependency in the patient. After an exploration of her needs and some clarification regarding the patient's behavior, the mother was able to understand and gain insight into her feelings and to manage her situation with less anxiety, hostility, and defensiveness. Most relatives are resistant to accept "treatment" and interpretation of self-entanglement. Therefore, it is necessary for the relative to desire help in understanding his attitude in order to prevent resentment and hostile feelings toward the hospital. An evaluation of the relative's personality, and his ability to accept such treatment, is necessary if the service is to be successful. The case worker must also evaluate problems of the relative in terms of the function of the agency and the effect of the problem on the patient's treatment.

**Discharge Planning:** 13 Cases

Ideally, discharge planning is a continuing process that begins when the patient enters the hospital. Contacts with the family are focused on the patient’s eventual return to the family and community. However, when the family is faced with the prospect of his return to the home, they may demon-
strate mixed feelings of pleasure and dread. They may, without necessarily being aware of their behavior, display indecision, immaturity, and irresponsibility in reacting to the forthcoming reality of the patient's being home. The case worker not only helps them with their feelings, but she also aids them in understanding some of the effects of their reactions on the patient. An example of the need for discharge planning was indicated because of a wife's behavior toward the patient when she was informed of the plan for discharge. She made arrangements to have the children sent on an extended vacation because she felt they would annoy the patient. Her own feelings were reflected in her lack of acceptance and her fearfulness of having the patient in the home. With some interpretation of the meaning of the wife's behavior, as it affected the patient, she was able to understand that a natural spontaneous environment would be more helpful to her husband in his rehabilitation. The family is helped toward a realistic recognition of the patient's difficulty in readjustment to family relationships essential to the patient's well-being. Imposed upon the social worker is the obligation to render such help as may be necessary to the maintenance of the normal functioning

of the family unit.

Other Services: 8 cases

Other services offered, but not included in the previous categories mentioned, were mainly related to tangible services. The most frequent rendered was assistance in securing money benefits, to which the family or patient was eligible due to hospitalization. The hospital provides another service that assists in obtaining benefits, therefore, the social worker merely suggested the possibility and made the referral. In several other instances, the social worker helped the family in having money released to them from the patient's account.

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4 Minna Field, "Role of the Social Worker in a Modern Hospital," Social Casework, Volume XXIV, 39, November 1953, 400
CHAPTER V
EVALUATION OF THE SERVICES

The relatives bring to the hospital a wide range of social and emotional problems which have resulted by reason of the patient's hospitalization. Whether the problems originate in, or are complicated by, the external situation, or the relatives' own motivations, the social worker may be called upon to render services which meet practical reality needs. In the sixty cases included in this study, where services were offered to families by Social Service, fifty-three accepted and benefited from the services. While in seven cases, although the services were offered, there was no indication of movement or change in behavior.

The successfulness of the service was indicated in the record. The movement was exemplified by the family's ability to accept a referral for casework services or financial assistance, understand the patient's illness as a result of interpretation, consent for treatment, and follow through with hospital recommendations. In addition the caseworker was able to plan with the family toward discharge; relieve tension, anxiety and guilt feelings through a supportive relationship; and adjust behavior due to modification of attitudes.
The following table indicates the number of services offered to the families.

**TABLE VI**

**NUMBER OF SERVICES OFFERED TO FAMILIES**

<table>
<thead>
<tr>
<th>Number of services</th>
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</thead>
<tbody>
<tr>
<td>1 service</td>
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<tr>
<td>2 services</td>
<td>23</td>
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<td>15</td>
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<tr>
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<td>Total</td>
<td>60</td>
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</table>

The figures for table VI suggest that the average number of services received by a family were 2.4. The majority of families received one, two, and three services. The services seemed to be fairly well combined, including all of the eight types. However, there was noted, some combinations occurring more frequently than others.

The following table presents the frequency with which each service was offered.
TABLE VII
FREQUENCY OF EACH SERVICE OFFERED TO FAMILIES

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Frequency</th>
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<tr>
<td>Referral for Casework Service</td>
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<tr>
<td>Referral for Financial Assistance</td>
<td>6</td>
</tr>
<tr>
<td>Interpretation of Patient's Illness</td>
<td>29</td>
</tr>
<tr>
<td>Interpretation of Treatment and Hospital Recommendations</td>
<td>40</td>
</tr>
<tr>
<td>Assistance with Discharge Planning</td>
<td>13</td>
</tr>
<tr>
<td>Psychological Support</td>
<td>29</td>
</tr>
<tr>
<td>Help in Modification of Attitudes</td>
<td>14</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>143</td>
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</table>

Table VII indicates the predominance of interpretation of treatment and hospitalization recommendations as a service to families. In many cases some type of somatic therapy was recommended, therefore, it was necessary for the family to consent for the treatment. The reluctance manifested by the relatives was due to improper and invalid information received from various sources. The fact that the word "shock" is included in the name of a frequently used type of treatment, frightens families into resistance. After effects of somatic therapies cause families great concern, and they often feel guilty with regard to giving consent. The noticeable reactions of the
patient cause anxiety, and relatives may become hostile toward the hospital. The social worker begins with a sensitivity of the relatives' feelings, and usually asks about their knowledge of a particular type of treatment. From the family's knowledge, she interprets, clarifies, and initiates additional discussion. During the process of treatment, it is necessary to re-interpret, or reassure the family, to prepare them for some of the patient's behavior, in order to relieve anxiety.

Interpretation of hospital recommendations helps to prevent feelings that obstruct treatment and inappropriate planning on the part of the family and the patient. The success of this interpretation, which of course is related to the other services, is reflected in the large proportion of planned discharges. Thirty patients were discharged with maximum hospital benefits, which fact means that the patient had utilized all available therapy resources within the hospital, and had attained maximum improvement. Thirteen were released on trial visit. This fact indicates that the patient is not officially released from the hospital, although he maintains himself in the community. Trial visit represents an opportunity for the patient to effect a reasonably healthier transition from the hospital to community life, with discriminative use of psychiatric and casework facilities for the veteran's
Commitment of the patient to this hospital or to a state hospital was recommended in seven cases. In all cases the relatives were able to follow through with plans for commitment due to continued interpretation by the case worker. The relatives were also supported during the process and there was evidence of movement by the family by their reduced anxiety and guilt feelings. In three cases the patient died in the hospital and similar kinds of services were necessary, as given to families where the patient was being committed.

In sixteen cases the patient or family requested a discharge against medical advice. With interpretation and support nine of the AMA's were withdrawn. The social worker and possibly other personnel were able to interpret the continued need for hospitalization, and the inadvisability of the patient's immediate discharge. The relatives, in turn, interpreted to the patient who complied with the recommendations. Within the seven cases of AMA discharges, three families accepted the hospital recommendations, however, they were unable to persuade the patient of possible repercussion of

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his action. The social worker offered additional services to these families by explaining out-patient treatment resources and other hospitals within the community.

Interpretation of the patient's illness and establishing a supportive relationship with the relatives were other services offered frequently. There was also noted a high correlation between relatives receiving these two services and their ability to accept an interpretation of treatment, and hospital recommendations. The family gained confidence in the hospital and felt assured of its competence. Social Service brought about these attitudes by offering services, by recognizing the needs of the family, and by taking an interest in their situation during the time of stress. The hospital was therefore not seen as hostile because it prevented the patient from being home. But the hospital furnished a place of refuge whereby the patient could receive treatment for his illness, and, at the same time, the family could secure help with their problems, created by the hospitalization. The family was recognized by the hospital as an integral part of the treatment which perpetuated kindly feelings toward personnel and motivated a desire to cooperate.

There were only five referrals for casework services. Undoubtedly many families were able to secure enough help from Social Service to clarify their own feelings and probably
were not too threatened to admit, that they also needed "treatment". Referrals for financial assistance were also few. In most cases the veterans were receiving some type of compensation from the government, due to a service connected disability. In other cases, the wife sought employment, the patient's family received benefits from his past employment, or they were eligible for Veterans Administration benefits due to the hospitalization of the veteran.

Attempts to modify attitudes were successful in twelve of the fourteen cases, where there was an attempt made. These attitudes were seen as retarding or obstructing treatment and the patient's satisfactory adjustment after discharge. The relatives gained insight into their own feelings and understood how they could cooperate in aiding recovery through their relations with the patient. The result of this service was reflected in the relatives change of behavior.

Preparation of the family for the patient's discharge was important, because in all cases except two, the patient returned to live with his family. Where there was continued contact throughout hospitalization, with the family, plans for discharge were made with less anxiety. The social worker helped to pave the way for the patient's return to a normal life in the community, by anticipating problems that might arise and helping the family to make plans for the period of readjustment and rehabilitation. The fact that fifty patients were discharged
after receiving maximum benefits from this hospital, indicates the high incidence of cooperation and acceptance of medical advice as to when to leave the hospital.

TABLE VIII

<table>
<thead>
<tr>
<th>Number of Contacts</th>
<th>Telephone</th>
<th>Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>5 - 10</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Over 10</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>60</td>
<td>60</td>
</tr>
</tbody>
</table>

Approximately two-thirds of the relatives had one to five contacts with Social Service through phone calls. The telephone contacts were used chiefly to secure reports of the patient's progress during hospitalization and interpretation of treatment, as well as hospital recommendations. The cases selected in this study were concerned with the families who made planned arrangements to visit Social Service, therefore, they had less need to phone to secure information. The frequency of phone calls decreased during hospitalization. Usually, the first weeks after admission anxiety was created which was alleviated by calling the hospital frequently for information concerning the patient, and to thereby receive reassurance. In some cases, when it was inconvenient for the family to visit,
frequent phone contacts were encouraged.

Forty of the families maintained contact with Social Service in 1-5 interviews. The number of interviews was directly related to the number of services rendered. In the cases where there were 1-5 interviews, the families did not receive more than three services; where the family was interviewed over ten times, not less than three services were received. Length of hospitalization affected the number of interviews with the family. In all except two cases where the family had over ten interviews with Social Service, hospitalization extended for over a year. This, in turn, affected the number of services offered the family. When a family was seen by the social worker over ten times, the family received more than three services. Therefore, it is possible to speculate that prolonged hospitalization results in the increase of social, emotional, and financial pressures upon the family.

The following table indicates the persons in the veteran's family who received the services.
Table IX shows that in almost one-third of the cases more than one member of the family received services. The most frequent combination was wife and parents, wife and a sibling, and parent and a sibling. This table also indicates that all of the wives included in this study received services. A large number of parents received services, although some did not reside in the same household as the veteran. The number of persons in a family had no effect on the number of services received by the family. Neither, was there any
obvious relationship noted, between the kind or type of services rendered and the particular family member who received the services. However, closeness of the relationship to the patient, prior to admission had some bearing on the number of services rendered. For instance, a landlady who had assumed the role of a parent to the veteran, received six services. Another example was a mother, although not residing in the veteran's household, but maintained a close relationship after his marriage, received five services.
CHAPTER VI

METHODS OF COMMUNICATING SOCIAL SERVICE
INFORMATION TO OTHER DISCIPLINES

Social Service contact with the family, beyond the
history taking process, provides an opportunity for securing
additional pertinent data, which may not be included in the
formal social history. Since it is the psychiatrist's responsi-
sibility to coordinate the planning for the patient, it is
essential that the social worker share the additional infor-
mation with the psychiatrist. It is recognized that the social
worker contributes knowledge of the familial, social, cultural,
and economic context within which the patient lives, and to
which he must adapt himself. Therefore, she must feel a pro-
fessional responsibility for communicating this knowledge to
other members of the clinical team in order to broaden their
understanding of the patient. The social workers employed
within the framework of Psychiatry must practice selectivity
in providing information to another discipline. She must

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1 Education for Psychiatric Social Work: Proceedings
of the Dartmouth Conference. AAPSW, New York, N.Y., June 1950,
62-63.
adapt herself to the structure and function of the setting. Therefore, the focus is continually on the patient and how the psychiatrist can use the information in treatment.

The following is an evaluation of the methods of communicating information to the doctor within this setting.

Consultation with the doctor

This study revealed that the social worker had 1-3 consultations with the doctor in 32 cases, and over three consultations in seven cases. Twenty-one records contained no recording of a consultation. The purpose of the consultation seemed to be twofold. The social worker discussed her material, as well as secured information from the doctor. The consultation was often motivated by questions raised by the family during interviews. These questions concerned the patient's progress and response to treatment, the expected length of hospitalization, and observation of the patient during visiting hours.

In attempting to secure data regarding contacts with the doctor, there was an awareness of the informality and size of the setting, both factors contribute to facilitating informal conversation about the patients. In most cases these discussions are not included in the record, but there was an implied indication of the worker's having secured some additional information from the doctor. The nature of the recording
made it impossible to evaluate this type of exchange of data. Accessibility of the team members and permanency of personnel assigned to various teams also facilitate informal contacts.

Team Presentations

The team meetings and diagnostic staffings present opportunities in which the social worker can communicate additional social information to other disciplines. The service team is conducted as follows:

1) Psychiatrist presents information he has secured from the patient along with observations he has made.

2) There is a review of the present situation by the social worker. This review includes her evaluation of the situation.

3) The individual team members give impressions of the patient, and his problems, with suggestions toward working out a coordinated plan.

4) The psychiatrist presents an analysis of dynamics, possible treatment problems, and how he sees the involvement in the case with respect to various team members.

5) There is mutual clarification of case dynamics, establishment of goal, and limitations in treatment.

6) Future arrangements are made for consultation.

The social worker's function is concerned with a presentation of the social history material and an evaluation of the situation in terms of potential obstacles in treatment and their effect on the patient. There is also an assessment of the family's ability to cooperate in patient's rehabilitation. The continuing process of evaluation necessitates re-evaluation because of possible changes in goals. Therefore, the psychiatrist is not only informed of early contacts with the family, but also is given additional knowledge of the situation in terms of patient's needs. The weekly team meetings provide an opportunity to discuss this pertinent data.

In addition to the regular team meetings there are diagnostic staffings which are initiated by the doctor because the patient presents special problems in diagnosis and the establishment of an appropriate treatment plan. The staffing is not only attended by the patient's service team, but by interested personnel as well. The social worker's function here is similar to her function in the service team, however these meetings are more formal. Also in some cases the psychiatrist incorporates all the data from the patient's record including social information in presenting the patient. However, the personnel working directly with the patient is expected to contribute additional knowledge of the situation and observations.
The result of findings indicate that in two-thirds of the cases studied, reports of team meetings were recorded in the social service record, including recommendations to Social Service. In twenty-six cases there was evidence of the patient's having been presented in only one, while in fourteen cases it was observed that the patient was presented to more than one. In the latter instances, diagnostic staffing was included. The large proportion of team meetings indicates the case worker's opportunity to present her material to the other disciplines. In addition, she obtained information which would assist her in working effectively with the family during the patient's hospitalization, and the planning of his discharge. The social worker's awareness of patient's treatment plans and the additional knowledge gained from special consultations increase her ability to interpret treatment to the family as well as the implications of the illness.

Reports Sent to the Patient's Record

The patient's clinical chart is a permanent record of his hospitalization, and it contains diagnosis, observation of the patient's behavior by the doctor, treatment plans and special recommendations. Also included are the results of the patient's mental and physical examination, laboratory findings and consultant's reports. All of the disciplines contribute to the patient's clinical chart.

Social Service has its own folders which contain the
the continuing record of service rendered to the patient and his family. There is also included, recordings of the contacts with the patient and his family, correspondence, and any pertinent material that is of value in Social Service contacts with the patient and his relatives. The doctor's admitting statement, neuro-psychiatric history and discharge summary are also an important part of the Social Service Record.

The copy of the social history and social service closing summary are automatically sent to the clinical chart. Unless otherwise specified, no other material is routed in this manner. Therefore, it is expected that at least two reports would be sent to the chart. The closing summary presents the purpose of Social Service contacts with the patient and his family, the nature of the service rendered, an evaluation of effectiveness of the service, and a description of the family at the point of discharge.

Reports for other services will be designed to answer the specific request or based upon the social worker's recognition of the need for such a report. In selecting information to be included in the patient's permanent hospital record, the social worker focuses on the value of information to the doctor in his contact with the patient. She attempts to summarize, submitting only pertinent data. The worker is usually selective in reporting information which evolves from an awareness of her function, the doctor's needs, and the function of the total
hospital program.

In fifty-one cases there was material submitted to
the chart. Within this number, 1-3 reports were sent in
thirty-seven cases, and over three reports were submitted in
fourteen cases. It might be expected that more cases should
have been included in the latter category because, undoubtedly,
the material secured was of value to the psychiatrist. However,
the verbal informal reports and the weekly team meetings were
the best means of communicating with the doctor.
CHAPTER VII

CONCLUSIONS

The purpose of this study was to enumerate and evaluate services offered to families of patients hospitalized for a psychiatric disorder at Veterans Administration Hospital, Hines, Illinois. There was consideration given, the way in which the families become known to Social Service. Also, there was concern about the means of communicating pertinent information of the family situation, to other disciplines. The following conclusions are based on the findings of this thesis.

This study indicates that a large portion of the referrals to Social Service were made by the doctor, requesting a social history. Although the initial referral gave little indication of the kinds of services needed by the family, securing a social history constituted the principal means by which the social worker learns of the family situation, and problem areas where services could be offered. In addition, the referrals made promptly after the patient's admission to the hospital, presented a better opportunity to offer services to the family. This observation was substantiated by the direct relationship indicated between the length of hospitalization and the number of services
rendered. Therefore, it seems that promptness of referrals, facilitates establishing a relationship with the family, in which they can freely discuss problems with the social worker and receive help in finding solutions. Since this relationship seems evident, consideration might be given to an emphasis on prompt referrals for social histories, especially in cases where the patient resides with his family.

Since the primary purpose of this study was consideration of services offered to families, the following is an enumeration of the services, in order of the frequency rendered.

Interpretation of treatment and hospital recommendations
Interpretation of the patient's illness
Psychological support
Modification of attitudes
Discharge planning
Referral for financial assistance
Referral for casework services

The fact that a larger proportion of families received interpretation of treatment and hospital recommendations indicates their ability to effectively use help, beyond the history taking service, in this area. Furthermore, it shows the family's willingness to participate in collaboration with the hospital for the benefit of the patient. The findings also note that a large percentage of families, who received the major service, used psychological support and interpretation of the patient's illness. Interpretation of the patient's illness usually seemed to pave the way for better understanding of the nature of hospital planning. In addition, the psychological support received through
the relationship between the social worker and the family, facilitated acceptance of and cooperation in treatment and hospital recommendations.

These findings reveal that discharge planning was not a primary service given to families. This conclusion raises the question, that since discharge planning is a continuing process and most of the families in this study were seen consistently throughout the patient's hospitalization, formal consideration was of less importance.

Since there were only six referrals to another agency for financial assistance, this indicates that concrete, tangible services were of less importance to the family, than assistance in dealing with emotional components of the illness. Referrals to other agencies for casework services were directed toward helping a particular relative with individual personal problems. The casework services offered within this setting, were flexible and sufficient to handle the multiple problems arising in the family situation, resulting from the patient's hospitalization.

The fact that three-fourths of the families received more than one service, presents the possibility, that an ability to receive service in one area, is an indication of the family's capacity to use help in other areas. However, there was an awareness of the close relationship between the various services,
Personal interviews with the doctor, were the most frequently used means of communicating additional information secured, by continued contacts with the patient's family. This appears to be a natural method, because it presents ease in exchanging data and the informality of this setting lends itself to this type of communication. Although many of the records did not reveal exchanging information, by reason of experience, there is an indication that these records did not reflect the fullest extent of communication.
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PAMPHLETS


PERIODICALS


Field, Mirna, "Role of the Social Worker in a Modern Hospital", Social Casework, November, 1953.


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**Diagnosis**

Race
- White ______
- Negro ______
- Other ______

Religion
- Catholic ______
- Protestant ______
- Jewish ______

Age
- 18 - 25 ______
- 25 - 35 ______
- 35 - 45 ______
- 45 - 55 ______
- 55-Over ______

Marital Status
- Married ______
- Single ______
- Divorced ______

Household Composition
- Wife ______
- Children ______
- Parents ______
- Siblings ______
- Other ______

Type of Discharge
- MHB ______
- ANA ______
- TV ______

Length of Hospitalization
- Under 1 month ______
- 1 - 3 months ______
- 3 - 6 months ______
- 6 - 12 months ______
- Over 1 year ______

Time Lapse Between Entry to Hospital and Referral to Social Services
- Less than 1 week ______
- 1 - 2 weeks ______
- 2 - 4 weeks ______
- Over 1 Month ______

Source of Referral
- Doctor ______
- Parent ______
- Relative ______
- Patient ______
- Wife ______
- Other ______

Nature of Request
- Secure Social History ______
- Communication ______
- Discharge Planning ______
- Shock Consent ______
- Discuss patient's illness ______
- Other ______

(Comments) __________________________________________

_____________________________________________________
**Services Offered to Relative**

**Referral to Social Agency**

1. Casework Services
2. Financial Assistance

**Interpretation of patient's illness**

**Interpretation of treatment and hospital recommendations**

**Preparation for Discharge**

**Support during hospitalization**

**Modification of Attitudes**

**Other**

**Person Receiving Services**

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<td>Sibling</td>
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**Number of Telephone Contacts**

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**Number of Interviews**

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</table>

**Utilization of Information by hospital**

<table>
<thead>
<tr>
<th>Consultations with Doctor</th>
<th>1 - 3</th>
<th>Over 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Presentations</td>
<td>1</td>
<td>1 - 3</td>
</tr>
<tr>
<td>Reports Sent to Chart</td>
<td>1 - 3</td>
<td>Over 3</td>
</tr>
</tbody>
</table>

**Evaluation of Treatment**

<table>
<thead>
<tr>
<th></th>
<th>1 - 3</th>
<th>Over 3</th>
</tr>
</thead>
</table>