A study of the social services offered on the female psychiatric ward, receiving hospital Detroit, Michigan

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A STUDY OF THE SOCIAL SERVICES
OFFERED ON THE FEMALE PSYCHIATRIC WARD, RECEIVING HOSPITAL
DETROIT, MICHIGAN

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
MARION MOORE WOODLAW

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
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CHAPTER I

INTRODUCTION

Significance of the Study

Wherever social work exists in hospitals, it is concerned with trying to accomplish the three things so well stated by Dr. Alter as Vorsorgo, Fursorgo and Nachsorgo—prevention, hospital treatment and later treatment.¹

Massachusetts General Hospital was among the first city hospitals to add a psychiatric clinic to their hospital program.² Many adults with mental and emotional problems are treated in the clinics of general hospitals.

The patients in these clinics may be those who came directly for help with their emotional problems, or they may be those who entering the hospital with a claim to some physical disability, upon analysis are discovered to be suffering from an emotional upset.³

This growing awareness of emotional factors in disease, and the incidence of nervous and mental disorders in a certain proportion of general hospital patients have a significant bearing on the function of psychiatric social work in a general hospital.⁴

To the general hospital come the psycho-neurotic patients whose disorders are revealed in physical symptoms. If emotional disturbances are recognized by the clinic to which the patient comes, he may be referred immediately to the psychiatric clinic.⁵

The aim of the caseworker in illness is to help in the restoration of health and to prevent personal and family deterioration as a

³Ibid., p. 418.
⁴Ibid., p. 420.
⁵Goldstine, op. cit., p. 260.
result of the disease or handicap. To help the client move along the progressive road toward recovery, the caseworker must see illness or handicap in its social and psychological framework rather than an isolated phenomenon.\(^1\)

The emotional ingredients of fear, pain, anxiety, guilt and shame and related feelings which form the variable emotional components in illness tend to isolate the sick person. Therefore, the social worker should attempt to help the client to see himself as a member of the family and of the community of which he is actually a part.\(^2\)

The caseworker should always attempt to preserve and increase the strength of the various family members at the time of a family crisis or dislocation such as created by illness. If the illness creates a financial problem, the patient's family should be helped to make constructive efforts to utilize available social resources. The worker should have a broad and thorough grasp of various types of agency and community resources.\(^3\)

During a workshop discussion at Lake Forest Academy in 1951, there was an agreement that the job of the social worker is to help the patient with social and interpersonal problems during hospitalization in order that he may adjust as a patient, and then help him to leave the hospital. The ways in which the social worker might work with the patient were enumerated as follows:

1. Help the patient make use of hospital facilities. This implies identifying resources within the hospital for the patient to use...

2. Assess the patient's ability to relate to the hospital community and to move out of it.


\(^2\)Ibid., p. 47.

\(^3\)Ibid., pp. 48-49.
3. Help the patient to make satisfactory social relationships in the hospital. This is especially true where the relationship tolerance is very low.

4. Initiate a relationship with the patient which will help him move into psychiatric treatment....

5. Interpret hospital regulations and medical procedures to the patient.

6. Provide direct therapy when staff agrees it is the preferred treatment....

7. Offer help with the social reality or family problems that are apart from, or contingent upon, the intrapsychic conflict represented by the patient's emotional disability. This can be of significant therapeutic value for the patient.

Frequently a social worker establishes a relationship with a patient because he has helped the patient with anxiety about how his family is getting along or has provided some concrete services. The social worker can then be the link between the patient, his family and community.¹

The principles and the basic content of casework are the same whether they are practiced in a private hospital, a family agency, a court, or in other settings. The psychiatric setting contributes variables to the casework process because of the administrative function. This is the collaborative activity of several professional disciplines functioning together in the interest of the patient and those close to him, and other factors.

The decision to use social workers in hospitals grew out of the medical staff's awareness of unmet needs, and of dissatisfaction of patients and relatives which often led to interrupted treatment. Underlying this is the interpersonal relationships in which every aspect of the person's life situation may be thrown out of balance. The basic

structure of our culture, including the family, the school, the church, and the community, is the fundamental source of individual security and comprises the social matrix to which the individual is bound.

While in a psychiatric setting, the primary focus is on the medical problem which is not an isolated fragment of psychopathology but part of this complicated system of interpersonal relationships involving patients and significant persons in their life situation.¹

The social worker recognizes that presenting one's self as a psychiatric patient promotes strong feelings in both patient and relatives. "What happens during the initial period of becoming acquainted may influence the whole course of treatment."² At Receiving Hospital every psychiatric patient is assigned a social worker at the time of admission to the ward.

The patient may not be able to take responsibility for himself, and the relatives may have many conflicting feelings about the situation. During this time the social worker helps in interpreting hospital procedures including correspondence, visiting, and telephone calls as means of communication between the patient and relative. Legal responsibility and other administrative matters are talked over. This dynamic process is concerned with the orientation of the relative to the hospital, the securing of social history data, and a consideration of feelings and attitudes of the relatives. This is the beginning of a continuous casework relationship that extends over the entire period of treatment of the patient, whether for a few days or for many weeks.

²Ibid., p. 108.
Purpose of the Study

The purpose of this study was to describe the social services that were offered on the Female Psychiatric Ward of Receiving Hospital, Detroit, Michigan.

Method of Procedure

Information about the social services that were offered on the Female Psychiatric Ward was obtained from the Social Service Manual. Additional information about the Social Service Department's function on the Female Psychiatric Ward was obtained by interviewing the professional workers on the ward in order to secure supplementary material regarding policies and procedures.

Data were taken from the case records of patients admitted during the period September 1957, through February 1958, without respect to age, race, presenting problem, and disposition after diagnosis. The cases were chosen by random sampling; that is, by selecting every fourth case until twenty-five cases were chosen. A schedule was used to assemble the data from the cases.

Because of the rapid admission, often no written social service notes were recorded by the professional workers. The relationship between the psychiatrists and the professional workers was such that information was shared verbally with the doctors. For this reason it was necessary for the writer as a student to select a sample from the cases that were assigned to her during her placement.

Scope and Limitations

The universe was all social services that were offered on female psychiatric wards in general hospitals. However, this study was limited
to a sample obtained from cases assigned to the writer during the period September 1957, through February 1958, on the Female Psychiatric Ward of Receiving Hospital, Detroit, Michigan.

The Director of Social Service believed that in an ideal situation, recording would be more complete. However, because of the nature of the Receiving Hospital setting, an increase in the material recorded could mean a sacrifice of the time that the caseworker spends with patients and relatives. Confronted with the problem of sacrificing the recording for the patient, or vice versa, the Director believed that the decision should be in favor of the patient.¹

CHAPTER II

DESCRIPTION OF HOSPITAL SETTING

Receiving Hospital, a municipal emergency hospital, was authorized in 1913 by a city charter under the auspices of the Detroit Department of Public Welfare. Its primary function was to provide medical care for the emergency and/or indigent cases of Detroit residents. On January 1, 1950, the hospital became a part of the Board of Health.

The first unit of the hospital was opened October 12, 1915. Because of the rapid increase in population, additions to the original structure were made in 1921 and 1927. The most recent addition, the Farwell Annex, which houses the Out-Patient Clinics as well as the laboratories for cardiac and cancer research, was officially dedicated in December, 1952.

The hospital has a bed capacity of 789. Of this number, 148 beds are allocated for services for mental patients and police prisoners. The remainder consists of emergency, medical and surgical patients, and "boarders." There are 33 clinics operating within the hospital.

Initial treatment is given in the Emergency Ward to all. Patients are billed for services rendered. After admission, a patient who is hospitalized over 72 hours is referred to the Wayne County Department of Social Welfare. If he is accepted as a county charge, arrangements for payments, or decision as to free care are made by
the county.¹ All patients with a minimum income are required to pay according to a budget arranged by the hospital investigators. Free Out-Patient Clinic care is provided through the City Physician's Division to those patients found eligible by the hospital Investigation Bureau.

Psychiatric wards are maintained for temporary custodial care for those patients under mental observation. State laws provide that any person within the limits of the city of Detroit whose overt behavior symptoms warrant custodial care, may be admitted upon the signature of "any officially appointed" physician on a citation. Patients are held five days on the citation; subsequent extensions are for ten days. More than one extension may be granted, if necessary. It is the function of the Department of Neuro-Psychiatry to service the psychiatric wards. The female psychiatric wards will be discussed in detail in a later chapter.

For administrative purposes, the hospital is divided into three units: Administration, Medical Care of Patients, and Plant Operation. Under the Division of Administration is the Admitting Office, Ambulance Division, Business Office, Communications, Dietary Department, Medical Records and Stenographic Pool, Personnel, Storekeeping and Timekeeping. Under Professional Care of Patients are Medical Activities and Nursing Activities. Medical Activities include: Pathology, Medicine, Surgery, Radiology, Psychiatry, Anesthesiology, Pediatrics, Dermatology,

¹Manual of Policy and Procedure, (City of Detroit, Department of Public Welfare, Bureau of Social Service), Item 207. ( Mimeographed.)
Urology, Ophthalmology, Gynecology, Orthopedics, Oral Surgery, Otolaryngology, Dental Clinic, Intern Training, Pharmacy, and Social Service. The Nursing Department comprises the Registered Nurses, Practical Nurses, Medical Attendants, and Physiotherapists. Under the Division of Plant Operation are the Maintenance and Housekeeping Departments.

Through the years, Receiving Hospital has maintained an invaluable affiliation with the Wayne State University College of Medicine. It is a teaching hospital for third and fourth year students from the College and graduate students in Psychology from Wayne University. It also provides placements for students in social work from various universities, among which is the Atlanta University School of Social Work.

The Social Service Department

The Social Service Department is an integrated division of the hospital. The social workers are assigned to specific services within the hospital and work with the physicians and other professional staffs in a team relationship. The social worker's area of function is to help the patients, relatives, social agencies and interested persons to further their understanding of the patient's illness.\(^1\)

The Social Service Department of Receiving Hospital was established in 1916 as a service to the patient, the physician, the hospital administration, and the community. It is designed to help meet the problem of the patient whose medical need may be aggravated by social factors and who,

\(^1\) Receiving Hospital Social Service Manual (City of Detroit Receiving Hospital). (Mimeoographed.)
therefore, may require social treatment based on his medical condition and care.¹

The Social Service Department is under Medical Activities. Its members are recruited, promoted, transferred, discharged, or retired through the Detroit Civil Service Commission. However, they are responsible through administrative channels to the Chief Personnel Officer of the Department of Health.

The Director is responsible jointly to the Business Manager and the Medical Superintendent. In addition to the Director, there is an Assistant Director, five psychiatric caseworkers, six medical case-workers, two student caseworkers, three clerical workers, and two court workers.

There is one-hundred per cent coverage by Social Service of the psychiatric wards and clinic. The workers on medical and surgical wards and clinics accept cases by referral. Recording is brief and pertinent, as it is a part of the unit record. The two court workers are expected to interview the mental patients on the psychiatric wards and obtain the necessary data for the preparation of allegations to be presented in the Probate Court at the sanity hearings of the patients. The court workers also prepare petitions for the sanity hearings of the patients. They are also expected to give testimony in court in all commitments involving Receiving Hospital patients.

One of the responsibilities of the Social Service Department is to conduct a student field work training program leading to a master's degree in social work. At this writing, two students from the Atlanta

¹Ibid., Item 213.
University School of Social Work are completing their training. The duties of the student worker closely approximate those of the professional caseworkers assigned to the wards.

The Neuro-Psychiatric Department

Receiving Hospital has four mental observation wards, with a total bed capacity of 146. One ward is devoted to female patients under mental observation, alcoholics, police prisoners, and medical and surgical patients who are under observation. Another ward is comprised of patients for temporary detention until a hospital bed is available in a state hospital, private hospital or a veteran's hospital. The same procedure applies in both male and female wards. "The temporary detention of any mental patient to a public or private hospital for observation, further custodial care, or treatment is provided by the laws of the state of Michigan."¹

There are ten psychiatrists, one psychologist, and five psychiatric social workers at Receiving Hospital. The Clinical Director of Neuro-Psychiatry has two administrative assistants who are staff doctors. The other psychiatrists are staff doctors, junior and senior residents. The admitting room is covered by the psychiatrists on a rotating basis. Skeleton coverage on week ends and holidays is also on a rotating basis.

The chief function of the mental observation service within the department is to screen patients on the psychiatric wards, and to

determine by means of interviews and other available methods whether the person is to be recommended for hospitalization, referred to some other service, or released. All staff psychiatrists handle a small number of cases in the Out-Patient Clinic. It is also the function of the Neuro-Psychiatric Department to conduct weekly seminars as part of an in-service training program for resident psychiatrists. They are held jointly with the social service staff, interns, and medical students.

Female Psychiatric Wards

The female psychiatric wards are located on the second floor of the hospital in the original structure (more popularly called the "old building"). "The original structure of the wards has not been changed nor has there been any addition to the original structure."¹ There are approximately 75 beds allocated on the female psychiatric wards.

The Female Psychiatric Service is divided into two main wards. One ward is comprised of patients who have been "filed on"; that is, a petition for commitment has been filed in the Probate Court. The disposition of the patients is the outcome of the action taken by the Court. The "intake ward" houses the new admissions, psycho-surgery patients, police prisoners, addicts, and patients who are under general mental observation care.

The Social Service Department has two offices located on the "intake ward" situated at both ends of the ward. The nursing station is located in the center of the "intake ward". All admissions to the ward are carried out through the nursing station. A social worker

on the "intake ward" assigns the patients to the psychiatrists after
the admission has been completed by the nursing station. There are
two caseworkers, each assigned to work with one of the three psychia-
trists. Both caseworkers work with the third psychiatrist.

The "intake ward" is known as ward 2-2 and the "filed-on ward"
as 2-1. Ward 2-2 consists of a police prisoner ward which is kept locked
at all times. There are three open wards and a dining room, in addition
to three seclusion rooms. The hall that is outside of the open ward,
dining room and other offices is equipped with metal benches where the
patients sit during the day. Recreation is limited to a television set
that is placed at one end of the hall.

The "filed-on ward" is separated from the "intake ward" by the
Out-Patient Clinic. This ward's physical structure is similar to the
"intake ward". However, the main purpose of this ward is to provide
detention for those patients who are awaiting transfer to a state
hospital. This ward does not have a social service office, but the
patients on this ward are followed up by the workers from the "intake
ward". Visiting hours are restricted to three times a week, from the
hours of two until three, on Tuesday, Saturday and Sunday. The Social
Service Department is available on week days only, from 8:00 A.M.
until 4:30 P.M.
CHAPTER III

SERVICES OFFERED ON THE FEMALE PSYCHIATRIC WARD

In order that one might see the specific activities and services of the Social Service Department, it is necessary to present a general picture of the functioning of the Social Service Department within the frame of reference of the whole.

As mentioned in Chapter Two, the City of Detroit's Receiving Hospital, by statutory requirements, is an emergency hospital. This fact in itself determines not only the constructs within which various services have to be offered, but also influences in many direct and indirect ways the nature and content of these services. One of these influences is the time limit which determines the length of time the patient can remain on the psychiatric ward in view of its emergency nature.

This study revealed that of the 25 cases, the average length of stay on the ward was eight days, with the shortest period being one day and the longest 28 days. A decision on the patient's disposition must be reached within 15 days. As a result, the psychiatrists and the caseworkers operate under some degree of pressure.

Initially the psychiatrist interviews new patients, and on the basis of these interviews, he makes a recommendation that the patient be released immediately or that the patient be held so his behavior can be further observed. In the cases of the patients whose immediate release is recommended, the social worker is very often active in the coordination of plans, however, the method of case selection did not
involve any cases of this nature. In the cases of the patients who were held for observation, the social worker carried a direct and more extensive role in relationship to the patient's care and planning. The study revealed that the responsibilities of the social worker with respect to these types of cases fell within seven rather clearly defined categories. They were:

1. Social worker's role in relation to the diagnostic process.
2. Social worker's role in interpretation of agency function, policy and procedure to family and patients.
3. Social worker's role in helping the patient in ward adjustments.
4. Social worker's role in keeping the family informed of the progress in hospital planning.
5. Social worker's role in handling feelings of relatives in relation to patient's illness.
6. Social worker's role in helping the patient to accept the need for further hospitalization.
7. Social worker's role in the implementation of medical dispositions.

Social Worker's Role in Relation to the Diagnostic Process

Due to the constant pressure of time, it is not possible to hold diagnostic conferences at which time the social worker's contribution around the social factors are formally presented. This does not mean, however, that the social worker does not make a contribution to the diagnostic process. The significance and importance of the social worker cannot be minimized. Neither should the amount of effort that goes into compiling a social history be ignored.

The study revealed that a social history was done on each of
the twenty-five cases sampled. The study also revealed that the sources of information for social histories varied widely; extending from the patient's families, friends, other social agencies, and neighbors to employers and other associates. The caseworker prepares a social history if the psychiatrist has requested one. In this setting, it is understood that the psychiatrist has secured the social history information which the patient could give and is requesting the caseworker to obtain supplementary information from relatives.

When a social history has been indicated, often because of the illness or unwillingness of the patient to have relatives contacted, caseworkers must use various resources to obtain names and addresses of relatives. If at all possible, the relatives are contacted and an appointment is made for an interview with them. During this interview the caseworker secures the supplementary information for the social history and explains the possible recommendations to the relatives in light of the information given by the relative.

Diagnostically, the social history is important because it tells when some deviation started, and knowing when it started and under what circumstances we are in a better position to understand what it is today. The following example is illustrative of the supplementary material secured by the caseworker from relatives for the completion of the social history:

Patient—Mrs. L.M., age 24 - diagnosis, schizophrenia.

Informant—Mrs. R.J., mother of patient.

Mrs. J. stated that patient had a "nervous breakdown" on December 8 of 1954 and was hospitalized at Z private hospital
for a period of eight to ten weeks. At this time the patient was married and the mother of a two-year-old daughter. Following this hospitalization, the patient was somewhat stable until November of 1955, when she again became irritable, agitated, argumentative and destructive. As a result, she was admitted to the psychiatric ward at this hospital. After four days the patient was discharged. Shortly after the patient's discharge from Receiving Hospital, she divorced her husband.

At this point she moved into the home of her father and step-mother; however she did not remain in her father's home long as her habits of cleanliness and neglect of the child were not acceptable by her step-mother, who would also not tolerate the patient's drinking. The patient was accepted into her mother and step-father's home but the same type of behavior continued; she was consequently forced to leave her mother's home. This time the patient chose a boarding home for herself and her child. According to the informant, the patient often left the child with other boarders at the home for several days at a time without notifying anyone where she could be reached in case of an emergency. On one occasion the manager telephoned the informant that the child had been left with the women at the boarding house for four days and she wanted her to come for the child. The informant immediately went for the child. The next day the patient came to the informant's house asking for forgiveness. She moved back into her mother's home and for several weeks was quite cooperative, but this behavior did not continue long as she began to become restless and would leave the house late at night after the family was asleep.

During this time the patient would not feed the child adequately, nor keep her clean. Several times the informant would return from work and find the child "crying, dirty and hungry," and the patient would be in the bed "drunk." According to the informant, she was awakened the previous night by screams and choking sounds from her granddaughter, and on entering the patient's bedroom, she found the patient trying to "stuff a sandwich into the child's mouth." The informant became upset and took the child into her bedroom for the rest of the night as the patient was "drunk" and was unable to talk coherently.

The following day, the informant discussed the patient's behavior of the previous night with her and the patient began to cry and said she was "sick and needed help." The informant consoled the patient and told her that she would call the family doctor and discuss the situation with him. After telephoning the doctor, the informant went to the store and left the child asleep in her room; and the patient was going to
the bathroom to take a shower. Upon returning, the informant found the house a "wreck". The patient had torn the linen from her bed and was looking under the bed screaming and crying. When the informant tried to talk to the patient, she ran into the bathroom and began to throw articles from the medicine cabinet. At this point the informant became frightened and ran into her bedroom and picked up the crying child and rushed from the house. According to the informant, she telephoned the police department. Several policemen arrived and made the necessary arrangements and the patient was later admitted to the psychiatric ward for mental observation. Her condition was diagnosed as schizophrenia.

Mrs. J. stated that she was financially able to provide for whatever treatment the psychiatrist might recommend. The patient was later transferred to a private psychiatric hospital.

Such social information makes a definite contribution to the psychiatric study of the patient. Both the psychiatrist and the caseworker exchange their findings about the patient until the psychiatrist is in a position to make a recommendation for the patient's care.

Because of the rapid admissions on the ward, often no written social service histories are recorded in the patient's chart. The relationship between the psychiatrist and the caseworker is such that the social history is generally shared verbally with the doctor.

Usually the material secured from the relative will supply the necessary information for the face sheet and this information will supply the doctor with adequate information in order to make a recommendation.

Social Worker's Role in Interpretation of Function, Policy and Procedure to Family and Patients

Often the worker is the first real contact that the family has with the hospital after the patient has been admitted to the ward. In some instances the patient's family is familiar with the hospital procedures and policy. If they are not, an extremely valuable opportunity
is offered for the worker to interpret the hospital facilities and
program to the family.

Oftentimes, the patient seemed to be confused on the function
of the hospital. He had been laboring under the impression that the
hospital was a treatment center rather than a diagnostic one. Conse-
quently, it became necessary for the writer to interpret the function of
the hospital to the patient. Sometimes the diagnosis and recommendations
are not given immediately. During this period the patient is very im-
patient and interested in immediate treatment or release.

The study revealed that the caseworker interpreted the function,
policy and procedure to twenty families and five patients. The following
case presents an excellent example of the caseworker's role in this
respect.

Mrs. D., aged 71, prior to her hospitalization, lived in
the home of her niece. According to the niece, the patient had
become irresponsible and unmanageable in the home and could not
be left alone. Mrs. D.'s niece was interested in leaving the
patient on the ward for a period of two months during which
time she would be on vacation. Mrs. D.'s behavior on the ward
did not indicate the need for further hospitalization in this
setting and the hospital could not keep her as a means of con-
valescence. The City of Detroit's Receiving Hospital does not
provide a convalescent service.

It was necessary for the caseworker to explain the program of the
hospital to Mrs. D.'s niece. It was suggested that admittance to a con-
valescent home could probably be arranged if that was what she actually
wanted, as Mrs. D. was not diagnosed as being mentally ill by the
psychiatrist. However, there was evidence of senility and she could not
be left completely alone and unsupervised. The same case provides an
case of interpretation to the patient:
Mrs. D. asked if she could go home. She seemed to feel that she was not "crazy". The worker explained that the doctors were interested in giving her a thorough physical examination first, after which they wanted her to get some rest. Mrs. D. knew that her niece did not want her back into the home, therefore she was curious to know exactly where she was going. The worker told Mrs. D. that the hospital was exploring the possibility of getting her into a convalescent home. She further described the congenial atmosphere and the companionship that she would receive at the home. Mrs. D. seemed interested because she "liked to talk and be with people."

Undoubtedly there had been some discussion in the home about possible convalescent care. Therefore, it was not too difficult for her to grasp the meaning of this kind of care when the worker interpreted it to her.

Social Worker's Role in Helping the Patient in Ward Adjustment

Although any illness may require hospitalization or long-term care away from home, the re-adjustment of living in a new environment creates difficulty that is almost inevitable. "Much of the patient's unconscious anxiety is often displaced onto reality factors which appear to be blocking factors in his adjustment to the hospital."¹ His difficulties with personnel and other patients may arise from projected hostility due to unconscious fears of helplessness. The patient in the hospital must adjust to medical authority, to restraints and long-drawn-out care. "If his resentments are understood and handled both in the reality situation and in the dynamic context, the patient can be helped to make a successful adjustment."²

Of the 25 cases used in this study, it was revealed that only seven patients were interviewed by the caseworker. Of the seven, there were four contacts that showed the worker's activity as she attempted to help the patient make a satisfactory ward adjustment. The writer felt that the following case was an example of the services offered in this category.

Mrs. B. was a twenty-eight year old married woman whose diagnosis was schizophrenia. During the time the worker was on the ward, she noted that the patient resisted going to her room to rest (which was customary in the afternoon). Worker asked Mrs. B. why she did not want to go to her room. The worker listened as the patient ventilated her feelings of fear. The worker attempted to allay these fears. She was eventually able to escort the patient to her room. Worker assured her that she would be safe in her room, and it would be necessary for her to try to conform to the small routines at the hospital. Of course the worker would be willing to help her.

People normally resist change, because it is going from the known to the unknown, which tends to create fear. The routines were somewhat traumatic to Mrs. B., as she was not accustomed to the consistency of such procedures in her own home. Perhaps her actions suggested mild instances of marked impairment of habits, of self regard, of social sensibilities and of judgement in practical matters. The social worker should be empathetic with the patient but firm in attempting to socialize her; then a reasonable, adequate adjustment may be maintained for some time.

Social Worker's Role in Keeping the Family Informed of the Progress in Hospital Planning

The social worker should be honest in discussing the patient's

\[1\] Ibid., p. 193.
condition with the family. She should not withhold relevant facts except for valid reasons. There should be a sharing relationship between the hospital and the patient's family where the caseworker acts as the liaison between these forces. The 25 families were kept informed as to the progress of the patient while hospitalized, and of the necessity of extended care in the same setting or elsewhere. The following case is an example of the worker's role in this respect:

Mrs. X was a thirty-two year old woman, who had been separated from her husband for two years and had lived in her parents' home prior to her hospitalization. Mrs. X's condition was diagnosed as schizophrenia. The caseworker informed the family that the psychiatrist's examination had revealed that the patient was mentally ill and that he had recommended commitment to a state hospital. The worker further informed them of the patient's transfer from ward 2-2 to ward 2-1. In this case, the date for the court hearing was held prior to the patient's transfer to the state hospital, and the worker informed the family of the date of the court hearing. The worker encouraged the family to visit the patient as often as it was convenient for them, prior to the patient's transfer to the state hospital and during long term care.

The caseworker should encourage the family to be interested in the confined patient. The family should be sympathetic toward the patient because lack of sympathy tends to add to patient's feelings of discomfort and insecurity. The social worker should be aware of the emotional support of all persons concerned and attempt to help the family in appropriate ways throughout the patient's psychiatric care.

The Social Worker's Role in Handling Feelings of Relatives in Relation to Patient's Illness

The caseworker has been taught to understand the psychiatric implications in family situations and to recognize the

1Upahm, op. cit., p. 41.

2Ibid., p. 45.
mechanisms that prevent adequate adjustment. The social worker works with the family and seeks to change their attitudes, while the psychiatrist endeavors to correct the behavior of the patient.¹

There is one fact that must be kept in mind: the social worker does not work for the psychiatrist, she works with him and together they work for the patient.

The caseworker recognizes that presenting one's self as a psychiatric patient tends to promote strong feelings, both to the patient and relatives.² The caseworker attempted to establish a relationship with the patients' families which would encourage them to maintain a positive, non-rejecting attitude toward the patient's hospitalization. Family relationships play an important part in the continued improvement of the patient, and the caseworker needs to understand them just as the family needs to understand the patient. Often family relationships have played an important part in the patient's breakdown.

The study revealed that in 22 cases the social worker worked with families in relation to their feelings about the patient's illness. The following case is an example of the worker's activities in this respect.

Miss P., the patient's sister, expressed her punitive behavior toward the patient prior to patient's hospitalization. The patient was an attractive, well-developed, twenty-four year old woman who had been the only member of the family to complete high school. The patient had been employed as a secretary for a law firm for three years until four months prior to her hospitalization. At this time she had been released from her position as the law firm had been discontinued.

The patient had become despondent because she was unable

²Lowrey, op. cit., p. 193.
to secure immediate employment. According to the patient's sister, the patient refused to assist with the household duties. She often ran to her room crying when the informant reprimanded her for this behavior. The patient's sister further stated that she had the telephone disconnected and would lock the television set in her bedroom so the patient could not use the telephone nor watch television during the day. These actions were done to force the patient to seek employment. However, the patient became more withdrawn and depressed as she continued to sit around the house in an aimless fashion. Miss P. was extremely tearful as she related her past behavior toward the patient.

The caseworker supported Miss P., exhibiting some understanding of the difficulty involved in working all day and being forced to do the housework when she returned home. This is especially true when another member of the family is in the home and is expected to be supported and has nothing to do during the day. It must be quite difficult for Miss P. to meet current expenses with a teen-aged brother to support also on her small salary.

The caseworker was empathetic with Miss P., however, she did not know that the patient was sick and her actions were not normal. The worker further told Miss P. that she would contact another agency and explain her situation, and she was sure there was something that could be done to help her with the current hospital expenses.

Social Worker's Role in Helping the Patient to Accept the Need for Further Hospitalization

"The aim of the social worker in illness is to help in the restoration of health and to prevent personal and family deterioration as a result of the handicap or illness."\(^1\) The achievement of these goals depends greatly upon developing in the patient the capacity to

\(^{1}\text{Upham, op. cit., p. 43.}\)
use medical care. Many patients, with the help of their families, can accept the need for further care.

The process of growing up and adapting to life is never entirely easy and comfortable, even under the best of circumstances. Unfortunately many people fail to make satisfactory adjustments between the needs and demands of their personalities and those of the environment in which they live; consequently they become mentally ill.

Of the 25 cases used in this study, four patients were helped to accept the need for further care. The following case is an example of this service.

Mrs. Q. was an intelligent, attractive, well-to-do married woman, thirty-six years old, and the mother of two children, aged eight and nine. She had been discharged from a state hospital some years earlier after having made an extremely gratifying improvement from violently compulsive symptoms of such nature that she had been given a poor prognosis.

Her prolonged treatment at the state hospital had made her a "new person" according to her husband. Since her discharge she had been an ideal wife and mother. The sudden change was noted several weeks prior to the Thanksgiving holidays. She became restless, irritable and depressed. Prior to her admission to the psychiatric ward, she had made a suicide gesture, by turning the gas on in the kitchen and failing to light the jets on the stove. This attempt might have been fatal had her husband not returned to the home because he had forgotten his brief case.

During the patient's hospitalization at Receiving Hospital, the caseworker noted that Mrs. Q. was withdrawn and often sat on a bench by herself away from the other patients. One afternoon while the caseworker was on the ward, she observed that Mrs. Q. sat huddled in a corner crying violently. The social worker approached her to inquire if she could be of some help. Mrs. Q. told the caseworker that she was informed that she would be going to another hospital and she did not want to be "put away again." Mrs. Q. continued to cry as she told the caseworker to tell her family and the doctor that she was all right. She admitted that sometimes she did become depressed, however, she stated she would not attempt to commit suicide again.
The caseworker pointed out to the patient the value of further hospitalization on the basis that she was a young woman and the prognosis was favorable, in light of her stability after the hospitalization some years before. The worker further pointed out to the patient the family's interest in relation to her "getting well." The worker was eventually able to allay Mrs. Q.'s fears as she assured her and continued to point out to her the advantage of hospitalization at this stage. Worker informed Mrs. Q. that arrangements were being made to get her into a private hospital in the city which would allow her family to visit her almost every day. Mrs. Q. was eventually able to accept the need for further hospital care with a minimum of anxiety.

Social Worker's Role in the Implementation of Medical Disposition

Following a period of observation resulting in a diagnosis, a recommendation is made by the psychiatrist as to a medical disposition of the case. The medical recommendation and the hospital disposition are the same in practice on the Female Psychiatric Ward. Table I shows the relationship between the diagnoses and the medical recommendations. Table I shows that of the twenty-five cases in the sample, six patients with a diagnosis of schizophrenia and one patient diagnosed as having a character disorder, were committed to a state hospital; five patients with a diagnosis of schizophrenia were transferred to a private psychiatric hospital; and one schizophrenic was discharged to herself.

Of the 25 cases studied, six whose diagnosis was senility without psychosis were transferred to a convalescent home. Two patients whose diagnosis was chronic brain syndrome were discharged to themselves. There was one alcoholic who was discharged to herself. In addition, two patients whose diagnoses were possible character disorder were discharged to themselves; and one patient whose diagnosis was character disorder was discharged to herself.
TABLE 1

DIAGNOSIS AND MEDICAL RECOMMENDATION

<table>
<thead>
<tr>
<th>Medical Recommendation</th>
<th>Senility</th>
<th>Chronic</th>
<th>Character</th>
<th>Schizo-</th>
<th>Alco-</th>
<th>Possible</th>
<th>Senility</th>
<th>Chronic</th>
<th>Character</th>
<th>Schizo-</th>
<th>Alco-</th>
<th>Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospital</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Convalescent Home</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to Self</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>6</td>
<td>2</td>
<td>2</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td></td>
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</tr>
</tbody>
</table>

The medical disposition defines certain other responsibilities which the social worker must carry in the implementation of the recommended disposition. Some of the recommendations as to disposition that were made on the Female Psychiatric Ward which involved some participation by the social worker were: (1) commitment to a state hospital, (2) transfer to a convalescent home and (3) transfer to a private psychiatric hospital.

**Commitment to a State Hospital.**—A patient is committed to a state hospital after the petition for commitment has been filed in the
Probate Court, a hearing date is set, and the patient may or may not be detained until the hearing. At the time of the hearing, based on the allegations, testimony of relatives or friends and medical reports, the judge decides whether or not the patient is mentally ill. If so adjudicated, the patient is ordered admitted to a state hospital. The social worker has responsibility for interpretation to relatives and/or patients, as well as preparing a social history for the hospital to which the patient is transferred.

Transfer to a Private Psychiatric Hospital.—When the psychiatrist finds that on the basis of his examination the prognosis is favorable, short term treatment is often recommended. This type of treatment is often more readily available in a private hospital. The financial status of a patient is not a determining factor in private care. If the patient does not have hospitalization insurance and the family is unable to finance the patient's treatment at a private hospital, the caseworker gives the family an application filled out and signed by the psychiatrist stating the patient's diagnosis and the recommendation for short term care. This application is taken by a legally responsible relative (husband, wife, father or mother) to the Wayne County Department of Social Welfare requesting that they undersign the bill, with the responsible relative stating they will repay the county under the terms set up by the county.

When the application has been processed by the representative of the Wayne County Department of Social Welfare, the representative will contact the caseworker of the decision as to whether the application
was accepted or rejected. The caseworker will inform the psychiatrist of the decision and arrangements will be made for the patient's transfer.

Transfer to a Convalescent Home.—A patient is transferred to a convalescent home when the psychiatrist makes a diagnosis of senility without psychosis and the family is unable to provide adequate supervision for the patient at home.

In this setting, convalescent home placement is used for senile patients without psychosis. After the recommendation has been agreed upon, the caseworker contacts a convalescent home in order to secure a bed. When a vacancy has been located, the caseworker informs the psychiatrist of the progress of the recommendation. She further informs the nursing station to prepare the patient for transfer by Receiving Hospital ambulance service. The patient's family is informed of the patient's transfer to the convalescent home.

When the patient is an active old age recipient, the caseworker writes a letter to the Wayne County Bureau of Social Aid asking them for supplementary assistance with the nursing care bill. The worker also informs them of the medical diagnosis, recommendation, the date of transfer to the convalescent home, and the rate per day. The social worker also handles the problem of referral to agencies when the patient is not an active old age recipient.
CHAPTER IV

SUMMARY AND CONCLUSIONS

This study was initiated to describe the social services offered on the Female Psychiatric Ward of Detroit's Receiving Hospital. Receiving Hospital was a municipal emergency hospital whose primary function was to provide medical care for the emergency and/or indigent cases of Detroit residents. There were approximately 75 beds allocated to the Female Psychiatric Ward.

The chief function of the psychiatric wards at Receiving Hospital was to screen patients, and to determine by means of interviews and other available methods whether the person was to be recommended for further hospitalization at a state hospital, private hospital, or released. This chief function was carried out through two major functions which were diagnosis and recommendation. The psychiatric wards, contrary to popular belief, were not treatment centers. Instead they functioned primarily as a screening or diagnostic service and for emergency detention.

The study revealed that the caseworker's role was clearly defined by the resultant recommendations for the patients as made by the psychiatrist. The findings revealed that the social services offered on the female ward fell into seven categories and they were as follows:

1. Social worker's role in relation to the diagnostic process.

Contributions to the diagnostic process were not formally presented, however, the caseworker did make a contribution in terms of securing supplementary information from the family for the completion of the social history. She further utilized her knowledge of available community
resources when the doctor indicated the need.

2. Social worker's role in interpretation of function, policy and procedures to family and patients. This role was utilized in explanation of the program of the hospital to patients and families when necessary.

3. Social worker's role in helping the patient in ward adjustments. The social worker's role was evidenced in this respect as she helped the patient to adjust and to conform to the small ward routines.

4. Social worker's role in keeping the family informed of the progress of hospital planning. The performance in this activity was exhibited as the worker pointed out the emergency services of the hospital and acted as a source of information for the family.

5. Social worker's role in handling feelings of relatives in relation to the patient's illness. The utilization of services in this respect were exemplified as the worker maintained a positive relationship with the family as she helped them with the reality situation of illness.

6. Social worker's role in helping the patient to accept the need for further hospitalization. It was evident that the social service performance in this respect was effective as the worker pointed out the value of hospitalization to patients that showed some resistance toward further hospitalization.

7. Social worker's role in the implementation of medical disposition. The medical disposition defines certain other responsibilities which the social worker must carry in the implementation of the recommended disposition. Some of the recommendations as to disposition that were made on the Female Psychiatric Ward which involved some participation by the social worker were; (1) commitment to a state
hospital, (2) transfer to a convalescent home, and (3) transfer to a private psychiatric hospital.

Of the 25 cases studied, six whose diagnosis was senility without psychosis were transferred to a convalescent home. Two patients whose diagnosis was chronic brain syndrome were discharged to themselves. There was one alcoholic who was discharged to herself. In addition, two patients whose diagnosis was possible character disorder were discharged to themselves; and one patient whose diagnosis was character disorder was discharged to herself.

Of the 25 cases in the sample, six patients with a diagnosis of schizophrenia and one patient diagnosed as having a character disorder were committed to a state hospital; five patients with a diagnosis of schizophrenia were transferred to a private hospital, and one patient with a diagnosis of schizophrenia was discharged to herself.
BIBLIOGRAPHY

Books


Miscellaneous Material


Periodicals


Public Documents


Unpublished Material


SCHEDULE

CODE NUMBER ________

DIAGNOSIS ________

1. Age ___ Race ___ Marital Status
   Married_____
   Single_____
   Divorced_____
   Separated_____
   Widowed_____

2. Previous Hospitalization
   a. If Yes Where ______________________________ Number of times____
   b. No____

3. Financial Status
   a. Dependent_____
   b. Marginal_____
   c. Independent_____

4. Medical Recommendation
   a. Private Hospital_____
   b. State Hospital_____
   c. Outline Hospital_____
   d. Room and Board_____
   e. Convalescent Home_____
   f. Discharge to Self_____

5. Hospital Disposition
   a. Private Hospital_____
   b. State Hospital_____
   c. Outline Hospital_____
   d. Room and Board_____
   e. Convalescent Home_____
   f. Discharge to Self_____

6. Social worker's role in assessing patient's ability to utilize hospital and community resources.

7. Social worker's role in helping the patient to utilize hospital and community resources.

8. Social worker's role in assisting the patient's adjustment in the area of relationship.

9. Social worker's role in agency interpretation.

10. Social worker's role in the diagnostic process.