CASEWORK WITH PSYCHIATRIC PATIENTS

AN EMPIRICAL STUDY OF TREATMENT TENDENCIES

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CHAPTER I

PROBLEM FORMULATION, SCOPE AND METHOD OF INVESTIGATION

1.1 Introduction

Social casework as one of the methods of social work has been used in various fields, either alone or in conjunction with social group work and/or community organisation.

Throughout its development it has, inter alia, been greatly influenced by psychoanalytic theories. This influence even gave rise to some confusion amongst social caseworkers of the 1930's and 1940's. The influence of psychoanalytic theories is still felt amongst social workers, e.g. use of ego psychology in casework practice, use of transference, etc. In Chapter II of this study the relationship between psychiatry and social work is discussed at length.

Social casework can be easily adapted to suit the setting in which it is practised. In this study social casework is studied in a setting where the social caseworker works in close collaboration with psychiatrists and nursing sisters in an attempt to help psychiatric patients.

The psychiatric social worker did not find it easy to establish her place in the psychiatric team, due to the longstanding traditional background of medical practice. Thanks to her determination she is now an accepted member of the psychiatric team.

In the Republic of South Africa psychiatric social work is practised in psychiatric hospitals, general hospitals

with psychiatric wings, child guidance clinics and mental health societies.

The setting of this study is the Mental Health Society of the Witwatersrand. Background information on the Society is given in Chapter V.

This chapter discusses the aims, motivation, problem formulation and methodology.

1.2 Motivation for the study

The researcher's first practical contact with psychiatric patients was in 1973 when she was employed as a medical social worker in a state general hospital. Psychiatric patients were admitted to the medical wards of this hospital (which had no psychiatric wing) before being certified and sent to a psychiatric hospital.

The researcher observed that these patients were repeatedly admitted to the general hospital and then certified to the psychiatric hospital. Some had four to five readmissions per year.

While the patient is in the psychiatric hospital, or soon after his discharge, he is referred to the local mental health society for follow-up treatment. The main objective of this referral is two-fold:

(a) The society's social workers are expected to establish and maintain contact with the patient's family to help them accept the patient's illness and know their role in his readjustment and rehabilitation after discharge;

(b) once the patient is discharged, the society's social workers keep contact with him and his family and assist him in readjusting and remaining in mental health (See Chapter II).

Some of the patients get a relapse while they are still under the society's care, and they are then certified directly by the society to a mental hospital. Others get readmitted from home to a general hospital and are then certified to a mental hospital.

Over the years the researcher felt concerned about these readmissions. Research into what the social workers of a mental health society do and should do to help the patients remain outside the mental hospital, seemed appropriate and very necessary.

Social casework services were selected for this study because that is the method currently used most widely by the Society mentioned.

Because of lack of funds, manpower, time, etc., agencies seldom undertake evaluative research on their services. It is hoped, therefore, that this study might provide vital information to the specific Society and to the field of social work practice in general.

1.3 Purpose of the study

The aim of this study is two-fold:

Firstly it aims at finding out whether there are specific treatment tendencies that are employed by the psychiatric social workers in the individual treatment of patients at

The Mental Health Society of the Witwatersrand; secondly it aims at assessing the extent to which each particular treatment tendency is used. It is implied that the findings will reflect which treatment technique is most or least employed.

1.4 Hypothesis

This study is exploratory in nature. Selltiz et al says:

> ... the first step in analyzing the data of an exploratory study is to develop a working hypothesis that will yield classificatory principles.
> (Selltiz, C. e.a. 1965, p. 399)

The following hypothesis was postulated for this study:

There is an inclination towards certain procedures in the casework treatment of psychiatric patients at the Mental Health Society of the Witwatersrand.

1.5 Research design

After the problem was formulated, it was decided that the formulative or exploratory design would be the most suitable for this study. Exploratory or formulative research purposes to formulate a more precise investigation or to generate further hypotheses.

Findings of exploratory or formulative study lay foundations for further investigation because in this type of research little is known about the phenomenon studied at the onset. It is an initial phase in an on-going research process.

The investigator familiarises himself with a particular setting where a further study may be undertaken as is the case in this study. The researcher familiarised herself with The Mental Health Society of the Witwatersrand during the process of this study (See Chapter V).

1.5.1 Literature survey

Selltiz et al (1965) single out the survey of applicable literature and discussions with practitioners as two ways in which the important variables may be identified and a hypothesis formulated.

Library research (see Chapters II, III and IV) undertaken before the actual research helped in reaching a decision as to which treatment typology should be used as a basis for content-analysis.

The works of Austin (1948) and Hollis (1964) were used as a basis for coding the contents of the case records used in the sample.

1.5.2 Interviews with practitioners

The researcher interviewed two lecturers at the School of Social Work of the University of the Witwatersrand, both of whom are former employees of the Society.

Further discussions were held with the staff of the Society. In their daily routine these specialists acquire experience that is of tremendous value to anyone wishing to undertake a study in the particular setting or field.

The persons interviewed were selected on the basis of their experience and their ability to communicate this experience.

The respondents were selected with the help of the Director of the Society and represented different types of experience. They included the Director, two psychiatrists, a nursing sister, a social work supervisor and three social workers.

1.5.3 Empirical research

The actual research itself was based on the technique of content analysis, which is defined by Berelson (in G. Lindzey, 1954, p. 489) as "... a research technique for the objective, systematic and quantitative description of the manifest content of communication."

This technique was mostly used in quantifying narrative documents or the effect of mass media on public opinion. It has, however, been used extensively in social work research for categorizing kinds of services rendered by social workers or categorizing communications in a social work interview (Hollis, 1964). The first researchers believed to have used this method in social casework research are Dollard and Mowrer (Polansky, 1975, p. 123). This technique was further developed to enable the social worker to use it as a research instrument.

Cartwright (in Festinger and Katz, 1953, p. 435) explains the aim of content analysis as follows:

> ... to convert recorded 'raw' phenomena into data which can be treated in essentially a scientific manner so that a body of knowledge may be built up. More specifically, content analysis must be conducted so as (1) to create reproducible or 'objective' data which (2) are susceptible to measurement and quantitative treatment, (3) have significance for some systematic theory, and (4) may be generalized beyond the specific set of material analyzed."

The use of this technique requires clearly defined categories on which the classification will be based; that the researcher does not have a free hand in reporting but relies only on the prescribed code and classifies all relevant material in the sample on the basis of that code.

The number of classes (in as far as treatment techniques are concerned) was determined by the question to be answered. All of Hollis' classes and those of Austin were selected on the basis of their comprehensibility in answering the research question. These classifications were used as a guide for coding the content of communications between the client (patient) and his relative(s) and the worker in the case records in the sample.

The data were categorized by means of a technical procedure called coding. In this procedure the raw material is transformed into symbols - usually numerals - which can be counted. This transformation involves judgment on the part of the coder.

The procedure used in this study is explained in greater detail in Chapter V.

1.6 Sampling

The sample was drawn from the case records of the patients who were receiving social casework treatment from The Mental Health Society of the Witwatersrand at the time of the study.

The sampling method applied was that of stratified random sampling. A stratified random sample is a form of sampling whereby the population is divided into two or more

strata to increase the chances of inclusion in the sample. The population from which the sample was drawn is made up of two strata, i.e. case records of mentally retarded patients and case records of mentally ill patients.

Random sampling was done on both sections to ensure that both patient groups have a chance of being included in the sample.

The agency employs 14 social workers, but files of only 13 of these, housed in the main office, were available for study. Files of the Indian social worker operating from Lenasia outside the city, were not available. Only long-term cases were included in the sample. This excluded the records of the intake workers; those of two other social workers who had only been with the agency for about one month at the time of the study; those of the two supervisors (they handle very few cases; the chances were that these would be left out in the sample); and the records of the Indian social worker (See Chapter V).

The case records in the sample were then selected from the case load of 9 of the social workers, each of whom has an average case load of 250.

Each social worker submitted 15 case records (which were picked randomly) and these made up 135 case records. Every third case record was then included in the sample. This yielded 45 case records.

1.7 Conceptualization

The following concepts will be defined for the purpose of this study:

1.7.1 Social casework

Social casework has been defined by various authors, and no single definition explains the concept exhaustively.

Many definitions have been coined since the first definition of M. Richmond. These definitions reflect that caseworkers responded to the psychosocial conditions prevailing from time to time.

After studying about 34 definitions, Bowers posited the following most widely used definition:

> ... Social casework is an art in which knowledge of the science of human relations and skill in relationship are used to mobilize capacities in the individual and resources in the community appropriate for better adjustment between the client and all or any part of his social environment.
>
> (Bowers, S., 1949, p. 19)

Perlman defines it as:

> ... a process used by certain human welfare agencies to help individuals to cope more effectively with their problems in social functioning.
>
> (Perlman, H.H., 1957, p. 4)

The above definitions signify that social casework is an art which derives its knowledge from scientific investigation. It is practised by skilled (professionally trained) persons who function under the auspices of a welfare agency in helping individuals and families with their problems.

The following assumptions may be made: the individual and society are interdependent; social forces influence behaviour and attitudes, affording opportunity for self-development and contribution to the world in which we live; not only are all problems psycho-social -inner and outer- but most casework problems are interpersonal, i.e. more than one person is likely to be involved; the client is a responsible participant in every step in the solution of his problem.

The casework method

The casework method comprises three stages: social study or investigation, diagnosis and treatment. These stages will be discussed individually but in real practice they take place concomitantly.

(a) Social study or investigation

This phase aims at collecting data from the client which will enable the worker to assess whether the client's problem falls within the scope of the particular agency's services and how the agency can be of assistance to the client. The information collected here concerns the client's interaction with his social environment, significant events in his life and the people in his present as well as past life. The information may be provided by the client or a collateral source.

In the case of the psychiatric patient - especially the severely disturbed case - the information is provided by a close relative.

Strean, H.S. (1971, p. 17) says that during this phase the worker concentrates on the following aspects:

> ... precipitating factors; how the client has managed in the past and what he has already done about the problem that has brought him to the caseworker's attention; significant persons involved in the problem; how the individual is affected and affects his cultural milieu; and facts that relate socio-economic, psychological and cultural factors for the individual and his family.

The caseworker employs several techniques to obtain information. These techniques as cited by Hamilton, G. (1959, p. 193) are: a study of the situation and history, home study and observation, the use of collateral sources as well as special tests and examinations.

(b) Diagnosis

Perlman (1957) refers to diagnosis as the thinking in problem-solving. It is the worker's professional assessment of what the problem is and how the person can be helped. It follows on a cross-sectional study of all the elements that are at interplay in the client's problem situation. Its objective is the formulation of a plan of treatment.

Perlman cites three types of diagnosis, i.e. dynamic, etiological and clinical. A dynamic diagnosis involves a study of all the aspects that are at interplay in the client's problem; an etiological diagnosis looks into the client's past history as related to his problem, while a clinical diagnosis seeks to label the client according to his psychological disturbance. She further

states that the clinical and etiological diagnoses are incomplete without a dynamic diagnosis.

(c) Treatment

This is the phase where the goals that have been agreed upon by worker and client are pursued and the plan to solve the problem is implemented.

As early as the 1920's social workers attempted to coin treatment typologies (See Chapter III). M. Richmond referred to Direct and Indirect treatment (environmental manipulation).

In 1947 Austin referred to social therapy (modification of the environment), experiential therapy, supportive therapy and insight therapy (direct treatment) (Austin, L., 1948). Later Hollis outlined a series of six treatment procedures under direct treatment: sustaining procedures, direct influence; exploration-description-ventilation, pattern-dynamic reflection, person-situation reflection and developmental reflection. She also identifies indirect treatment where some of the techniques of the direct treatment methods are applied (Hollis, 1964).

The social caseworker uses a blend of the procedures depending on the problem and the client's need.

1.7.2 Mental illness

According to the Encyclopaedia of Social Work, mental illness refers to:

> ... a range of disorders, related to a still unclear combination of physiological, psychological and sociological factors that lead to acute or chronic physical, emotional and/or behavioural disabilities. Many mental disorders are accompanied by distortions of personality function and also by more or less severe distortions of the affected persons social relationships.
>
> (ed. Lurie,H., 1965, p. 486)

The Mental Health Act No. 18 of 1973 contains the following definition:

> ... any disorder or disability of the mind and includes any mental diseases, any arrested or incomplete development of the mind, and any psychopathic disorder and 'mentally ill' has a corresponding meaning.

Mental illness is therefore not a disturbance of the mind only; this disturbance may affect the physical make-up of the patient as well as his social relationships. The second definition encompasses sociopaths as well as mental retardates.

A futher definition of mental retardation appears necessary at this stage to distinguish it clearly from mental illness per se. The following two definitions are cited by Kisker, G.W. (1964, p. 433):

> ... a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independently of supervision, control or external support.
>
> (Tredgold, A.F.)

> ... subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behaviour.
>
> (The American Association on Mental Deficiency)

Two major classes of mental disturbances are psychosis and neurosis with an overlap of symptoms. Sociopaths and mental retardates also form large groups in mental institutions.

People with emotional problems and adjustment problems fall under the above two major classes, because some have symptoms that are typical of these groups. However, these symptoms are mild, and the persons may be able to hold on to "normal" existence.

According to the above Act, a patient means "... a person mentally ill to such a degree that it is necessary that he be detained, supervised, controlled and treated, and includes a person who is suspected as being or is alleged to be mentally ill to such a degree."

In this study the mentally ill patient is referred to as the "mentally ill or psychiatric patient".

A definition of psychiatric social work is not given here as the concept is fully discussed in Chapter II.

The terms "caseworker" and "psychiatric caseworker" have been used interchangeably in this text to refer to a trained social worker who helps patients and families in a psychiatric setting on an individual basis.

1.8 Problems of methodology

In undertaking a study, a certain procedure for collecting and processing the data is set out. In certain fields of research, especially in the natural sciences, one may set out certain procedures to be followed right from the beginning, and throughout the study the procedure may be adhered to.

It is different in the human sciences, because the material dealt with is far more complex and dynamic. Social work research also has its complex problems and this type of study (analysis of case records) has its own peculiar problems.

The case records used in this study were originally compiled for practice purposes. This led to the question whether they would be good material for research purposes. Hamilton, however, has the following to say on this issue:

> ... the purposes of keeping social case records ... are usually formulated as practice, administration, teaching and research.
>
> (Hamilton, G., 1946, p. 4).

The most significant consideration in this type of study is that the records were in fact compiled for practice purposes.

During the course of the study the following problems were encountered:

1.8.1 The records were not a verbatim report of the communications between the client(s) and/or relatives and the caseworker. The caseworker

recorded what she judged important or significant, and mostly from memory. Factors such as bias, forgetfulness, prejudices and stereotypes cannot be ignored here.

1.8.2 Until very recently the agency had a critical staff problem. The few social workers had little time to compile complete and meaningful case records. With the procurement of more staff the quality of the records improved. Current case records were studied, because their contents appeared to provide richer study material than old files which are mostly joint casework-medical files. They reflect only an intake form and the rest of the file is made up of medical records.

1.9 Data analysis

The analysis of the data was done through tabulation. Tabulation is an operation of counting to determine the number of cases that fall within the various categories. Tabulation here was done by hand, because the sample is relatively small (45 case records).

Cross-tabulations were done at certain points; these were also manual for the reasons stated above.

The tabulation was based on ticks (✓) made when data were coded into given categories. The data were then presented in the form of several tables and one bar graph (See Chapter V).

1.10 Presentation

This study is presented in five (5) chapters as follows:

Chapter I outlines the motivation, aim, definition of concepts and the method of study.

In Chapter II a history of psychiatric social work is given as well as an outline of psychiatric social work as one of the specialized areas of social work practice.

Chapter III traces various treatment typologies and an analysis is made of Hollis' and Austin's typologies on which this study is based.

Casework treatment techniques with specific psychiatric types are discussed in Chapter IV. The various settings in which psychiatric casework is practised, are discussed.

Chapter V presents the findings, conclusion and recommendations.

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CHAPTER II

AN OVERVIEW OF PSYCHIATRIC SOCIAL WORK

2.1 Introduction

Psychiatric social work is social work practised in the field of the mentally ill.

In terms of the Mental Health Act No. 18 of 1973 mental illness means "any disorder or disability of the mind and includes any mental disease, any arrested or incomplete development of the mind and any psychopathic disorder, and 'mentally ill' has a corresponding meaning."

Mental illness can generally be divided into psychosis and neurosis. Medical opinion on the causes of psychosis is varied.

Some believe that it is a result of biochemical disturbances which are possibly glandular in nature, while others maintain that it is psychogenic in nature.

With regard to neurosis, however, there is general agreement that it is due to the interaction of unhealthy patterns developed during childhood with stress in the present environment. Nevertheless, it will take time before the real cause of mental illness can be established, because a multiplicity of factors are at interplay here.

Until recently care of the mentally ill centered on the patient himself. However, the Child Guidance Movement realised that the treatment of the child is incomplete without the involvement of the mother. Now the whole

family or the immediate environment is given attention, hence the presence of the psychiatric social worker in the team treating the mentally disturbed.

Psychiatric social work, like all specialised fields of social work, has undergone various influences, sometimes from non-social workers such as psychiatrists and psychotherapists like G. Bibring.

2.2 Historical development

Far back in history it was commonly believed that mentally ill persons were possessed of the devil or demons, or that they were paying for sins they had committed.

These beliefs led to the ill-treatment of the mentally ill by way of flogging or being shut up in dungeons.

Such means of handling the mentally ill were superceded by institutional treatment. In some places the insane were placed in the same institutions with abandoned children, delinquents and prostitutes. As time went on, there was a growing concern about the plight of the mentally ill, and in 1824 the first hospital designed for the institutionalization of the mentally ill was established in Lexington, Kentucky, U.S.A.

2.2.1 The United States of America

Near the middle of the 19th Century certain advocates of social reform emerged, with Dorothea Dix being actually involved in improving conditions under which the mentally ill were detained.

She approached the Massachusetts Legislature on the issue.

By the first decade of the 20th Century the influence of the teachings of men like Sigmund Freud and Kraepelin began to tell.

Freud's psychoanalysis brought about a new understanding of mentally ill persons and of the impact of the environment on the development of personality. This led to a new approach in the treatment of the mentally ill.

Fink et al (1964, p. 243) say of these changes:

> ... Psychiatry was turning from preoccupation with custody and classification to a concern with causes; psychoanalysis was introducing a dynamic approach; while psychology was tracing the growth of the child and stressing the nature of individual differences.

From these developments a completely new outlook on the causes of mental illness emerged.

Much as Freud and others made a significant contribution in the above respect, the history of the treatment of the mentally ill would be incomplete without mentioning Clifford Beers and the Mental Hygiene Movement.

Clifford Beers (1876 - 1943) was repeatedly institutionalised for suicidal tendencies due to depression caused by fear of epilepsy which he had for a period of six years. He was committed to three types of institutions. Two were privately owned, with the difference that one was profit-making, the other not. The third was a State hospital. In all three institutions the treatment was harsh and brutal.

In 1908 a book by Clifford Beers, titled A Mind That Found Itself, appeared, with an introduction by an eminent psychologist of the time, William James.

This book recorded Beers' experiences in the various institutions.

Within the same year the Mental Hygiene Movement was born, with Beers as secretary. This Movement emphasised the following points on its fight for the improvement of the conditions in the institutions of the mentally ill:

1. Improvement of institutional care;

2. Analysis of causative factors, so as to uncover the roots of the disorder. Personality disorder and personality adjustment were given emphasis as against categorisation and classification, which had been receiving all the emphasis up to that time;

3. Prevention - a knowledge of the causes would make prevention possible, and there was a move from remedial to health-preserving measures;

4. The dissemination of knowledge concerning causes, prevention and treatment to the general public through publications, meetings and study groups.

Along with the shift in emphasis from the biological to the social causes of mental illness psychiatrists became interested in studying the environmental conditions of their patients and relating them to the patient's mental condition. They realised that aftercare was necessary to help the patient in readjusting to the environment,

his job and the community to prevent readmission, if possible. Even where a biological factor was found to be present in the cause of mental illness, the psychiatrists of the time believed in looking into the home conditions of the patients.

This realisation gave rise to a new approach in the treatment of the insane.

The need was felt for an additional person who would make a total study of the patient's environment and engineer a follow-up programme after his release from the hospital. This led to the employment of the first psychiatric social worker in 1905 at Massachusetts General Hospital in Boston, and in both Bellevue Hospotal and Cornell Clinic in New York City. These psychiatric social workers were known as "after-care agents" at that time (Fink et al, 1964, p. 249).

The 'agents' at Massachusetts General Hospital worked under the guidance of Dr. J. Putnam, a psychiatrist. Contributions of doctors such as Meyer, Southard and White are worth noting. These men contributed greatly to the development of psychiatric social work.

It is believed that the term "psychiatric social work" was actually coined by Southard and Jarrett (a social worker). They stated in their book The Kingdom of Evils (1922) that this was not a new approach, but merely a new emphasis within existing methods of practice. They gave an outline of the activities in this field as

(a) casework,
(b) executive duties,
(c) social research, and
(d) public education.

In 1918 the Smith College, the National Committee for Mental Hygiene and the Boston Psychopathic Hospital joined forces to introduce an emergency training course under the leadership of Jarrett. This was the first formal training of psychiatric social workers and had a duration of 8 weeks. Within a year a permanent graduate school for social work training was introduced at the Smith College. Other schools established, such as the New York School of Social Work, the Pennsylvania School of Social Work and Health Work and the Chicago School of Civics and Philanthropy, perpetuated the interest in psychiatric social work.

In 1920 psychiatric social workers met at the Boston Psychopathic Hospital to discuss the formation of a professional association, having realised that psychiatric social work was firmly established as a form of practice. A psychiatric social workers' club was formed. Later the club petitioned the American Association of Social Workers for affiliation. Their wish was granted in 1922, and the club became the Section of Psychiatric Social Work of the American Association for Hospital Social Workers. In 1955 this association became a part of the National Association of Social Workers.

The rapid development of this field of practice was largely due to the two World Wars where psychiatric social workers served on draft boards as medical field agents, helping with the screening process and providing services to the servicemen and servicewomen.

The American military system continues to employ psychiatric social workers in neuropsychiatric hospitals, mental health consultation services, disciplinary barracks and divisions or squadrons throughout the States and overseas.

Psychatric social workers have also been instrumental in setting up diagnostic and treatment facilities for military dependents.

The Child Guidance Movement also had an influence on the development of psychiatric social work. Growing concern about problems of children and delinquents led to the establishment of the Child Guidance Movement. Child guidance clinics were established to look deeper into the problems of children and to treat children with emotional and mental problems. In 1922 the Commonwealth Fund gave the Movement a financial boost, which led to the establishment of 8 (eight) clinics. Until recently there were more psychiatric social workers in clinics than in hospitals.

2.2.2 The United Kingdom

Psychiatric social work was introduced much later in the United Kingdom (1926), although care of the mentally disturbed had been undertaken from as early as 1877 when there was a heightened awareness that the discharged mental patient required after-care. Various bodies of people who were concerned about the plight of the mentally disturbed, came into existence (Timms, N., 1964).

In 1926 an English magistrate, St. Loe Strachey, visited the U.S.A. and was impressed by the work done on juvenile delinquents. She observed that psychiatrists, psychologists and psychiatric social workers co-operated in the juvenile court in treating the problems of the juvenile delinquent. The result of this visit was an appeal to the Commonwealth Fund of America to help initiate a similar type of service in Great Britain. A Child Guidance Council was established, which led to the establishment

of children's departments at Tavistock Clinic as well as the establishment of the East London Child Guidance Clinic. Social workers were employed at both these clinics, but there was as yet no formal training.

In 1929 the London Mental Health Course was established for the training of psychiatric social workers. This training was started at the School of Economics. The London Child Guidance Clinic was used as the centre for fieldwork training. Much as this course had had its beginning in some aspects of the American version of psychiatric social work, the British did not copy the American view completely. They adapted the course to meet British needs. The course had a span of ten (10) months, but the trainees had an opportunity of having practical work training with children and with adult patients on a proportional basis, a feature which distinguished this course from the American one.

Many of the teachers were from America. In 1930 home visiting was introduced as part of the course. This course was open to people already trained as social workers. As from 1940 the duration of the course was extended to one year.

2.2.3 South Africa

2.2.3.1 Early beginnings

During the days of the Dutch East India Company, all the mentally ill and prisoners were kept at Robben Island without proper facilities. The conditions at the Cape during that time were conducive to the increase in mental disturbance, alcoholism and related illnesses.

The influence of the French Revolution, especially that of Pinel who brought about changes in the handling of the mentally ill, was also felt at the Cape, although at a much later stage. Changes came about eventually.

In 1818 the Zeeman's hospital, which was later renamed the Somerset hospital, was erected. "Lunatics" were still kept at Robben Island, however. The conditions at these places left much to be desired. The wards were small and most patients slept on the floor because of lack of adequate beds.

During this period Cape Town was the only area which provided services for the mentally ill for an area with a radius of 600 miles.

The British, after taking over the Cape, continued to house the mentally ill on Robben Island. The policy from 1845 was to concentrate all mental patients on Robben Island. More buildings were gradually added, but conditions still left much to be desired.

In 1934 the first doctor by the name of Bickersteth was appointed. Due to dissatisfaction in the community, and a strong feeling that the mentally ill be cared for on the mainland, a Select Committee was appointed by Parliament to investigate the conditions on the Island. This Committee then recommended that the patients be transferred to the mainland. Patients were gradually transferred to the mainland as from 1913 until 1920, when the institution was finally closed.

Little or no mention is made about the care of the mentally ill in other racial groups at this stage.

Several laws pertaining to the mentally ill were passed at the Cape, but most of them were concerned with the property of the mentally ill. Thus Act No. 20 of 1879 provided for the custody of the insane. This Act was later replaced by the Lunacy Act (Act No. 35 of 1897) which set out:

(a) proceedings for restraining dangerous lunatics,

(b) provisions relating to criminal lunatics,

(c) lunatics who were not dangerous or criminal,

(d) provisions for the care and administration of a lunatic's property,

(e) certain offences and penalties under this Act, and

(f) certain miscellaneous provisions.

By 1910 the four provinces each had its own laws pertaining to the care of the mentally ill. These were as follows:

Cape Province	Lunacy Act of 1897
Natal	The Custody of Lunatics Law 1868
Transvaal	The Lunacy Proclamation 1902
	The Asylums Board Act 1908
O.F.S.	Lunacy Ordinance 1906.

Some of these Provincial laws were amended in 1914 by the Lunacy and Leprosy Laws Amendment Act (No. 14 of 1914) which was enacted by Union Parliament in 1914. In 1916 the Mental Disorders Act (No. 38 of 1916) was passed.

The first mention of work amongst the non-White section was made in 1952 when an extension was erected to the Grahamstown Mental Hospital to house non-White patients.

2.2.3.2 Mental Disorders Act of 1916

The Department of Interior in the Government of the Union of South Africa appointed a Committee of 4 persons to report on the conditions of mental hospitals in the country.

Amongst these persons was Dr. Dunston who had travelled to the U.S.A. and studied the conditions pertaining there to the care of the mentally distrubed. His reports revolutionised the methods of caring for the mentally ill and the feebleminded.

In consequence of his impressive work on the Committee mentioned above he was appointed to draft the Mental Disorders Act (No. 38 of 1916). He was later appointed as Commissioner for Mentally Disordered and Defective Persons as laid down in the Act. This title was changed to Commissioner for Mental Hygiene and later to Commissioner for Mental Health. The Mental Health Act of 1973 makes provision for the post of Chief Psychiatrist to replace the Commissioner as mentioned. The Chief Psychiatrist advises the Secretary for Health.

The Department of Health assumed responsibility for psychiatric services in 1944, although the Department itself had been established in 1919.

Among other things the 1916 Act dealt with the admission of patients to hospital, the detention of mentally ill criminals, the admission of voluntary patients, patients detained in private dwellings, licenced institutions,

the admission of patients to general hospitals, the appointment of a Commissioner for Mental Health directly responsible to the Minister, the establishment of hospital boards and the administration of the property of mentally disordered persons (Mental Disorders Act No. 38 of 1916).

2.2.3.3 Protection and care of the mentally retarded

The work of Dr. Jean Itard concerning the re-education of a youth who had been found running wild in the forest, brought about a revolution in the care and training of the mentally retarded. A pupil of Itard, Eduard Seguin, also thought that he could cure mental deficiency. The theories of Seguin have profoundly influenced our educational system.

Active interest in the care of the mentally retarded was at a low ebb until Binet and Simon developed their Intelligence Tests between 1905 and 1908.

By 1912 the influence of Clifford Beers had reached the Cape shores. During that year the Child Life Protection Society held a baby exhibition in Cape Town at which they drew the attention of the public to the shortcomings in the care of the mentally retarded. A Committee was formed in 1913 to raise funds and investigate issues related to the care of the feebleminded.

The Committee later urged the Government to make statutory provisions for the care of the feebleminded. They wished for a Mental Deficiency Act. This led to the passing of the Mental Disorders Act No. 38 of 1916. All this was achieved through the hard work of amongst others Dr. Dunston, then Superintendent of the Pretoria Mental Hospital.

The Binet and Simon tests as well as the Stanford Revision were used and found to be unsuitable in South Africa. In 1927 Dr. Fick, after graduating as a Doctor of Education at Harvard University, standardised Intelligence Tests for South African conditions. This scale developed by Fick became the standard scale used in South Africa to aid in the diagnosis of mental deficiency.

The National Society for the Care of the Feebleminded was founded and together with the Transvaal Education Department became active in the field of the feebleminded.

The "Poor White" problem had a great impact on the care of the feebleminded. An investigation into the problem revealed that most of the poor whites had a low I.Q. This led to the appointment of an Interdepartmental Committee on Mental Deficiency by the Minister of the Interior in 1928. This Committee concerned itself with the whole Union. The Committee's recommendations included the following: The Department of Mental Hygiene should deal with the care and supervision of the feebleminded; special schools should be provided; probation periods for juvenile delinquents should be extended; and sheltered employment facilities should be created.

In 1967 a report was tabled by the Committee of Inquiry into the Care of Mentally Deficient Persons. The recommendations of this Committee were unexeptionable. However, they were expensive and could only be carried out over the long term. It was noted that there were no facilities for the non-White feebleminded. Most of them are still kept in mental institutions where there are no training facilities. The only non-White institution for the feebleminded is at Westlake for the Coloureds.

2.2.3.4 The National Council for Mental Health

Mention has already been made of the impact of the Mental Hygiene Movement in the Cape. A Society for the Care of the Feebleminded was also formed in Johannesburg on the same lines as the Cape Town one.

When Dr. Dunston became Commissioner for Mental Hygiene in 1916, he influenced the Government to promise financial backing for a National Council. This was granted, and a National Council was formed in 1920 with its headquarters in Cape Town.

The first annual meeting was held in 1922 in Johannesburg. At that time there were 11 Societies doing mental hygiene work, and this included Child Welfare Societies.

The aims of the National body were amongst others to inform and enlighten the public on mental health and thus remove the stigma attached to mental illness, furthermore to urge the Government to provide better facilities and to improve services for the mentally disadvantaged.

The name was changed to National Committee for Mental Hygiene at the suggestion of Dr. Dunston. The national body grew with more societies affiliating to it. In 1925 the first court psychiatrists were appointed. This was a result of Dr. Dunston's report in which he urged the Government to introduce compulsory psychiatric examination for all persons who have been convicted of crime more than once.

The headquarters of the National Council moved to Johannesburg in 1926, and in 1929 the name was changed again to National Council for Mental Hygiene.

The Council experienced financial problems due to the Depression. Permission was granted for a street collection to be held in Johannesburg, and this swelled the coffers of the Council.

The name was altered yet again in 1946 to National Council for Mental Health. Various bodies were represented on the Council; bodies such as the Medical Association of South Africa, the South African Nursing Council, Government and Provincial Departments.

2.3.3.5 Recent developments

Social workers were seconded to mental hospitals for the first time in 1964. The social workers were expected to play an active role in the treatment team and to provide after-care and reconstruction services.

In 1970 a Commission of Inquiry into the Mental Disorders Act (Act No. 38 of 1916) was appointed and the chairman was the Hon. Mr. Justice J.T. van Wyk.

The work of this Commission was, amongst other things, to revise the 1916 Act. This led to the passing of the Mental Health Act of 1973 (Act No. 18 of 1973).

The above Act makes provision for the admission and discharge of voluntary patients, the treatment of cases of urgency and mentally ill persons who are dangerous, the detention of persons in single care, the duty of the medical practitioner in cases of a dangerous patient, the duty of the police, the reception orders, ill treatment or neglect of mentally ill persons in a hospital and the care of patients housed in private dwellings.

The procedure when a person becomes mentally ill on board ship or aircraft and lands in South Africa, is laid down.

2.3 Psychiatric Social Work

The psychiatric social worker deals with the emotionally as well as mentally disturbed persons through the basic methods of social work, casework being the most popular. Group work and community work are used on a minimal level, although there are some clinics and hospitals which use group work exclusively.

Psychiatric social work may be practised in a hospital (psychiatric or general), in a clinic, a juvenile court, a rehabilitation centre or a child guidance clinic.

As far back as 1929 attempts were made to define psychiatric social work. Two definitions may be quoted here, one emphasising setting and the other emphasising the qualitative nature of the practice regardless of the setting. Porter R. Lee and Marion Kenworthy (1929, p. 161) define psychiatric social work as "social casework established within psychiatric agencies as a form of service essential to the medical program of such agencies". The second definition regards psychiatric social work as a "... practice possessing certain qualities deriving from knowledge of psychiatric concepts and from the ability to adapt them to the social casework process" (Berkman, T.D., 1953, p. 1).

After studying the above definitions, Ginsburg, E.L. (1948, pp. 470 - 472) concluded that the "difference between the psychiatric social worker and her colleagues is one of setting, not of quality".

After the First World War psychiatry had a profound influence on social work to the extent that some social workers were unable to draw a line between their practice and that of the psychiatrist. However, there is no doubt that a deeper psychological knowledge is required in a field dealing with maladjustments and conflicts such as is the case in social casework and in particular psychiatric casework.

While social casework is known to deal with personality maladjustments related to environmental pressures, persons whose major complaints are focussed on symptoms will go to a psychiatrist. The caseworker often deals with problems that have a bearing on social relationships, marital relationships, parent-child relationships and adjustment to the social milieu (Hambrecht, L.M. in Lowrey, F., 1920 - 1938).

Treatment by the caseworker does not involve delving deep into the early history of the person to come up with unconscious conflicts of early childhood, but it focusses on personality problems as they may affect the social functioning of the individual. The aim of casework is not to dig into the internal underlying causes of the client's disturbance but to help him find a satisfactory form of social adjustment.

The psychiatrist on the other hand makes use of the method of "free association", the goal of which is to change the patient's neurotic personality and thus effecting a complete modification through insight. Bibring says of this insight that it "... frequently requires a laborious and time-consuming 'working-through' which consists of mitigating and removing the opposing forces of the ego, on the one hand, and furnishing repeated, detailed and multi-

form evidence of the repressed on the other hand. Frequently, though not always, it leads to a temporary reactivation of the unconscious tendencies and conflicts" (Bibring, G.L., 1947, p. 205). In his efforts to promote a positive healthful growth, the psychiatrist exercises a deliberate and controlled influence on the psychic functions of the patient.

From the above, one can conclude that the treatment of personality disorders can be undertaken from within as well as from without, or by a combination of both (psychiatry, psychoanalysis as well as casework).

The psychiatrist is basically trained as a medical practitioner and has taken up psychiatry as a special field, while the psychiatric social worker is basically trained as a social worker and has taken up psychiatric social work as a special field. The training of the psychiatric social worker is focussed on equipping her with knowledge of "... the psychological development of the personality, its main phases and their disturbances, the various outcomes of these disturbances, the different personality types as a result of inner development and outside influence, the main mechanisms of these different types the basic causes of conflicts, failures, the main possibilities of success and adjustment, the role sublimation plays and transference, in short, the fundamentals of the psychology and psychopathology of personality" (ibid p. 209).

2.3.1 The field of practice

In her daily life the psychiatric social worker is in close contact with people whose lives are in turmoil.

Ashdown and Brown define psychiatric social work as "... an endeavour to help individuals, in personal difficulties as social beings, to reach a better understanding of the baffling frustrating situations in which they are placed and to release in themselves unsuspected capacities for dealing with them" (Ashdown and Brown, 1953, p. 149).

The "individuals" of the foregoing definition may be the patient himself or his relative who may either be disturbed as a result of the patient's instability, or who, by his own instability may be the cause of the illness.

The client of the psychiatric social worker is so disturbed, emotionally and mentally, that he is prevented from functioning effectively in the community and in some cases may have to be hospitalised.

The psychiatric patient may be suffering from one or more of the following disturbances: psychoneurosis, psychosis, alcoholism, drug addiction, psychosomatic illnesses, personality disorders, emotional and mental disturbances of childhood as well as emotional and mental disturbances of old age, to name only a few.

The social worker assumes various roles in rendering aid to her clients, and these roles are determined by the setting in which she practises at a particular time.

Whatever the setting, however, her major role is that of history-taking, assisting in diagnosis and treatment of the patient. She helps the patient and his family to understand the illness as well as the treatment and

to involve all in the treatment programme, preparing them to accept the patient upon discharge and play a major role in his efforts to readjust in the community. Now of late emphasis is placed on prevention and on maintaining mental health.

While her role is predominantly to serve the patient directly, the psychiatric social worker also participates in research, educational programs, public health programs and in correction work.

2.3.1.1 Teamwork

The psychiatric social worker functions as a member of a team comprising a psychiatrist, a psychologist, a nurse (psychiatric trained), and an occupational therapist.

According to Webster's Unabridged International Dictionary, teamwork is "... work done by a number of associates, usually each doing a clearly defined portion, but all subordinating prominence to the efficiency of the whole".

Effective teamwork rests on two basic requirements, viz. unity of purpose and a difference in knowledge and function. This means that each team member has to have the well-being of the patient at heart according to his own professional calling. This can only be possible when each team member respects the others for the contributions they make and for their standing in their professions. The extent to which teamwork can be successful, depends on the personalities of the people involved, their educational background and past experience which lends some confidence. The team needs to be an integrated body of mental health experts, not just a group of people working together.

The psychiatric social worker finds herself working in close collaboration with the psychiatrist. She can be described as being "in at the start" in the treatment of the patient. The casework in this field has to be closely related to the psychiatric diagnosis and treatment.

In her training the psychiatric social worker should be professionally prepared to understand her relationship with the psychiatrist, and that of both of them to the patient. Role confusion should be avoided, i.e. the psychiatric social worker should not occupy herself with therapy which is the prerogative of the psychiatrist, especially therapy which unravels hidden material.

The social worker in the Child Guidance Clinic may find herself working closely with the mother of the child, while the psychiatrist concentrates on the child. In the hospital her role becomes a bit extended, as also in her participation in the team. She has to handle the patient and his immediate family or surroundings and participate actively in the team which may be bigger than the clinic team.

The social worker occupies a unique position in the team. She is the only one who has - and maintains - close contact with the community for the benefit of the patient. She is also invaluable to the team because of her knowledge of community resources.

The history of the care of the mentally ill patient is a long one, and the psychiatric social worker is a relatively late entrant in it. This does not make her role an easy one, especially in a mental hospital. She often has the difficulty of trying to discover where in the

particular hospital she can fit herself in and play a meaningful role towards the well-being of the patient. This requires her to strike a balance between what is expected of her and what she knows her role to be (Ashdown and Brown, p. 139). She may find herself experiencing problems because of the ignorance of other team members concerning her role.

The psychiatric social worker may practise in any one of the following settings: a mental hospital, a general hospital with a psychiatric wing, a child guidance clinic, a neuro-psychiatric clinic, a psychiatric out-patient clinic, a court or a mental health centre.

2.3.2 The role of the psychiatric social worker

In some cases the work of the psychiatric social worker is closely related to and dependent on the opinion of some team members, and in some cases she can make her own independent appraisal of the situation and go ahead with helping the client.

The functions of the professionally trained psychiatric social worker may therefore be summarised as follows:

(a) Provision of help to patients and their families. This can be done on an individual, group or community basis. This is common practice in any setting, while in a mental health clinic the social worker may have to render emotional and material support to the family and the patient, assess the suitability of the patient for the services rendered by the centre, liaising with other community agencies on behalf of the patient, educating patients and staff groups and rendering supervision to staff and social work students;

(b) Recognition of the fact that social work with persons who are mentally unbalanced requires special skills, knowledge and resourcefulness on the part of the social worker; that living with a mentally handicapped person or being a mentally handicapped person adds to the common day-to-day needs that have to be met;

(c) Assessment of the situation and specific needs of the mentally disturbed client and his family as well as immediate environment. This assessment may be done with or without the assistance of the other team members;

(d) Provision of care, support, guidance and advice with the focus on rehabilitation of the patient. This preparation for rehabilitation involves either planning alone or with other team members for the patient's readjustment in the community. This involves looking into the environment and available domiciliary supportive services. A knowledge of the community is indispensable.

(e) Giving lectures, advice and supervision to social work students, medical students, nursing staff and also educating the community on mental illness, the role of the psychiatric social worker and available services.

The psychiatric social worker maintains a close relationship with the patient, his family, members of the therapeutic team and the community.

Implicit in the above functions are the following roles as outlined by Strydom, K. (1977):

(i) Diagnostician

The psychiatric team makes a study of the patient and his history and then formulates a diagnosis only in as far as the patient's mental and physical condition is concerned. The psychiatric social worker formulates a dynamic diagnosis to complete the whole picture of the various forces that are at interplay in the patient's life circumstances.

She is the only one who provides the data that enables the therapeutic team to understand the patient as a social being. She makes an appraisal of the patient's feelings, fears, anxieties and defences as well as those of the informant.

(ii) Intake worker

In some settings, especially in psychiatric clinics, it is a foregone conclusion that the psychiatric social worker is the first team member who comes into contact with the patient.

She assesses the reason for the referral and whether the patient will benefit from the services offered by the clinic. She requires a lot of skill, knowledge and clinical experience to be able to handle this aspect well.

(iii) Care giver

There are individuals, groups and families who require supportive care, counselling, protective services and crisis casework. The psychiatric social worker must be at hand to provide such services and help the person concerned to meet his needs.

She provides information about care and facilities available in a given community, and she also enables the family to handle a disturbed child or adult in their midst.

(iv) Behaviour changer

One of the approaches used in casework is that of behaviour modification. The social worker as behaviour changer needs a wide range of techniques directed towards effecting a change in the client's life, thus making better living possible.

Fisher, J. (1978, p. 157) defines behavior modification as "... the planned systematic application of experimentally established principles of learning to the modification of maladaptive behavior, specifically to decreasing undesired behaviours and increasing desired behaviors".

The social worker aims at bringing about change to maximise the client's coping mechanisms. She uses skills which are focussed on interrelationships, interactions and transactions.

(v) Discharge worker

The psychiatrist has the final say in as far as the patient's admission and discharge are concerned. The social worker plays a significant role in assessing the readiness of the family and the suitability of the environment to receive the patient upon discharge and promote his readjustment into the community.

More will be said about this role in a later chapter (Chapter IV).

(vi) Outreach worker

This is closely linked with the above role. The psychiatric social worker does not automatically come to know of resources in the community, and of the suitability and readiness of the environment to receive the patient. She has to move and reach out into the community to detect and identify resources.

She keeps constant contact with the patient outside the hospital for a considerable length of time after discharge. She provides after-care services and supervision.

She looks into the patient's class, value systems, social and cultural mores and taboos, his interaction with his family, and other realities involved in the rehabilitation of the patient.

(vii) Broker/advocate

These two roles are often interrelated. As a broker, the psychiatric social worker helps the client to get needed services and alternative services where necessary. She ensures that the client gets these services.

As an advocate, she pleads on behalf of the client who would otherwise be rejected by a service system, and she also pleads for adjustments or modifications of rules, laws and regulations which would otherwise bar the client from benefiting from a certain service.

(viii) Mobilizer

Closely linked to the roles of broker/advocate is the role of mobilizer in which the social worker works towards developing new, as yet unavailable services and facilities. She makes certain services available to people who would otherwise not benefit from them.

(ix) Teacher/supervisor

The essence of casework is to teach the client certain basic skills which will enable him to cope with future problems which would otherwise send him to the social worker to seek professional help. The social worker's teaching role ranges from teaching the client simple day-to-day things (like how to dress, how to eat and keep a particular place tidy) to teaching the "well" person in the community how to remain in health.

A greater percentage of the community requires these lectures which are often given by the social worker under the auspices of the programmes arranged by the community mental health centre.

This teaching role may be extended towards other staff members as well as social work students. The pscyhiatric social worker supervises students who are still receiving social work training.

(x) Research worker

The psychiatric social worker has to collect and process data concerning her work in the clinics and community. She gathers data on which her decisions are based, and she further uses such data to assess whether the

services rendered are relevant and beneficial to the recipients. Her role varies from simple data gathering to more sophisticated research.

(xi) Administrator

As administrator the psychiatric social worker may be involved in personnel and financial management, supervision, policy making and public relations on behalf of the agency.

(xii) Community planner

Because her concern is not only with the individual per se but with the whole community, the psychiatric social worker has to be involved in community planning and preparation of community programmes. She has to see to it that her services or those of her agency are integrated into the aims of the community.

(xiii) Consultant

The expertise and knowledge of the psychiatric social worker may be used by other professional as well as non-professional workers. The social worker should possess substantive knowledge and communication skills. She has to be able to describe and explain basic procedures to be used in any given situation.

This consultation can be provided on an individual, group or community basis; it may be short-term as well as long-term.

The psychiatric social worker may assume any of the above

roles in helping the mentally ill client. She may employ any of the methods of social work for this purpose.

2.3.2.1 Social casework

The psychiatric social worker has to adapt her knowledge of social casework to meet the needs of the psychiatric patient. This means that psychiatric social work is not a new method altogether, but it is social work adapted for the field of the mentally disturbed.

Casework with the psychiatric patient is discussed in greater detail in a later chapter (See Chapter IV).

2.3.2.2 Social groupwork

Groupwork in the psychiatric field was introduced much later than social casework. Literature has very little on the history of groupwork in this field. Grace Coyle (1959) is about the only author who gives a detailed background of groupwork in the psychiatric field.

A very scanty outline of groupwork will be given here because the aim of this study is to focus on casework in the psychiatric field. It should, however, be borne in mind that groupwork services are not a substitute for casework, but that both methods can be used with the same client at different times or simultaneously. The methods are complementary.

Social groupwork in the psychiatric field will be discussed under the following headings: stages of group development, goals, types and functions, relationship to other services and preparation for discharge.

(a) Stages of group development

Most mental patients have been institutionalised for periods of up to ten years and have completely lost their sense of socialisation. The groupworker has a task of developing a relationship with the patient first, before assisting him to develop a relationship with fellow patients. For those patients with ego impairment the socialisation process must begin anew.

It is essential for the group worker to have this patient-worker relationship as a starting point because it offers the patient "... consistency, continuity, and the sameness of experience that will develop a social mutuality as well as strengthen the patient's self-identity" (E. Erickson quoted by Weisman, C.B., 1963, p. 89). The passive, uncommunicative and withdrawn patient will require a longer relationship with the groupworker in order to venture forth.

The patients in the hospital have already been grouped by being placed in various wards. The worker when moving in will find that these groups are characterised by considerable emotional and physical isolation and by a paucity of verbal communication. The worker finds that she has to "... create consciously a climate of informality and warmth and stimulate social interaction out of which positive and negative sentiments are formulated, roles assigned and statuses attributed"(Weisman, op cit p. 90).

The groupworker engages the group in physical activities to enable them to develop a sense of belonging. It is not unusual to find patients who will not be stimulated to participate in physical activities unless the groupworker addresses herself directly to them.

Through these physical acts the groupworker can then create role expectations. Each member assumes a particular role and then acts accordingly. The mental patient has been hospitalised because of his failure to fulfil a certain role in society and meet the expectations and demands addressed to him. It is not an easy task for him, therefore, to relearn social functioning and assume more than one role. He is only aware of his role as a patient and having things done for him.

The physical acitivities become a form of nonverbal communication which preceeds group discussions. Through verbal communication, more interaction will be observed and group cohesiveness may develop.

(b) Goals

The aim of the groupworker is to help the patients "... find legitimate avenues through a reality-based structure for gaining prestige, achieving status and recognition, and assuming new roles, so that psychological deprivation is alleviated and patients can become more receptive to treatment efforts" (ibid p. 89). The worker with her guided intervention enables each group member to gain maximum benefit from participation.

One has to have a clear understanding of the type of patient involved in a psychiatric setting before undertaking to engage him in a group session. Mental patients have problems in their interpersonal relationships, and hospitalisation creates additional problems such as resistance, withdrawal, dependency and regression.

Rostov, B.W. (1965, p. 24 and 25) mentions the following as goals of the groupworker:

- to socialise forming satisfactory social relations, establishing an awareness of others and relearning social skills;

- to increase communication;

- to offer ego support and developing ego strength;

- to test reality;

- to increase responsibility, develop good judgments;

- to influence one another in a positive way and channel group hostility;

- to feel and exert some control over one's future;

- to prepare and test for discharge and a return to community life;

- to accept and understand one's illness and use individual therapies more positively; and

- to increase opportunities for observation and diagnosis by the staff.

(c) Types and functions of groups

Because of the varying diagnostic types the groupworker finds it essential to regroup the patients according to what she hopes to achieve with each individual and according to what area of impairment she wishes to concentrate on.

Eisen, A. et al (1963, pp. 751 - 753) discuss the following types of groups and their functions:

The situational, time-relevant groups

These groups are concerned with short-term transitional problems. They are made up mostly of patients about to be discharged or relatives of such patients to prepare them for receiving the patient and helping him to adjust.

Patient ward councils

Here groups are formed in which patients can determine to a limited extent and under the guidance of a psychiatrist their direction and partial self-management through a democratic process. The group provides a channel for complaint, confrontation and comparison with the acceptable structure.

Productive task or work groups

These groups are an integral part of the treatment programme. Patients are assigned certain tasks and these may provide opportunities for dealing with problems of interrelationships as they affect and are affected by the work situation.

Peer social groups

Adolescents tend to experience a strong peer identification when living amongst adults. These adolescents can be grouped together. Other groups may comprise married women or their non-hospitalised husbands, married men, unmarried women. This type of service can be extended beyond the hospital where the worker may deal with the

following types of groups: children of divorced parents, divorced or about to be divorced individuals, step-parents, sexuality groups for the different sexes, etc.

(d) Relationship to other services

It often happens that other team members feel that they can do group work with the patients just as the social groupworker can. They tend to confuse group work with recreation. This is not a problem peculiar to psychiatric social work. It happens in almost all fields where the social worker finds herself working within a team situation.

Depending on the diagnosis and treatment plan, most patients receive both casework and groupwork services. Each method has its unique contribution to make towards the well-being of the patient. The groupworker like the caseworker comes with a knowledge and understanding of the dynamics of individual as well as group behaviour, skills in the conscious use of oneself in relation to people and processes, knowledge of programme media and skill in applying this knowledge (Rostov, p. 27).

(e) Preparation for discharge

The preparation for a patient's discharge begins paradoxically upon admission. His treatment plans are all geared towards enabling him to leave the hospital and to remain outside the hospital.

The worker provides opportunities for the patient to bridge the gap between hospital life and outside life through group discussions, excursions to the local supermarket, etc. The group discussions provide a suppor-

tive experience where patients discuss their anxiety and fear with regard to the outside world. The group worker makes maximum use of community resources.

2.3.2.3 Community work

Here the psychiatric social worker is mostly concerned with rehabilitation and prevention. She has to integrate services of various agencies in order to render maximum service to a client or group of clients.

The psychiatric social worker may not be specifically trained for the community work method, but in her every-day contact with mentally disturbed persons she realises the extent of their problems in the entire community and that these will not be overcome solely by the use of the person-to-person method of helping. She becomes aware of the role of the community in rehabilitation and in helping the discharged patient to take his place again in the community and also the extent to which the ignorant community may undo the work of the hospital.

The social worker becomes involved in programmes for community mental health because the ultimate in treatment is complete rehabilitation and a life-style that will enable the patient to remain outside hospital. She covers the following areas in her work:

(i) administrative services - she may be directly involved in programme planning together with other team members as well as with personnel from other agencies with similar aims;

(ii) direct operation or support of clinical services that deal with adults as well as children or spe-

cialised clinics for people with certain defects, e.g. alcoholics, mentally retarded persons, etc.;

(iii) direct involvement or financial backing of educational services aimed at prevention;

(iv) training;

(v) research.

Mental health centres are established in the community to deal with problems of adjustment, crisis situations, community or national disasters, crime and juvenile delinquency.

In certain industries personnel from mental health centres are used for staff adjustment problems, prediction of success in a position, placement and efficiency. In schools mental health personnel assist in early diagnosis of learning problems, defects, relationship problems and adjustment problems. The aged person or the one who has just retired may also benefit from the services of the mental health centre.

2.4 Conclusion

Psychiatric social work has gone through various stages of development as shown earlier in the chapter. The psychiatric social worker did not find it an easy task to make her presence felt and be accepted in the psychiatric team, because of her late appearance in relation to the other team members, especially the psychiatrist and the nurse.

However, the attitude of the psychiatric team is changing because of the assertiveness of the social worker in her determination to demonstrate her much needed services in the treatment of the mentally disturbed patient. She is gaining more respect from her colleagues because of advances in the training of the psychiatric social worker.

In addition to caring for her patients the psychiatric social worker has a further responsibility: that of supervising other social workers. If she holds a senior position, she also trains social work students and gives lectures to nurses and interns on the role of the psychiatric social worker in the mental health field.

She has to possess special skills and knowledge, and she should also have the correct attitude towards persons who have lost or are about to loose touch with reality. Needless to mention that she has to believe in her role in the treatment of the mentally disturbed person.

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CHAPTER III

AN OVERVIEW OF TREATMENT TYPOLOGIES

3.1 Introduction

A person who comes to the caseworker to seek help, is one who is experiencing problems in either of three areas of his life, viz.

(i) infantile needs and drives, left over from childhood, that cause the individual to make inappropriate demands on his adult life;

(ii) excessive pressures from his current life situation;

(iii) faulty ego and ego functioning.

The resultant degree of maladjustment or unadjustment may vary from one individual to another.

Richmond, in the first published definition of social casework, saw it as comprising "... those processes which develop personality through adjustment consciously effected ... between men and their social environment" (Richmond, M. 1922, p. 98).

It has since been realised that this adjustment can be effected through a modification of certain aspects of the individual's personality and sometimes through intervention in his social environment.

During the twenties and thirties the impact of psychoana-

lysis and psychology in the field of Social Work gave rise to changes in the treatment approach. Caseworkers came to understand that problems do not emanate from the environment only. This insight broadened the scope of the discipline to include more sophisticated clients with personal or interpersonal problems.

It cannot be disputed that psychoanalysis still has a profound influence on the practice of social work and social casework in particular. The meeting ground for psychoanalysis and social casework is psychotherapy as we shall see later (cf. 3.3).

The following will be discussed in this chapter: the components of the treatment method, the various casework typologies and their development. A detailed analysis of Hollis' (1964) and Austin's typologies will be made.

3.2 Components of the treatment process

The following components are discussed: relationship, method, techniques, focus and goals.

3.2.1 Relationship

Each and every person is involved in relationships with other persons, some of which are natural, whereas others are formed as life goes on. These relationships enable one to draw "... nourishment of love or sustainment and the stimulus of interaction" (Perlman, H.H., 1957, p. 57). This means that the relationships are growth-promoting and are not purposeless. The relationship between the worker and the client is also a growth-promoting relationship. It exists through an interchange of emotions

and attitudes between the client and the worker. It provides a medium of communication between the worker and the client. Hamilton (1964 , p. 29) says what differentiates a professional relationship from a mere friendly association is "... the professional self is controlled towards the end one is serving - namely, to understand and meet the psychosocial needs of the clients". Biestek (1957) says that the relationship can in some cases be regarded as the principal form of treatment while in others it is in aid to treatment.

The worker communicates acceptance to the client and demonstrates a willingness to help him overcome his difficulty; this is the goal of treatment. This relationship is formed for a purpose which is recognized by both worker and client; it ends when the purpose is achieved or has been assessed as unachievable.

The positive attitudes expressed by the worker regardless of the type of problem are of therapeutic value in the relationship. These attitudes will determine whether the client will continue in treatment or whether he will discontinue prematurely. The client may initially continue coming for treatment because of desperation; later, because of the worker's positive communications, he comes because he senses genuine concern on the part of the worker.

If the client's problem is personality-based or one that requires a lengthy time for solution, unrealistic attitudes (transference) often emerge. Garrett (in Parad 1958, p. 55) says that "it is impossible for a person to place himself for long in such a dependency

situation without a transference to this new situation of his infantile attitudes". Transference is an unconscious projection by the client on to the worker of feelings and attitudes actually meant for a potent figure of his early childhood. This figure is usually a parent or a close relative.

In some cases, when not properly handled, transference can retard the purpose of the relationship, e.g. in cases where a client derives such satisfaction from the transference that he drifts into transference-neurosis which is characterised by regression, aggression and childhood hostility.

On the other hand, if the transference is handled well, it can have the following therapeutic effects:

(a) The worker in his role as parent surrogate is able to give the client meaningful suggestions as well additional strength and courage.

(b) The client draws sustainment from the strength of the worker and can then put suggestions into practice and bring about meaningful changes in his life.

(c) The client's weak ego is reinforced by the worker's strong ego.

(d) The client feels that his problem is being shared and that he is not carrying it alone.

(e) The client is willing to abandon resistances and adopt means and ways of modifying his personality and perceiving his role in the cause of his problem.

These effects of transference do not occur in isolation; they occur in close interrelation in all aspects of treatment. Garrett says of the effect of transference "... although considerable and often far-reaching, ... should not of course be over emphasized. It is but one aspect of treatment procedure. It is but the leaven of treatment, not treatment itself" (op cit p. 17). The caseworker controls transference through interpretation and reduction of frequency and length of interviews. This control is unlike that of the psychoanalyst who uses methods of free association and brings out more of the unconscious material on to the surface. The caseworker on the other hand tries to maintain the relationship on a realistic basis.

The worker is also subject to projection of unrealistic attitudes and reactions. These can be controlled through supervision, self-management and laying aside those feelings that are not relevant to the situation.

3.2.2 Method

A method is a systematic step-by-step manner of pursuing a given end. Simon (1960, p. 30) defines it as "the overall use of techniques and relationship to achieve the overall goal or treatment aim".

The caseworker does not proceed haphazardly in pursuing the aim of casework. After agreeing upon certain goals with the client, he plans systematically how he is going to achieve the aim, to introduce each technique, which techniques to use and at what stage of treatment.

Casework has a twofold approach to the client's problem - direct and indirect intervention. In both levels of

intervention, the caseworker has a systematic approach based on his knowledge of relevant techniques. His methods may be termed "modifying", "supportive" or "insight development", depending on what the ultimate goal of treatment is.

3.2.3 Techniques

When the client comes to the caseworker with a problem or request, there are specific ways in which the caseworker responds to the request. These responses are termed techniques. The techniques are theoretically related to the treatment method and goals.

Technique is defined in the Oxford Dictionary (6th ed. 1976) as "mode of artistic execution", "the part of artistic work that is reducible to formula". It is "... a particular way in which a principle of methodology is translated into action. It is the expression of an individuality, the unique manner or style in which the individual acts out his conscious purpose" (Perlman, op cit p. 158).

The choice of techniques according to Hollis, (1964, p. 325) follows "... definite principles and rest upon most careful evaluation of the nature of the client's problem, external and internal etiological factors and their modifiability, the client's motivation and pertinent aspects of his personality". The worker blends the various techniques to make an appropriate response to the client's need and this blend is not of the worker's making, "artistry and intuition".

The techniques can be divided into two major areas: those that have to do with altering the client's en-

vironment and those that have to do with a re-education of the client's point of view, habits or attitudes. Thus techniques are acceptance, reassurance, advice, environmental manipulation and clarification, to name only a few.

A detailed classification and analysis of the techniques will be made in a later section (cf. 3.6).

3.2.4 Goals

In casework there are long-term as well as short-term treatment goals. These goals are usually mutually agreed upon by the worker and client. The ultimate goal of casework according to Hollis (op cit p. 284) is "... some type of improvement in the client's personal-social life, that is, in his personal sense of comfort or satisfaction in life and often in his functioning as it affects the people with whom he is associated". This must be achieved within the client's wants, his capacities and the resources of the particular agency in terms of skill and material aid. She goes on to say that in casework we never seek the ultimate goal of "cure" as in medicine or psychiatry.

The objectives of treatment must be thought of as fluid, i.e. they are dependent on diagnosis and they must change with the changes in the client's perception and understanding of his situation, needs and motivation. This means that the goals must be individualised (Perlman, 1957). To have goals in mind, enables the worker to proceed systematically and not end up in blind alleys (Hollis, 1964).

Long-term goals can be said to be identical with the general goals of casework, while short-term goals are goals that the worker and client can pursue basing their action on the understanding of the person-situation configuration at a given time (Simon, 1960). Hollis refers to short-term goals as intermediate goals because they are "always way-stations on the road to the ultimate aim" (op cit p. 285).

Simon goes on to say that, in order to understand short-term goals, one has to try and answer the following questions: "What kind of and how much adaptation; what kind of and how much comfort; what degree of adequacy for this person, with his problem, in this situation, at this time?" (op cit p. 46).

Hollis suggests that in the case of external problems the chosen treatment goal can either be:

(i) to bring about changes in the outer situation directly or by engaging the client to do this; or

(ii) that the client should learn to cope with such situations so that in future he can be able to handle such situations on his own. In the case of problems of interpersonal adjustment she suggests that the caseworker make efforts to enable the client to achieve a better way of functioning in this area of life and not concentrate solely on finding a solution for the immediate problem.

3.2.5 Focus

The problem presented by the client is often of such a nature that it requires to be broken down into various

segments to make a meaningful pursuit of goals possible. The worker has to pay attention to a sector of the problem and this is called a focus. Focus is arrived at through the diagnostic process. "Focus is the result of partialization. It is the marking out of a part or parts of the problem that are accessible to the worker" (Simon, op cit p. 46). Perlman defines it as "... the selection of some center of attention or consideration" (Perlman, op cit p. 145).

It has a dual relationship to what the client wants and is willing and able to work on and to what the worker has seen as the relevant problem (Simon).

The focus should be flexible so that one part of the problem is given attention at a given time and another part is introduced opportunely. One focus should be readily abandoned through the diagnostic process for another.

Smith (1964) says that it is a common occurence that focus inevitably centres on the presenting problem and warns that the worker should guard against accepting too readily a client's initial presentation. However, the worker has to accept the client's initial focus before switching the focus on the strength of the diagnosis. The selection of focus should be made carefully because, as Smith warns, "the danger remains that selection of focus can be a euphemism for an oversimplified or static approach to a dynamic casework situation. A carelessly selected focus can be positively harmful" (op cit p. 203).

The success of the treatment process depends on the client's motivation to be involved in the process of

alleviating his distress. The client's motivation is one of the important factors in the determination of treatment goals. Hollis says that the client's motivation involves his discomfort with his situation, his values, his appreciation of his problem and his hope structure. About the latter both Hollis and Perlman agree that the client's hope should be for things that can be attained.

Perlman goes on further to say that "discomfort without hope spells resignation, apathy, fixation; it means that the person feels so depleted of energies, so disabled and bereft, as to have no future orientation, no sense of 'becoming'" (Perlman, op cit p. 187).

The most telling test of motivation or willingness is when the worker explains the realities of the situation to the client, the type of help available and the conditions under which service can be available.

3.3 Psychotherapy and casework

Psychotherapy and casework are the two major fields in our society which are engaged in helping people with emotional problems. Both fields are concerned with treatment that has as its goal at best a cure or a relief of symptoms, but psychotherapists have a background of medical training. Psychotherapy aims at effecting internal change in the patient and modifying his behaviour, while the aim of casework according to Bibring (1947, p. 208) is "... not to eliminate the internal causes underlying the client's character disturbances but to help him find the satisfactory form of social adjustment - on the basis of psychological understanding, yet frequently through direct help with the social problem".

Psychotherapy has been defined by various authors, and the definitions vary in emphasis from those who concentrated on the goals to those who concentrated on the methods.

Wolberg, L.R. (in Grinker et al p. 110) made a study of 13 definitions and finally posited the following:

> ...Psychotherapy is a form of treatment for problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient with the object of removing, modifying, or retarding existing symptoms; of mediating disturbed patterns of behavior, and promoting positive personality growth and development.

This definition implies that the therapist works only within a relationship (one-to-one) which he establishes by communicating warmth and understanding towards the patient. The relationship should be perceived as a learning experience by the patient through which he changes his perception and concept of himself.

Austin (1948, p. 111) says that psychotherapy deals with a reorganization of personality, which clearly does not belong to the field of casework. She goes on to say that therapy in casework will be essentially a psychosocial development.

A recent definition by Strupp is cited by Grinker (op cit p. 125): "... a controlled interpersonal relationship which is integrated for the purpose of effecting changes in the patient's feelings, attitudes and behavior through the systematic application of psychological techniques". A closer look at this definition makes psychotherapy appear as a helping process which takes place within a

professional relationship; the therapist intervenes in the patient's life by the use of techniques that are therapeutically oriented to effect basic changes in the patient's life. The therapist listens to and makes observations of the patient's verbal and non-verbal presentations of his conflicts, and he communicates understanding, acceptance and a willingness to help. The psychotherapist deals with the actual dynamics of the patient's illness/disturbance rather than with their genesis as is the case with the analyst.

Casework on the other hand has been defined by various social work writers as "a problem-solving process" (Perlman), a "psychosocial treatment method" (Hollis) and "processes which develop personality through adjustment consciously effected ..." (Richmond).

Social casework is then a helping activity designed to give assistance to individuals and families with problems in the personal, interpersonal, intrapersonal, health and economic aspects of life.

The caseworker also involves the client in a person to person relationship. The therapeutic goal is to help the person cope more effectively in his social functioning. Perlman makes mention of multiple factors in the development of personality and that a person is in "process" with the environment, of "being" in the present and "becoming" in the future. This implies that even in casework a client can be influenced and his capacity developed to enable him to adjust in the environment.

The history of casework reflects the influence of psychoanalysis and psychology, but as Austin (1956, p. 48)

points out: "The basic ties of casework are to social work, not to psychiatry and medicine, or the social sciences".

The influence of psychoanalysis and psychology has enabled the caseworker to understand human behaviour, deal with human motivation and understand the etiology and dynamics of social maladjustment, and this understanding is the key to treatment methods.

Differentiating casework and psychotherapy

Psychotherapy is universally performed in any two-person relationship. Bibring (1947) contends that professions such as education, applied law, social work and guidance of any kind all do psychotherapy. Social workers and psychotherapists, however, do psychotherapy as a basic form of service, although their area of emphasis as well as their goals differ.

Some social work writers such as Garrett and Hamilton feel that there is no point in differentiating between psychotherapy as performed by psychiatrists and psychotherapy as performed by caseworkers. Hamilton in Grinker (op cit p. 114) says: "Good psychotherapy must be essentially the same process whether executed by one profession or another."

Torgerson (1962) and Coleman (1949) both feel that although there are differences between the two, there is a great deal of overlap especially with regard to procedures and skills. Bibring agrees with them on this issue, although she points out that a psychotherapist needs the same basic knowledge as a psychoanalyst. The

points of similarity are considerable, and this may be the reason why most caseworkers feel that they can also perform psychotherapy as well as the psychiatrists.

In casework the situation is different because the client comes to the worker at times for other than psychic help. Psychological difficulties may be involved in his problem, and he may or may not be aware of them. In psychiatry the psychiatrist deals with the patient exclusively, while in casework significant others are involved in the problem-solving.

The areas of overlap between the two can be summarized as follows:

(a) Interviewing skills are necessary to both methods. In both the therapist must have the ability to communicate acceptance, understanding and willingness to help. He must be able to create an atmosphere of confidentiality and share the respect for the person's individuality and his right to self-determination. The interview is usually a face-to-face one.

(b) The person seeking help usually comes voluntarily, and the problems have an emotional import. Both recognize the role of unconscious processes in the influence of personality and that the act of asking for help is a painful and complex-determined activity. They apply the same theoretical assumptions as to human behaviour, development, dynamics and personality.

(c) They both recognize the phenomenon of transference. The caseworker will relate the transference to the reality situation and will try and keep the relationship on a realistic basis at all times. Coleman says that the caseworker works within the transference, while the therapist works with the transference. Both are liable to counter-transference phenomena.

(d) Both handle the client's feelings through the use of techniques such as interpretation, clarification, reassurance and support.

The above range of similarities between the two treatment forms makes it difficult to draw a line between them. Torgerson (op cit p. 44) feels that because there are more similarities than differences, the treatment of one person by both methods should be encouraged, as one supplements the other. He goes on to say: "What is done within this relationship is a continuum, with the simple direct, isolated service at one end and structural personality change at the other". The line drawn should not be absolute.

Psychotherapy and casework as defined above are two separate but interrelated disciplines. They are mutually exclusive ways of dealing with certain types of problems, utilizing procedures that are similar in most respects. Consequently there often is "... a difficulty of maintaining differentiation of professional function ... a matter that requires constant awareness, self-examination, and study of procedure, and, in addition a relative absence of competitive impulses, as well as pride in and identification with one's own profession and its special contributions" (Coleman in Kasius, C. ed 1950, p. 391).

3.4 Treatment typologies for caseworkers

Casework is a helping activity which is made up of a number of constituent activities employed by the caseworker to attain a desired goal. Caseworkers felt that they needed to classify the various techniques to make a meaningful whole.

During the late twenties until the early sixties caseworkers were preoccupied with classifying treatment procedures both in America and Britain. A number of typologies were suggested and these typologies have a great deal of overlap as will be observed later (cf. 3.6 and 3.7).

A typology has been defined by Selby (Younghusband, 1966, p. 125) as forms of "... symbolic representation, aiding communication and common understanding by providing a profession with a kind of ideological shorthand". This means that certain common factors or items can be recognized or categorized into a logical system.

Treatment typologies are derived from diagnosis. The nature of the problem, the elements involved in the problem and the plan of treatment all emanate from the diagnosis. The medical profession has diagnostic and treatment typologies which impart relative specificity and sureness to the practice of medicine. The type of material used in social work does not lend itself to a typology in the true sense of the word where there is a strict dichotomy between one form of technique and another. There is often an overlap or a blending of procedures. Clients cannot be neatly fitted into a classification scheme.

After a study of 25 cases Hollis concluded that there is

indeed an overlap in the use of various types of techniques. Her study was based on the use of clarification and supportive techniques.

Social workers have experienced problems in compiling a typology. The difficulties are outlined as follows:

1. How to set up categories when categories cannot be mutually exclusive;

2. Categories should be such that they synthesize the worker's thinking and dichotomize or stratify it;

3. Categories are "magic formulas" or are used as gadgets;

4. Categories should assist rather than inhibit the social worker in participating with the client in the creation and dynamic interaction that is the heart of the social work process. Each interaction should be individualised and perceived for what it is - a unique experience for each client;

5. Typologies should be compiled in such a way that they will permit the individualisation of the person and the problem.

Caseworkers have been divided on the use of a typology. Some contend that "typing would be construed as an activity interfering with the dynamic interaction between worker and client, as well as a sure way of denying the client's impulse to maintain his integrity, to change, or to pursue his own goals in his own way." (op cit p. 126).

However, typologies cannot be completely condemned, be-

cause indeed there are common elements in certain types of cases. Typologies can be put to good use if the caseworker assesses the situation, draws some inferences from the facts, grasps the significance of the feelings involved and gets some idea of what help is needed (op cit p. 134). The selection of a particular group of treatment techniques should be based on a sound diagnosis where the caseworker makes an assessment of the situation and the appropriate help to be given. The helping effort should be adapted to the needs of the situation.

3.4.1 The need for a classification

The question one has to ask at this stage is whether a classification is necessary in casework. Hollis (1964, p. 72) says that a classification can be used to serve the following purpose: it makes an orderly description of casework possible, both in writing and in teaching; it serves a need in the agencies where reports have to be systematized for accountability, work distribution, evaluation and statistics for research where applicable; classifications also serve the purpose of facilitating the study of casework itself. She further states that classifications should help one answer the following questions.

> ... In what way does a given procedure affect a client? What are the relationships of client personality factors to choice of treatment method? What is the relationship between problem and treatment steps? What factors in the client's response in a particular interview indicate the advisability of using a particular procedure? What procedures in early interviews are most likely to encourage the client to remain in treatment?
>
> (op cit p. 72)

Greenwood (1975, p. 28) agrees with Hollis when he says that typologies will enable caseworkers to answer the question: "What type of action is indicated in a given type of situation to achieve a given type of goal?"

3.4.2 Reasons for the choice of certain procedures

In order to attain the goals that have been mutually agreed upon by worker and client, the worker has to make use of certain treatment procedures. The worker should be attuned not only to the type of problem but also to the personality types of the people with whom he is working, the quality of the relationship, the person's state of mind and the various means of helping from which the worker can make a choice.

The worker's choice is based on certain factors which are the overall objectives of social casework. These factors are the client's competence and his self-worth.

Competence here refers to the client's doing things for himself, especially if those things are within his powers and capacities. The effecting of changes in the milieu should be left to the client, with assistance from the worker only if the latter has satisfied herself that the client is unable to do so on his own because of depression, anxiety or lack of motivation. On the other hand it should be borne in mind that some milieu factors are more responsive to the worker because of her role and status and her association with the agency.

> ... The decision of when and when not to intervene in the environment rests upon the knowledge gained in the diagnostic assessment of both the modifiability of milieu factors and the client's capacity to handle them.
>
> (Hollis, op cit, p. 303)

An impression of the client's personality is essential in evaluating his capacity to handle a given task. This evaluation is not done in abstract, it is done in direct relation to the situation at hand. A person may be able to take and use advice in situation A and be completely helpless in situation B.

Another overall casework objective is that of maintaining the client's self-worth. His belief and confidence in himself should be activated and maintained and not be removed from him for whatever reason.

When it comes to problems pertaining to internal change and interpersonal relationships, the use of lengthy interpretations discourages clients to the extent that they discontinue treatment. A study, conducted by Hollis, of clients with marital problems showed this (Hollis, 1939). The worker should not overload the client, but should be on the look-out for cues and know which threads to pick up and follow through.

Once again: For treatment to be effective, the worker has to use a combination of techniques to enable the client to overcome a difficulty at a given time in a given situation.

3.5 Trends in the development of a typology

In their varied attempts to classify treatment techniques social workers have mooted various designations such as "environmental", "sustaining", "experiential", to name just a few. These designations sometimes refer to the treatment method, while others refer to the aims or a combination of aims and methods.

In her article "Analysis of Processes in the Records of Family Case Working Agencies" Virginia Robinson (1921) differentiated between processes which alter the material environment to meet the client's needs, and processes that have to do with the re-education of the client's point of view or habits, as well as changing other people's attitudes towards the client. From this classification we can deduce that Robinson was already aware at this early stage in casework that clients' problems emanate from two sources, viz. sources outside the client and sources within the client.

In 1922 Mary Richmond came up with a classification based on "acts" and "insights". This classification came about as a result of a study she undertook on 6 cases (Richmond, M., 1922). She came up with our first definition of social casework quoted earlier. This definition also recognizes the role of internal as well as external factors in the causation of problems. Richmond stated that sometimes factors in the environment and sometimes factors within the client himself need to be modified.

Richmond's classification had two major divisions, viz. direct and indirect treatment, which were further divided into:

1. insight into individuality and personal characteristics;

2. insight into resources, dangers and influences of the environment;

3. direct action of mind upon mind; and

4. indirect action through the social environment.

The Twin City Chapter of The American Association of Social Workers studied and isolated techniques used in 10 interviews during 1925 and 1927.

From this study 86 different techniques were named, and these were grouped into 7 general classifications, as follows:

(i) techniques for lessening tension in the interviewee;

(ii) techniques for bringing or keeping the interviewee to the main issue;

(iii) techniques used for helping the interviewee to make difficult decisions;

(iv) techniques used for breaking down defence mechanisms;

(v) techniques used for influencing the judgment of the interviewee;

(vi) techniques used to help the interviewer gain time;

(vii) techniques used to help the interviewer regain from a bad start.
(Salsberry, P., in Younghusband op cit p. 18).

These categories were further broken down into subclassifications, some of which had up to 11 sub-groups.

In 1929 the Milford Conference published a report in which they identified three fundamental processes which are at interplay in attaining the ultimate goals of

social work, viz. to develop in the individual the fullest possible capacity for self in the group. The processes are:

1. the use by the caseworker of resources that have a part in the individual's adjustment to his social living;

2. enabling the client to gain an understanding of his needs and of possible means of meeting these; and

3. helping the client work out his own social programme through the use of available resources.

During the early 1930's Burlingham, S., Lowry, S. and Hambrecht, L.M., published papers on differential diagnosis and treatment in which they attempted to classify casework methods.

Hamilton made mention of "executive" and "leadership" forms of treatment. She later (1964) mentions the following as the basic forms of treatment: administration of a practical service, environmental manipulation and direct treatment.

Hollis published her first classification in her book Social Casework in Practice (1939). She is one worker who has attempted diligently to classify casework techniques. Some of her later attempts will be discussed shortly. In the book already mentioned she classified treatment processes as "those aiming to improve the environment in which the person lives and those attempting to increase the client's capacity for meeting whatever environment he finds himself in." She further broke

down these categories as follows: under "reducing environmental pressures" she had techniques of bringing direct relief of external pressures from activity which encourages the client to introduce changes in his own situation; and under "reducing the inner pressures" she identified four techniques employed by the worker to enable the client to deal adequately with his own reality. These are

(i) bringing about modification of an inadequate or over-restrictive conscience;

(ii) lessening the need for repression;

(iii) reducing feelings of anxiety, inadequacy and defeat; and

(iv) helping the individual to see the nature of outer reality and his own relationship to it (Hollis, 1939, pp. 294 - 299).

This classification was revised by the same author in 1947 in her book Women in Marital Conflict. A chapter was later published in Social Casework Vol. 30 in 1949. In this article Hollis mentions the twofold approach of social casework: the intervention in the environment and the use of various psychological methods - influence of mind upon mind. The categories are:

1. modifying the environment;

2. psychological support;

3. clarification, and

4. insight development.

Bibring, a psychoanalyst who had worked closely with social workers, mentions five classifications which she says are used by both caseworkers and psychotherapists (Bibring, 1947). The classification was as follows: suggestion, emotional relief, immediate influence (manipulation), clarification and interpretation. This classification reflected the influence of psychoanalysis on casework. She distinguished between interpretation which had insight development as its goal and other techniques. This classification was similar to that of Hollis of 1947 because "both attempted to group techniques according to the psychological dynamics by which they operated" (Hollis, p. 60).

In 1948 Austin suggested a different classification. She had psychotherapy and social therapy. She further divided psychotherapy into supportive therapy at the one extreme and insight therapy at the other. In the middle she had intermediary therapy. Social therapy then consisted of "the use of techniques designed to influence positively various factors in the environment and the use of social resources" (Austin, 1948, p. 205).

In 1953 a committee of the Family Service Association of America published a report which reflected a new classification of casework treatment into type A (supportive work) and type B (modification of adaptive patterns). The techniques in the type A form of treatment were "manipulation of the environment, reassurance, persuasion, direct advice and guidance, suggestion, logical discussion, exercise of professional authority and immediate influence" (F.S.A.A., 1953). The major technique in type B was clarification.

The above classification was further developed by the Community Service Society of New York in 1958. They published a document Method and Process in Social Casework in which they described in more detail the supportive treatment method and the modifying treatment method. Clarification was recognized as the predominant method.

Hollis revised her earlier classification, and in 1955 she suggested a twofold classification of supportive treatment and development of self-awareness. She contended, in a paper presented in Boston during the same year, that both these forms of treatment aimed at improving the individual's social functioning. She focussed supportive treatment as attempting this improvement without substantial increase in self-understanding, whereas development of self-awareness sought to increase the individual's awareness of previously hidden aspects of feeling and behaviour (Hollis in Parad, 1958).

In her Casework A Psychosocial Therapy (1964) - described by Younghusband (op cit p. 24) as the "most comprehensive and ambitious book" - Hollis considered certain factors which led to the development of yet another classification of treatment procedures. She studied 25 cases drawn from 6 agencies. She studied supportive and clarification techniques as to whether they can be classified as separate in their application. She concluded that there was no sharp dividing line between the two. She further pointed out that "... this pointed in the direction of seeking a classification that would permit us to study the blending of different techniques as they are used over a period of time within a particular case, rather than one that classified a case in terms of an ordinary degree of clarification" (Hollis, 1964, p. 74). The material (recorded interviews) was studied line by

line to bring out the various processes that took place between the client and the caseworker. This led to a classification that had two major divisions, viz. direct work with the client comprising procedures that take place between worker and client, and Richmond's indirect work, i.e. treatment of the environment.

There are six major procedures in the first form of treatment, viz. sustaining procedures, direct influence, exploration-description-ventilation, person-situation reflection, pattern-dynamic reflection and developmental reflection.

In the second major category Hollis distinguishes between treatment of the environment and treatment through the environment. She further delineates three ways of classifying environmental work which has its values and uses in terms of type of resource, type of communication and type of role.

3.6 The components of Hollis' classification (old and new)

Mention has been made in the previous section that Hollis made a major contribution in casework in the classification of treatment methods. An attempt will be made here to study the components of the various treatment groups in depth (1939, 1947, 1955 and 1964).

3.6.1 The first typology (1939) comprised the following two major categories: reducing environmental pressures and reducing inner pressures. Hollis distinguished four ways in which the worker can help the client to reduce inner pressures. These are:

(i) Bringing about modification of an inadequate or an overrestrictive conscience;

(ii) Lessening the need for repression;

(iii) Reducing feelings of anxiety, inadequacy and defeat;

(iv) Helping the individual to see more clearly the nature of outer reality and his own relationship to it (Hollis, 1939).

Under reducing environmental pressures she distinguished two forms of activity: direct relief of external pressures by the worker and activity which encourages the client himself to bring about changes in his situation.

3.6.2 Hollis subsequently revised this classification in 1949 in her book Women in Marital Conflict. She points out that casework has been recognized to have two major components: the environment, both human and material, and man's personality. This then means that the approach to an individual's problem is a twofold one. These two threads, i.e. the internal and external causes of problems, are so interwoven that it is true that all casework is psychosocial.

Her classification is based on the means by which change is brought about, i.e. the processes in which the caseworker is involved. The means are: environmental modification, psychological support, clarification and insight development.

3.6.2.1 Modifying the environment

The environment here is a physical, social and human one. Modification of the environment involves, according to Hollis, "steps taken by the caseworker to change the environment in the client's favor by the worker's direct action" (Hollis, 1964, p. 236).

The caseworker should have knowledge of community resources and of the human part of the client's environment which requires modification.

The feelings of the people approached in the client's interest should also be given attention by the caseworker. Hollis discusses this issue further in her 1964 book where she states that there often is a fallacious assumption that environmental treatment does not make use of psychological methods.

An understanding of the client and his problem is essential because little would be achieved and, in fact, the effort would be wasted if help were directed to an area that is not in the client's interest.

Hollis further cautions that environmental modification should only take place in areas in which the client is himself unable to control the pressures that bear upon him, or when the pressures are "... more likely to yield to change when handled by the worker rather than the client himself" (Hollis op cit p. 237). She makes mention of "competence" as one of the overall objectives of social casework; the emphasis is on the client "... doing things for himself when the task is not beyond his power and that he be encouraged to gain understanding of his milieu, of others and of himself" (op cit p. 301). The client should be given an opportunity

to introduce changes in his environment, whilst the worker is also helping out in another direction.

> ...The person who needs outside help of an environmental sort usually is also to some extent insecure emotionally, at least temporarily, and in need of psychological help as well". (1949, p. 237)

3.6.2.2 Psychological support

The processes of psychological support, clarification and insight development have a common ground in that here contact is directly with the client - on a face-to-face basis. However, they differ from each other in the following respects:

(i) the predominant quality of attitudes, comments and activity of the worker,

(ii) the depth of the material brought into treatment by the client,

(iii) the type of worker-client relationship. (ibid).

Psychological support and clarification are considered to be the most predominantly used and are often used conjunctively.

The following steps are covered in psychological support:

> ... encouraging the client to talk freely and express his feelings about his situation, expressing sympathetic understanding of the client's feeling and acceptance of his behavior, indication of the worker's interest in the client, his desire to help; expression of the worker's confidence that a way can be found to improve the situation, confidence in the client's ability

> to solve his difficulty, to make his own decisions; indication of the worker's respect for and approval of steps the client has taken or is planning where these attitudes are realistically warranted.
>
> (ibid)

Psychological support may include giving guidance and advice, because the type of client here is one who needs reinforcement of his ego strengths and guidance in release of tension. This can be achieved through a warm good-parent type of relationship between the caseworker and the client.

Psychological support aims at decreasing tension, increasing self-confidence and encouraging a healthy way of functioning that may lead to maintaining equilibrium.

This technique should rest on a sound diagnosis to avoid the development of regression and dependency feelings. The caseworker should evaluate the client's ability to use this form of help. The caseworker should have an adequate understanding of the client's circumstances, his social situation and personality. A lack of understanding can easily result in undesirable effects, chief among these being regression, transference and countertransference.

"In general, it may be said that psychological support is useful in carrying the basically well adjusted client over a period of severe stress and strain caused by painful life experiences." (op cit p. 239).

3.6.2.3 Clarification

This technique has to do with understanding - understanding by the client of himself, his environment and the people with whom he is associated.

> ... It is directed towards increasing the ego's ability to see external realities more clearly and to understand the client's own emotions, attitudes, and behavior.
>
> (ibid)

This understanding is distinguished from insight development in that in this understanding the quality ranges from simple intellectual processes of thinking through uncomplicated matters, while in insight development the understanding reaches deeper levels (cf. 3.6.2.4).

The matters handled in clarification are those than can be easily discussed and are not subject to emotional blocks, "... but even here the emphasis is on the fuller understanding of conscious material rather than on matters that are held from the client's view by their ties to repressed mental content". (ibid).

The depth of a relationship is determined by the level of the material discussed. A friendly relationship is sufficient for the discussion of matters that are not of deep emotional import, while matters pertaining to more profound feelings require a relationship greater in depth but without strong undercurrents of transference.

Clarification may consist of the following activities:

> ... giving the client information about the environment, which he does not possess and without which he can not see clearly what steps he ought to take ... helping the client to line up more clearly the issues in a decision: to evaluate the attitudes of other people toward him in correct perspective; to understand what motives may have influenced actions of others of which he may be critical; to see the needs of others or the results of his own actions as they affect other people; or to see the probable results of contemplated action. He may be helped to become aware of his feelings, desires and attitudes.
>
> (op cit p. 240)

The above can be achieved by firstly encouraging the client to talk freely, and this can be accomplished if the matter to be discussed is not heavily weighted with internal components. The client can be provided with accurate information to enable him to see matters in their correct perspective, and interpretation can also be used to enable the client to see the significance of his reactions to others. Questions can be asked and comments made on inappropriate responses to enable the client to see more clearly and realistically and to plan wisely.

Clarification as a technique presupposes a client who is healthy in his personality adjustment. The method can be used alone or, in some instances, with psychological support and insight development.

3.6.2.4 Insight development

With this technique understanding is carried into a deeper level than in clarification. The purpose of this form of treatment is to increase the client's understanding of his life and his situation, so as to enable him to abandon the use of destructive defence mechanisms.

Here "... current and past emotions must be relieved in a therapeutic atmosphere in order that some of the affect may be discharged and in order that irrationalities may be brought so clearly to the surface that they can be recognized, at first in the safety of the treatment situation and later in real life" (op cit p. 241). Feelings dealt with here are feelings that have been carried over from the past into the present. They have been repressed or suppressed in the recent past.

The caseworker should pay special attention to the worker-client relationship. The discussion of deep feelings often leads to the development of positive as well as negative transference. The transference here is not as deep as in the case of transference-neurosis, a fact which distinguishes the caseworker's role in insight development from that of the psycho-analyst. The caseworker comments on the suppressed material, while the analyst indulges in interpreta-tions of symbolic material and insists on "free asso-ciation."

Like in the use of any other technique, insight de-velopment should be preceded by a sound diagnosis based on understanding the client's need and his inte-rest in this type of help. This form of help is sui-table especially for clients who cannot adjust to their situation because of a mild neurosis or character dis-turbance. The agency should have psychiatric consul-tation at its disposal and the workers should be close-ly supervised.

The caseworker using this method should have a "... thorough understanding of psychological mechanisms and typical growth patterns, awareness ... of his own feelings, keen perception of the client's reactions and the ability to interpret them correctly and know-ledge of techniques used in this type of treatment" (op cit p. 243).

3.6.3 Hollis revised the fourfold classification. She came to a conclusion that there are in fact two forms of casework treatment, viz. supportive treatment and development of self-awareness.

In her paper "Personality Diagnosis in Casework" (Parad P. 83) she gives the crux of these two forms of treatment: Supportive treatment is "... treatment that aims to improve general functioning of the person without substantial increase in the ego's understanding of previously hidden aspects of self." The second form of treatment, the development of self-awareness, is "... treatment that holds as a major aim the improvement of the individual's functioning by seeking to better the ego's understanding of previously hidden aspects of individual's own feelings and behavior" (Parad p. 84).

Evidently both these forms of treatment are aimed at improvement of the individual's functioning through bringing about certain changes in the individual's life. The change sought in supportive treatment is "... one that may occur without the client's awareness of change in functioning ... or with his better evaluation of the reality situation but without substantial increase in his knowledge of himself. The improved functioning is brought about by environmental changes, by the effects of catharsis, by the influence of an encouraging, anxiety-relieving relationship with a caseworker, and by a better perception of external reality" (ibid). This form of treatment is not aimed at uncovering any hidden material as in the case of the second form of treatment.

The changes brought about in the second form of treatment involve "... greater self-understanding and require that the client examine previously hidden aspects of his own thoughts, feelings and behavior" (op cit p. 84). This form of treatment arouses a great deal of anxiety in the client. The user of this form of treatment should be aware that a great deal of tension

will be aroused and this should be permitted to continue to enable some of the hidden answers to come to the fore. The opposite happens in supportive treatment where communications are aimed at lessening anxiety and minimising tension.

Development of self-awareness according to Hollis comprises the following forms of efforts "... unveiling of current feelings of which the person is unaware ... the bringing to light of suppressed memories about childhood attitudes and experiences which have lain dormant for many years" (ibid).

Hollis later pointed out that the development of self-awareness through clarification and unravelling of suppressed material leads to heavy demands on the client's ego for the following reasons:

(i) The client's discomfort is increased because the worker refrains from making reassuring remarks where they are needed;

(ii) Feelings of anger are aroused in the client towards the worker who is then regarded as a source of discomfort;

(iii) Anxiety is increased until such time that the client is able to come to terms with the anxiety provoking material;

(iv) Becoming aware of these suppressed feelings means that the client is more exposed and is vulnerable to pain and discomfort.

Hollis further says that the use of this method calls for the worker to be "... certain that the client has

the kind of ego that can sustain itself during a period of tension without recourse to too much aggression, extensive additional symptom formation, unwise acting out, or immobilization" (Hollis, 1962, p. 113). The caseworker should take heed that this method does not bring forth material of a nature which the caseworker cannot handle.

3.6.4 Hollis' final classification appeared in her book Casework A Psychosocial Therapy (1964). She says about the task of formulating this classification that it was "... soon discovered that it is no simple matter to formulate a logical and useful classification of casework treatment, especially if this formulation is to be rich enough in its dimensions to make conceptually worthwhile distinctions and yet not so elaborate as to be impractical" (p. 72).

This classification was based on a study of two sets of cases. The first set was from three agencies in Boston. The communications in the process reports were analysed line for line until a logical system with non-overlapping categories began to emerge. The classification was used by graduate students on an experimental basis. The experiments served to demonstrate the applicability of the classification.

The second set of cases was drawn from a number of agencies in New York, Cincinatti and Cleveland, to mention just a few. The material consisted of more than 100 individual interviews and 29 joint interviews. All were cases of marital discord.

Various procedures emerged and Hollis maintains that the extent to which each procedure is used, will vary from case to case and from interview to interview within one case. She further predicted that "... there will be gross differences among cases in regard to the blend of procedures used and that such differences are related to such variables as diagnosis, problem, causation, phase of treatment and objectives ..." (1968, p. 3). The classification provides a gross definition of what takes place in the interviews.

The classification as mentioned earlier, is based on communications that take place between worker and client and these communications have the following five dimensions:

(i) the person towards whom a worker directs a communication;

(ii) the person who is communicating;

(iii) the means by which a communication can be expected to take effect;

(iv) the subject of a communication;

(v) the change context of the communication." (ibid).

Shortly after the formulation of the typology, Hollis secured a grant from the National Institute for Mental Health to conduct experiments with a view to testing the reliability of the typology. The classification was found to be appropriate and reliable and is now widely used as a research instrument in a number of studies.

The typology has two major divisions:

(i) direct work with the client;

(ii) the interaction between the client and his environment.

The first group of procedures are further divided into two groups: sustaining procedures, direct influence and exploration-description-ventilation being procedures that derive their force from the worker-client relationship, how the client regards the worker and the extent to which he allows the worker to have an influence in his life. The latter group of procedures in the first category are reflective processes which lead to better understanding and awareness (person-situation reflection) of himself and others in his situation; an understanding of personality patterns and dynamics (pattern-dynamic reflection) and a change in the client's awareness of causative connections between his childhood and present behaviour (developmental reflection). These techniques involve the client's active thinking about his situation.

6.3.4.1 Categories of worker-client communications (direct treatment)

In the following discussion of the six categories outlined above to show their applicability in the treatment situation, Hollis' original category symbols (A to F) will be maintained for clarity and consistency.

A. Sustainment

Sustaining procedures are perhaps the most basic of all

casework activities. They are aimed at reducing the anxiety which is known to be coupled with every problem brought to the caseworker. The anxiety may have various sources, viz. feelings of guilt, problems reflecting personal failure in the intrapersonal level of functioning, inability to adjust, sense of incompetence or concern about some external situation.

The greater the client's anxiety, the more the need for the use of sustaining procedures. These sustaining procedures are aimed at demonstrating a sympathetic and accepting attitude towards the client through listening with concern to the client's version of what is the matter. This attitude can be expressed verbally as well as non-verbally. The worker's bodily position, gestures, facial expressions and the atmosphere in the interviewing situation may often convey the message to the client.

One of the techniques most commonly applied is acceptance which is an acknowledgement of reality, of certain qualities in the client. Acceptance means that the caseworker conveys to the client his awareness of the client's weaknesses as well as strengths, congenial and uncongenial feelings, positive as well as negative attitudes. It means "... that whether the worker approves or disapproves of what the client has told about himself, he continues to feel and convey a positive understanding attitude towards the client" (op cit p. 91). Hollis says that this concept is often misunderstood; it is often assumed that acceptance means that "... the worker must be without an opinion about the rightness, wrongness, the advisability or inadvisability, of the client's activities" (ibid). This technique requires that the worker be free from biases and prejudices based on cultural, ethnic and religious backgrounds.

Actual reassurance as a technique may also be applied in certain cases where the worker needs to express understanding of the existence of certain feelings within the client. Hollis warns that this technique must be used with delicacy and discrimination: "Bad timing of reassurance or overuse of reassurance may have a harmful effect in the client who may feel that he is misunderstood or that the worker is overwhelmed by his anxiety and cannot bear it" (1964, p. 91). Premature reassurance can also lead to the suppression of deep feelings which the client needs to express at a particular point in the interview.

It sometimes happens that the anxiety is due to a fear of an external situation, e.g. when a client has to attend an interview for a job and feels incompetent. The reassurance here must be justified by reality. It is better at this stage to create an atmosphere in which the client can express his anxiety and experience relief through ventilation.

Reassurance can also be used with clients who are afraid that they may not be in control of their drives. The worker can reassure the client only if the reassurance is based on the fact that the client can master his drives. This reassurance should be accompanied by reflective discussion and be based on a good knowledge of the client. The client's ego needs to be reinforced.

It is sometimes necessary to encourage the client when his self-confidence is weakened. A client will often make attempts to handle a situation alone, and the worker should give encouragement and express confidence in the client's activities. This should be based on

the worker's honest opinion and not be an attempt to flatter or give false confidence. Some clients know their strengths and short-comings and may show much sensitivity in this respect. Hollis points out: "... the very fact that people are insecure makes them extremely sensitive to hollow insincerity, and their confidence in the worker will evaporate if they once suspect his encouraging comments are merely a technique to inject courage into their personalities" (ibid).

The worker should offer praise or encouragement with limitation and point out shortcomings or failures where possible so as not to create an impression in the client that standards are being set for him. The client will then strive to attain those standards to please the worker. The client should not fear to loose the worker's "approval" or acceptance if he fails. Anxiety that will obviously be aroused by such a situation should be immediately dealt with through acceptance and reassurance.

The client's capacity to function is at such a low level, his anxiety at such a high peak that he is distrustful of any attempts by an outsider to enter into his life. Here the worker should make use of actual "gifts of love". This technique is most helpful with children with whom a relationship can be established with small gifts or physical contact. It is sometimes necessary to use these techniques with adults as a demonstration of goodwill, especially with the hard-to-reach clients. The worker sometimes has to run small errands for the client or talk to someone on behalf of the client. This technique should be used with great care and discrimination.

The client should understand it for what it is, and the worker should not be doing things for the client to encourage dependency or to be regarded with gratitude by the client.

Success with sustaining procedures is based on self-understanding by the client coupled with faith in the worker's competence and goodwill.

B. Direct influence

Procedures of direct influence refer to "... the various ways in which the worker tries to promote a specific kind of behavior on the client's part" (op cit p. 96).

In earlier days casework was associated with advice-giving; the worker telling the client what to do. Clients in fact went to agencies to receive this type of direction from the caseworker. With increasing understanding of human behaviour and motivation, caseworkers gradually learnt that it is futile to try to run the client's life. On the other hand they realised that there are some clients who need this type of help from the caseworker.

The success of the use of these procedures lies in the client's complete trust of the worker as someone who can guide him and influence his behaviour. The worker should use these procedures of direct influence with the following three safeguards in mind as suggested by Hollis:

(i) The worker has to be sure within reasonable bounds that he knows what is best for his clients. It

has been found that very few workers know enough about their clients to justify giving them advice on major issues that would change their lives. Reflective discussion could be of help here so that the client arrives at a particular decision himself and the worker is then at hand to give the necessary encouragement.

(ii) Workers are sometimes tempted to tell clients what to do because of their (workers) superior knowledge coupled with positions of authority that they hold. The need for advice should come from the client and not the worker.

(iii) The client should ask for and receive help with dignity. He can only feel "whole" in the case-work situation if he participates and arrives at certain decisions on his own, with the help of the worker where necessary.

The client should therefore be always granted an opportunity to think matters through on his own and thus retain his dignity and the little self-confidence that he may have. Workers should always be on the alert for those clients who may push them into giving advice even where it is not necessary - so that, if they fail, they can always have someone to blame and not assume responsibility for their failure.

The above forewarnings do not imply that caseworkers should not make use of techniques of direct influence. There are situation in which it is appropriate that the worker makes use of his superior knowledge, experience and strength.

Hollis says that the techniques of direct influence can be represented in a continuum. At one end of the continuum is the client's need for direction; at the other end of the continuum is the worker's insistence that the client take action on the worker's advice. In the centre of the continuum we then have suggestions and a milder form of influence where the worker places emphasis on action already contemplated by the client. These techniques can be applied in the following situations:

(i) Clients who are anxious or depressed are often in need of direction from the worker. Infantile personalities, ambulatory schizophrenics, persons with a weak sense of reality and borderline psychotics often express a need for dependence. "As long as the worker is philosophically committed to the value of self-direction, reasonably conscious of his own reactions to the client's need for dependence, and alert to every possibility of encouraging his client to think for himself, he will make wise use of procedures of influence (op cit p. 98).

(ii) The worker may make suggestions in which his inclination towards a particular form of action is implied. The client then has a choice of acting on that suggestion or rejecting it without feeling that he has gone contrary to the worker's wishes.

(iii) The client may sometimes have a course of action in mind. The worker, after weighing it, may give emphasis to that course of action. Should the

course of action bring success, then the client will take full credit for it, and this is ego-boosting. On the other hand, if it fails, he will not feel solely responsible, because someone of superior knowledge had also thought that the plan would work out.

(iv) The worker may give advice and put some forcefulness behind that advice - "... when there is a possibility of severe consequences of an impulsive ill-considered action, or when sufficient time is not available to help the client think a matter through rationally ..." (op cit pp. 99 - 100). It often happens that a client has to get treatment from a visiting specialist and there is no time to contemplate the situation; the worker urges that the client be attended to. At times the client may take action which may have unpleasant consequences. The worker should be at hand to deal with the disappointment and accompanying guilt.

(v) The technique of <u>actual intervention</u> is not represented on the continuum. It is the most extreme of the techniques of direct influence. Here the worker makes forceful interventions which must rest on a conviction that the steps taken are justified by the circumstances, and on knowledge of community resources. Firmness and kindness are needed in this kind of intervention. The removal of a child from a cruel though familiar environment needs great skill on the part of the worker in handling the accompanying anxiety and ensuring that the client does not sense the worker's anxiety.

Hollis (op cit) gives the following guidance in the use of this technique:

(a) It should be used hand in hand with procedures for developing understanding. Here the worker's influence lies in supporting the client's own conclusions; and

(b) The worker should preferably use the most gentle form of influence.

The compulsive client will always ask for advice because of his lack of direction, need for dependency and cunningly wanting to prove that the worker's advice does not work or even trying to place the blame on someone else, if things do not work out as planned. These clients have a very strong superego and need advice because they like to please persons in authority.

Treatment will only be effective if the client is willing to participate and accept the worker's guidance. Procedures of intervention will only be useful if they are applied with the client's assent. These procedures should be used along with sustaining procedures and procedures for developing understanding. The goal is, where possible, to develop the client's sense of direction. However, the worker will also "... see that some clients are not ready to select their goals unaided, and that almost all clients require a degree of temporary dependence as a necessary bridge across which the process of treatment moves" (op cit p. 103).

C. Exploration-description-ventilation

This division of the typology has to do mostly with

communications from the client to the worker. It is part of the psychosocial study wherein the client described his situation and problem to the worker as he sees it and the feelings accompanying the discomfort. Hollis mentions that there is a clear distinction between experiencing and expressing feelings.

A client may experience strong feelings without showing it, and the worker has to be on the alert for the restrained or suppressed feelings. The worker should encourage this expression where it is not spontaneous. The expression of feelings is therapeutic in that it brings relief and reduces the intensity of the feelings.

Guilt feelings require skillful handling because they are more intricate. The client's guilt may be due to some fault of his own, a misdemeanour or oversight, and the worker's attitude here is very important. The worker should repeatedly demonstrate acceptance of the client to make it easy for the client to handle his guilt. In this case, ventilation should be followed by sustainment. Expression of sympathy also helps the client.

Hollis says that guilt is sometimes necessary to "... reinforce the building of sound ego controls" (op cit p. 104).

There are cases in which talking does not bring emotional relief to the client but engrosses him in more guilt and anxiety. Ventilation should be held in check here, because the client is not benefiting from the expression of feelings. The worker should, after realising that this is the situation, direct the discussion to other issues that are of less "emotionally laden content".

Some clients take advantage of the casework situation to express feelings that are otherwise unacceptable in certain circles; like for instance a client who will brag about his sexual escapades to the worker. The worker will realise that the client is not benefiting therapeutically from such communications but is instead deriving sexual or masochistic pleasure. Care should be taken to move away from such communications without affecting the relationship. The worker will need to be direct and discuss with the client the reason for the change of subject, and this can be done successfully if the worker is "... free of the hostile countertransference reactions that are so easily aroused by clients who make use of ventilation primarily for self-gratification" (op cit p. 106).

Ventilation can also be used in joint interviews. The worker can channel the expression of feelings towards the other partner, especially hostile feelings which are often suppressed and are often brought up under conditions where they may cause irreparable harm. This expression of feeling may lead to honest communication between the partners in future, to a better understanding and self-awareness. Hollis warns that this expression of negative feelings between the spouses "... should not be allowed to continue if it creates too much anxiety in either partner or leads to ever-increasing hostility and counter-hostility instead of greater understanding or the emergence of positive feelings" (ibid).

D. Reflective discussion of the person-situation configuration

This type of treatment is aimed at increasing the client's

understanding; an understanding of his situation, other persons, his reactions, the effects of his reactions, his feelings and his thoughts, his awareness of the nature of his behaviour; his evaluation of himself and of some aspect of his behaviour. It deals with current and recent events.

Hollis breaks down this category of treatment into four areas:

(i) The Situation: People, Condition, Health

The kind of communication here is termed extroreflection because it is a form of reflection that is directed outward - towards the client's situation. A distorted picture or knowledge of only one side of an aspect may lead to reactions which are unwarranted in a particular situation. Our concern here is with distorted perception and lack of knowledge.

Lack of knowledge and distorted perception have been known to lead to a lack of understanding. Distorted perception can be a result of various factors, one of which may be preconceived ideas about a person or situation. The client will see only what he wants to see in a given situation and may not change his opinion even in the light of contrary information, unless the worker steps in with a view to showing the client his misperception and its effects. If a client picks up on what the worker shows him and is able to discuss it openly, or even where he requires some prompting from the worker Hollis says that "... it is not necessary to pursue the whys and wherefores ..." of the person's previous failure to perceive a distortion.

Hollis gives lack of knowledge as another reason for a person's distortion. A lack of knowledge can lead to prejudices and biases, and further a lack of understanding of the situation. Knowing why people live, behave, dress like they do or prefer what they do leads to an understanding of those people and to more patience and tolerance.

A lack of understanding may also be due to "... a lack of imagination about another person's feelings or behavior or failure to identify with the feelings of another" (op cit p. 112). One can readily jump to conclusions about a person because of lack of imagination. An understanding of another person's feelings leads to a change of one's behaviour.

Compared to direct influence (advice giving), this procedure is considered to be quite tedious because it is aimed at increasing understanding and self-awareness. The worker can make use of the following techniques in helping the client to reach an understanding of people, situations and events:

(i) The worker can explain things to the client in a didactic way.

(ii) The worker may help the client to think things through in his own way. This second technique helps the client to be less dependent on the worker, and if he has reached some reasonable conclusions about certain acts by thinking them through on his own, then he becomes convinced about them and his capacity.

(iii) The client can also be guided on how to introduce changes in his situation through legal or social action. The worker provides the client with information about resources that are within the client's reach.

(ii) Decisions, Consequences and Alternatives

This type of reflection involves decisions and activities of the client and their effects in interaction with the environment. This type of reflection lies between extroreflection and intrareflection and partakes of both. It is mainly concerned with the effect of the client's behaviour on another person.

Actions are usually the reflections of one's decisions about practical issues. Whether to move to a new neighbourhood, adopt a child, divorce or undergo surgery; are some of the minor as well as major decisions required in daily life. The client weighs the pros and cons of his daily life and the outcome of his decisions in order to gain experience in the sequence of various actions.

The worker should make information about resources easily accessible to the client to increase his knowledge and understanding. When the client has to make use of a resource, the worker should give him step by step guidance rather than advise him to do this or the other.

Hollis suggests that the best way is not to give the client direct explanations about the relationship between behaviour and consequences but to rather let the client see the sequence himself.

(iii) Inner Awareness, Responses and Distortions

This subdivision has to do with increasing the client's inner awareness; i.e. awareness of "... so-called hidden feelings or reactions ..." (op cit p. 116). Hollis refers to these feelings as "so-called hidden", because at times the client is aware of the feelings but is afraid of discussing them because of their shamefulness or the pain that accompanies them. The client may at other times not recognise the significance or importance of the feelings and may be reluctant to discuss them.

It may happen that the client is not aware of the existence of certain feelings (especially negative ones) towards important persons in his life, e.g. feelings of hatred towards a parent or a child. The feelings referred to here are feelings that are currently in the client's life, not memories.

The worker may sometimes be able to read the client's thoughts. If this is the case, he should lead the discussion of these hidden feelings. The client should not fear criticism from the worker or judgment when discussing some of these feelings. Casework skill lies in creating an atmosphere in which the client can talk freely and not need any prompting.

Closely related to the ability to enable the client to discuss his feelings freely, is helping the client to become aware of the relatedness of certain feelings and actions and also the recognition of inappropriate, unusual, or problem activities or reactions. The worker brings certain reactions, or lack of reaction, to some situations to the client's attention. Here again the client should be encouraged to think things through for himself.

Interpretation can be used, but the worker should be sure of his ground; he should also not rush to give explanations. Self-evaluation is yet another type of intrareflection. The client should be encouraged to evaluate his self-image, principles, values and preferences in relation to the demands of the situation. A distorted self-image can be corrected by reviewing external realities - "... but consideration of external reality here is for the purpose of enabling the client to become aware of dysfunctional aspects of his own behavior, not primarily to understand another person" (op cit p. 119).

(iv) Reactions to the Worker and to Treatment

This type of reflection is concerned with the client's "... thinking about the worker in his treatment role and about his reactions to the worker, to treatment or to agency rules and requirements" (op cit p. 120).

The client may have distorted perceptions about the worker and about the casework situation. Just as in the case of situations discussed earlier, the distorted perception may be due to early experiences and to a lack of knowledge. The client may lack knowledge about the casework situation, the role of the worker, his participation in the treatment process and what is expected of him. The worker handles attitudes and responses towards him as he would handle these towards other persons. Certain reactions are interpreted and explained.

The client may have certain expectations about the caseworker, and if these are not met, he may need more knowledge to clarify the misunderstanding, disappointment

and even hostility that may follow. "Where distortions or misunderstandings exist, the worker tries to straighten them out by demonstrating the realities of his behavior towards the client and the actual nature of the treatment" (op cit p. 120).

Here again it is best to encourage the client to express the feelings he has towards the worker and his possible dissatisfaction about what happens in the casework situation.

The client is able to overcome his difficulties in an atmosphere of trust. Differences of race and sex coupled with previous experiences do lead to misunderstandings. The worker should not readily decide on the source of the misunderstanding or hostility within the client, before making a thorough study of the client and his immediate situation.

E. Pattern-dynamic reflection

This type of reflection is an extension of intrareflection, but in this procedure the client is helped "... to pursue further some of the intrapsychic reasons for his feelings, attitudes, and ways of acting to understand the influence of one characteristic of his personality upon another - in other words, how his thoughts and emotions work" (op cit p. 125).

The client will sometimes show some inconsistency in his reactions. At times his reactions may even be inappropriate. The worker should interpret or offer explanations only where necessary; otherwise it should be left to the client to recognise and seek reasons for these inappropriate or inconsistent reactions.

The inconsistencey or inappropriateness of reactions may be due to fear of rejection or loss of affection or even fear of gaining unwanted attention.

A client's reactions may be induced by some earlier behaviour, e.g. a mother rejecting a teenage son because the son was once apprehended by police for some reason or other - or the reaction may be meant for someone else, e.g. a mother taking it out on the child while the source of her hostility is the child's father.

"A client will seek understanding of his thoughts or actions only when he feels some dissatisfaction with them, recognises them as unprofitable, or in some way inappropriate or ego-alien. Until this attitude exists, dynamic interpretation will fall on deaf ears"(op cit p. 127). The client may be deriving pleasure in these inappropriate reactions. They may be used as defences against feelings of insecurity, against threats and feelings of inadequacy. The defensive behaviour may be manifested through intellectualisation, projection, rationalisation, projection and so forth.

It is sometimes necessary to explain defensive behaviour, because clients are not familiar with defences and do not understand how these work. One of the aims of this form of treatment is to enable the client to recognise some of his defences, once the manifestation of these has been explained to him.

Another aspect of personality that is handled in this form of reflective discussion, is the superego. Clients with a severe superego tend to punish themselves, setting standards they cannot attain and being for ever concerned about pleasing authority. The client perceives the

worker as some authority, and his dealings with the worker will reveal this self-punishment. The worker should then show some more indulgent standards, without giving the client an impression that he approves of anti-social behaviour.

Clients tend to suppress hostile impulses, and the worker should use sustainment and offer interpretations of the hostility and its sources.

The client's reactions to the worker in the worker-client relationship enables him to understand the inner workings of his personality. This understanding can be used in recognising similar dynamics operating in other life experiences.

This understanding of the client's psychic patterns can be achieved with the use of sustaining procedures and procedures of direct influence.

F. Developmental reflection

This type of reflection deals with early life experiences which have been internalised to a degree that they form a part of the client's responses to current situations. "The procedure is used to help the client to become aware of the way in which certain of his present personality characteristics have been shaped by his earlier life experiences and sometimes to modify his reactions to these experiences" (op cit p. 132).

Experiences or events are considered as having "contributed" in shaping a person's personality and are not considered as having actually done so because "... casework never reaches all the determinants of a given

phase of behavior" (ibid). Certain forces or influences in a person's later life or a balance of some forces may lessen the impact of the influence of early experiences in the shaping of one's personality.

A discussion of the client's early life does not always serve the purpose of developing understanding. Hollis says that exploration of the client's past may serve other purposes, such as:

(a) It may aid the worker to arrive at a diagnosis.

(b) It serves the purpose of catharsis.

(c) The past may be used as a defence of a present situation; where the client tries to justify present behaviour, feelings or attitudes.

(d) A discussion of the past helps the client to avoid discussing current issues.

(e) The client will dwell on the discussion of the past if he thinks that that is what the worker wants to hear.

Understanding of present behaviour can come about if the client understands the source of his behaviour and attitudes. This can be achieved when the client's attention is drawn towards inconsistent and inappropriate behaviour. It is best to let the client develop understanding and seek explanations on his own, but sometimes it does become necessary to lead the client towards thinking about past events and their relationship to the present.

The worker picks up the cue of how to lead the client when the client discusses present issues and occasionally touches on his past life.

Hollis points out that some clients may have no anxiety when discussing matters related to their past life. Such clients dicuss these issues freely, and all the worker has to do is to guide them to see a connection between present and past. On the other hand, the recollection of past events may sometimes evoke anxiety, pain and fear of criticism, and the result is that the client will suppress or repress these events.

An understanding of past circumstances sometimes leads to a modification of one's feelings about significant persons in one's earlier life. In some cases a displacement on to a child by the client of feelings (especially hostility) originally meant for a parent, may change when the client understands the source of the hostility and has a different picture of events at that time.

Hollis gives the following guidance on this issue:

> ... Before moving into the re-evaluation process, it is often necessary to allow considerable ventilation of initial hostile feelings, partly because of the relief the client obtains from such an outpouring and from the worker's continued acceptance of him despite feelings about which he may feel quite guilty, but also because he will probably not be ready to reconsider his earlier relationships until he has had an opportunity for catharsis.
>
> (op cit p. 135)

The re-evaluation should be well-timed otherwise it evokes undesirable feelings in the client towards the worker.

Sustainment procedures come in useful especially where transference is observed and has to be interpreted. The worker should guide the client in seeing a connection between his past and present and thus reduce the client's dependence on him. Where interpretations have to be made, they "... should be made tentatively, unless the worker is absolutely sure of their accuracy" (op cit p. 136).

A worker making use of dynamic and developmental reflective discussions as a form of treatment must have a good understanding of the "... workings of personality - of unconscious as well as of conscious factors - and with the way in which the personality develops and early life events find continued expression in the adult personality" (op cit p. 137).

3.6.4.2 Environmental work

Environmental work is often used in conjunction with direct forms of treatment, while direct treatment may be used without the use of environmental methods of treatment.

Environmental work can be perceived in three ways:

(i) communication between worker and collateral source;

(ii) resources involved;

(iii) role or function of the worker.

(i) Type of communication

There is a fallacious belief that skill in communication is only required in the use of direct methods of treatment. This has led to many a failure in the use of the environmental method as a form of treatment because of the oversimplification of this method.

The use of collaterals requires the employment of procedures such as sustainment, direct influence, ventilation, person-situation and pattern-dynamic reflection as we shall later see. The client is not the only one who has fears of being criticised, who has anxieties or needs guidance and an opportunity for ventilation. The collateral source also has hostile feelings which may be vented either on the worker or on the client, and these have to be handled in the same way as the client's feelings. The collateral source may be harbouring hostile feelings which need to be brought into the open; he may also need to develop an understanding of his reactions, and this understanding can be attained through reflective discussions. Procedures involving thinking about the self are rarely if ever used.

(ii) Type of resources

Certain types of cases require that the worker make use of certain resources in order to make treatment a total experience for the client. It is often presupposed that the worker has knowledge of the resources and how these can be utilized by the client to overcome his undesirable situation. The resources are varied, and the worker has to know when to make use of a particular resource.

The various types of resources are briefly the following:

1. Employing social agency

This is the agency in which the particular caseworker is employed. She makes use of the resources available in her agency to assist the client. There are two types of agencies, viz. the private agency where the worker has an opportunity of influencing policy, and the public agency which is mainly under State control. A very small proportion of social work is found in the latter type of agency.

2. A social work department directed by another profession

In this type of agency social work is practised on an auxiliarly level, e.g. in a school, a prison or a hospital. The primary control here is in the hands of the other professions, as a result of which the social worker has very little say in policy matters. In this type of agency the caseworker should try to demonstrate her role and not to loose her professional identity.

3. Institutional resources where the worker is not a staff member

This is yet another type of resource which the worker can exploit without being on the staff. Upon entering a new community, the worker has to acquaint herself with all the resources in the community.

4. Organisations not employing social workers

There are a number of voluntary bodies which do not employ social workers but which are willing to work hand in hand with social workers.

5. Task-oriented collaterals

These resources are the ones which the client makes use of in an instrumental way. Here the worker deals with people who have their own interest at heart like the landlord, credit accountant to name only two. These people are usually hostile towards the client because of their wish to protect their own interests.

6. Feeling-oriented collaterals

Here we are concerned with people who have a feeling-oriented relationship with the client. These can be friends, relatives or immediate family.

(iii) Type of role

The worker assumes various roles in her attempt to help the client:

1. The worker as provider

The worker makes certain resources and services available to the client on behalf of the agency. Both direct and indirect methods are employed by the worker to help the client deal with possibly negative feelings towards the agency.

2. The worker as locater

A thorough knowledge of the community is an asset in this role. The worker helps locate certain types of services on behalf of the client.

3. The worker as interpreter

The nature of the problem may sometimes require that the worker explains the client to someone else. In this role the worker needs skill in communication in addition to his knowledge of the client.

4. The worker as mediator or aggressive intervener

These two roles are different angles of advocacy. The worker sometimes has to apply a form of pressure on the collateral, and this may arouse hostility and resistance.

3.7 Austin's typology

In 1948, at the National Conference of Social Work, Austin cited a typology with two major sections: social therapy and psychotherapy.

3.7.1 Social therapy

This treatment corresponds largely to Richmond's environmental treatment. This treatment consists of techniques aimed at influencing the client's environment and putting certain resources at his disposal, as well as changing certain negative elements in the environment. It is appropriate where there is a belief that the client's problem lies in the environment.

Treatment is based on the diagnosis of personality and the social environment. The worker-client relationship is used maximally as "... the medium through which the client is enabled to state his problem and through which attention can be focussed on reality problems, which may be as full of conflict as emotional problems" (Austin, 1948, p. 205).

Procedures such as reassurance, clarification and encouragement are used to prevent the bad effects of accumulated strains and to preserve self-confidence in the client. The use of educational techniques should be made with great care so as not to give the client an impression that the worker wishes to improve or reprove him.

Summarily this form of treatment can be said to include "... some of the elements of the old classification of environmental treatment but is enriched by the use of relationship in treatment and by psychological knowledge about the way external dangers generate anxiety and weaken the ego" (ibid).

3.7.2 Psychotherapy

Austin (ibid) defines psychotherapy as a form of treatment "... designed to bring about some modification of behavior and attitudes, and rests on a diagnosis of the total personality". Further on she quotes Dr. Ackerman who defines it as "... a systematic interpersonal procedure in which a professionally qualified person excercises a deliberate, controlled influence on the psychic functions of the patient. The aims of such procedures are, on the one hand, to eliminate psychic disabilities and, on the other, to promote positive, healthful growth of personality".

From these two definitions it transpires that a sound relationship is the basis of successful psychotherapy. Diagnosis of the total personality and the influence of the psychic functions of the patient can only take place where a good warm relationship has been established. This means that this treatment is not short-term.

Austin makes a further breakdown of this form of treatment into insight therapy on the one hand and supportive therapy on the other hand. In fact these subcategories can be represented on a continuum, with insight therapy and supportive therapy at the two extremes and "experiential" or intermediary therapy in the middle.

3.7.2.1 Supportive therapy

This form of treatment is used mainly with chronic cases where the problem lies in the personality of one or more of the members of a given family group rather than in the environment. The aim of this treatment is to prevent further beakdown.

The treatment focusses on supportive techniques such as reassurance, permissive attitudes that relieve guilt and a protective relationship, along with work in the environment. All these are aimed at supporting ego strengths. This means that the clients helped through this method have weak ego structures. Severe neurotics, infantile personalities and psychotic characters are within this group.

Because of the nature of their illness, these people do manage to live and function in the community in certain areas of their lives. The worker aims at maintaining present strengths and improving functioning.

3.7.2.2 Intermediary or "experiential" therapy

This form of treatment is regarded as a blending of techniques of supportive and insight therapy and aims at bringing about change in behaviour and attitudes. "In this group, change represents primarily better adaptations within the existing personality structure, although in certain cases maturation under way is carried through to completion. Change is brought about through the use of transference as the dynamic for providing a corrective emotional experience and through stimulating growth experiences in the social reality" (op cit p. 207).

The worker makes use of carefully selected interpretative techniques and becomes active in the environment on behalf of the client. This treatment is useful with clients who have strong or partially strong egos to be able to withstand the interpretation and gain insight into the pattern of their responses, i.e. their uselessness or destructiveness. This leads to a development of self-awareness, concentrated on dynamic elements only and not on genetic ones.

The worker makes use of transference to emancipate the client from early emotional ties which may be restricting his current functioning. During the transference the client allows the worker to influence his life; anxiety is reduced, and defences break down. Energy mobilised is correctly channelled. "The client then is accessible to some corrections in his way of relating to reality" (op cit p. 208).

Austin cites the following cases that have responded to

this form of treatment (ibid): "some adolescents whose ego is not strong enough at this particular period to tolerate deeper insight; young adults, either single or married, who have not fully resolved their oedipal ties in independent living arrangement, or in handling their marital problems and parent-child relationships; some more severely neurotic clients whose egos are strong enough to make a better reality adjustment, and some schizoid personalities and schizophrenics where ego controls exist."

The worker has to make regular use of psychiatric consultation in order to establish the diagnosis, to supervise the transference (lest it develops into transference-neurosis) and to guide the selected interpretations. Garrett (in Parad p. 64) points out:

> ... The chief dangers in the therapeutic use of interpretation to the client are that the worker may interpret too soon, too deeply, or too much, or that he may interpret inaccurately, or may use the interpretation as an attack.

3.7.2 Insight therapy

This form of treatment is aimed at "... achieving a change in the ego by developing the patient's insight into his difficulties and increasing the ability of the ego to deal with them through the emotional experience in the transference situation" (op cit p. 210).

As in the case of experiential or intermediary therapy, psychiatric consultation is necessary to establish a diagnosis, and the worker makes use of transference. Experienced workers are, however, able to work independently and make use of psychiatric consultation occasionally.

This form of treatment is suitable in cases of mild neurosis and character disorders where the ego is relatively strong enough to withstand the introspection used in this form of treatment. The worker makes use of interpretative techniques to help the client gain an insight into his unconscious feelings and motivation, to understand irrational impulses and to relate his past to his present. Interpretative techniques are also used to "... lead the client gradually into greater awareness of the nature and extent of his feelings, and of the unconscious motivations that underlie his actions. Relevant childhood memories are recalled and blocking emotions discharged" (op cit p. 211).

Austin has repeatedly emphasised the use of psychiatric consultation in the employment of insight therapy, intermediary therapy and supportive therapy. She further suggests that social caseworkers who wish to employ these treatment techniques, should be exposed to long and intensive teaching which includes practice in institutions where they can be in contact with psychiatrists.

3.8 Conclusion

Casework treatment is an experience shared by worker and client. The client looks to the worker for guidance; the worker provides the guidance by dint of his professional training and his position in a particular agency. The worker provides the client with this experience without making the client feel that he has lost his dignity by asking for help.

The caseworker makes use of certain techniques in helping the client, and sometimes these techniques are used in

combination. The classification of these techniques has not been an easy task for caseworkers because of the nature of the material dealt with.

From the various classifications one can conclude that there are two common elements, viz. direct and indirect forms of treatment, as originally coined by Richmond. The terminology used by the various authors differs, but there is an agreement about the fact that casework treatment is psychosocial. The worker looks into factors in the environment at one stage, and factors within the client at another stage.

Various terms have been used - clarification, development of self-awareness, person-situation reflection, insight development - which connote the same basic aim of casework: that of enabling the client to gain a better understanding of himself and of his environment, so as to adjust and cope. Changes can be effected within the client and also in the environment.

The choice of procedures is not predetermined by the worker. It is based on a sound diagnosis of the individual's personality as related to the situation and the nature of the problem. Hollis says the following on the choice of treatment procedures:

> ... The treatment of any person is an individualized blend of procedures, themes and goals. The nature of the blend is not a matter of individual worker artistry or intuition, important though these may be. On the contrary, choice and emphasis follow definite principles and rest upon most careful evaluation of the nature of the client's problem, external and internal causative factors and their modifiability, the client's motivation, and pertinent aspects of his personality. In addition, there must

> be comprehension of the nature, effects, and demands of the different types of casework procedures and of the criteria by which the worker can match the client's needs and capacities with the particular combination of procedures most likely to be of value in enabling him to overcome, or at least lessen his difficulties... The evaluative process is an ongoing one with the emphasis in treatment varying in harmony with the changing needs and capacities of the client.
>
> (1964, p. 325)

The typologies of Hollis (1964) and Austin were expounded in greater detail, because they seem to embrace the common elements in other typologies.

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CHAPTER IV

CASEWORK TREATMENT TENDENCIES WITH THE PSYCHIATRIC CLIENT

4.1 Introduction

Psychiatric social work is a special field of social work, in which the objective is to help persons with emotional and mental problems.

Casework in the psychiatric field concerns the person-to-person treatment of the patient and his family. The caseworker helps the patient and his family to accept, understand and adjust to the illness. She further helps the family to perceive the patient as a person struggling to understand himself and to discover himself as a source of fuller living.

The caseworker sees her role in mental illness not as one who knows all and can predict the outcome at all times, but as one who, through building up a relationship with the patient, will enable him to discover his potential.

The discussion in this chapter entails the taking of a social history, the practice of psychiatric social work (casework) in various settings, casework and non-medical psychotherapy and casework treatment techniques applied in assisting patients with specific psychiatric diagnoses.

4.2 Social history

The social worker does not regard the individual, the social, the material and the personal in isolation. She perceives them as interwoven and pervading the patient's life at all levels and at all times.

> ... Psychosocial theory starts from the premise that a proper understanding of man that will lead to responsible and demonstrably effective intervention requires that a balanced position be taken between man as a psychological entity and man as a social entity.
>
> (Turner, F.J., 1978, p. 2)

The practice of social casework in the field of mental illness is closely aligned with the psychosocial theory.

The need to obtain a social history of the patient was observed by Crutcher, H. as early as 1933. She said:

> ... To understand mental illness, one must know the environment (past and present) of the individual and his reactions to it, for these stresses have usually played an important part in the patient's breakdown. The patient's relationships within the family situation, both current and earlier, as well as his social relationships are important. The obtaining of such material is one of the functions of the social worker.
>
> (Crutcher, H., 1933, p. 9)

The patient's social history is essential in reaching a working social diagnosis and formulating a plan of treatment. While the assembling of facts, their interpretation and the use in which these are put are different processes, they cannot be separated in actual life.

The social history is put to different uses by the psychiatric social worker. This is determined by the setting in which she finds herself, i.e.: out-patient clinic, hospital or child guidance clinic.

Ashdown and Brown (1953 p. 157) consider a social history to be "... an account of the patient composed by a social worker on the basis of the information given by someone closely associated with him and familiar with his social environment, which gives special attention to environmental influences, including such elements as family relationships from early days onwards, material conditions such as economic level and stability, and the cultural influences of racial, religious, occupational and other groups".

The social worker has to be highly selective in the taking of a social history. Not all the information presented will be used in reaching a diagnosis. It is also time-saving to be selective and to avoid redundance. Attention should be paid to only those factors which have a significant bearing on the illness.

Munro and McCulloch (1969) observe that relatives may sometimes be reluctant to give personal information about the patient. Before taking a social history, the caseworker should first decide on which of the relatives will be used as informants and whether they will be seen separately or together. The information usually collected covers the following:

(i) <u>The patient's family history</u>

Any nervous or mental illness in the family should be

noted as far back as the grandparents (maternal and paternal). This should also cover the personalities of the parents and siblings, their stability or instability, their idiosyncrasies and the extent to which they can adjust to their life circumstances.

(ii) Home circumstances

This section should cover current circumstances. If the financial circumstances have a bearing on the illness, then information on this should be obtained to the finest detail. The social worker will require to know the patient's home and its occupants in relation to the wider community. The home atmosphere also needs to be gauged - whether the family has petty jealousies, strains and whether domestic friction is a prominent feature of the home.

(iii) Personal history

This covers the pre-school as well as the school period, the psychosexual development which calls for considerable sensitivity and tact on the part of the interviewer. If the patient was employed prior to his illness, then his employment record should not be ignored. If the patient is married, the circumstances of the marriage, the children and the patient's attitude towards having children, the personal data about the spouse are all of importance. The chronological age of the children; their sex; their individual names; whether they are welcome additions to the family or not - all such data help to complete the record.

(iv) Health

Details of the patient's physical and/or mental illness, records of any previous hospitalization are to be examined. Present symptoms as observed by a family member are to be included to give the psychiatrist a better picture of the patient's behaviour.

(v) Personality

This is the most important part of the social history. Here the psychiatrist will be able to gain a picture of characteristics which may be submerged by the symptoms of illness. The patient's mood and the extent to which he could be relied upon prior to illness should be described.

In the past psychiatric social workers felt that they were used as "time savers" by the psychiatrists in history taking. This was mainly because the psychiatrists did not recognise the taking of a history as a basis for the formation of a relationship between the patient, his family and the social worker; and that this relationship is a forerunner to treatment.

The information required for a social history (as outlined) cannot all be obtained in a single interview. The position is, however, different in an observation ward where this information has to be obtained during a single interview and where the worker cannot form a sound relationship with the relative before the patient is transferred and the relative gets involved with another worker. The period prescribed by law for the patient's stay in an observation ward, gives a sense of urgency to the whole procedure.

4.3 Service in various settings

Psychiatric social workers' practice and their roles are determined by the setting in which they find themselves.

Psychiatric social workers are employed in: state psychiatric hospitals, psychiatric wings of general hospitals, in-patient and out-patient clinics, rehabilitation centres, adolescent units, therapeutic communities, child guidance clinics, mental health centres and community health clinics. In all these settings the social workers are involved in essentially the same tasks, and all work in close collaboration with other members on the psychiatric team - basically the psychiatrist and the psychiatric trained nurse.

4.3.1 The psychiatric social worker in a hospital

The decision to certify a patient as suitable for institutionalisation in a mental hospital is often taken by two physicians, usually on legal sanction. In some cases, especially in the Republic of South Africa, a social worker's report containing descriptive material about the individual, his family and community is attached. The mentally disturbed person may be brought in by his family, employer or local police (in case of aggressive behaviour).

The psychiatric social worker may be in a position to see the patient's relatives on admission and obtain descriptive material about the individual, his family and immediate neighbourhood. This may be the initial step towards establishing a relationship with the family, a relationship which will be maintained throughout treatment. In most cases the first contact between the psychiatric social worker and relatives is merely

for the purpose of providing factual data about the practices and policies pertaining to admission and treatment.

On the other hand the patient may become known to the psychiatric social worker some days after admission when treatment by the psychiatrist has already commenced. The psycniatrist will require further particulars about the patient's background in order to relate them to the diagnosis and treatment.

Psychiatric social workers feel strongly that they should come into contact with the patient and his family immediately on arrival at the hospital, because of the anxiety of the patient and relatives. The anxiety is often activated by the nature of the illness and the prospect of possible hospitalisation which may be a first experience. Casework service at this stage will be directed at lessening the fears and anxieties.

The handling of these fears and anxieties of the patient and relatives as well as explaining hospital procedure and policy and the role the relative has to play in the treatment process requires great skill and flexibility on the part of the social worker.

Contact between the worker and the new patient is more frequent than with an old patient.

4.3.1.1 Social history in hospital service

The social history may be discussed with the psychiatrist or it may be made accessible to him through the medical file, depending on the pattern followed by a

particular hospital. Where an early diagnosis has been made, the time for obtaining a social history is very limited. A diagnosis is often made 2 to 6 weeks after admission; this allows the social worker enough time to obtain the required data for a social history.

4.3.1.2 The period of hospital treatment

The period of hospitalisation of a psychiatric patient may extend from one month to a number of years, depending on the patient's condition. The services rendered by the caseworker may then be determined by the period of hospitalisation.

Short-term care is most likely to be effective in a crisis, although the results may not be permanent. Fink et al differentiate between services rendered by the social worker and those rendered by the psychiatrist as follows:

> ... The psychiatrist is necessarily working with the illness of the patient, with those aspects of illness that interfere with resolution of the patient's inner difficulties. More usually the social worker works with those areas of wellness that can be directed toward participation in the reality of everyday living and working.
>
> (Fink, et al 1964, p. 250)

The psychiatrist has the psychiatric and medical treatment as his responsibility. He has legal authority in respect of admission and discharge of the patient.

Social services in a psychiatric hospital may then be classified into the following categories: help concerned with feelings, attitudes and conflicts in the patient or relative, and responsibilities stressing a tangible service. It should, however, be born in mind that such a clear-cut division of service does not exist in casework. The classification is convenient for social workers to enable them to report their services, because any tangible service rendered to a patient cannot altogether exclude feelings and attitudes of the patient or relatives.

Within the first category of service, i.e.: the one dealing with feelings and attitudes, the social worker's responsibility comprises:

(i) Interpretation to the patient (where possible) and his relatives of the psychiatric illness; the treatment and the problems and relationships growing out of the illness;

(ii) Help with problems concerning family relationships;

(iii) Supportive therapy; and

(iv) Psychotherapy.

Within the second category of service two areas are identified:

(i) Help with concrete, practical problems e.g. job placement, financial and other material aid,

(ii) Interpretation of outside agencies and liaison with them.

The methods of long-term casework are many, and the caseworker has to use her skill and knowledge to find the most suitable techniques for a particular patient.

(a) Help with attitudes and conflicts

Here the casework approach is used for the better understanding and acceptance of the psychiatric illness by the patient and his relatives. The nature of the service becomes individualised as the period of hospitalisation becomes extended and more knowledge of the patient is gained. The emphasis shifts from the general nature of the service towards meeting the particular needs of the patient.

Assistance to relatives in this category of service includes family counselling, family casework and marital counselling. In most cases the patient's spouse receives marital counselling. The area of concentration is usually the effect of the illness on the entire family and the impact of the family relationships on the patient's mental health. Techniques often used here are supportive therapy, sustaining procedures and insight therapy.

(b) Tangible services

These are often services which the patient cound have provided himself if he were not ill. These services are provided according to agency policy. If after diagnostic evaluation it appears as though they will be of value in a given case, then they are rendered.

Here the social worker finds herself involved in pro-

viding simple as well as complicated services such as letter-writing, locating lost articles, arrangements with the landlord or employer etc; all of which represent a meaningful individualised service to the patient.

Other tangible services require technical knowledge on the part of the psychiatric social worker, knowledge concerning pensions, insurance policies, mortgages and other legal problems.

The interpretation of and liaison with external social agencies becomes necessary with long-term cases.

Such services would include referral of the particular family for foster care of the children of a hospitalised mother, or the granting of relief to a family whose breadwinner has been hospitalised. The psychiatric caseworker then forms a link between the hospital and community agencies, because she has to provide the particular agency with information concerning the patient's condition and medical progress.

When improvement of the patient is observed, steps are taken to modify the treatment programme. When discharge or foster care is considered by the team, the social worker takes the lead in the discussion because of her knowledge of community resources. The caseworker has to handle the fears and anxieties of the patient and his relatives when the patient has to leave hospital.

4.3.1.3 Work with relatives

When the patient is admitted to hospital, the relatives

are as anxious about the hospitalisation and the type of illness as the patient himself may be. They also have guilt feelings which aggravate matters. These guilt feelings are often related to the role the relative may have played in causing the illness.

The social worker works with the relatives during this period, especially the first few days, to allay their anxieties by explaining the illness and the treatment, visiting hours, legal responsibility, means of communication between patient and relative, social worker and relative; fees; as well as other matters pertaining to hospital procedure. The relative may be taken around to get a general feel of the hospital and to meet team members who will be involved in the patient's treatment. What happens during this period of becoming acquainted, may influence the course of treatment.

The social worker forms a relationship with the patient and with a significant relative who may be a spouse, parent or child of the patient. This relationship is maintained throughout treatment and will be the foundation on which the social worker will prepare for the patient's discharge and release from the hospital.

The social worker's attention to the relatives is also based on the fact that "... relatives of mentally ill patients are often quite disturbed individuals themselves ..." (Tennant, M.A., 1954, p. 234). Psychiatric consultation is often made available to the relatives.

The patient's illness may result in tensions and anxieties in the relatives. Unless these are handled timeously and appropriately, there will be no point in releasing

the patient into such an environment when the time for discharge comes. Ashdown and Brown (op cit p. 172) mention that the social worker has to concentrate on removing the "sting" which is caused by the turmoil inside the relative.

The social worker needs to understand the relatives and their attitude towards the patient and his illness. The family has a long-term responsibility involving constant planning and personal sacrifices which may not be easy to shoulder. The social worker then moves in with sustaining work to enable the family to cope without further breakdown.

Faris has the following to say about the matter :

> ... The way in which the relative participates is important whether the problem is one of taking responsibility for admitting a suicidal patient to the hospital, of being able to relinquish control over a patient and allow him to develop more independence, or of firmly limiting the hysterical person who flies in every direction at once in dependent, hostile outbursts.
>
> (Faris, M.T., 1955, p. 110)

Freeman (1947) mentions that the social worker encounters with three types of families:

(a) Those that are capable of meeting the patient's demands and needs. This family has real interest and concern for the patient. They are responsive to suggestions, reassurance and simple interpretation of mental illness.

(b) Those that present problem attitudes which are modifiable. These relatives have emotional disturbances of their own which affect the patient's readjustment, if overlooked. These relatives may be so disturbed that they may lean heavily on the patient, even while he is still hospitalised. They may feel that they need help for themselves, and if such help is provided, they will then be less dependent and place less emotional pressure on the patient.

(c) Those that have a rigid and flexible pattern of attitudes. In this family foster care (cf. 4.3.1.5) is often the answer, until the family can be given thorough attention to modify their harmful attitudes which will obviously retard the patient's readjustment. The hospital will sometimes need to assume an authoritative role. Most relatives find themselves too preoccupied with their own needs and frustrations to be able to give the patient the required emotional support and care during and after hospitalisation.

4.3.1.4 Aftercare

From the historical development of psychiatric social work it is evident that the issue of the aftercare of discharged patients brought the psychiatric social worker on to the scene. Aftercare essentially means that the patient is a medical and legal responsibility of the hospital and continues to be such until his aftercare period is successfully concluded and the patient is discharged. This is so because even after the patient has left hospital, he is being treated

with certain types of drugs, which requires that he be closely watched and supervised.

Patients receiving aftercare services are patients that are released from hospital and are no longer receiving 24 hour care from the hospital as in-patients. The psychiatric social worker plays a dominant role here as the one person who maintains a link between the patient's home and the hospital. The aim is to make constant visits to the patient's home to assess the situation in terms of a good readjustment of the patient.

The link between the social worker and the patient is easiest to maintain only where there are no problems of transport and distance.

The hospitals often refer patients to agencies, e.g. mental health societies in South Africa, which have no link whatsoever with the hospital.

The psychiatric social worker's responsibility in the aftercare of the post-hospital patient falls into the following broad categories:

(i) An objective evaluation of the situation to which the patient is about to return;

(ii) Assistance with the attitudes and feelings of patient and relative activated by the imminent changes in the patient's situation;

(iii) Assistance with changes in the patient's social situation which could lead to a better adjustment outside the hospital.

4.3.1.5 Foster home care

This is yet another area which requires great competence and skill on behalf of the psychiatric social worker. Foster home care involves the placement of discharged mental patients in homes other than their own on a temporary basis.

Very few hospitals make use of this service because of its demands on staff and funds. The patients are financially maintained by the hospital while under foster care.

While the psychiatrist has the responsibility of selecting patients suitable for foster home care, the psychiatric social worker, because of her knowledge of community resources, selects a suitable family for the patient.

The psychiatric social worker has to ensure that the needs of the patient are suitably met by the selected family. She maintains contact with the family while the patient is with them, and at the same time she works on the patient's own family to prepare them for his ultimate return home.

Some patients return to their own families, while others make other living arrangements with or without the help of the social worker.

4.3.1.6 Discharge from the hospital

When a patient is discharged from hospital, there is a shift in emphasis in the services of the social worker.

There is a shift from work with relatives in the direction of work with the patient. The patient is assisted in understanding and adjusting to his environment, while earlier help was directed at helping the patient to understand his illness (where possible), the treatment and hospital procedures.

There is an emphasis on community resources which will be utilized for the readjustment of the patient to his environment. The preparation of the patient for discharge must begin the minute the patient enters the hospital.

Unless a patient is well prepared by the hospital for what life is like outside, he will find readjustment so difficult that he would prefer to remain in hospital.

The danger of long-term institutionalisation is that the patient becomes so adjusted to the institution that he develops a sense of belonging and perceives the outside world as a threat.

If he is declared medically fit for employment, efforts are made to help him find a job. In most cases this service is provided by social workers in the community.

The psychiatric social worker remains a link between the hospital, the patient and the community agency. Should re-hospitalisation prove necessary,the social worker will be at hand to explain readmission procedures.

4.3.2 The psychiatric clinic

The psychiatric clinic is another area in which the psychiatric social worker helps the mentally disturbed person.

The clinics in question are of the nature where the patient is treated on a daily basis but lives with his family. The majority of these clinics are attached either to a hospital, a school, or a juvenile court. There are however community sponsored clinics and child guidance clinics. Child guidance clinics will be discussed later (cf. 4.3.3).

The role of the social worker here differs from that of the hospital based psychiatric social worker, although at times the clinic may be considered as an extension of the hospital and the same social worker may attend at both the hospital and the clinic.

The role of the clinic psychiatric social worker may be perceived in the following areas:

4.3.2.1 The intake process

During this stage the psychiatric social worker meets the prospective patient or relative. The patient and social worker explore the possible problem area and examine the agency resources in relation to the difficulty.

Here the clinic and what it offers, are interpreted to the disturbed person or relative, who will be assisted in making a decision as to whether he will benefit from the services or not.

The service rendered at the various clinics mentioned above is essentially of the same kind, with a slight difference in emphasis on certain areas during history taking.

4.3.2.2 Services prior to the intake interview

These services are brief in nature and are provided in cases where it has been assessed that the service requested will not be given at the clinic. When it is discovered that the clinic is able to offer the services required, then this stage merges with the intake interview.

These services are provided upon request by a person who may be concerned about a prospective patient's behaviour. Such referrals are often made by teachers, nurses, psychologists, judges, probation officers or other social workers. The independent or community-sponsored clinic receives requests from the community at large.

The role of the psychiatric social worker here involves the interpretation of the clinic to the entire community or source of referral, and the referral of the patient to a suitable social agency. In cases where the referral comes from a professional body, the function of interpretation assumes the features of interprofessional teamwork.

4.3.2.3 The intake interview

In virtually all clinics the intake interview is the sole responsibility of the social worker.

The person seeking psychiatric help comes to the clinic with doubts and fears as well as anxieties that are accompanied by resistance and hostilities. The psychiatric social worker has had the necessary training to handle these feelings.

The intake interview is often held with the patient himself, where his condition allows, or with a spouse or other relative. At times the intake interview is held with a representative of a social agency in the place of a relative.

In cases of adolescents referred by the juvenile court, the youth may be seen first and later his parents.

During the intake interview the social worker is largely responsible for helping the prospective patient come to a decision about accepting or rejecting treatment and also preparing him for the interview with the psychiatrist. The social worker seeks information from the patient concerning his age, residence, previous medical history, whether they can afford the fees or not and whether they are eligible for State assistance or some other form of help.

After the first psychiatric interview a conference is then held by the therapeutic team for discussing the information gathered and for planning treatment. The team has to arrive at a joint diagnostic formulation, which is the final step in the intake interview. It should, however, be borne in mind that any separation of intake and diagnosis is superficial.

4.3.2.4 Social history in clinic service

Berkman (1953, p. 58) says that psychiatric social workers define "social history" according to the time at which the information is acquired and its scope, but that they all agree that it is their responsibility.

In a large number of instances the taking of the social history is combined with the intake interview. It is usually not possible to acquire all the required information for a social history in one interview. The taking of the social history may stretch over a period while fragmentary information is put together to form a meaningful whole. The information acquired serves as a foundation for future work with the patient.

4.3.2.5 The period of psychiatric treatment

During this period contact is maintained with the patient and his relatives. The social worker offers tangible service while dealing with fears and anxieties on the other hand. As in the psychiatric hospital, there is a complementary relationship between psychiatrist and social worker.

At one stage therapy is undertaken by the psychiatrist and at another stage it is done by the social worker, under the close supervision of the psychiatrist. The social worker makes use of the skills and techniques in casework, and she is indebted to the psychiatrist for her understanding of the psychiatric patient.

Casework treatment techniques such as clarification, counselling and supportive treatment are also used as

well as psychotherapy to supplement the treatment given by the psychiatrist. Supportive work is often used with adult patients and not with their relatives.

There is an agreement that the psychiatric caseworker uses her knowledge and understanding of the individual to help him (the patient) define his problem in terms of his living situation. She stresses those problems of an interpersonal nature and then tries to help him come to grips with his reality situation. She is guided by the principle of acceptance and the non-judgmental attitude.

The caseworker may recognise the existence of deep negative feelings within the patient towards a mother, father or sibling. The illness may be related to the way in which these feelings have affected the patient's basic relationships. "She accepts the patient's viewpoint that his feelings have arisen out of his previous personal relationships but makes no attempt to uncover repressed material involving instinctual drives" (Wood, 1953, p. 65). The psychiatric caseworker leaves the uncovering of unconscious material to the psychiatrist because "... to work with unconscious material involves experience and skill in that area, as well as self-discipline coming out of understanding one's own instinctual drives" (op cit p. 66).

The psychiatrist may terminate his treatment before the social worker is ready to terminate contact. The social worker may maintain the contact directly with the patient or through relatives and/or a social agency.

With regard to queries of former patients, the social worker becomes the representative of the clinic.

4.3.3 The child guidance clinic

This area in which psychiatric casework is practised will not be discussed in great detail, because the agency at which this study was undertaken does not offer child guidance services.

The child guidance clinic has as its fundamental aim the treatment of the socially and emotionally maladjusted child who lives at home.

The significant influence of Freud and other psychoanalysts during the early stages of social work, led to the development of the Child Guidance Movement. Freud and his psychoanalytic theory of the importance of the first five years of life led to the belief that mental illness could be prevented in adults if children got the proper attention early in life.

The Mental Hygiene Movement (cf. Chapter II), was also interested in the mental health of the child. This interest led to reformed treatment of the juvenile delinquent. It was believed that an understanding of the adult criminal should always begin in understanding his early life. Interest in delinquency and the Child Guidance Movement went hand in hand.

The first child guidance clinic was established in Pennsylvania in 1885 by Chapin. Other institutions later followed the example of the Pennsylvania State Hospital. Some of the clinics established were attached to State hospitals, while others were attached to juvenile courts.

4.3.3.1 Types of cases and the procedure

The child guidance clinic approaches the child and his problems as a "totality". The social worker with her training in the behavioural sciences cannot claim to have the complete ability required in this holistic approach. She works in close liaison with experts such as the psychiatrist, psychologist, nurse, home-maker and home economist. The most desirable ratio has been suggested as one psychiatrist and one psychologist to three social workers.

Most cases come through referral from schools, churches, child welfare agencies and juvenile courts, but some may come through direct requests for help by parents.

Because of the lack of manpower, the child guidance clinic concentrates on children who are "total life problems", i.e. a child whose functioning is problematic at all levels. Treatment may call for regular interviews between the child and psychiatrist, as well as between the parent and social worker. At times, especially where treatment has been continuing for some time, joint interviews of parent and child may be held by the social worker.

The child guidance clinic concentrates on direct treatment, i.e. the treatment is aimed at modifying certain things within the child and his parent, and not conditions in the environment. The environment is included only in as far as it has an influence on the client's needs and problems.

The types of cases handled at the child guidance clinic are: disobedience, negativism, stubbornness, rebelliousness, nervousness, temper, stealing, truancy (home and school), lying, feeding difficulties, retardation in school, "does not get along with other children", enuresis, school failure, speech difficulties, disturbing behaviour in school, thumb-sucking, placement, adoption, overactivity, shyness, withdrawal, sleep disturbances, fears and excessive fantasy.

Not all the clinics deal with all the problems mentioned above. The various clinics select the types of problems depending on peculiarities of staff, community needs, resources and special circumstances of a particular time.

The intake work is done by the social worker to determine the type of problem and whether the referral was relevant. Here the social worker assesses whether the clinic will undertake the case (this may sometimes call for staff consultation) and whether the case will be a long or short term one.

The caseworker's training equips her to evaluate with the person seeking service (usually a parent) and to assess her readiness to use it and the effect of environmental pressures. The applicant is presented with a total picture of the services available to enable her to arrive at a decision. The parents' ability to support the child during treatment is assessed, and the parents' own problems in relation to the child are attended to.

The social worker's task in child guidance calls for

much skill, because she does not form a relationship with the person to be helped (the child) but with a person who seeks help on behalf of another (the parent). The parents should be helped to see their role in treatment and to give the child such support that he will be able to assume responsibility in making use of the treatment himself and thus benefit from it. For the caseworker, "... such balancing of relationship means the fullest utilization of casework ability to establish the professional relationship while maintaining the focus of this as a supporting relationship rather than one with its direct purpose" (Sylvester, 1955, p. 150).

The child then undergoes a physical examination (where necessary) and a test conducted by the psychologist. In the meantime the social worker starts compiling the social history. Data are collected from the parents and teachers. The caseworker must be continuously aware that she should seek data that will be of value and importance to other team members in the planning, offering and giving of service.

The psychiatrist shares the information with the social worker and the psychologist, but he has the sole responsibility of interpreting such data. This interpretation will guide each team member on how to be of assistance to the child. If there are problems in specific areas, the relevant team member assumes leadership, e.g. the physician where there are physical problems, etc.

In their treatment of the child the clinic staff always have in mind that for every problem child there is a

problem parent (Stroup, 1960). The child's family is the chief social influence in his life.

The caseworker gives continuous support to the child and to the parents. She deals with the parents' feelings, needs and tempo.

Regular conferences are held with the psychiatrist, so that each should know of the progress of the other.

The caseworker's role in child guidance may therefore be summarised as follows:

(a) She must develop and maintain a relationship with the parent and define the parent's role in the treatment programme.

(b) She collaborates with the therapist to understand and recognise the child's problem and the help given.

(c) She must define to the therapist the parents' relationship to these problems and the role the parents have played in creating these problems.

(d) She utilises the knowledge gained of the child's needs of the process in therapy and of the parents' relationship to this.

4.4 Casework and non-medical psychotherapy

The psychiatric caseworker is expected to work with a heterogeneous client population where she renders services of various kinds depending on the problem.

Another problem area encountered by the psychiatric caseworker is the "younger-older person relationship" where the generation gap and related issues are handled through expert counselling.

4.5 Casework treatment techniques with specific psychiatric types

The practice of casework in psychiatric settings makes it particularly necessary for the practitioner to "... adapt basic skills to the needs of clients who are excessively unrealistic and fantasy-ridden. Such adaptation essentially means learning to link in with ways of thought and feeling which at first are likely to seem alien, since only in this way can our relationships with clients become established and make possible a helping process" (Ferard, M. in Goldberget al 1957 p. 19).

The patient in psychiatric social work is not someone who is capable of self-direction. The psychiatric social worker may therefore not be justified in refusing to treat these clients because she has a preferred method which she does not wish to adjust. Some patients may improve to an extent that the psychiatric caseworker may not need to make adaptations in her handling of them, although in some cases the problem may be presented in a more lasting form.

The selection of treatment techniques is determined by the nature of the worker-client relationship. The nature of the relationship between worker and client differs from that formed between psychotherapist and patient mainly in depth, because casework is not aimed at pro-

found personality changes, but rather at changes in underlying attitudes which will make life more tolerable, both for the patient and his relatives.

When a relationship is established between one who seeks help and the one who offers help, there are unconscious forces that come into play. The patient may unconsciously project on to the worker feelings and attitudes that are irrelevant to the situation but that were felt towards significant figures, usually parents or close relatives, earlier in life. The caseworker, unlike the therapist, will strive to maintain a balance between the "inner" and the "outer" needs of the patient, although it is to be accepted that some of the patients dealt with in this field are not capable of insight.

Goldberg (1953, p. 12) has this to say when discussing the use of relationship in psychiatric social work: "... the use of relationship needs to be carefully adjusted to the setting in which we work, to the type of client and problem we deal with, and the aims we are pursuing."

In outlining the various treatment techniques used by the psychiatric social worker, the specific psychiatric types are designated according to the classification of Munro and McCulloch (1969). The various symptoms will be discussed very scantily, if at all, because it is felt that they are not the subject matter of this study.

In the actual practice of casework, patients cannot be categorised under a blanket label of "psychotics" or "neurotics" - "An individual's being psychotic or not

may be secondary to a consideration of other factors such as current life adjustment, his degree of relatedness to reality and the strengths he brings to treatment" (Brill, 1953, p. 176).

The caseworker relies on the psychiatrist's final diagnosis (which may come at the termination of treatment), but this is not perceived in isolation, because mental illness does not take place in a vacuum. Social and environmental pressures exert an appreciable influence on the causation of mental illness, and this is where the caseworker's concern lies.

4.5.1 Psychosis

Some of the early workers were skeptical about the treatment of psychosis and did not hope to achieve any positive results in this regard. Freud believed in the schizophrenic's ability to establish a transferrence and benefit from therapy, although Federn disagreed with this (Brill op cit). Federn believed that "... every psychotic had enough intelligence to grasp and accept the explanation of his own mechanisms; and felt that psychotic productions must be analysed to be understood" (op cit, p. 168).

Psychoanalysts like Freud and Federn had an influence on the casework treatment of psychotics. Federn for example discarded the use of the couch, "free association" and long histories. He instead "... emphasized the special need to work closely with the psychotic's family and to help him achieve a satisfactory social adjustment" (ibid). He further emphasised a life-long contact to prevent a relapse.

Sullivan on the other hand spoke strongly against strict classifications of mental illness. His approach to treatment was not in terms of classifications but in terms of "... understanding ... all mental disorder as an expression of, and attempt at warding off, anxiety which is always seen in an interpersonal frame of reference" (Brill op cit p. 169).

Brill points out that casework has lagged behind in applying the most recent findings of psychiatry in the treatment of psychotics.

Caseworkers should note that the psychotic has varying strengths which he brings with him to treatment. Such patients have been discovered to have a frustration tolerance, reality testing, denial and are capable of insight, growth and cure. These patients are therefore sensitive to the presence of disrespect, pessimism, and anxiety in the therapist. The worker should be honest and able to admit mistakes. Hollis' reflective discussion of the person-situation configuration may be an appropriate technique with these patients. This technique is important in building up the patient's sense of reality.

The goals set by the caseworker should be individualised in terms of the client's own needs and not in terms of conventional methods.

There are unusual demands on the worker's patience and flexibility in terms of the patient's attempt at social adjustment. The worker should therefore be able to respond appropriately to the needs of the individual client by assuming a maternal attitude of permissive-

ness, walking or shopping with the patient at one stage or assuming a firm protective and direct manner at another.

4.5.1.1 Functional psychosis

There are two major classifications here, viz. the affective disorders and schizophrenia:

(a) Affective disorders

The most common form is depressive illness. It is treatable outside the hospital, but if the patient shows signs of possible suicide, then an order for compulsory hospitalisation should be made. The patient may be treated with drugs or E.C.T. (electroconvulsive therapy) in very severe cases.

When the patient is hospitalised, there are a few problems. The family or relative has to be reassured that the condition is temporary and treatment short-term.

The patient himself requires reassurance and guidance; because his short stay in hospital may affect his job. During the period of recovery the patient will benefit from further sustaining work, because his self-confidence may have suffered and his ability to resume his former roles may have been affected.

With the outpatient the social worker should be on the look out for fluctuations in mood states, which may at times lead to suicidal tendencies. The caseworker should communicate any signs of indications towards suicide to the psychiatrist, because suicide is a common and serious problem with the depressive patient, and its possibility should never be ignored.

Another type of affective illness is mania, which can be regarded as the antithesis of depression. In some cases mania and depression may occur in the same individual. The patient usually refuses hospitalisation, as he regards himself as perfectly normal. He requires help and encouragement to enable him to accept treatment.

The family and dependents need help of a material as well as psychological nature, because due to his uncontrollable behaviour the patient may have incurred debts, damaged property and strained relationships due to his extramarital adventures. Support and practical advice are necessary.

Usually after treatment the patient may develop depression and the caseworker should keep a close watch.

(b) Schizophrenia

In this disturbance there is no true intellectual deterioration, and if the patient does recover, the recovery may be complete. There are four types of schizophrenia which are not exclusive, because the patient may change from one set of symptoms to another during the course of treatment. The four types are: Simple, Catatonic, Hebephrenic and Paranoid. These patients form the highest percentage of psychiatric hospital inmates.

The hospitalised schizophrenic should be kept occupied, and efforts should be made to ensure that he is never isolated. The caseworker should always bear in mind: "Patients do respond to warm, friendly environments where they are treated with respect as individuals. Conversely, when they are locked up in crowded wards,

deprived of almost all human rights, and given no attention, they tend to become more withdrawn and unco-operative" (Kelly, 1965, p. 34).

The schizophrenic requires personal contact of the hospital personnel as well as the relatives who are encouraged to visit regularly. At times the relatives themselves may be distrubed and filled with anxiety and therefore require attention. Lines of communication between the hospital staff should always be open so that the family may feel free to discuss whatever problems they may have. In mild cases the hospital may serve as a therapeutic milieu.

Where the prognosis is good and improvement is observed, the patient should be encouraged to undertake short visits to his own home. This requires much involvement on the part of the social worker, because not only the patient should be ready, but also his family should be in a position to receive him and give him the necessary support.

When final discharge is imminent, the patient will require assistance with a job. He may not be in a position to return to his old job, even after complete recovery. The patient and his family will then require practical help and support.

Most schizophrenics become detached from their families because of the type of illness and lengthy hospitalisation. Where there are no half-way houses for ex-patients, the caseworker has to arrange accommodation and keep constant contact to help prevent a relapse. The ex-patient may also require supervision if he is still on drugs. Most patients can, however, function on their own without casework help.

When trying to arrive at casework goals with these patients, the caseworker should try to determine realistically in what areas and to what extent a capacity for improvement exists.

The treatment of schizophrenics with shock therapy places added demands on the social worker as well as relatives. The social worker should be in possession of the technical knowledge of the procedures involved to make it easier for her to help the patient or the relative to understand and accept the purpose and technique of the treatment, its possibilities and limitations.

The patient who has to undergo shock therapy, should be visited at regular intervals by the social worker, and reassurance should be given. Adjustments should be made to the social worker's treatment techniques to enable her to relate meaningfully to such a patient. This relationship should be a unique experience for the patient and it should not contain elements of authority.

In working with relatives, the caseworker has to realise the special responsibilities placed on them as the persons who have to give consent for this form of treatment. The relative may suffer from guilt feelings and inflict punishment on himself during the patient's hospitalisation and for an indeterminate period thereafter.

> ... It should be remembered that the final decision regarding the administration of shock treatments rests with the relative who signs consent and that this involves a serious responsibility for not only the present but the future welfare of the patient.
>
> (Ryerson, R., 1945, p. 294)

The treatment of patients with shock therapy has resulted in a high percentage of discharges from hospital. These patients still require the protection of the hospital, because at this stage sufficient stabilisation has not occurred to assure lasting improvement.

Ryerson says about casework treatment of these patients:

> ... The direction of case work treatment with the post-schizophrenic patient is towards synthesis of the patient's personality, the aim being to aid in whatever way possible the repression of the conflicts precipitating the breakdown, a decrease in self-preoccupation, and the diversion of the patient's energies toward normal external interests.
>
> (Ryerson op cit p. 292)

Kelly recommends that social workers should be involved in extensive community rehabilitative programs, because he believes that the rehabilitation of the schizophrenic should be long-term and should be designed to meet individual needs. According to him most patients who are placed in productive employment, usually get relapses because of lack of contact with social work services which could sustain the patient. He feels that all those who are involved in the treatment of schizophrenics, would do well to realise their limitations (Kelly, 1965).

(c) Pueperal psychosis

This is a preventable functional disorder which occurs in women following childbirth. It occurs mostly in women with a neurotic disorder. The disorder may flare up because of the woman's fear concerning whether she will be able to look after the baby well. The symptoms

may be a mixture of affective and schizophrenic symptoms, but most are manic-depressive.

The patient may respond well to reassurance, sedation or psychotherapy. The rest of serious psychiatric illnesses should not be overlooked because of the many hormonal disturbances during this period.

4.5.1.2 Psychiatric conditions due to old age and to organic causes

(a) Psychiatric illnesses of old age

There are various forms of mental illnesses in old age. Some are, however, known to have a good recovery rate. It is common knowledge that mental as well as physical capacities deteriorate during old age. Mental states may be affected by physical illness as well as environmental pressures, especially changes in the environment.

Old people also have neurotic illness which is often ignored and generally dismissed as the inescapable effects of old age. The neurotic symptoms represent a breakdown in the old person's defences, and the social worker could move in with practical help and supervision. Help should be directed towards making the patient's life a happy and pleasant one.

The psychotic illnesses peculiar to old age fall under five main categories.

1. Affective disorders

These are the most common and take the form of depression

rather than mania. The depression is mainly due to physical changes such as illness, blindness, loss of hearing and also bereavement and subsequent loneliness. The risk of suicide is high, and this makes hospitalisation a necessity.

The social worker can do sustaining work and shorten the old person's period of agitation and uncertainty. Practical aid as well as supportive visits may prove rewarding.

2. Late paraphrenia

The patients here are a mixed group, although most of them suffer from schizophrenia of late onset. Although other factors such as isolation and physical illness contribute to this illness, most patients have had schizoid tendencies earlier in life. There are also paranoid tendencies which may lead to lack of co-operation and make the social worker's task a difficult one. Hospitalisation may be necessary when the patient makes an unnecessary fuss about her delusions and causes social disturbances. If the patient lives in a solitary situation, alternative accommodation should be arranged.

3. Organic psychosis in the elderly: delirium

This illness may be caused by physical illness or organic brain damage. Certain drugs, if used excessively, may cause delirium. The common symptoms are confusion, disorientation and memory disturbance. Treatment of the mental state should be treatment of the underlying illness. Services such as district nursing, home visiting and meals on wheels help the patient towards recovery.

4. Organic psychosis in the elderly : dementia

Here the brain has deteriorated, and this often leads to death. There are two forms of dementia; viz. senile dementia and arteriosclerotic dementia. The first group is due to brain atrophy; the second is brought about by disease of the cerebral blood vessels. Practical help from the social worker helps the relative to cope with the patient.

(b) Psychotic illnesses due to organic causes

Organic illness can appear at any age. These may be classified as delirium or dementia depending on whether there is recovery or not.

1. Delirium

This may be closely associated with certain physical illnesses such as pneumonia, typhoid, etc., as well as the use of certain drugs. This condition is, however, reversible. The condition may not require social work intervention, except where there are problems such as drug addiction or alcoholism.

2. Dementia

This disturbance is due to brain damage. Here the patient's mental state deteriorates gradually, and the patient may never recover his faculties. Hospitalisation may become necessary. The social worker needs to give the family support and to make it possible for them to cope with the patient at home for as long as possible. The patient may be able to resume his role prior to the illness, and the family should be helped

in adjusting roles. The patient's behaviour may be unpredictable, and the family may find itself involved in a lot of problems. Patients in this group may be those suffering from after effects of head injuries and epileptic cases.

4.5.2 Psychoneurosis and psychosomatic illnesses

1. Psychoneurosis

This type of mental illness is less severe than psychosis. There are five subdivisions of this illness, and their symptoms are so closely related that the divisions are not mutually exclusive. The subdivisions are: anxiety neurosis, neurotic depression, obsessional neurosis, phobic states and hysteria. The symptoms may be physical as well as psychological.

The majority of cases of psychoneurosis never need to be attended by a psychiatrist. Where the symptoms are relatively mild, the patient can be helped by the social caseworker who gives reassurance, lends a sympathetic ear and is readily available in times of crisis. The patient may experience a great deal of relief from tension by talking to someone who is sympathetic, does not condemn and does not moralise.

Supportive therapy is the most appropriate technique with these patients. The more severe cases are referred to the psychiatrist, by whom they may be treated individually or in groups. The patient is enabled to re-live the anxiety producing experience and thus overcome his problem (mood, hysteria, etc.).

The social worker makes use of the hospital or clinic as a therapeutic milieu which encourages recovery by helping the patient to develop his social potential and to take responsibility to help others. The patient is kept in constant contact with other human beings, which prevents isolation and thus rekindling of anxieties and silent suffering.

2. Psychosomatic illnesses

Mind and body are inseperable in health and illness. Psychosomatic illnesses are complaints which are often found to have emotional rather than physical origins.

Kisker (1952, p. 29) describes these illnesses as follows:

> ... These reactions represent visceral expression of affect which may be thereby largely prevented from being conscious. The symptoms are due to a chronic and exaggerated state of the normal physiological expression of emotion, with the feeling, or subjective part repressed. Such long continued viscertal states may eventually lead to structural changes.

Psychosomatic illnesses are therefore by-products of a process by which the body is attempting to project itself against adverse influences, be they internal or external.

The more common psychosomatic illnesses are cardiovascular disorders, gastrointestinal reactions, respiratory reactions, skin reactions, genitourinary and muscular reactions and disorders of other body systems such as endocrine glands and the skeletal system.

4.6.3 Suicide and attempted suicide

The suicidal act is not always indicative of mental disorder. Causes of suicide are varied, and the act may be a result of mental disorder, an attempt to change another's behaviour or attitude or to call for help for oneself.

In psychotic suicide acts depression is caused within the person, and in non-psychotic acts depression is due to factors in the environment.

Suicidal behaviour can be represented on a continuum with the desire for death at the one end, and an attempt to call for help with no real wish to die at the other end.

The social worker should be able to locate where her patient fits on the continuum, because this helps give direction in the treatment approach. Most of the persons who attempt suicide, end up in hospital. The social worker should then be easily accessible to the patient and the key acquaintance, who may be the person closely embroiled in the situation at the time of the attempt.

The social history should be obtained immediately, so that treatment can be effected while the information is fresh and the worker can assess what the precipitating factors were and who the key persons are.

The suicidal attempt causes a disruption in the patient's immediate environment, and the act itself may be an indication of the presence of an ill person in the patient's immediate environment. The patient's behaviour may be a

way of wishing to bring about modification in the behaviour of a key person. After contact with the social worker an improvement in the patient may be an indication that the key person has changed his undesirable behaviour.

The caseworker has an "unrivalled opportunity to step in with treatment before the old emotional situation reasserts itself and also to try to alter any adverse material circumstances which have been causing distress" (Munro and McCulloch op cit p. 202). Attempts to treat the patient as an entity are useless; the partner should be brought into the therapeutic situation. The caseworker has to make a quick assessment of how much support the patient can get from the environment.

Where suicidal behaviour is a result of mental illness, the patient is referred to the psychiatrist.

4.5.4 The personality disorders and psychosexual disorders

4.5.4.1 Personality disorders

Personality disorders are a manifestation of recurring maladaptive behaviour, usually a lifelong process, as opposed to manifested symptoms. These patients do not usually suffer from symptoms, but they have problems in living. They do not usually seek help unless urged to do so by persons who have observed that they are leading an unsatisfactory life. There are various types of personality disorders, but the various groups have characteristics which are not exclusive to any one group.

(a) The anxious personality

The majority of anxious persons do not require treatment for the particular train if it remains within reasonable limits. If the tension symptoms become troublesome, then psychiatric treatment becomes necessary. The person's life may have been affected in the domestic and work sphere, and this may increase the tendency to be anxious. The social worker looks into this area to see if any remedy can be applied.

(b) The depressive personality

Psychotherapy of the supportive type is essential in dealing with this patient. Practical aid consists of helping the patient to develop self-confidence and make his own decisions. When dealing with this patient, the caseworker should not miss an actual depressive illness.

(c) The obsessional personality

The problems of the obsessional personality are observed when his strictness and rigidity lead to environmental problems and social ostracism and when his tension and depression prevent complete relaxation. Whatever treatment is instituted, it is directed at the secondary psychiatric features such as tension or depression.

(d) The hysterical personality

Most of these patients do not require treatment. If their problems are caused by interpersonal relationships and anxiety provoking situations, the social worker is called upon to give supportive treatment and to

focus on the external factors rather than on the patient himself. The family is often found to be worn out because of the patient's emotional outbursts. The social worker will focus on giving them support and help of a practical nature.

(e) The cycloid personality

This patient will find that his mood swings interfere in his job and in interpersonal relationships. The social worker meets such persons quite often when dealing with manic-depressive relatives, and she should identify the patient as a potential manic-depressive.

(f) The schizoid personality

The aloofness of this patient results in problems in the relationship with his spouse and children. A mother may be unable to provide the children with the necessary warmth and support. She may be insensitive to their pains and emotional needs. The children will then display behaviour problems. The social work approach is effective to ensure that the family receives the necessary emotional support.

(g) The affectionless personality

The affectionless personality oftend needs to be confined, because he is dangerous both to himself and to others. He may have suicidal tendencies. He is often a product of emotional deprivation during early childhood.

(h) The paranoid personality

This patient may prove difficult to handle because of his unfounded complaints and convictions. It may sometimes be necessary to refer him to a psychiatrist for management.

4.5.4.2 The psychopath

The treatment of the psychopath is uncertain, because he does not regard himself as ill. He is therefore an unwilling patient. The social worker often comes into contact with him when handling his spouse or children who have been affected by his asocial behaviour. The social worker should be forwarned when dealing with the psychopath and know exactly on what terms she is meeting him; lest he take advantage of her role and make her do what he wishes.

4.5.4.3 Psychosexual disorders

The development of the sexual drive may be adversely affected for some reason, and this may result in a variety of effects. There are certain forms of sexual behaviour which are socially acceptable, while others are shunned by society. The most common psychosexual problems which the social worker comes into contact with are: impotence, frigidity, masturbation, lesbianism and homosexuality. These conditions do not, however, indicate the presence of mental illness. The social worker can handle these with reassurance and supportive treatment.

Human sexuality may be perverted and certain sexual deviations reflect inadequate emotional development, lea-

ding to the patient deriving sexual pleasure by inflicting or receiving pain. These deviations are: sado-masochism, voyeurism, exhibitionism, transvestitism and trans-sexualism. Most of the patients come to the attention of authority after creating a public nuisance or after committing a crime of sexual violence.

4.5.5 Alcoholism and drug dependence

4.5.5.1 Alcoholism

Alcoholism is a social problem in many civilised cultures, except in the Muslim countries where drinking is completely shunned. Treatment of the alcoholic can be successful in cases where he is hospitalised and physicians as well as psychiatrists are involved in his treatment.

The alcoholic's relationship with his family and other close contacts, especially in his work situation, deteriorates because of his persistent irritability and self-imposed social isolation.

Social workers often come into contact with alcoholics who have fallen out of the sphere of medical treatment or who have had a relapse after hospitalisation. Some have proved resistant to treatment.

Some alcoholics are beyond treatment. Others who are well motivated often benefit from social support and practical help from the social worker. The social worker may help him in finding a job or straightening out his finances and repairing broken social ties. The social worker acts with authority while remaining non-moralistic, especially when the alcoholic's problems

overwhelm him to the extent that he resorts to drinking again.

The wife of the alcoholic becomes the centre of attention, due to the problems caused by the patient's behaviour. The problems she encounters often lead her to seek psychiatric help for herself. She may either be a strong person able to deal astonishingly with the situation, or she may be excessively meek and passive and accept the blows she receives without complaint.

The children suffer greatly because of constant fear and uncertainty, which have a damaging effect on the personality. If the family breaks up inevitably, then the wife and children will require practical help and support especially where there was physical maltreatment.

Where there is improvement in the behaviour of the alcoholic, the family should be encouraged to rally around him and to make his environment warm and secure in order that he may have a real incentive to remain abstinent.

4.5.5.2 Drug dependence

The social worker often comes into contact with persons who use drugs and who may be addicted to them. Drug addiction leads to social problems. With some youths, drug-taking was acceptable as a cult.

Some addicts end up receiving psychiatric treatment, because the struggle within him to drop the habit becomes too much to bear. Social support will strengthen the addict who is reacting positively to treatment.

The addict who has responded well to treatment needs help to reastablish social contacts, find and keep a job and form new and stable interpersonal relationships. This process is long-term, because the patient feels inadequate and has to be motivated time and again.

The social worker should help in rendering the environment less stressful to prevent a relapse.

4.6 Conclusion

The psychiatric social worker should possess special skills to enable her to deal with the mentally disturbed person. She must basically have a sense of security in and respect of her profession and of casework. She has to have a clearly defined place in the multi-disciplinary team and be able to subordinate her own personal drives and ego satisfactions to the clinic or hospital purpose of integrated service to patient and relatives.

In adjusting her treatment techniques from patient to patient, she should do this with the full confidence and knowledge that she is the only team member who understands the patient from the psychosocial point of view. This should be done without the fear of losing her professional integrity and dignity.

The caseworker's practice in this field is closely related to that of the psychiatrist because they both do psychotherapy. The emphasis is placed on what the goals of her profession are. There is therefore a thin boundary, if at all, between psychotherapy as practised by caseworkers and psychotherapy as practised by psychiatrists.

The treatment of psychiatric illness is a long-term process and very demanding on the caseworker's time and patience. The caseworker does not behave in a stereotyped manner but makes suitable adjustments. She aims at building a preventative element into the treatment of such conditions.

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CHAPTER V

FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

As mentioned in Chapter I the method used for obtaining data for this study was that of content-analysis of the casework records of the Mental Health Society of the Witwatersrand (which will hereafter be referred to as "the society" or "the agency"). This agency practises all the methods of social work (as will be shown under 5.2), but because this study concerns itself with casework, only the case records of the casework section were studied.

As mentioned in Chapter I, no direct contact was made with the clients or patients as such. Verbal contact was made with the agency staff (Director and social workers) as well as with the psychiatrists.

In view of the hypothesis stated in Chapter I, this study aims at ascertaining whether there are specific treatment techniques that are used by caseworkers in the treatment of psychiatric patients.

The coding of the contents of the case records was based on Austin's (1948) and Hollis' (1964) classification of treatment techniques. An explanation is given in this chapter (5.5) on how these classifications were used together.

The records used were all "open files", i.e. records of cases that were receiving attention from the social

workers on a long-term basis. Most records reflected that three or more interviews had taken place and that contact between the patient, his family and the case-worker was continuing.

The recording system in the agency is done on an intake form for first contact (Annexure A). A cursory inspection of the Intake Form enables one to have an idea of the patient's identifying particulars, and the subsequent eight pages bear all the information pertaining to his social and psychiatric history.

The content of subsequent interviews is reflected on a Process Report, a Progress Report and finally an Evaluation Report (Annexures B, C and D respectively).

In this chapter the following will be discussed: the background of the agency at which the study was undertaken, limitations of the study, the method used for collecting the data,the findings and finally the conclusion and recommendations.

5.2 Description of the agency

5.2.1 Name and geographical situation

The name of the agency is The Mental Health Society of the Witwatersrand. The Society is one of the affiliates of The South African National Council for Mental Health. Other affiliates are in the following areas: Cape Town; Port Elizabeth; East London; George; Kimberley; Uitenhage; Klerksdorp; Potchefstroom; Pretoria; Vanderbijlpark; Bloemfontein; Welkom; Durban; Pietermaritzburg; Lebowa; Empangeni and the Johannesburg Child Guidance Clinic.

Both the offices of the National Council and those of the Society are situated in Johannesburg.

The Society operates within the Witwatersrand area - embracing the following magisterial areas: Alberton, Benoni, Boksburg, Brakpan, Germiston, Johannesburg, Nigel, Delmas, Edenvale, Kempton Park, Krugersdorp, Randburg, Roodepoort, Randfontein and Springs.

The offices are situated in the city centre, but the Society is able to render its services in all the above areas through its various committees and clinics run under its auspices in Soweto and on the East and the West Rand.

The Society shares the offices on the 14th floor of the North City Building with the psychiatrists and nursing staff of the Community Psychiatric Services which function under the Department of Health, Welfare and Pensions. The Society and the psychiatric staff have a close working relationship.

5.2.2 Historical background

This Society was formed in 1919 and was then known as The Society for Mental Hygiene. In 1920 the Society altered its name to Society for Mental Hygiene and Care of the Feebleminded. It was then functioning under the Department of the Interior. During this very year a National Council was formed (see Chapter II on history of psychiatric social work in S.A.).

The need for a paid secretary was felt in 1921, and her duties amongst others would be to move to various places and give lectures.

The Society began experiencing problems with returned soldiers, and a need for a psychopathic ward in the Johannesburg Hospital was voiced. During this time mentally disturbed persons were confined in jail while awaiting transfer to an appropriate institution. A special committee was formed in 1924 to study and later propose amendments of The Mental Disorders Act of 1916. The committee was to look specifically into the detention of the mentally ill.

In 1926 a move was initiated to interest university students in the work of the Society.

By 1927 attention was being given to the Coloured feeble-minded, and an urgent need was felt for an institution to be established for them in the Cape.

At the 1930 Annual General Meeting of the Society it was proposed that a subcommittee be formed to discuss the formation of a child guidance clinic. This clinic was duly established and is affiliated to National Council.

The procedure in the agency then was that patients were first seen by the psychiatrist and/or psychologist and subsequently referred to the social worker. This system was altered in 1932. Patients were first seen by the social worker and then referred to the psychiatrist or psychologist.

For the first time mention was made of "non-European work" at the Annual General Meeting of 1939. This was followed by the formation of a Mental Hygiene Society in the East Rand.

On November 10, 1941 the Society ceased to function under the Department of the Interior. It then functioned under the Department of Social Welfare, and the subsidies were transferred accordingly. A subcommittee was formed to organise the running of services in the agency.

A psychologist, Miss Lejeune, was appointed in 1942.

The Society extended its services to the Alexandra Health Clinic, which was the first of its kind in the Union. The patients were referred to the psychiatric clinic from the general section and from the Entokozweni Family Care Centre by the social workers.

It was decided in 1955 that the Mental Health Society of the Witwatersrand in terms of its constitution (see Annexure E) undertake to investigate the operation of the clinic for purposes of investigation, diagnosis and aftercare of the non-European mentally ill.

A post for the first non-European social worker was approved in 1955 because of the extension of services to the non-European section. The non-European social worker was employed in 1956.

During the same year a fund-raising committee was formed. The Society still makes use of a fund-raising committee headed by a professional fund-raiser.

The Society presently works in close collaboration with the psychiatrists and nurses from the Community Psychiatric Services. Fourteen social workers are on the staff, and the number is soon to be increased. The Society now has four sections in which services are rendered: White, Black, Coloured and Indian, all under the Director (see 5.2.5 below).

5.2.3 Purpose and nature of services rendered

The aims of the Society are set out in the constitution (Annexure E).

The social work services of the Society are divided into three major sections:

- services to the mentally retarded;
- services to the mentally ill; and
- services to those who have problems in living (see Chapter IV , 4.4).

Auxiliary work related to psychiatric social work is also undertaken, as will be shown later (5.2.5.3).

5.2.3.1 Mental retardation

Social work services to the mentally retarded consist of counselling, support, guidance and crisis intervention. The patient and his family are involved in treatment - the family more so, because the patient is in most cases unable to communicate meaningfully. Single care grants are available to this group, and these are State grants administered by the Society.

The social workers in this section are also involved in establishing needed facilities for the patients, working in close collaboration with staff at existing facilities, and they are also involved in the creation of protective workshops for adult patients who cannot be accommodated in existing day-care centres.

5.2.3.2 Mental illness

Services to the mentally ill include:

(a) Assistance with admission to mental institutions;

(b) Reconstruction services to the family while the patient is hospitalised;

(c) Aftercare of discharged patients;

(d) Investigations on behalf of other organisations (mental hospitals, other agencies) on patient's home circumstances and obtaining social history for the psychiatrist.

5.2.3.3 Problems in living

Services in this area include group counselling as well as individual counselling to persons with problems of maturational stages and adjustment.

5.2.3.4 Community work

In the area of community work the social workers are involved in:

(a) Identification and assessment of needs in the community in consultation with field social workers, intake worker, supervisors and the Director;

(b) Sensitising and educating the community to become aware of its needs;

(c) Planning community work services;

(d) Attending of relevant meetings and participation in an advisory capacity;

(e) Involving the community in proposed community projects;

(f) Establishing facilities and services to meet community needs;

(g) Developing the community to maintain the services established;

(h) Co-ordinating, training and motivating committee members of the day training centres, hostels and other facilities functioning under the auspices of the Society (Mental Health Society publication 1980 and Chapter II of this study).

5.2.4 Clientele

The clients of the Society come from all walks of life. According to the above publication (p. 4) the Society renders social work services to "... members of all race groups irrespective of age, sex or creed". The clients are psychiatric patients and persons experiencing problems in life, as well as their families, residing within the Witwatersrand area.

Some of the clients come or are brought directly to the agency to seek help, while others are referred by general hospitals, psychiatric hospitals; other agencies, churches, schools, employers and concerned relatives. Most of the cases become known to the agency

through the various clinics run by the Society in the community.

Some clients seen by the agency are disturbed to the extent of requiring hospitalisation, while others are managing to cope outside hospital with the help of the Society and relatives.

The psychiatric social worker may make a clinical diagnosis, and this may be later confirmed by the psychiatrist.

In some cases the agency works with the relatives of the patient while the patient is still hospitalised, preparing them for his release and handling problems of interrelationship. Sometimes there are problems of material need, and the social worker makes the necessary provision.

The psychiatrist may request the social worker to compile a report on social history, and this may initiate a relationship between the client, his family and the agency.

5.2.5 Staff of the agency

The staff of the agency is made up of professional as well as non-professional persons.

5.2.5.1 Professional staff

The Society is headed by a Director who is a social worker/clinical psychologist.

There are fourteen social workers on the staff. Some are working part-time (especially in the White section). Two of the social workers hold supervisory posts, one

in the Black section and another in the White section. The ratio of the professional staff is as follows:

Table 1

Agency professional staff

(Excluding the Director)

Race Group	Number	%
White	5	35.7
Black	6	42.9
Coloured	2	14.3
Indian	1	7.1
TOTAL	14	100

Duties attached to the above posts (briefly)

(a) Director

The Director is responsible for the general management of the Society's affairs, i.e. supervising the execution of the decisions of the Executive Committee, hiring staff, setting and maintaining a high professional level, supervising the running of community services established by the Society, supervision of administration, compiling annual reports, delivering addresses, organising in-service training, presiding over professional case discussions, liaison with government bodies; National Council and other organisations, signing cheques and attending conferences and meetings.

(b) Supervisors

The following are the duties of the supervisors:

(a) Supervision of casework, group work and community work;

(b) Administration and research;

(c) Orientation of new staff;

(d) Implementation of in-service training and staff development programmes;

(e) Training of social work students;

(f) Liaison with other agencies;

(g) Public education;

(h) Attendance of all committee meetings;

(i) Assessment of staff performance with a view to upgrading professional standards and motivating for additional posts.

(c) Intake officer

The intake officer screens new cases, does crisis work, refers long-term cases to respective social workers and screens cases to be referred to psychiatrist or psychiatric nurse with a detailed psychosocial report.

(d) Social workers

The social workers provide casework and group work services to all patients on the case load, they undertake statutory supervision of all single care grants, they

carry out investigations for psychiatrists and other agencies and then compile case histories, and they also do administrative work (report writing, recording, filing, compiling statistics).

(e) Community worker

The community worker's duties are:

(a) Identifying and assessing community needs;

(b) Educating and conscientising the community on agency services and facilities;

(c) Planning community programmes and involving the community in them;

(d) Attending relevant meetings; and

(e) Participating in an advisory capacity in meetings for community planning.

5.2.5.2 Psychiatric staff

There are six psychiatrists who work in close collaboration with the agency. Some psychiatrists are available on a parti-time basis, while others are available full-time under the auspices of the Community Psychiatric Services.

The psychiatric section also has nursing sisters and senior sisters and their own switchboard operator.

The Society makes use of clinical psychology interns. This means that at the beginning of each academic year the Society gets a new intern.

5.2.5.3 Administrative staff

There are eleven people on the administrative staff. These are as follows:

(a) A bookkeeper who administers the financial matters of the agency;

(b) A Trust bookkeeper who administers State grants in conjunction with the social worker handling a particular case (part-time post);

(c) Four typists who type correspondence for professional and administrative staff;

(d) One minutes secretary who attends all committee meetings for minutes taking. She prepares and types notices and distributes same;

(e) A clerk who keeps records of donors and the balance of the Trust account;

(f) A switchboard operator who mans the switchboard and takes messages for the staff;

(g) A Fund-raiser who organises and supervises fund-raising projects. He compiles and keeps a list of regular donors. He budgets for fund-raising projects;

(h) A messenger who runs errands, prints stationary, makes photocopies and prepares tea for meetings.

5.2.5.4 Volunteers

The Society utilises the services of volunteers in all its committees (each race group has its own committee). Volunteers are also involved in administrative work as well as in fund-raising.

Other personnel of the agency are stationed at the various centres run by the Society, e.g. Pumelela Day Centre in Soweto, Rand Youth Hostel for White patients.

5.3 Limitations of the sample

The method of sampling as well as the size of the sample has been discussed in Chapter I.

The sample has the following limitations:

5.3.1 Although the services of the agency are rendered to all race groups, the Indian section is not represented in the sample. The Indian section operates mainly from Lenasia where their files are kept. The researcher did not have access to these files.

5.3.2 The ages of four of the patients are not reflected on the face sheets in the case record.

5.3.3 The case records are not made up of a verbatim report of the transactions between worker and patient or worker and collateral source. They were mostly compiled from memory.

5.3.4 The case records included in the sample are those of long-term cases only and they exclude the case records of workers with one month's service in the agency.

5.3.5 The coding was based on the judgment of the researcher only. No second judge was used in the coding of the contents of the case records. This may have implications on the findings.

The study is reliable in terms of the fact that the researcher is well versed in matters pertaining to the question to be answered.

5.4 People of the study

As already mentioned the Society handles patients of both sexes from all racial groups. Factors such as history or other background material such as source of referral or number of contacts with psychiatrists were disregarded in this study. Only the patient's sex, age, racial group and medical diagnosis were regarded as significant, not because of their bearing on the outcome of the study, but only in so far as they give the reader a clear picture of the distribution of the patients in terms of these variables.

5.4.1 Age

The ages of the patients ranged from 4 to 69 years. It has already been mentioned that the ages of four of the patients were not reflected on the face sheets. The age range of 4 to 69 years therefore refers to only 41 of the patients in the case records in the sample.

Of the 41 patients, five are between 1 and 10 years, 10 between 11 and 20 years, 6 between 21 and 30 years, 9 between 31 and 40 years, 7 between 41 and 50 years, 2 between 51 and 60 and another 2 between 61 and 70 years. The age group 11 to 20 has the largest number of patients, and these are mostly mentally retarded patients.

According to agency staff this number is thus because between the ages of 1 and about 10, the mentally retarded patient is still manageable in as far as the family is concerned. The family usually moves out to seek help when the patient is at school-going age and is becoming unmanageable at home. After age 20 he is beyond any schooling efforts and is receiving a pension of his own which enables the family to cope with him financially. This is the position with most Black patients. In the other racial groups where there are better facilities and opportunities, he may either be in sheltered employment or in receipt of a State grant and will occasionally require the services of a social worker.

The age group 31 - 40 also has a considerably large number, but no scientific reason could be advanced for this.

Table II below reflects the age and sex distribution of the patients in the sample.

Table II

Age and sex distribution of the patients in the case records

Age in Years	Males		Females		Total	
	Number	%	Number	%	Number	%
1 - 10	2	4.4	3	6.8	5	11.2
11 - 20	3	6.7	7	15.6	10	22.3
21 - 30	4	8.9	2	4.4	6	13.3
31 - 40	4	8.9	5	11.1	9	20
41 - 50	2	4.4	5	11.1	7	15.5
51 - 60	0	0	2	4.4	2	4.4
61 - 70	1	2.2	1	2.2	2	4.4
Unknown	3	6.7	1	2.2	4	8.9
TOTAL	19	42.2	26	57.8	45	100

The average age of the patients - excluding the four whose ages are unknown - is 38.4 years.

4.2 Sex

The sex distribution of the patients in the case records studied is 42.2% (19) males and 57.8% (26) females as reflected in Table II above. An interesting study would be to find out whether the agency handles more females than males, or whether more females suffer from psychiatric illnesses than males.

As it is, there is no scientific explanation for the unequal sex distribution.

5.4.3 Racial group

The patients whose records were studied come from the Black, White and Coloured sections of the population. The researcher felt it unnecessary to make a further breakdown of the various groups.

Table III below shows the distribution of the case records in the sample in terms of racial groups.

Table III
Racial distribution of the case records

Race	Number	%
Black	26	57.8
White	15	33.3
Coloured	4	8.9
TOTAL	45	100

The above classification is based on the agency procedures.

Twenty six (57.7%) of the case records in the sample are from the Black section, 15 (33.3%) from the White section and 4 (8.8%) from the Coloured section. According to the Manual "Motivation for Black Social Workers" (1980 Nov.) the Black section has more clients than the other three sections.

According to this manual this client distribution may be further illustrated from the single care grants that are supervised by the social workers. See Table IV.

Table IV

Race distribution in terms of single care grants

Race Group	Number of Patients	%
Black	700	61.1
Coloured	105	9.2
Indian	40	3.5
White	300	26.2
TOTAL	1 145	100

A glance at the above table shows that the Black section has the largest number of patients, followed by the White section, the Coloured and the Indians. The ratio is 140:60:21:8.

The above table (Table IV) concerns patients falling within the mentally retarded group only. According to the Black supervisor this group forms the largest number of patients receiving help from the agency. One can then justify the use of the above table to show the distribution of patients helped by the agency in terms of racial classification.

The reason for the largest number of patients being in the Black section may be linked with demographic factors.

When one looks at Table III and IV in relation to Table I (Staff distribution), one observes an imbalance. The figures in Table IV give one an impression that the Black section is seriously understaffed.

5.5 Data collection

Mention was made in Chapter I that the method of collecting data was that of content-analysis.

A classification system was drawn up to facilitate the data-gathering process. This classification as already mentioned was based on Hollis' and Austin's classification of treatment typologies.

In Direct treatment, the symbols A to F as used by Hollis, are retained for consistency, and additional columns were added for Austin's classification of Direct treatment or Psychotherapy.

The additional columns for Austin were designated G_1, G_2 and G_3 because Austin has one main category of Psychotherapy with three subcategories.

The classification is therefore thus:

A	Sustaining Procedures	
B	Direct Influence	
C	Exploration-Description-Ventilation	
D	Pattern-Dynamic Reflection	
E	Person-Situation Reflection	
F	Developmental Reflection	
G_1	Supportive Therapy	Psychotherapy
G_2	Intermediary/Experiential Therapy	
G_3	Insight Therapy	

Hollis' environmental work according to type of communication, type of role, and type of resource was designated A_1, B_1 and C_1. Austin's social therapy was incorporated into this classification because it has the same elements as Hollis' Environmental work in many respects (Chapter III).

A separate column was made for medical diagnosis (psychiatric label) and another for social work diagnosis. The psychiatric labels are based on the following classification by Munro and McCulloch (1969 pp. 59 and 60).

1. Psychoneurosis and psychosomatic illnesses

Anxiety neurosis, neurotic depression, obsessional neurosis, phobic states and hysteria.

2. Personality disorders and psychosexual disorders

Anxious personality, depressive personality, obsessional personality, hysterical personality, cycloid personality, schizoid personality, paranoid personality and affectionless personality.
Psychopathy.
Psychosexual disorders.

3. Alcoholism and

4. Drug dependence.

5. Psychosis

   A. Organic - Acute (delirium), Chronic (dementia)
   Miscellaneous conditions including personality change due to brain damage and chronic epilepsy.

   B. Functional - Affective disorders
   Schizophrenic states
   Others

6. Suicide and attempted suicide.

7. Mental subnormality.

8. Child psychiatry.

9. Psychiatric illnesses of old age.

In the table used for the study only the major categories are reflected, although in the actual study even the subcategories were considered to enable the researcher to fit them into the appropriate columns.

The names on the files were not used, only the file number was used, to protect the patient involved. This was followed by a column each for racial group, sex and age. See Table V below.

Table V

Classification for data collection

1	2	3	4	5									6			7			8							
Ref. No.	Race Group	Age	Sex	Medical Diagnosis									Social Work Diagnosis			Indirect Treatment			Direct Treatment							
				1	2	3	4	5	6	7	8	9	1	2	3	A	B	C	A	B	C	D	E	F	G_1	G_2	G_3

From here on the researcher read through the file and obtained information for the first five columns from the face sheet. As the researcher went through the whole case record, a tick (✓) was made in the relevant column (column 6 to 8) depending on the information available as well as the judgment of the researcher.

The ticks made in columns 7 and 8 pertained mostly to the content of communications (verbal as well as non-verbal) that took place between the patient, the worker and a collateral source.

The study did not aim at assessing whether the communications were initiated by the worker or the client, or to differentiate the content of communications in terms of whether the client discussed voluntarily or not.

The main purpose was to judge what the content was in terms of the various treatment techniques.

5.6 Findings

The Society classifies its patients into two major groups, viz. mentally ill and mentally retarded. The method of sampling ensured that patients from the two groups as well as all racial sections were included in the sample. The table below shows patient distribution according to psychiatric diagnosis and racial group.

Table VI

Patient distribution according to psychiatric diagnosis and racial group

Race	Psychiatric Diagnosis			
	Mental Illness		Mental Retardation	
	No	%	No	%
Black	14	46.7	12	80
White	13	43.3	2	13.3
Coloured	3	10.0	1	6.7
TOTAL	30	100	15	100

The distinction between mental illness per se and mental retardation has been given in Chapter I.

5.6.1 Psychiatric diagnosis

In the column for psychiatric (medical) diagnosis it was found that some cases could not be classified into exclusive categories because of the overlap of symptoms.

The issue of classification is quite simple and straightforward on paper, but in actual practice one finds it "... difficult to assign a particular case to its diagnostic niche" (McCulloch and Munro, 1969, p. 60). The patient often manifests symptoms that are suggestive of more than one diagnostic group. This fact is further illustrated in Table VII below.

Table VII
Patient distribution according to psychiatric type

Group	Number
1	3
2	2
3	4
4	3
5	26
6	1
7	15
8	1
9	0
TOTAL	55

One can observe from the total of 55 (as against the sample population of 45) that there is an overlap in the various groups. This overlap has been explained earlier on.

The data reveal that the highest number falls within the psychotic group and the second highest within the mentally retarded group. However, this finding does not contradict the information given above (Table IV) to the effect that the mentally retarded group comprises the largest number of cases handled by the agency. The cases falling within group 5 and group 7 do not show mutually exclusive symptoms.

5.6.2 Social work diagnosis

All cases receiving care from a psychiatric unit or from a social work agency attached to a psychiatric unit have a clinical diagnosis.

The clinical diagnosis is made by the social worker, and in more obscure cases it is made by the social worker in consultation with the psychiatrist.

The columns under social work diagnosis are also not mutually exclusive. A case with a clinical label may also have a long-standing history of causation (etiological) and without a cross-sectional view (dynamic) of the situation, the diagnosis becomes incomplete. Perlman (1957, p. 170) says:

> ... the specific content and conditions of usefulness are different for each of these types of diagnoses, but there is frequent overlapping among them. A dynamic diagnosis always contains some etiology, at least of the problem's recent causation, and it may, depending on the nature of the problem and on the caseworker's perceptiveness, contain some rough clinical appraisal of the client's personality.

Table VIII below shows the various diagnostic groups in relation to the sample. The extent of overlapping between the first two diagnostic typologies is evident.

Table VIII

Sample distribution in terms of social work diagnosis

Type	Number of cases
Clinical	45
Dynamic	45
Etiological	4

5.6.3 Indirect treatment

Some clients require environmental help, while others do not. The nature of the client's need and the availability of resources will guide the worker as to what steps to take.

Clients who require milieu therapy, also have problems which require direct treatment. The worker then finds herself blending various treatment methods in order to help the client. Environmental help therefore goes hand in hand with direct treatment (Hollis, 1964, p. 139).

Hollis is of the opinion that indirect treatment or environmental work may be viewed in three ways, viz. in terms of communication between worker and collateral, in terms of resources available and finally in terms of various roles assumed by the worker in her attempts to help the client (Hollis op cit).

The various types of subclassification of environmental work were used interchangeably in the sample according to the client's (patient's) need (See Table IX below).

Austin's social therapy was blended into the three subcategories of Hollis' environmental work because of the common elements in both.

Table IX
Indirect treatment (social therapy or environmental work)

Type of help	Frequency of use
Communication with collateral	15
Resource	27
Role assumed	9
TOTAL	51

There is an overlap in the use of the various modes of indirect help. These overlaps are due to the fact that during the course of treatment, the client's needs change and certain forms of help which were not deemed necessary at one stage become necessary at another.

The findings reveal that in 15 instances the worker(s) communicated with a collateral source. This method was used to a great extent with mentally retarded patients because of the underdeveloped or completely lacking communication skills of such patients. It was also used with some of the severely disturbed patients.

Further, the sample reveals that resources were used 27 times. This may refer to material or institutional help within the agency or outside agencies. It has already been mentioned that the Society rarely gives material assistance. Mentally retarded patients receive State grants (Single care grants and Disability grants), which are administered by the Society.

Should patients require other forms of material assistance such as food parcels, financial help for dependents or assistance with schooling, they are usually referred to other agencies such as The Quaker Service Fund, etc.

5.6.4 Direct treatment

The choice of treatment techniques is determined by the diagnosis, problem causation and treatment objectives (See Chapter III). The worker does not make use of one technique only to attain the desired goal. Depending on the diagnosis, the client's need, motivation, capacity and opportunity, she selects from several treatment methods and blends some with others.

Hollis has the following to say about the matter:

> ... the treatment process is conceived of as a blend in which different proportions of the different processes are present in the totality of a case, in different phases of the same case, and in different interviews within a given phase.
>
> (Hollis, F. in Roberts, R.W. and Nee, R.H., 1970, p. 65)

The communications within the case records were coded on the basis of what treatment technique was applied. In the coding, only the content of the communication was considered, whether it was a sustaining remark or a reflective discussion aimed at increasing understanding of other persons, etc.

The classification consists of verbal and non-verbal communications, and these are described in the case record. The communications are classified according to several dimensions. The dimensions are divided into two major categories i.e. reflective and non-reflective communications.

The non-reflective dimensions include:

> ... (a) communications in which the worker attempts to sustain the client through expressions of interest, sympathy and understanding, desire to help, confidence in the client and acceptance of him; (b) communications that directly promote or discourage client behavior through expression of the workers opinions or attitudes; (c) communications that encourage exploration or ventilation of content concerning the nature of the client or his situation and their interactions, or on the client's part describe, explain or ventilate content.
>
> (Roberts and Nee op cit p. 66)

The second category is made up of communications by the client whereby he seeks to gain a better understanding of his reactions and certain aspects of his situation. These communications are reflective considerations, awareness and understanding of "... (d) the client's person-situation gestalt in the present or adult past; (e) the psychological patterns and dynamics ofthe client's behavior; or (f) aspects of the client's early life that are thought to be relevant to his present behavior" (ibid).

Austin in her classification did not make a breakdown in terms of the direction assumed by the communications. Her subcategories are based on the diagnosis of the client's ego.

While coding, the researcher found that in certain case records a direct mention of the treatment procedure was made, while in others the researcher had to make a judgment after reading through a phrase, sentence or paragraph.

This brings us to the question of validity. The case records were compiled by social workers who used their own discretion throughout any one particular interview as to what to include in the report and what to leave out.

The extent to which each direct treatment procedure was used is reflected in Table X.

Table X

The use of the various treatment procedures in the sample

Type of treatment procedure	Frequency of use
A Sustaining procedures	27
B Direct influence	6
C Exploration-description-ventilation	10
D Pattern-dynamic reflection	9
E Person-situation reflection	4
F Developmental reflection	1
G_1 Supportive therapy	9
G_2 Experiential/Intermediary therapy	10
G_3 Insight therapy	5

From the above table it is evident that sustaining procedures were the most frequently used. If the issue of the worker's discretion and bias did not enter into recording the content of the interview, perhaps one could have found that this procedure was used even to a greater extent than the study reveals.

It is a known fact that social work clients need sustaining help, because their problems are often complicated by accompanying anxiety and defences. One could believe that the position is slightly more serious with the psychiatric patient and his relatives where most relatives require help themselves.

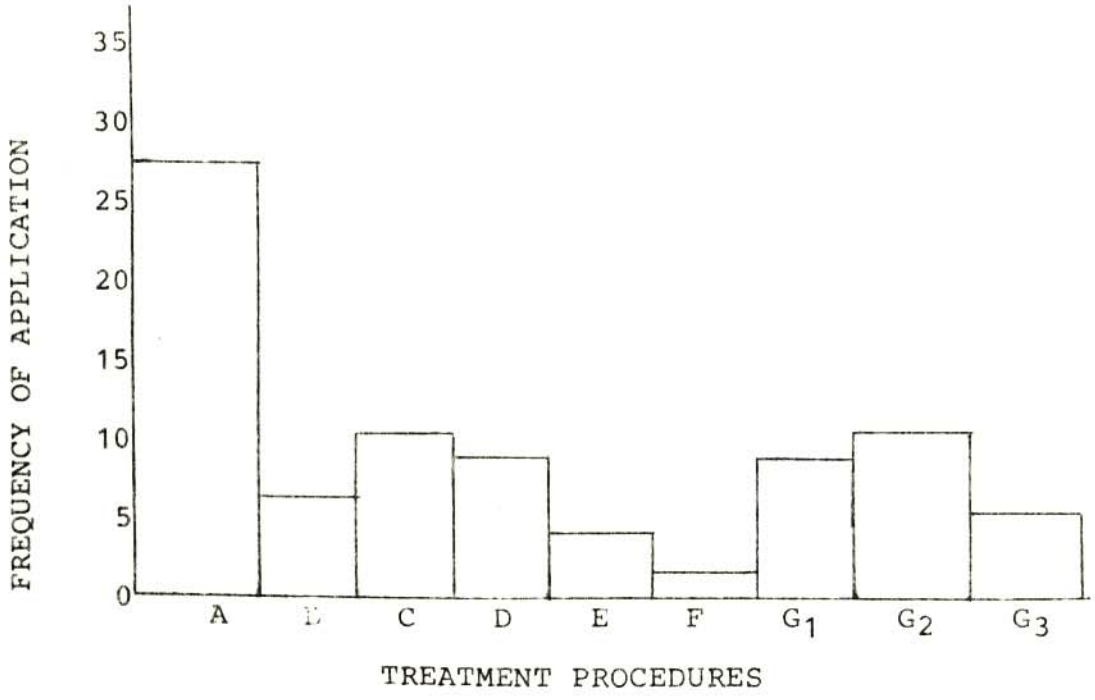
This means that, when one looks at the extent of all the procedures as reflected in Table X, one should bear in mind that both recording and coding were influenced by personal factors such as bias, preconceived ideas etc.

According to the findings, the second largest group of procedures used were Hollis' exploration-description-ventilation and Austin's experiential/intermediary therapy. Both were used in 10 instances. Austin's supportive therapy and Hollis' pattern-dynamic reflection were used 9 times.

The other procedures were used as follows: direct influence 6 times, person-situation reflection 4 times, developmental reflection once and insight therapy 5 times.

A graphical presentation of the data follows:

Table XI
Graphical presentation of the use of direct treatment procedures



5. Conclusion

This study was undertaken in a setting where the psychiatric social worker can make use of all three basic methods of social work in helping the psychiatric patient. The casework and community work methods are used extensively, while the group work method is used minimally.

Two classifications of treatment procedures were used for this study and these were selected above all other classifications (See Chapter III) because of their all-embracing nature and the characteristics that they have in common. Hollis' classification is the most widely known and applied in social work research and practice (Golan, M., 1978, Hollis, F., 1964, 1968, Roberts and Nee, 1970 and as research instrument Hollis, 1964, pp. 181 and 182).

The records in the sample were compiled for practice purposes, but they could be and were used for research purposes. The content analysis of the case records yielded data that reflected that social workers make use of both Direct and Indirect forms of treatment as outlined by Hollis and Austin; and that there is an inclination to use certain procedures more than others.

The hypothesis postulated in Chapter I has therefore been confirmed.

One could advance the following reasons for the findings, especially where certain treatment procedures seem to have been more popular than others.

The policy of the agency is to give aid to psychiatric patients of all races residing within the Witwatersrand

area. This area is a very wide area considering the number of social workers employed by the Society. The Society has made attempts to decentralise its services, but most areas within the Witwatersrand boundaries are given very little or not attention at all.

The average case load of the social workers is 250, and this obviously means that they work under great pressure. This further means that their professional as well as administrative work is not done to the satisfaction of either the workers or the patients served.

One is convinced that the findings would be different with more staff and less patients, especially when it comes to the time-consuming techniques such as insight therapy, experiental therapy, supportive therapy and Hollis' reflective procedures. This includes also exploration-description-ventilation.

The success of sustaining procedures and the use of direct influence both draw on the client's dependence on and confidence in the worker. The data reflect that sustaining procedures were used to a high degree. In addition to the reasons already advanced, this may be due to the fact that they are less time-consuming and that their communication may be verbal as well as non-verbal. They are also used to promote the success of the application of the other treatment techniques.

Patients and their relatives who are handled by the Society, have emotional as well as mental problems which may hamper or block their ability to communicate. Reflective procedures require that the client be able to verbalise, and the worker uses skill to stimulate the

client. In a recent study Mullen (1969) and Reid and Shyne (1969) reported that most workers avoided using these techniques (reflective techniques) because of either lack of training or lack of capacity to do this work.

This study also reveals that these procedures were used sparingly (Pattern-Dynamic Reflection = 9, Person-Situation reflection = 4 and Developmental Reflection = 1).

This brings us to the issue of the training of the Society's social workers, a factor which may have had an influence on the data.

The qualifications of the social workers range from a Diploma in Social Work, to a B.A.(S.S.) or B.A.(S.W.) degree, and Honours B.A.(S.W.) degree. The Director holds a B.A.(S.W.) degree and an M.A. in Clinical Psychology. As far as can be assessed from the researcher's source of information within the Society, none of the social workers holds any qualification in psychiatric social work. One of the supervisors is currently studying with the University of South Africa for a Master's degree in Social Work in Mental Health.

However, the Society runs in-service training programmes for the professional staff. Experts in the psychiatric field are invited to address the workers, and once a month a workshop is held on a regional basis.

Austin (1948) recommends that the subcategories of psychotherapy as seen by her may be applied to the following types of cases: chronic cases such as severe neurotics, infantile personalities and psychotic characters

(supportive therapy); people with problems in living, schizoid personalities and schizophrenics where ego controls exist (experiential therapy) and finally cases of mild neurosis and character disorders (insight therapy). The groups of cases cited above are typical of the types of patients in the case records studied, but the data reflect a minimal use of these procedures. The reasons for this could be the ones already cited above.

The data in relation to Indirect treatment methods reflect that the workers made use of various modes interchangeably as in the case of Direct treatment methods.

One other factor that may have had an influence on the data is the fact that all the clients have clinical labels. One is bound to believe that the treatment techniques used by the caseworkers yielded the mentioned results because of the client type handled by the Society. Treatment typologies are derived from diagnosis (See Chapter III).

In summary: the data (findings) of this study were influenced by the staffing of the Society, the qualifications of the staff, the client groups, the services rendered by the agency and the fact that only one judge was used in coding.

5.8 Recommendations emanating from this study

This study was an exploratory study from whose findings further hypotheses may be developed.

Further research can be undertaken on the following topics:

(a) The relationship between worker qualification and the use of certain treatment tendencies;

(b) A study of casework treatment tendencies with specific psychiatric types.

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13. Prof. LUIZ Psychiatrist. Personal Communication.

14. Dr. ROSENBERG Psychiatrist. Personal Communication.

15. Mrs. I. GROBLER Director. Personal Communication.

16. Mrs. C. SITHOLE Supervisor. Personal Communication.

ANNEXURE A

INTAKE FORM

AANMELDINGS VERSLAG

DATE/DATUM:_____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY/VERWYS DEUR:_____

1. IDENTIFICATION/IDENTIFISERENDE BESONDERHEDE:

Surname/Van: _____

First Names/Eerste name: _____

Date of Birth/Geb. Datum: _____ Sex/Geslag: _____ Race/Ras: _____

Nationality/Nasionaliteit: _____ Home Language/Huistaal: _____

Marital Status/Huwelikstatus: _____ Date of Marriage/Dat. van Huwelik_____

Identity No./I.D.No: _____ Pension No./Pensioen No: _____

Level of Education/Opvoedkundige peil: _____

Occupation/Beroep: _____

Financial Situation/Finansiële toestand: _____

Earnings/Inkomste: _____ p/w _____ p/m

Religious Group/Kerkverband: _____ Tel. Home/Huis: _____

Address/Adres: _____ Tel. Work/Werk: _____

_____ Tel. Other/Ander: _____

_____

_____

Psychiatric Diagnosis/Psigiatriese Diagnose: _____

FAMILY COMPOSITION/GESINSSAMESTELLING

Relation/Verband	Name/Naam	Age/Ouderdom	Comment/Opmerkings

DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY/VERWYS DEUR: _____

2. PRESENTING PROBLEM/HUIDIGE PROBLEEM:

3. SOCIAL BACKGROUND/MAATSKAPLIKE AGTERGROND:

Infancy and Childhood: Pregnancy of mother. Birth Complications. Nature of infantile and childhood diseases and injuries. Deprivation.

Baba en kind stadium: Geboorte, baba en kindersiektes en beserings, verwerping.

DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY:/VERWYS DEUR: _____

SCHOOLING: Grade attained and at what age. Attitudes towards schoolmates and teachers.

SKOLING: Std. behaal op watter ouderdom. Gesindheid teenoor maats en onderwysers.

Bright Slim	Normal Normaal	Dull Stadig

GROWTH AND DEVELOPMENT: Disposition. Play life. Sex life. Age first manifested. Attitude towards own sex. Love affairs.

ONTWIKKELING: Disposisie. Speellewe. Geslagslewe. Aanvangsdatum. Houding t.o.v. eie geslag. Liefdesverhoudings.

PERSONALITY: Degree of sociability and adaptability. Self estimation. Functional level. Emotional stability. Anti-social trends. Dominant trends.

PERSOONLIKHEID: Graad van sosialisering en aanpasbaarheid. Selfdenke. Graad van funksionering. Emosionele stabiliteit. Anti-sosiale neigings. Dominante neigings.

DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY/VERWYS DEUR: _____

OCCUPATION: Steadiness. Type and quality of work.

BEROEP: Standvastigheid. Soort en kwaliteit.

HABITS: Alcohol Tobacco Drugs

GEWOONTES: Alkohol Tabak Dwelmmiddels

MARITAL: Previous engangements. Divorces. Years married. Number of children. Compatibility and health of spouse.

HUWELIK: Vorige verlowings. Egskeiding. Aantal jare getroud. Aantal kinders. Aanpasbaarheid en eglied se gesondheid.

HOME SITUATION: Irritating factors. Special worries. Inter-relationships. Response to authority and criticism.

HUISLIKE OMSTANDIGHEDE: Irriterende faktore. Besondere bekommernisse. Interpersoonlike verhoudings. Houding t.o.v. gesag en kritiek.

DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY:/VERWYS DEUR: _____

PREVIOUS ATTACKS OF MENTAL ILLNESS: Age at onset. Apparent causes. Contributing factor. Nature. Duration. Outcome.

VORIGE PSIGIESE SIEKTE: Ouderdom. Oorsaak. Bydraende faktore. Soort. Duurte. Uiteinde.

_____

_____

_____

_____

FAMILY HISTORY: Parents. Sisters. Brothers. Temperament and Physical condition.

GESINSGESKIEDENIS: Ouers. Susters. Broers. Psigiese en fisiese toestand.

Mental Retardation Swaksinnigheid	☐	Insanity Geestesversteurdheid	☐
Epilepsy Epilepsie	☐	Syphilis Sifilis	☐
Alcohol Alkohol	☐	Mental Breakdowns Psigiese Ongesteldhede	☐
Other Ander	☐		

_____

_____

_____

SYMPTOMS: Nature, Time of onset, Apparent Causes, Contributing Factors. Treatment

SIMPTOME: Soort, Aanvangstyd, Oorsaak, Bydraende Faktore, Behandeling.

Depression Depressie	☐	Headaches Hoofpyne	☐
Anxiety Angs	☐	Allergy Allergie	☐
Menopause Menopause	☐	Heart Problems Hartprobleme	☐
Other Sexual problems Ander Seksuele probleme	☐	Sleep Slaap	Good/Goed Bad/Sleg

Sterility Steriliteit	☐	Epilepsy Epilepsie	☐
Other Med. Disease Ander Med. Probleme	☐	Faintness Lighoofdigheid	☐
Appetite Eetlus	☐	Rheum. Arthritis Rumatiek	☐

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DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY:/VERWYS DEUR: _____

CURRENT CONDITION: (Social Worker's Observation)

HUIDIGE TOESTAND: (Maatskaplike Werker se Waarneming)

General Appearance and Behaviour:

Algemene Voorkoms en Gedrag:

Unusually attractive Besonder aantreklik	☐	Friendly Vriendelik	☐
Unusually unattractive Besonder onaantreklik	☐	Practical joker Grapmaker	☐
Marked flushing Besondere blos	☐	Dramatic Dramaties	☐
Marked Facial pallor Besonder bleek	☐	Manipulation Manipulasie	☐
Visible physical defect Waarneembare fisiese gebrek	☐	Evasive Ontwykend	☐
Alert Wakker	☐	Distrustful & Suspicious Suspisieus	☐
Dazed Stom	☐	Fearful Bang	☐
Perplexed Verward	☐	Sarcastic Sarkasties	☐
Eye contact established Maak oogkontak	☐	Verbal hostility Verbale teenkanting	☐
Avoids eye contact Vermy oogkontak	☐	Physically threatening Fisies dreigend	☐
Stares Staar	☐	Mute Stom	☐
Eyes Closed Oë toe	☐	Seemingly unresponsive Skynbaar sonder reaksie	☐
Dress acceptable Drag aanvaarbaar	☐	Restlessness Rusteloos	☐
Dress meticulous Oordrewe netheid	☐	Clumsy Lomp	☐
Sloppy Slordig	☐	Hands in constant movement Hande in konstante beweging	☐

Bizarre Vreemd	☐	Tics Trekkings	☐
Overweight Oorgewig	☐	Other Ander	☐
Underweight Ondergewig	☐		

REMARKS/OPMERKINGS:

_____

_____

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_____

DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY:/VERWYS DEUR: _____

MOOD:/BUI:

Unduly happy Ongewoon gelukkig	☐	Over optimistic Optimistic	☐
Depressed Depressief	☐	Remorse Jammerte	☐
Anxious Angstig	☐	Exaggerated opinion of self Oordrewe selfwaan	☐
Excited Opgewonde	☐	Guilt Skuldgevoelens	☐
Indifferent Ongeërg	☐	Fluctuation Fluktuasie	☐
Very pessimistic Baie pessimisties	☐	Failure Faal	☐
Suicidal Neig tot selfmoord	☐		

TALK:/SPRAAK:

Incoherent Onsamehangend	☐	Groping Soekend	☐
Too fast Te vinnig	☐	Total amount Totaal	☐
Affected Geaffekteer	☐	Slurred Sleeptong	☐
Rambling Rigtingloos	☐	Meaningless Doelloos	☐
Too slow Te stadig	☐	Sudden suspension Skielike ophou	☐
Monotonous Eentonig	☐	Not spontaneous Nie spontaan	☐

CONTENT OF THOUGHT: Dominant ideas, superstitious, special religious beliefs, dreams, illusions, delusions and hallucinations.

GEDAGTE INHOUD: Dominante idees, bygelowe, besondere geestelike gelowe, drome, illusies, delusies en hallusinasies.

DATE:/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY:/VERWYS DEUR: _____

ORIENTATION: Spatial, temporal and personal

ORIENTASIE: Tyd, persoon, plek.

MEMORY: Short term and Long term

GEDAGTE: Korttermyn en Langtermyn

RETENTION AND RECALL/HERROEP EN RETENSIE:

GENERAL INTELLIGENCE/ALGEMENE INTELIGENSIE

JUDGEMENT AND INSIGHT/OORDEEL EN INSIG:

DATE:/DATUM: _____ FILE NO:/LÊER NO: _____

CLINIC NO:/KLINIEK NO: _____

REFD. BY:/VERWYS DEUR: _____

SOCIAL DIAGNOSTIC EVALUATION:

SOSIALE DIAGNOSTIESE EVALUASIE:

PLAN OF ACTION:

PLAN VAN AKSIE:

SOCIAL WORKER:

MAATSKAPLIKE WERKER: _____

ANNEXURE B

PROCESS REPORT

VORDERINGSVERSLAG

DATE/DATUM: _____ FILE NO:/LÊER NO: _____

CONTACT WITH/KONTAK MET: _____

NATURE OF INTERVIEW (OFFICE, TELEPHONE, HOME VISIT):

VORM VAN ONDERHOUD (KANTOOR, TELEFOON, HUISBESOEK):

_____

CONTENT:/INHOUD: _____

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PLAN OF ACTION:/PLAN VAN AKSIE:

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SOCIAL WORKER:

MAATSKAPLIKE WERKER: _____

ANNEXURE C

PROGRESS REPORT

VORDERINGSVERSLAG

A. INTRODUCTION: Summary of client's condition when referred to Agency:

INLEIDING: Samevatting van kliënt se toestand met opname:

_____

_____

_____

B. Summary of Treatment and Therapeutic Measures and Client's Attitude towards Treatment.
Opsomming van Behandeling en Terapie toegepas en Kliënt se houding daaroor:

_____

_____

_____

C. Client's present condition:
Kliënt se huidige toestand:

(a) Physical:/Fisies: _____

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(b) Behaviour:/Gedrag: _____

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(c) Emotional adjustment and inter-personal relationships:
Emosionele aanpassing en inter-persoonlike verhoudings:

_____

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(d) Marital adjustment:/Huweliksaanpassing: _____

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(e) Vocational adjustment:/Beroepsaanpassing: _____

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(f) Financial position:/Finansiële posisie: _____

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(g) Accommodation:/Verblyf: _____

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(h) Other aspects:/Ander aspekte: _____

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D. Evaluation of client's progress:
Evaluasie van kliënt se vordering: _____

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E. Evaluation of Therapeutic services rendered to client:
Evaluasie van Terapeutiese dienste aan kliënt:

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F. Recommendations/Amended plan of treatment:
Aanbevelings/Gewysigde plan van behandeling:

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Senior Social Worker:
Senior Maatskaplike Werker: _____

Social Worker:
Maatskaplike Werker:

_____

ANNEXURE D

EVALUATION REPORT

EVALUASIEVERSLAG FILE NO:/LÊER NO: _____

1. DATE/DATUM: _____

2. Initial problem/Vorige probleem: _____

3. Particulars:/Besonderhede: _____

4. Evaluation/Evaluasie: _____

Evaluation cont.:/Evaluasie vervolg: _____

5. Present diagnosis:/Huidige diagnose: _____

6. Plan of action:/Plan van aksie: _____

SOCIAL WORKER:

MAATSKAPLIKE WERKER: _____

MENTAL HEALTH SOCIETY OF THE WITWATERSRAND

(W.O. 120)

CONSTITUTION

NAME:

The name of the Society shall be THE MENTAL HEALTH SOCIETY OF THE WITWATERSRAND.

NATURE:

The Society shall be a constituent of the South African National Council for Mental Health and shall co-operate actively with that body, more particularly with regard to the following:

The constitution of the Society, and the territorial boudaries within which it shall operate, shall be subject to the approval of the National Council. The Society shall in each year, immediately after its Annual General Meeting submit to the Council for its information, a copy of its Annual Report and audited Statement of Accounts for that year. All matters of national policy shall be dealt with by Council and all approaches in such matters to Government Departments and other national bodies shall be made through Council. In order to preserve uniformity, all literature except for local appeals, shall be submitted to the National Council for approval, prior to circulation.

AREA OF OPERATION:

The Society shall be entitled to function and raise funds either alone or together with any other organisation within the Magisterial Districts of:

Alberton, Benoni, Boksburg, Brakpan, Germiston, Johannesburg, Nigel, Delmas, Edenvale, Kampton Park, Krugersdorp, Randburg, Roodepoort and Springs.

OBJECTS:

(a) The conservation of the mental health of the community.

(b) The prevention of mental illness and mental retardation and the reduction of the impact thereof.

(c) The effective investigation, care, treatment and supervision of persons suffering from mental illness.

(d) The training, care and supervision of the mentally retarded.

(e) The administration of Guidance Clinics for the benefit of children, adolescents and adults showing symptoms of behaviour difficulties.

(f) The acquisition and dissemination of information on mental health matters.

(g) Co-operation with Government Departments, Local Authorities and Institutions, voluntary agencies and private individuals in respect of the welfare of persons suffering from mental illness and epilepsy.

(h) The stimulation of public interest in the problems of mental health by means of lectures and other such means as may suggest themselves from time to time.

(i) The promotion of special education for educationally sub-normal children.

(j) The promotion, either independently or in co-operation with Government Departments, of schemes for the care, betterment or employment of persons who are suffering from epilepsy and the establishment of workshops and hostels for the mentally retarded and mentally ill.

(k) The taking of all such actions as may be incidental or conductive to the attainment of the above-mentioned objectives.

MEMBERSHIP:

Membership shall be open to any residents within the Magisterial Districts as enumerated in Clause 3, subject to the approval of the Executive Committee.

KINDS OF MEMBERSHIP:

(a) Ordinary Membership: Any person shall be eligible to become an ordinary member of the Society on payment of the membership fee as laid down by the Executive Committee.

(b) Family Membership: On payment of the membership fee as laid down by the Executive Committee, any family will be entitled to membership. This includes husband and wife, and any children between the ages of 18 - 21 years.

(c) Student or Youth Membership: On payment of the membership fee as laid down by the Executive Committee, any person between the ages of 18 - 25 years shall be entitled to membership of the Society.

(d) Life Membership: Any person or family (husband and wife) subscribing the fee decided upon the the Executive Committee,shall be entitled to life membership.

(e) Honorary Membership: The Executive Committee may elect as an honorary member any person who has done, or is doing, valuable service for the Society for such period as it may determine.
Such a person shall have membership without payment of a subscription.

(f) Affiliated Membership: Representatives of local Welfare Bodies whose National Councils are affiliated to the South African National Council for Mental Health shall be eligible for affiliated membership. Any person thus eligible shall not be required to pay a subscription fee, but must be approved by the Executive Committee.

(g) Special Representative Membership: Representatives of Organisations or Business Associations, such as the Chamber of Commerce and Industries, Rotary, Round Table, or any other Society whose activities are connected with the promotion of any form of mental health, shall be eligible for special representative membership. Such representatives shall not be required to pay subscription fees, but must be approved by the Executive Committee.

(h) Corporate Membership: On payment of the membership fee as laid down by the Executive Committee from time to time, any corporate body will be entitled to membership subject to the approval of the aforesaid Committee. Any such corporate body shall be entitled to one vote.

6. PRIVILEGES OF MEMBERS:

All members of the Society shall be entitled to take part in and vote at all Annual General Meetings, and shall furthermore be entitled to attend all lectures or demonstrations arranged by the Society and shall receive such periodicals and pamphlets as are issued by the Society from time to time.

7. MEETINGS:

(a) The Annual General Meeting shall be held as soon as possible after the end of the financial year. At least fourteen days notice thereof shall be given to members.

The following business shall be transacted at the Annual General Meeting:

(i) Presentation and Adoption of the Annual Report and audited Financial Statement and Balance Sheet.

(ii) Election of President: The President shall preside at all General Meetings of the Society. He shall be elected for two years and shall be eligible for one further consecutive year. He shall be entitled to attend meetings of the Executive Committee, and shall have ex-officio voting rights at such meetings.

(iii) Election of Vice-President:

(iv) Election of Executive Committee of 10 members:

(v) Election of Honorary Treasurer, who shall be an ex-officio member of the Executive Committee.

(vi) Election of Honorary Auditor:

(vii) Election of Honorary Legal Advisor:

(viii) Election of Honorary Psychiatrist:

(N.B. The consent of a nominee for any office in the Society must be obtained and conveyed to the Chairman of the Executive Committee prior to the Annual General Meeting.)

(b) A Special General Meeting may be called by the Executive Committee at any time or shall be called by the Executive on a written requisition signed by at least five members of the Society.
At least fourteen days notice of such a Special General Meeting shall be given to members. Such notice shall state the business for which a meeting is called and no other business shall be dealt with thereat.

(c) At all meetings of the Society each member present shall have only one vote.

The presiding member at a meeting shall have, in the case of equality of votes, a casting vote in addition to a deliberate vote.

(d) A quorum of ten members shall be required at any General Meeting, except that referred to in Clause 15 relating to the dissolution of the Society.

8. MANAGEMENT:

(a) The affairs of the Society shall be conducted by an EXECUTIVE COMMITTEE consisting of TEN MEMBERS elected by the Annual General Meeting. This Committee shal at the earliest opportunity co-opt FIVE other members, consideration being given in this co-option to the multi-professional requirements of the Executive Committee... In addition to these FIFTEEN MEMBERS of the EXECUTIVE COMMITTEE there shall be Advisory Representatives, i.e. official or representatives of the National Council for Mental Health, Government Departments, Provincial Administration and Municipalities designated by the EXECUTIVE COMMITTEE. Such Advisory Representatives may be invited to attend meetings of the Executive Committee but shall have no vote as such.

(b) Ths Society shall, through the Executive Committee, employ a DIRECTOR to act as the Executive Officer in the administration of the affairs of the Society. The Director shall attend all meetings of the Executive, but shall not have a vote. In all matters pertaining to the affairs of the Society the Director shall act in accordance with the directives of the Executive Committee.

(c) The Executive Committee shall, at its first meeting after the Annual General Meeting, appoint from among its members a Chairman and Vice-Chairman.

(d) The Executive Committee shall meet as often as is necessary, but not less than four times per year.

(e) The Executive Committee shall have the right to fill vacancies on the Executive by co-option.

(f) Any member of the Executive Committee who fails to attend three consecutive meetings without adequate reason as judged by other members of the Committee, shall cease forthwith to be a member of the Committee.

(g) The Executive Committee shall have full power to further the objects of the Society in any way it deems fit.

(h) At all meetings of the Executive Committee, each member present shall have one vote. The presiding member at a meeting shall have, in the case of equality of votes, a casting vote in addition to a deliberate vote.

(i) A Quorum of five members shall be required at any meeting of the Executive Committee.

9. SUB-COMMITTEES:

(a) The Executive Committee shall have power to constitute such sub-committees as may be necessary for the better transaction of the business of the Society.

(b) Convenorship of any sub-committee shall be vested in a nominee of the Executive Committee. Sub-committees may include persons appointed or approved by the Executive Committee who are not necessarily members of the Society but who have a knowledge of the work with which such sub-committees are concerned.

(c) The Chairman of the Executive Committee and the Director of the Society shall both be ex-officio members of each of the Sub-committees.

(d) Each constituted sub-committee shall function in accordance with the powers given to it by the Executive Committee.

(e) At all meetings of sub-committees, each member present shall have one vote. The presiding member shall, in the case of equality of votes, have a casting vote in addition to a deliberate vote.

(f) In the event of any conflict between constituted sub-committees, the matter shall be referred to the Executive Committee as soon as possible for a decision.

10. FINANCE:

(a) A Banking Account or Accounts shall be opened in the name of the Society and the Treasurer shall keep such accounts as are statutorily required.

(b) The Banking Account shall be operated by the joint signatures of any two of six persons duly authorised by the Executive Committee.

(c) The year, for the purpose of the Society, shall run from 1st April to 31st March.

11. PROPERTY:

All property movable or immovable, belonging to the Society or to which it is or may be entitled, shall be vested in the name of the Chairman, Vice-Chairman and the Treasurer, for the time being, for the purpose and use of the Society. Any two of these office bearers, when authorised thereto by the Executive Committee shall have the power to acquire, hold, alienate, mortgage, exchange, let or hire movable or immovable property on behalf of the Society, and to execute all and any documents necessary to give effect to any such transactions.

LIMITATIONS OF RIGHTS AND LIABILITIES OF MEMBERS:

Membership of the Society does not, and shall not give to any member any proprietary right, title or claim to, or any interest in any of the property or assets of the Society, nor does a member, by such membership, incur any personal financial liability in respect of any claims made or action brought against the Society.

12. LEGAL ACTION:

(a) The Society shall sue or be sued in the name of the MENTAL HEALTH SOCIETY OF THE WITWATERSRAND.

(b) Powers to sue or defend shall be signed by any one or more persons authorised by the Executive Committee to do so on its behalf.

AMENDMENT OF CONSTITUTION:

The constitution may be rescinded, amended or added to by two-thirds majority of members present at any Annual General Meeting or Special General Meeting of the Society called for this specified purpose, provided however, that written notice of any proposed rescission, amendment or addition be sent to the Director of the Society not later than four weeks before the Meeting at which any such proposal is to be considered, and that the terms of any such proposal are included and sent out, with the agenda of the said Meeting, to the members fourteen days before the said Meeting.
Any rescission or amendment of, or addition to the Constitution, shall be subject to the approval of the National Council for Mental Health.

13. DISSOLUTION OF THE SOCIETY:

(a) The Society may be dissolved at any time by a resolution passed by two-thirds of the votes of members present in person at a General Meeting duly convened for the purpose, and confirmed by a Resolution passed by a majority of votes at a second Meeting of members held not earlier than seven days, and not later than twenty-one days, after the passing of the first resolution.

(b) A Quorum of twelve members shall be required at each of these meetings.

(c) In the event of the dissolution of the Society being agreed upon, and if upon winding up or dissolution of the Society there remains, after the satisfaction of all its debts and liabilities, any property whatsoever, the same shall not be paid or distributed among members of the Society, but shall be given or transferred to some other institution or institutions, having objects similar to the objects of the Society, to be determined by the members of the Society at or before the time of dissolution, and indefault thereof, by the Director of Fund-Raising.

(d) The Meetings referred to shall be convened by a notice posted to each member at his registered address at least fourteen days before the date of the first meeting. Such notice shall set out the object of the Meetings, and shall state the date on which, and the place at which both Meetings shall be held.

This is a certified true copy of the Constitution of the MENTAL HEALTH SOCIETY OF THE WITWATERSRAND (W.O. 120).

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CHAIRMAN

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