

## THE PSYCHIATRIC SOCIAL WORKER IN THE COMMUNITY.\*

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### INTRODUCTION.

As you probably know, in January, 1944, the Provisional National Council for Mental Health were asked by the Board of Control to provide a Social After-Care Service for men and women discharged from Service Psychiatric Hospitals. For the purposes of this work an experienced psychiatric social worker, known as Regional After-Care Officer, was appointed to each of the Civil Defence Regions to undertake and organize this service. The psychiatric social workers visited the Psychiatric Service Hospitals in their areas, obtaining a full history and recommendations from the psychiatrist referring the case, and interviewing each patient to discuss his needs and plans. These reports were then sent to the Regional After-Care Officer in the patient's home area and formed the basis of our work.

Soon cases began pouring in, not only from Service Hospitals but from other agencies interested in the resettlement of the psychiatrically disabled Ex-Service man, such as Disablement Resettlement Officers, Ministry of Pensions doctors, Red Cross workers and so on. By the end of 1946 some 10,000 cases had been dealt with under this scheme.

Throughout we have been faced with an acute shortage of trained personnel and in most regions it was only possible to have the services of one or two full-time psychiatric social workers, so that most of the Regional After-Care Officer's assistants were trained social workers without the Mental Health Certificate. These general case workers receive a great deal of tuition and supervision from the psychiatric social worker. This dilution is raising great controversy, but it must be stated that some of the social workers have done remarkably patient casework of a high standard and that the scheme would have broken down without their help. As I will show later, emphasis on the general casework side is much greater than in orthodox clinic or hospital psychiatric social work, so that there is a place for the general case worker, under the guidance of a psychiatric social worker, in such a community service.

It is the first time that a community service on a national basis has been provided for a selected group of psychiatrically disabled persons and it has offered the psychiatric social worker enormous scope in applying her skill in the wider social field.

After three years of hectic activity, I felt the need to assess the value of this new service and its possibilities for the future, and began a study of successes and failures in our work.

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## METHOD OF RESEARCH.

I have been studying roughly 12 cases from each Region—chosen by the Regional After-Care Officers—six cases in which they felt that After Care had a positive contribution to make and where our work led to a general improvement, and six cases in which our work, intensive though it may have been, did not lead to any substantial change or resettlement. I hoped that by investigating the outstanding positive and negative manifestations of our work we might be able to elucidate essential trends. As I will show presently, definite trends in our work stand out quite clearly in spite of so many different personalities doing the case work with different types of training and background, and in spite of wide variations as to the type of population, provision of treatment facilities, standard of Social Agencies and so forth.

## OUTLINE OF PAPER.

First of all I should like to discuss some of the outstanding characteristics of the success cases, both with regard to the type of patient and his disability and our methods of work, illustrating each group with one representative case. I will then analyze the outstanding failures in a similar way. From there I shall pass on to the social worker's essential role in this type of community care, touching on the difficult subject of the difference in the approach of social workers and psychiatric social workers. Finally, I am going to try to define in what way this type of psychiatric work in the community differs from the more orthodox psychiatric social work in the framework of a hospital or clinic, what its particular significance and contribution is for the present and for the future.

## SUCCESSSES.

It is a common characteristic of all the success cases that the patients are co-operative; that is to say, they feel the need for help and have sufficient intelligence and emotional drive to want to get well and to establish a fruitful contact with the After-Care Officer. Often they are people whose basic personality and intelligence are reasonably good and whose disabilities are reactive rather than constitutional. But amongst the success cases there are also a number of very "poor fish," people of low intelligence, of almost constitutionally anxious temperament. They have, however, possibilities of emotional growth in them, enabling them to reach the worker and enabling the worker to establish a real contact with them. This contact proves the first bridge or link with the community and its demands and with infinite care these rather poorly endowed personalities can be helped to make an adjustment, as one After-Care Officer put it "within their shaky limits."

Four specific groups stand out clearly in every Region as capable of benefiting by After Care in the sense described above. They are:

- (1) Fairly acute anxiety states in persons of good intelligence and basic personality, often associated with a difficult reality situation.
- (2) Affective disorders, often almost indistinguishable from the chronic type of anxiety, in the rather limited individual who cannot

cope with stress and complexities and who needs the tolerant approach and patient encouragement, which will give him confidence to tackle life more successfully.

(3) The recovering schizophrenic, who needs rehabilitation in the widest sense of the word, from encouraging and stimulating contacts with reality in everyday home life, to re-learning the wider social skills in the community.

(4) Some cases of post-traumatic disabilities, who need skilled help to make a completely new adjustment on a new and often more limited level.

#### THE ACUTE REACTIVE ANXIETY STATE (Case example).

This man, aged 35, was referred for After Care by a Neurosis Centre in 1944, and has been an active case for two years now. He had always been a neurotic personality with depressive trends, but had a fair occupational and social adjustment prior to the War and many compensating positive qualities. He had an excellent record in the Army and developed a reactive anxiety state after acute experiences in the Norwegian campaign. His early home background was extremely unstable and unhappy. He married a mother-substitute type and has two children. At the time of referral he was separated from his wife and his domestic difficulties were severe. He was out of work and suffering from bouts of violent depression. An excellent contact was established and the patient proved to have considerable intelligence and insight. His marital difficulties were discussed freely and he was also able to release his guilt about some new attachment which has possibilities of emotional satisfaction. The man lives in a mining area, but is unable to carry on in heavy industry. It was found that he worked with great pleasure and skill on his allotment, which yielded remarkable results. After very careful consideration and consultation with D.R.Os. and psychiatrist it was felt that the best form of resettlement for this man would be to enable him to employ himself full time on his allotment, which could easily be extended into a smallholding. This would give him real satisfaction and also enable him to work at his own pace. As the agricultural resettlement grants were not in force then, a £50 loan was obtained from the Red Cross and the patient was helped to extend his activities. At the same time much practical help was given in sorting out various other difficulties with the Ministry of Pensions and Ministry of Labour regarding allowances for his wife. The patient was working under extremely difficult circumstances as the grant was not really big enough to live on. Constant encouragement and opportunities for discussing difficulties were given by the After-Care Worker. Recently it has been possible to secure the agricultural resettlement grant of £150. The patient has been able to repay the £50 to the Red Cross, has extended the smallholding further and is at last beginning to see a certain margin of profit. His nervous condition has improved greatly, and he has had no major attacks of anxiety or depression. As you will see from this account this man had treatment at a Neurosis Centre, but it is clear that no amount of psychiatric treatment alone would have helped him to a tolerable adjustment as the domestic and employment difficulties would have acted as continuous disturbers of the peace. The After-Care Officer was in a position to take into account this patient's varied needs. She brought him psychological relief through the talks about his marital and personal difficulties, by discovering the occupation that gave him every satisfaction, she enabled him to make this his life job. She relieved him of some of the domestic anxiety by acting as an interpreter to the Ministry of Pensions, the Assistance Board and various other Social Agencies. The P.S.W. was able to deal with the whole of the problem in its social setting. Through her co-ordinating function the other Social Agencies involved were helped to understand the complexity of this man's problems. The patient himself would not have been able to carry on through periods of severe financial and domestic stress if it had not been for the feeling of support and security which he derived from the After-Care Officer's understanding.

## GENERAL.

It may be objected that this case relates to a patient who could and should have been helped by psychotherapy and that the social worker trespassed. It will have to be remembered, however, that psychotherapy is only available for very few people and that anxiety conditions which are closely bound up with difficulties in the reality situation often yield much more quickly to the combined approach of psychological understanding and practical help. It is obvious that by means of her training the Psychiatric Social Worker will be able to recognize when the condition becomes so severe as to demand psychiatric treatment. I have no time to quote a number of similar cases where the actual treatment part has been carried on at a Clinic, but where the After-Care Officer has played a vital part by attending to the material difficulties and needs of the patient, thus ensuring co-ordination.

## AFFECTIVE DISORDERS AND CHRONIC ANXIETY STATES.

A man of about 38 was referred by a Neurosis Centre, where he was being treated after his discharge from the Merchant Navy, with a diagnosis of anxiety with depressive features. He had a cheerless and slummy home background, had seen severe enemy action, his wife had left him and he was living with his aged mother. He was able to take work as a labourer on his discharge, but became increasingly depressed, particularly as his new girl friend was cooling off. He again applied for treatment and had another spell at the Neurosis Centre, but his depression became so severe that he was considered a suicidal risk and transferred to a Mental Hospital as a voluntary patient. He did not stay there but came home, tried to work as a labourer, but remained irritable, depressed and suspicious. He could not adjust to life at home, which was undoubtedly partly due to the dreary and cheerless environment created by his very old and ineffectual mother and his slovenly and uninterested sister. The After-Care Officer obtained material aid and finally arranged for him to go back as a voluntary patient to the local Mental Hospital. He only stayed a few weeks and expressed his ardent desire to go back to sea. After intensive negotiations it was possible to arrange this. The After-Care Officer provided clothing for him and literally nursed him on to the ship. This was in May, 1946, and up till now he has been making regular trips to Germany, Portugal and Spain. He writes regularly to the After-Care Officer and asks her for help with innumerable practical difficulties.

You will notice that this man was in three different hospitals and that treatment failed to bring about any improvement, but that when he was given intensive personal attention and support it was possible to encourage him in such a way that he was able to go back to his old job at sea. Although he is still rather inclined to be depressed, he is probably as well as he has ever been. The After-Care Officer was, in this case, the only source of support and encouragement to a depressed and lonely soul, living in a cheerless, affectionless environment. His dependence on the worker was very great indeed at one stage and she was having to work very hard to fulfil his ever-growing demands, but he now seems able to stand a little more on his own feet.

## GENERAL.

I should like you to observe that the unsparing intensive work on this and similar patients, who looked chronic and hopeless to begin with, was carried out by Social Workers, in contrast to the anxiety group which was handled

almost entirely by P.S.Ws. I feel that this is rather significant. The first group of patients needed a considerable amount of psychiatric assessment and the work of the P.S.W. amounted to something like superficial psychotherapy. In the second group of affective disorders, what was demanded of the worker was not so much interpretation of acute conflicts, but something which I should like to call "maternal care"—a form of positive support, material and psychological, making great demands on the Worker's willingness to give of herself unsparingly and this the less psychiatrically trained person seems well able to do. It strikes me that this group of depressed misfits in the community are people who have not had sufficient maternal love and instead of striking out aggressively like some of the psychopaths they have become depressed and ineffectual. Through the generous help of the Social Worker, who recognizes their deficiencies and who makes untiring efforts until positive feelings are stirred, the patient is able to move forward, at first utterly dependent on his new mother figure, but gradually emancipating himself as he is able to reach out for other satisfactions.

#### THE RECOVERING SCHIZOPHRENIC.

A boy of 19, with 18 months' service in the Army, was referred by a Military Hospital in May, 1945, the diagnosis being hebephrenic schizophrenia. The boy was the only son of a very over-protective mother. He was of superior intelligence, matriculated and was called up from school. He worked as a laboratory assistant in the R.A.M.C. When he was first visited he was still withdrawn and probably deluded and quite inaccessible. His mother felt that he was hopeless and by her attitude she was doing everything she could to keep him ill. The After-Care Officer visited regularly, won the confidence of the mother and was able to modify to a certain extent her attitude of over protection. She was encouraged to believe that the boy would improve and when there were signs that he was able to get into touch with reality she was taught how to encourage him and make the most of his recovery. In this way the boy was encouraged gradually to undertake more and more in the way of tasks at home and social activities outside, and when he was ready for work the After-Care Officer was able to find the one job he wanted to do, that of a junior chemist. He started this job about 10 months after his discharge from Hospital and he has gone from strength to strength since, as he is now also able to engage in social activities outside his work and his home. This boy probably made a spontaneous recovery from his severe schizophrenic illness, but I personally have no doubt that he would not have made anything like such a complete recovery had it not been for the help the After-Care Officer was able to give, first to his mother and secondly to him. This case shows what can be achieved by working through the environment first and changing the relatives' attitudes and by active help in the re-education of the recovering psychotic. There was a relationship of complete trust and confidence between the family and the After-Care Officer, who, with very good insight, made the right move at the right time, encouraging a gradual widening of interests and activities commensurate with the patient's capacities.

#### GENERAL.

The function of the After-Care Officer in this case did not so much involve the very intensive personal help the other group of patients required and was not so much dependent on transference and the relationship therapy, but was one of creating a social ladder, as it were, on which the patient was able to climb step by step towards social integration. It is a form of environmental help aimed at the patient, the possibilities of which have not, I think, been realized

fully. Here, I feel, lies a great field for experiment in psychiatric rehabilitation. I am inclined to think that many psychotics, after successful treatment, have a good chance of social integration if, at the optimum moment the right type of approach is made; if, in other words, the Psychiatric Social Worker is able to lay her finger on the one positive and real thing the patient is capable of achieving and that stirs his interest and imagination. I am afraid that we are still too stereotyped and unimaginative in our approach. Another essential point that emerges is the immense importance of following up quickly after discharge from Hospital, so that what I call the optimum moment is not missed. In civilian work we should be able to commence rehabilitation during the last stages of hospital treatment, and I have visions of rehabilitation centres following on occupational centres in the hospital and gradually leading towards everyday working conditions.

#### CEREBRAL TUMOUR PATIENT.

This patient is a married man, aged 37, who was referred in 1944 by a R.A.F. Station Hospital. He was said, at that time, to be anxious, depressed and retarded. He had a stable employment record, had reached the top class at his school and was apparently a stable personality. On the first home visit it was found that he was unable to carry out the simplest action on his own. He was immediately referred for psychiatric examination, admitted urgently to an E.M.S. Hospital and a tumour of the brain was found and operated on. He stayed in Hospital for 3 months and on his discharge he was expressionless, very slow, paralyzed completely down one side. He was attending as an out-patient the occupational therapy department of the Neurosis Centre. He was not receiving a pension and the financial situation in the home was very strained and required the After-Care Officer's attention. His speech was also impaired, and speech therapy had to be arranged, as well as elaborate arrangements for escorts. At that time the patient was very depressed and despondent and his wife, a rather neurotic type, was desperate, disgruntled and not encouraging patient at all. When the Neurosis Centre closed down, the last hope went as there was no occupational therapy available. The After-Care Officer was undaunted and after contacting many different agencies he was able to get a weaving loom for patient. He found an occupational therapist at the local Mental Hospital willing to go to patient's home and teach him once a week, and finally S.S.A.F.A. was willing to bear the out-of-pocket expenses of the occupational therapist. The loom was installed, the occupational therapist started to visit him weekly and the patient at last became active and hopeful. Finally, in order to provide a variety of interest, rug materials were obtained for him. The occupational therapist thinks highly of this man's ability and believes it is possible that he will eventually be able to do light work. Along with these practical developments went the After-Care Officer's close relationship with this patient's family. By providing outlets for the patient, relieving the intolerable financial strain and by general encouragement, he was able to lift a cloud of depression that had descended on the whole household, and outside people remarked how much more positive the wife's attitude was; instead of discouraging patient, she was now helping him and the last impression of the case was a write up describing patient sitting in a room with the sun pouring in, weaving happily.

This case, then, shows the Social Worker once more as a co-ordinator, seeing the patient's problems in his family setting. Occupational therapy alone would not have brought about improvement in the whole family outlook. Through the Social Worker's constant help, this man, severely disabled though he is, was enabled to use his limited capacity to the maximum, and both he and his wife have been helped towards a positive outlook.

## POST-TRAUMATIC PATIENTS.

The main issue with the post-traumatic type of case is to help the patient to make a new and positive adjustment on a level often much lower than he had previously achieved, to guide the patient and his family towards the acceptance of the disability, at the same time providing positive satisfaction within the patient's range. The task of the P.S.W. is often a very complex one here, as she will have to enlist the help of many social and therapeutic agencies. She must be constantly aware of the possibility of the patient developing hysterical symptoms and other pathological reactions on top of his organic disability, if life is too difficult for him to face. No amount of training or occupational therapy or material help will bring about real readaptation if the fundamental problem of psychological readjustment remains untouched.

This brings us to the end of our analysis of the successes.

## FAILURES.

They stand out remarkably clearly and fall into much more definite and uniform groups :

- (1) The allegedly uncertifiable unrecovered chronic psychotic, who, by virtue of his illness, is incapable of insight or of responding to our help.
- (2) The psychopathic personality, which I should like to divide into
  - (a) the delinquent psychopath,
  - (b) the unmanageable girl psychopath,
  - (c) the chronic alcoholic, and
  - (d) the paranoid type of psychopath, often subnormal in intelligence, who is frequently found in a derelict social setting.

## THE UNRECOVERED PSYCHOTIC.

A single man of 30 was referred by a Military Hospital in 1944 with a diagnosis of schizophrenia, having made only a limited improvement and receiving a 100 per cent. pension. There was no previous history of mental illness, but he had an erratic employment record. The mother was immensely over-protective, and her severe deafness made it difficult to have much contact with her. The After-Care Officer kept in regular touch with this patient, visiting at intervals of a month or six weeks. He remained withdrawn and probably deluded. Attempts were made to interest him in work or occupations at home with no result. He was referred to the Ministry of Pensions three times with a view to further treatment and each time he was sent home again with a note saying that he only required panel doctor supervision, although latterly he had become increasingly more restless and deluded. The Panel Doctor was satisfied with the Ministry of Pensions verdict and no one moved until the patient proceeded to murder his father and severely injure his old mother. He was then committed to Broadmoor Asylum. Here, then, we have a patient who is considered a harmless lunatic, although he was actively deluded and deteriorating steadily. The price the community paid for the freedom of the individual was two lives, as the mother is incurably shattered by her experience, though not physically dead. The Social Worker's ability to help constructively was limited and could not amount to more than referring patient for treatment to the appropriate agencies and to giving all the help she could to a very over-protective, but kindly mother.

## GENERAL.

It is evident that the function of the After-Care Officer in the case of the psychotic requiring treatment is to secure treatment, help relatives to cope with the patient and to co-operate with treatment. The serious situation prevailing all over the country is that the psychotic without insight will not consent to voluntary treatment and that some doctors and relieving officers are unwilling to resort to certification unless the patient is really a raving lunatic. This rigid limitation of the use of certifying machinery is alleged to protect the freedom of the individual. I wonder how long it will be until it is realized that the price we pay for the alleged liberty of an ill person, who would be much better in a hospital, is the life and happiness of otherwise normal and happy people. There is ample evidence that in all the Regions, After-Care Officers have left no stone unturned to get deteriorating psychotics into Hospital, but time and again they have met reluctance to certify and untold misery has resulted for the immediate environment of the patient, quite apart from the fact that the patient himself was not helped in any way. The reason for our failure in this type of case lies in the prevailing antiquated machinery of the Lunacy Laws, which, I hope, will be overhauled before long in the light of recent advances in the treatment of mental illnesses.

## THE DELINQUENT PSYCHOPATH.

This man, married, aged about 30, was referred to us in 1944 by the Ministry of Labour as he had great difficulty in settling down to a job. He had been discharged from a Neurosis Hospital with a diagnosis of psychopathic personality with severe neurotic traits. His history revealed great emotional difficulties in early childhood, centring round a terrifying and over-powering mother. He went to a Grammar School, entered a Theological College against his will and finally joined the Indian Army. Whilst in India he married a half-caste twice his age, and married an English girl bigamously later on. After his prison sentence he had various commercial jobs. He was imprisoned on one occasion for impersonating an Army Officer. In 1939 he joined up again, was often absent without leave and was unable to keep his promotions. After his discharge from the Forces he had approximately eight jobs before being referred for After Care, and the reason for his dismissal from most of them was delinquent and/or arrogant behaviour. When he was seen first he was in the most severe financial and domestic difficulties, aware of his deep-seated problems, but blaming his circumstances for his repeated failures. An attempt was made to secure psychological treatment for him, but he did not keep the appointments. Finally, after intense emotional scenes, he left home and arrived penniless at the After-Care Office. He was then in a very co-operative mood and opened up considerably about his early difficulties, and there seemed to be a gleam of hope that one would be able to help him. He was fixed up in a hostel and, after great efforts, the After-Care Officer, in close co-operation with the D.R.O., succeeded in getting him a job as a valet in a Canadian Army Officer's Camp. This was a job after the man's own heart and he departed full of hope for the future. After a fortnight he was apprehended for stealing from the Officers and served a six months' prison sentence. A year or two later he was in further trouble with the Police after a shop-breaking charge, which took place after a severe domestic upheaval. Here, as in other cases, this patient's deep-seated difficulties go back to a series of emotional disturbances and conflicts in his early home life. He was intelligent and on the surface willing to co-operate, but his unconscious drives were far too strong, and even when some of the reality stresses were removed and he was given a completely new chance away from home, he was quite unable to lead a normal life; he also faces a life of prison sentences.



## GENERAL.

Why are we so utterly unable to help these anti-social psychopaths, of whom many are above average intelligence, in spite of the fact that we have insight and sympathy with their problems? The fundamental reason probably is that their problems are so deep-seated and the pattern of delinquency so established that we are unable to break through to them. The establishment of any fruitful contact is made all the more difficult by their tendency to wander about the countryside. It seems fairly clear that this type of psychopath needs long-term treatment. One psychiatrist suggested that they would need some type of institutional treatment, which was a blend of a hospital and a prison, but even with long-term intensive psychotherapy one wonders whether any results will be achieved. I think it is important to bear in mind that in all these cases manifestations of disturbances and pathological attitudes were observed in childhood. Perhaps the only answer to this great problem is that by ample child-guidance facilities and wiser parent education we shall limit the number of anti-social psychopaths. (I will leave it to you to discuss this vexing problem further.)

## THE UNMANAGEABLE GIRL PSYCHOPATH.

This girl of 18, with one year's service in the W.A.A.F., was referred to us in 1945 by a Military Psychiatric Hospital after she had made a suicidal attempt by aspirin. She was of good intelligence and there is again a story of broken home life. Her mother died whilst she was young, and she lived in very close contact with her father, who took her out with him everywhere until his death in 1942. She then went to live with an uncle and aunt, who were strict and frowned on the free and easy habits she had acquired whilst living with her father. There was, further, some erotic attraction between herself and the uncle. A visit to the uncle before this girl was discharged from hospital revealed that the mother had been a flighty type. The uncle was very censorious of the patient's promiscuous habits, but at the same time was obviously attracted by her. On the girl's discharge from the Hospital, the After-Care Officer arranged for her to stay at a hostel and tried to keep in close touch with her. She seemed lost at first and started to stay out odd nights. She seemed depressed and also distressed that she did not belong anywhere and she expressed deep conflicts regarding her uncle. It was not possible to establish a really close contact with the girl, as she kept disappearing from the hostel. After she had been missing for several weeks she finally turned up, collected her clothes, and has not been heard of since.

This girl, who is drifting into promiscuity has again quite obvious deep problems connected with her childhood experiences. Reading through her case it becomes very clear that she is driven by something much stronger than her conscious self into her promiscuous life, which she does not really enjoy, as she seems depressed and unhappy most of the time. She was quite unable to make a contact with the Social Worker and had to be left to drift along her unhappy path.

## GENERAL.

This group of the unmanageable girl presents a grave problem, to which, I believe, no positive answer has been found yet. Some of these girls are sent to Approved Schools or Borstals, but so often they emerge from there only to repeat their previous pattern of behaviour. I think they are a serious problem,

not so much from the effect their asocial behaviour has on the community, but because they will become the type of unloving mother who produces a problem child, who, in turn, will hit back at society.

Have Psychiatric Social Workers any contribution to make to this problem which is so often regarded as purely a social one and dealt with by Moral Welfare Workers ?

#### THE CHRONIC ALCOHOLIC.

I propose to say very little about this group of failures because it seems to me that when alcoholism has reached the chronic stage necessitating Mental Hospital treatment it is too late for the Social Worker to do any constructive work. Very good contacts have actually been established with alcoholics in the sober remorse state, but in all the cases presented the relationship has never resulted in helping the patient to overcome his alcoholic bouts. I think the essential point here again is that the patient, though consciously even asking for help, has unconsciously accepted the "bottle" as a means of dealing with his conflicts.

#### THE PARANOID PSYCHOPATH.

This man, aged 44, was referred to the After-Care Service by a Council of Social Service as he seemed unable to settle down to civilian life. He was married and had four children. He showed no responsibility towards his family, refusing to support them, and they were living on Public Assistance. He was spending his time at dog racing tracks and was creating considerable disturbances in the home. He had apparently been fairly stable before the War, but it was not possible to check on this statement. When the After-Care Officer first met this family she referred patient to the local psychiatric clinic and the psychiatrist described the man as an irresponsible rogue, but he was prepared to help the family and see the man at the clinic. The After-Care Officer then set about trying to improve conditions in the home. Arrangements were made for the small children to attend a Day Nursery and for the older child to have meals at school so that patient's wife could give more attention to the home. Material assistance was obtained from the very co-operative Council of Social Service, and for a time it looked as though things were settling a little. Patient seemed more co-operative and inclined to do his bit. Patient's wife was responding to the Worker's encouragement and tried to keep the home better. However, this state of affairs did not last long; patient's aggressive and rather paranoid attitude got the better of him, he made unreasonable demands for large resettlement grants from the Ministry of Labour. The marital difficulties became very severe indeed and the wife began to neglect the home again. The parents were not able to get up early enough to get the children to the Nursery School, and conditions in the home deteriorated until they were again as bad as at the time when the After-Care Officer had first visited. It was then decided to close the case, as it was obvious that in spite of intensive family case work the After-Care Officer had been unable to bring about any improvement in the general situation.

#### GENERAL.

What has contributed to our failure in the psychopathic group? In most cases the work was on an intensive scale in co-operation with many other Social Agencies, as these people so often find themselves in the most involved and complex situations. One of the characteristics of this group is that unconsciously and at times consciously they prefer their way of life and do not really

want to be helped to achieve the social standards generally accepted. In most of their histories we find evidence that they have been emotionally thwarted in early life and they are now getting the emotional satisfaction of hitting back whether their aggression shows itself in being "agin" the Government and refusing to work unless they get a Government grant of £1,000, or whether it is the aggressive taking of denied pleasures, called stealing, or whether it is symbolized in sexual promiscuity, where quite often longing for affection and revengeful hostility are mixed. These people, emotionally immature, live like children according to what Freud called the pleasure principle. It is a force that drives them mercilessly and which they seem utterly unable to control; the price they have to pay for such behaviour is heavy we know, as most of these psychopaths are miserable, dissatisfied people, and this depressive colouring is, I think, due to an unconscious deep sense of guilt, of which the delinquent type rids himself by going to prison. Their values are, as it were, upside down and they do not possess the tools of control. Is it to be wondered at that in most cases we cannot reach them? In fact, I think by our understanding and unprejudiced attitude we often increase their unconscious sense of guilt as their pattern of life is built on the assumption that nobody wants them and everybody is against them. It is clear that only a very deep going process of rehabilitation, of tackling the problems, both from without and within, will stand any chance of success, that is to say, a process of undoing their false values, followed by a gradual process of helping them to grow up more normally. This is an immense task and probably even if it were feasible there would still be complete misfits in our community, those who are almost constitutionally unable to grow up emotionally along healthy lines. I do not want to appear too gloomy, however, and I must mention here that some few and all the more astonishing successes have been achieved with psychopathic personalities. With these cases I feel that difficult though they were the pattern as described just now was not fully and irretrievably established yet. One case was of a boy described by the psychiatrist of the invaliding Hospital as a criminal psychopath, who was in severe jungle fighting as a youngster, spending his time brothel crawling in India. He was generally completely wild and irresponsible after his discharge. He had experienced great friction in his home, where his mother rejected him, preferring a younger brother. He had always been impulsive and wild as a boy and was regarded as the black sheep in the family. When he came to the notice of the After-Care Service he was already labelled criminal psychopath, and he was full of aggressive impulses, but he was afraid of the aggressive forces in him, had a strong conscious sense of guilt and was still at the stage of openly longing for his mother's affection and approval. He was just standing on the brink, as it were, of becoming a confirmed anti-social being, compensating for the lack of security in his home. The After-Care Officer was able to make a real contact with this boy and to evoke his tender and positive feelings. She became his substitute mother for the time being and he opened up, confiding all his difficulties to her. Having the After-Care Officer's support he was able to relinquish his quest for his mother's love, when attempts to change her attitude towards the boy had failed. After a tremendous row at home he was helped to establish himself in lodgings, and eventually it was possible to fix him up in

agricultural training, which was no small task in view of the fact that he had been labelled a criminal psychopath and moral defective in the D.P.I. This boy has been on a poultry farm now for seven months, and apart from one outburst when he smashed up a few windows, is keeping a precarious adjustment. Here you see was a boy who had all the potential makings of a psychopath and who was just on the point of finding satisfaction in anti-social behaviour because he could not secure his mother's love and approval. It was his good fortune that just at that time he was sent to the people who recognized his fundamental problem and did not spare any effort to see him through this immensely difficult and significant period.

There is hope I feel when there is still a positive conscious longing for affection and approval and feelings of anxiety and guilt about anti-social trends, but even then the potential psychopath with his uncontrollable hunger for emotional satisfaction makes the most enormous demands on the P.S.W., and only mature people who have come to terms with their own aggressive impulses and are able to bear the strain of the patient's incessant demands without anxiety are capable of dealing with them. There are many Social Workers and Psychiatric Social Workers who cannot stand such severe demands and rather than cope anxiously and almost reluctantly it is better not to attempt the case at all.

Here I must reluctantly leave the fascinating subject of the psychopathic personality, a subject that needs much sociological and psychiatric research.

The clue as to why we succeeded in helping some patients and not others is the patient's accessibility. The first group of successes consisted largely of people who had basically a fairly normal structure of personality, but they had come up against specific problems that had created conflict and faulty attitudes or they had not been able to develop their potentialities. They were conscious of their disability and anxious to get better. It was possible, therefore, to establish a contact of dynamic quality, and they were able to take advantage of the help both psychological and material we were able to give them. The group of failures consists largely (though not always) of people with whom we were unable to establish a really creative relationship. The psychotic living in another world and the psychopathic personalities who, because of their abnormal basic pattern of behaviour, were unable to take advantage of the help offered.

#### THE ROLE OF THE PSYCHIATRIC SOCIAL WORKER.

What is the function in the work described above? I should say that our primary function, without which our work cannot be successful, is to assess correctly and on the deepest level possible the patients' problems and needs so as to arrive at a comprehensive social diagnosis. This applies particularly to the cases referred without a diagnosis from social agencies which naturally normally only recognize the immediate difficulty in the patient they have come across, i.e. the D.R.O. says "This man is unsettled in his work." This complete assessment involves a full social history; psychiatric insight, as we must be able to recognize the patient's possible need for psychiatric advice and for treatment, and sociological knowledge to evaluate the significance of the social problems.

Having made an adequate assessment of the patient's problems and needs it is our function to devise a plan of work. Although it is not always possible to have initial conferences on our cases as in Child Guidance practice, we should be clear in our minds about the basic problem and the aim in our case work. I think we social workers have an unfortunate inclination, through pressure of work and other less obvious mechanisms, to be driven to "do something," and we are not always clear what this "something" is. At times, I admit, we have to feel our way intuitively, but there comes a time when we should be able to say what we are aiming at and why. We hope that with the appointment of Consultant Psychiatrists to the Regions an initial conference with a psychiatrist will become a reality in most cases.

Having decided on the treatment plan I think our functions can be divided into three :

- (1) Personal help to the patient.
- (2) Interpretation of the patient's problems and needs to the family, helping them to adjust to his often changed personality.
- (3) Interpretation of the patient's needs to the community, mostly in the shape of social agencies which are enlisted to help in the rehabilitation of the patient.

The first part of our function is the vital one, without which we are not able to fulfil the other two. We all know that our personal help to the patient may vary from helping him to fill in a form, to a complex relationship amounting to some form of psychotherapy. The vital thing in both forms of contact is our relationship with the patient. Whether we are able to establish this relationship depends not only on the willingness of the patient to cooperate, but also on our own attitude. It is an attitude of opening your mind completely to the needs of another human being, a willingness to understand and accept the situation in which he finds himself as a reality, however confused or shocking this situation may be. It does not always matter so much whether we are completely able to follow the patient in his fantasies as long as we are really prepared to be receptive with our conscious minds, as free as possible from other preoccupations. This understanding and tolerance has an amazing releasing and therapeutic quality. It gives the patient a new feeling of relief and security. There is ample evidence in patients' letters that what they have valued most in the After-Care Service was the understanding and tolerance shown. This experience has been more important to them than practical advice or alterations in their material circumstances which we have been able to achieve. So often patients thank us for what we have done and our reply is that we have done nothing. We have been unable to get the house or the job they were hoping for, and yet they feel the reality of our help. The fact that we have taken their problems seriously and have tried to understand and have made real genuine efforts to help, has had a reassuring and therapeutic effect.

This relationship, which is the key to all personal social service, may make great demands on the tolerance and detachment of the social worker. In intensive case work of the kind described in the depressive group of success cases where patients tend to become utterly dependent for a time and we

clearly stand for a mother substitute, we have to guard against the dangers of the over protective and over-possessive mother. We also have to beware of the danger of the over-indulgent mother, whose child is always right, the danger of over identification with our patient. At the beginning of our relationship, when the patient is so helpless and immature, we may have to nurse him, but in our satisfaction at being able to help him, we should not accept his dependence as a permanent state, and aim at him helping to grow up toward independence. Similarly, in our ardent desire to help our patients, we tend to become so identified with their cause that we cannot see their problem in their wider social context, and so push their claims with a tenacity which, though laudable, ignores the existence of other urgent claims for different sections in the community. The only safeguard against emotional involvement, apart from our training, is, I suggest, to stop our frantic work occasionally and look at ourselves and ask ourselves "What am I doing here? What do I feel about this case, and why?" If we cultivate an awareness of our own attitudes, the danger of our emotions running away with us is minimized. This emotional detachment is also important because of its therapeutic value. We are able to bring relief to the patient because we are outsiders, seeing his problems more objectively. As soon as we become emotionally involved or over-identified with the patient we lose this ability to see his problems in their wholeness, and our usefulness to the patient will be limited.

Whatever the difficulties of this transference relationship, without it we can do very little to help our patients, and whilst we must guard against the dangers of emotional entanglement, we must equally guard against the desire to run away from such relationships. Some people prefer to tackle anything rather than the patient's inner problems. If the patient has difficulties within himself that need adjusting, no amount of environmental changes such as suitable work, material aid, rehousing, will bring about complete rehabilitation. We must, therefore, be at least prepared to acknowledge these personal difficulties, even if we cannot deal with them and shall have to refer them to a psychiatrist. This distinguishes our work from other forms of social work; that we should be aware of the underlying causes of social failure and relate social failure to personality difficulties. If we shut our eyes to these underlying emotional difficulties we shall make very poor interpreters of the patient's needs to the community.

Our role as interpreter to the family, explaining the patient's difficulties and trying where necessary to modify the relatives' attitude towards him, is an important one, as the psychiatrically disabled person is so much more dependent on his environment and his family's ability to understand him than the emotionally mature and balanced person. Indeed much of his eventual recovery will depend on the helpfulness of his immediate environment. Many unhelpful attitudes are due to ignorance and over-protectiveness and are often the result of real concern for the patient such as the mistaken ideas about rest, sanotogen and breakfast in bed! These attitudes can be modified fairly easily by convincing and imaginative explanation.

Often the family really bears the burden of the patient's illness, and much of our most valuable work consists in showing the wife or mother or husband of

our patient means and ways of shouldering this burden, particularly in cases of permanent personality defect or disablement. In our work with the patient's family we are occasionally faced with a very grave ethical issue. Sometimes the patient's instability is so severe as to endanger the happiness and perhaps permanent well-being of a young family, and yet the patient is utterly dependent on his family and their rejection of him would probably result in a final major breakdown. What are we to do in this dilemma? Encourage the wife with her young children to leave the husband and ensure the happiness of her children at the expense of the patient, or shall we encourage her to stick to the patient and help him toward recovery although the price paid in happiness and stability for the whole family may be very high indeed? It is no good saying the decision lies with the wife or husband. By our contact with the family we do, in fact, influence their decisions, and it is therefore important that we should ourselves face this problem squarely when it arises.

The range of our interpretative work to the community is ever growing and undoubtedly the most important development is adult psychiatric social work. I do not think that explanation of psychiatric illness, its social causation and resulting social problems has ever been carried so far into the community as in our After-Care work. There is now hardly a D.R.O. in the country who has not had personal contact with an After-Care Officer and the opportunity of discussing psychiatric problems as they affect employment. We all know that the D.P.I. in itself is hardly ever sufficient to explain psychiatric disability in terms of employment problems and that particularly in the more complex type of case a much fuller explanation of the patient's difficulties is needed. It is clear that our link with the Ministry of Labour will only be completely satisfactory if and when we have the services of a vocational psychologist also. Most D.R.Os. acknowledge freely that they have derived much help from discussing the bewildering problems of the psychiatrically disabled with us. We, in turn, have also learnt a great deal by coming out of our precious clinics into the hustle and bustle of employment exchanges and by having to face up to some of the grim reality problems in connection with the labour market.

Psychiatric social workers have, for the first time, co-operated with the commissioners of medical services. We have brought to their notice on many occasions the patient's need for treatment and have, I feel, done a great deal towards opening their eyes to the possibilities of skilled social work amongst the psychiatrically disabled. In many instances the Ministry of Pensions doctors have worked with us in a true team spirit. We, in turn, have learnt that the Ministry of Pensions is not quite such a remote, mysterious and inhuman machine as we imagined, and that they are concerned with the pensioner's human problems, and that they are prepared to use their cumbersome machinery to the pensioner's best advantage.

But our activities in the community take us much further than the Ministry of Labour and the Ministry of Pensions. We enlist the help of all possible social resources in the community for his recovery. This brings us into contact with a wide variety of social agencies, statutory and voluntary, and gives us a unique opportunity of widening understanding of mental illness, its social causations, and the possibilities of treatment and social rehabilitation. We

have all spent many useful, though occasionally exasperating, hours discussing a patient's case with the Hon. Secretary of the local S.S.A.F.A., with the Clerk to the Rural District Council, with the Secretary of a Price Regulation Committee, with some obscure official at the Board of Trade, with Area officers of the Assistance Board, with the Red Cross, and countless other representatives of Social Agencies in the community, not to mention colleagues in other fields of social work. I am sure we are not always aware of the cumulative effect of such unobtrusive educational work by personal contact, but I feel confident that its effect will make itself felt in demands for more information and a resulting better understanding of mental illness. Our interpretative function to the community is two-fold. It enables the patient to make use of the social resources in the community which, on account of his instability, he is not able to use efficiently himself, and it enables the social agencies to play a useful part in the rehabilitation of our patients once their problems and needs have been adequately interpreted to them. Without us as the communicating channel, as it were, those two might never meet, as the patient often does not know that the resources exist or are applicable to his case, and the social agencies do not recognize the patient's needs as they are often obscured by complex situations.

Here lies our major strength as P.S.Ws. in recognizing people's inner needs and being able to relate them to the social resources in the community in the widest sense. The more fully we recognize the patient's problems, and the more widely we permeate the community as an interpreter of their needs, the more amply will we justify our title Psychiatric Social Workers.

Finally, in what way does the Psychiatric Social Worker in the community differ from the Psychiatric Social Worker attached to a hospital or clinic? The main essential difference is that we work mostly on our own, and the focus of our work is the patient himself, although activity extends to his family and the community. The Psychiatric Social Worker in a hospital or clinic is the member of a team. She works definitely under the direction of a psychiatrist and her main concern is the patient's family and immediate environment. Some people maintain that, ideally, the P.S.W. in the community should be definitely linked with a psychiatric clinic or hospital. These people have overlooked a vital part of our work. Because we are free floating, as it were, in the community, and have the wide contacts described above, we come across problems of instability and maladjustment that will never reach a clinic without our intermediary help. We have access to them in the first place because we are P.S.Ws. not linked with a definite hospital or clinic. The patient, though unstable and causing concern, may not be aware of his need for treatment, and often we have to do much patient work to awaken this insight; or he may deliberately refuse treatment in which case most clinics and hospitals wash their hands of the patient, but we are able to carry on; perhaps supporting the relatives and seeking patiently for a solution. There are great numbers of unstable people in the community who will never find their way to the clinic directly, and who need at any rate preliminary work by a P.S.W. in the community. There is also the large group of the rather chronic neurotic type, that cannot be helped much at a clinic but needs the patient services of a social



worker with psychiatric insight, who, in conjunction with other social agencies, aims at bringing about some social adjustment within the patient's limits. There is further the large group of patients who only attend for a diagnostic interview, and whose problems are mainly of a social nature which could best be met by a Psychiatric Social community service. At present these patients are shot back into the community by the diagnostician with a short note to the panel doctor. As regards After Care and social rehabilitation of the ex-hospital patient, I feel strongly that we have proved the usefulness of a service radiating from the community rather than from the hospitals from which the patient is trying to break away. The After-Care Officer, working from the community, symbolizes to the patient the first step towards adjustment to community life and, whilst weaning him from the protection of the hospital, she is still able to provide continued support. In this way After Care has developed into a positive service rather than an after thought to treatment. In social rehabilitation, after specific psychiatric treatment is completed, it is further necessary to enlist the help of the social resources in the community, and this a P.S.W., working in the community, may find easier to achieve than the hospital P.S.W., who is of necessity more interested in treatment aspects and not so closely in contact with the wider social resources in the community.

I think, then, that there is a big field for the P.S.W. in the community. By means of her training she will know when to consult a psychiatrist and, in fact, once there are sufficient psychiatric facilities there will be very few cases in which such advice will not be sought. In many instances, however, as we have seen in the cases studied, the problem will be handed back to the social worker with valuable diagnostic guidance. The field that could be covered by the P.S.W. in the community might be summarized as follows :

- (a) Preventive work, spotting minor difficulties of adjustment by making her services freely available to all types of social agencies, including panel doctors.
- (b) Preliminary work with potential patients and their families to pave the way towards treatment.
- (c) After Care and rehabilitation work of the ex-hospital patient and participation in the social re-education of the chronic patient not suitable for clinic or hospital treatment.
- (d) Educational work and research.

Apart from the functional differences that lie in the fact that the P.S.W. in the community is not attached to a specific hospital or clinic and covers fields so far very largely untouched or insufficiently covered by the hospital or clinic P.S.W., her range of work is also, in some ways, different. Psychiatric social community care, as demonstrated by the After-Care service, is an attempt to combine psychiatric social work with general social case work in the widest sense. In clinic work the P.S.W. is usually concerned with the more psychiatric aspects of the patient's or the family's problems, and problems of social and material care are entirely left to the appropriate agencies and very often, I am afraid, they are not tackled at all. This is due to the fact that the clinic P.S.W. must confine herself to her specialist function and has not the time for wider social work. It is also due to her training, where the field is rather

purposely narrowed to the non-material side of her work. In community care, however, where we help the patient to readjust either after treatment is completed or in the absence of psychiatric treatment, we have to use both our trainings to the full, so that hand in hand with psychiatric rehabilitation goes social and economic rehabilitation. I think we have all been amazed to learn how material and practical aid given psychiatrically, that is to say, at the right moment, within the framework of a treatment plan, can contribute substantially to social adjustment.

As I see it, the services of the community P.S.W. are complementary to those of the clinic or hospital team. We hope to fill the gaps before and after treatment, linking up with the clinic services wherever necessary. This will in time mean that the clinic workers will be able to concentrate on the really worthwhile selected cases capable of responding to psychological treatment. So far we have not been able to do much of the sifting and pre-treatment work in the community as we have been overwhelmed with the demand for psychiatric after care, but I think we have proved beyond doubt that there is a useful and essential place for the P.S.W. in the community whose function last but not least will be to link effectively psychiatric and social services.