

# **Minnesota Welfare**

- **Ardo M. Wrobel**
- **Dale C. Cameron**
- **George T. Frohmader**
- **Arthur S. Rusterholz**
- **Albert T. Huebener**

-----**FALL, 1962**

# Minnesota Welfare

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1. A Pyramid of Music ..... Ardo M. Wrobel
6. Comprehensive  
Mental Health. .... Dale C. Cameron, M.D.
20. Family Courts ..... Albert T. Frohmader
25. A Rose by Any Other Name . . . Arthur S. Rusterholz
33. Nursing Homes in Minnesota . . . Albert T. Huebener
40. Let's Look at a Book (Book Reviews)

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# A Pyramid of Music

ARDO M. WROBEL



Mr. Wrobel

**MUSIC IN THE HOSPITAL SETTING** is usually conducted in conjunction with the recreation program; however, music also plays an important role in occupational and physical therapy. As it tends to be used more frequently in the hospital setting, we may begin to feel that music needs to be directed and conducted by someone who is trained in that particular field. Music is most valuable if it is integrated with the on-going recreation program rather than functioning as a separate entity. One could say that music has as many branches on its tree as does the field of recreation. Therefore, we should consider the type of music program we need in

relation to the nature of the recreation program.

Let us build a pyramid of music in the hospital setting. A pyramid begins with a broad base, and gradually rises to a point. Let us suppose that the base of the pyramid represents all patients in the institution.

Music plays an important role in our lives and it should play an important part in the daily life of the patient. Certainly every patient cannot actively participate in all types of music. However, a music program can and should be designed so all, or nearly all, patients can be involved through relatively meaningful participation. Such music activities would include listening (a few hospitals have developed listening to a relatively scientific degree).

First let us consider music on the

**ARDO M. WROBEL** is consultant, rehabilitation therapies, division of medical services, Minnesota Department of Public Welfare. He presented this paper at the Fifth Institute on Hospital Recreation at the University of Minnesota, June, 1960.

wards. Recorded music can be used in connection with some simple types of exercise activities for the regressed and the older patients. It can stimulate foot tapping, clapping, and it can be used as a vehicle for rhythm band.

#### Music's Vast Versatility

It can also be used in the library, during meal time, as a part of recreation activity, and in many other settings. Music listening can stimulate meaningful mental response even though it doesn't necessarily stimulate physical response.

Recorded music or live entertainment should have a definite place in recreation activity. Music can also serve as a stimulus for physical exercise programs on the wards, or it can be more highly developed to stimulate physical coordination and inner-group socialization.

As we progress from the base of the pyramid, music activities become more selective in terms of patient participation — obviously a listening activity requires little attention span and no previous skills, making no demands in terms of physical response. However, it may act as a means of stimulation, reduce tension, or simply have a great deal of meaning to the person. Progressive levels of music activity also place progressive demands on the patients' skill, interests, and emotional equipment.

Let us consider the rhythm band as a higher level of patient participation. This activity requires physical re-

sponse, mental attention, and some coordination between them. The anchor for this can be a pianist, recorded music, or a small group of patient musicians. It can be a successful program with either. Rhythm band can stimulate a response from the most regressed patient, but we should not over-estimate its value. Rhythm band is good with children, regressed adults, retarded children, and trainable adults. Adult psychiatric patients, especially the younger ones, will often identify this activity as childish and therefore, it is not a realistic activity for these patients.

The pyramid might next involve the many types of community or group singing. This, of course, requires some degree of physical response. The enjoyment one feels and shares through singing, and the bond it creates between the participants makes it a universal activity. Community singing can be led by a skilled person in a large auditorium, or it can occur spontaneously in a social activity. In its more highly developed stages the leader can get the patients, to sing rounds, clap to rhythm, whistle, or hum.

#### Keep It Simple

To become a bit more selective in regard to the number of patients who can participate, we should consider music appreciation. This is a loose term defining a somewhat structured activity in which reality, orientation, cultural exposure and active partici-

pation are all a part of the activity. This can be a relatively simple activity, depending on the type of patients being worked with, or it can be taught as a cultural study of the classics for selected patients. Likewise, music appreciation is a part of grade school courses, and is a part of the college curriculum, but on a vastly different level.

Through music appreciation one can help the patients identify musical instruments by their sound and their appearance. We can acquaint the patient with various forms of music, i.e., waltz, fox trot, and marches. We can acquaint them with the mechanics of the piano and can demonstrate how sound is produced. A skilled instructor should be able to teach effectively on the level of the patient's ability.

#### **Skill Makes It Meaningful**

Let's proceed to a more restrictive level of music activity. The church choir in the hospital setting usually sings the melody which is no more difficult than community singing. However, as far as demands on the patient is concerned, congregational singing in church, or in the choir, is more restrictive. We need also consider the purpose of the hymn, leadership received, and the need to use the hymnal. We should bear in mind that as participation requires more skill of the patient, it likewise usually becomes more meaningful to him.

If the church choir is an organized group, which rehearses apart

from the service, it is usually conducted by the minister or priest. If there is no choir, then singing takes the form of congregational singing. Some church choirs in the hospital setting are directed by a volunteer or a member of the recreation or music staff.

#### **Drum and Bugle? — Easy!**

The hospital drum and bugle corps can be a simple activity which would be less restrictive in terms of membership or it can be a highly-developed musical organization in which a degree of skill is required for performance. The drum and bugle corps seems to be less restrictive than a chorus, ensemble, band, or similar group because it does not necessarily require previous musical training or ability. A patient can be taught to play a drum or bugle in a relatively short time.

The drum and bugle corps cannot be composed entirely of patients without prior skill, so it is necessary to have a nucleus of a few patients who have some previous skill in music. The patients who participate should have a strong desire to want to participate and should understand that membership will involve two, three, or four months of continuous participation. The drum and bugle corps should perform in one or more local community parades or celebrations, as well as for hospital functions.

If the hospital has a male chorus or a female chorus, this group will

usually sing in one, two, or three parts. The patient member would have to have some reading ability or at least some ability to learn to read and sing. The male or female chorus should have an opportunity to sing for others, either through a recreation activity or as a featured program.

#### **Instrumental Is Therapeutic**

The next level of our pyramid would probably concern private or group instrumental lessons, vocal lessons or piano lessons. This kind of a music activity can be fairly simple, and can provide an excellent opportunity for skilled patients to continue studying their instrument. This kind of activity has a great deal of possibility as a prescribed therapeutic program for certain patients. However, the value of such an activity really depends on the skill and personality of the instructor.

Vocal lessons are a bit more challenging than instrumental lessons. There are some very definite reasons for this, which essentially involves the self-consciousness of producing a sound by one self. Through instrumental playing, mistakes can be blamed on the instrument. In singing one has only oneself to blame. This is difficult for patients to accept.

An activity which is more highly structured and more restrictive is the mixed chorus. The social relationship of the male and female patients is a secondary benefit, but often a very desirable one. A patients' mixed

chorus is more complex because it sings in at least two parts and very often in three or four parts. The patient needs to have a fairly good attention span.

In this activity the patients are usually able to accept authority of the director rather readily, where in some other areas, they may rebel against it. The chorus doesn't necessarily test a patient's skill because both poor and good voices are somewhat covered by the voices of other singers. This is good because it doesn't give the patient an opportunity to determine status based on voice quality.

The mixed chorus should concentrate on simple songs and aim at doing them well. A chorus can begin by singing rounds, hymns that are fairly slow, and as its skill develops, it may progress to singing part songs.

As we approach to the top of our pyramid, the instrumental ensemble should be considered. The small groups of patients playing for their own enjoyment can be an outgrowth of the instrumental lessons program.

#### **Some Training Necessary**

The band is usually composed of patients with previous music training. A patient taking lessons usually improves sufficiently so he can be placed in the band. The band members need to read music, must have a certain amount of coordination, a fairly good memory, and their behavior should be somewhat stabilized.

The dance orchestra requires skilled musicians who have had previous training or have been exceptionally good students through private or group lessons. The dance orchestra can and should participate in every type of hospital activity possible: social dancing, ward dancing, entertainment, some folk dancing, and a host of other activities. The dance orchestra may play old-time music, modern or standard music, and can be composed of the regular dance orchestra instruments, or of the various combinations of string instruments. An orchestra can be somewhat flexible in its instrumentation.

All organized groups of music activity (drum corps, chorus, choir, rhythm band, orchestra) should perform for others.

Stage performance by individual performers is rather difficult for some patients and is welcomed by others. The performing patient needs some artistic comprehension and ability. Somewhere in this same general area we should consider some formal instruction in harmony for patients. This should be definitely tied in with the dance orchestra, band, and patient chorus.

#### **Patients Teaching Patients**

Probably the top of the pyramid would represent using patients to teach other patients. This is a somewhat controversial area of patient activity. However, it has been done and it has been successful in some instances.

Our topic is dealing primarily with music in the institution and/or music as a part of the recreation program. We are not necessarily referring to the more highly structured, and more specialized field of music therapy. Music therapy should be an extension of a basic music program involving recreational programs. Likewise, in the psychiatric setting recreation fundamentally is community type activity for all patients, and as an extension of this program we can, and often do, consider certain aspects of recreation as being therapeutic if it is prescribed.

#### **Community Participation**

Volunteer service from the community is getting more and more attention and volunteers are becoming more active in hospital activities. They teach piano, conduct rhythm band activities, and entertain other patients. The members of the community or school band, chorus, choir or class play, are often willing to perform for the patients. In several instances a patient has been allowed to go to the community to rehearse with a church choir or the community band.

If volunteers teach piano or some of the instruments to the patients, some kind of music ensemble may be organized so that the patient-students would have some additional outlet and satisfaction through group participation. The high school band or choir director might be willing to teach patients in the hospital. Many  
*(Please turn to Page 48.)*

# Comprehensive Mental Health

DALE C. CAMERON, M.D.

IT is MY PRIVILEGE- to outline a comprehensive mental health program and indicate some important clinical and administrative principles for its implementation. In so doing, I shall discuss some of the more important findings and recommendations of the Joint Commission on Mental Illness and Health.

In the course of a very few years, as the history of man is measured, we have moved from concepts of mental illness based on mythological, demoniacal, and moralistic beliefs with their attendant violations of human dignity and decency, to medical and naturalistic concepts which foster preventive and treatment services. We are now in a period of broad, rapid, social, technological, and conceptual changes that influence mental health programs.

In turn, changes in mental health concepts and program affect the culture of which they are a part. There is a growing mental health movement and associated readiness on the part of the public to support improvements in our field.

According to Dr. Fillmore H. Sanford, there is not only a tendency to

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DR. DALE C. CAMERON, assistant superintendent, St. Elizabeth's hospital, Washington, D.C., delivered this talk before the 69th annual conference of the Minnesota Welfare association in Minneapolis on March 19, 1962.



Dr. Cameron

conceive human behavior in naturalistic terms (i.e. medical, psychological and social), but there is also a rising level of aspiration for health and well being and "the American belief in the almost infinite improvability of almost anything."

It should be the goal of each state mental health program to foster the development of community organization and integration of services that will afford each citizen his optimum chance to achieve his maximum potential for a personal, physical, men-

tal, and social operational capacity beyond the mere absence of disease or infirmity.

Please note that I did *not* say that each state mental health program should *provide* or *operate* all these services — merely to *foster their development*.

Achieving this goal involves the activities of many other state and local, official and voluntary, agencies. Thus, those responsible for the operation of state mental health programs should encourage those activities of other agencies such as Welfare, Public Health, Family Service, schools, churches, et cetera, that have a bearing on mental health. This means there must be a clear delineation of functions of the several organizations with overlapping goals.

It is my own view that the state mental health program should be concerned primarily with stimulating, supporting, integrating, and improving the quality of needed services, and should operate a particular needed service only when it is too large or complex for a smaller political subdivision or organization to administer.

#### **People's Needs Paramount**

Please note once again that I did *not* say too costly for a smaller political subdivision or organization. The question of the source of funds for a public program is a tax question, not a medical one, though it must be admitted that the question

of financial support often profoundly influences organization of a public program and the implementation of medical policy. What I am saying is that the question of who runs or operates a particular mental health service should be determined *not* on the basis of the source of funds — federal, state, local, or private — but on the basis of the medical needs of the people to be served, and efficient organization of these services as close to those to be served as possible.

#### **Six Basic Assumptions**

The *basic assumptions* upon which a program with the goal previously stated should be formulated are the following:

1. The patient is first of all a human being and must always be treated with a high regard for his human dignity.
2. The psychiatric patient has a right to easy access to all treatment resources, including the hospital.
3. The treatment of psychiatric patients is a medical responsibility.
4. The skills of many allied professions are essential to this process at all levels of treatment, and increasing use must be made of these skills.
5. There is a need for a balanced and totally integrated program for the prevention of mental disorders and treatment of patients with mental illnesses. The hospital is only one part of such a program.
6. Treatment services should be provided according to the patient's need. This is to say, the hospital should be used for the treatment

of a particular patient only when there is a positive indication that hospitalization is necessary and not as a substitute for other needed, but absent, resources.

Now to turn to the *elements of a comprehensive mental health program*. It can be divided into two broad categories: (1) direct services to people and (2) activities supporting direct services.

### **Two Types of Prevention**

Prevention is in the first category and is of two types: (1) Primary prevention occurs when the etiology of the illness is known and specific preventive measures can be taken. Vaccination for smallpox is an example from the general health field. The prevention of pellagra is another example with important mental health implications. Since it was learned that this is the result of a nutritional deficiency and people have obtained proper diets, pellagra has almost disappeared. Similarly, general paresis due to syphilis of the brain is becoming increasingly rare because we have excellent methods for the treatment of early syphilis and this early treatment is, in effect, a preventive measure as far as syphilis of the brain is concerned. (2) Secondary prevention, in contrast to primary prevention, involves the early recognition and treatment of the patient while his condition is mild so that more serious consequences may be prevented.

8

Early diagnosis and intensive treatment are direct services. These may be carried out at the outpatient level or in the hospital, depending upon the particular needs of the individual. In Minnesota, elaboration on the usefulness of community mental health programs is unnecessary. Your rapidly expanding program speaks for itself. (Incidentally, this is one of the programs with which I am most pleased, since with the help of many individuals and organizations, it became law during the time I was heavily involved in the mental health program of this state.)

One bit of gratuitous advice about this program may not be out of order. In my opinion, it has reached the point where consideration should be given to the establishment of day-treatment services in conjunction with the mental health centers. To the degree possible, these day-treatment facilities and other mental health centers' activities should be in reasonably close proximity to general or mental hospitals so that there may be ready availability of the skills of other specialists in the field of medicine and related health sciences.

### **Day-Treatment Desirable**

Day-treatment facilities in association with your existing and future mental health centers would undoubtedly make it possible to treat an ever increasing number of

MINNESOTA WELFARE

individuals at the community level and avoid the necessity of hospitalization for many patients. Such facilities would also foster the earlier release of patients from hospitals back to their homes and communities.

Day-treatment facilities, as you well know, provide more than psychotherapy on a one- or two-hour-a-week basis. They provide for activity programs for the individuals several hours each day. This is what mental hospitals are *supposed* to do, but in addition they provide bed space for sleeping. There is no need for this hotel service in the vast majority of cases and the patients could sleep at home if day treatment were available to them. The development of such facilities is strongly recommended in the Joint Commission Report.

Let us turn now to inpatient services. This is one of the areas in the Joint Commission Report that has been most controversial. The Report recommends that not one bed be added to a hospital already having 1,000 or more beds.

#### **Continuity is Important**

This "1,000-bed" recommendation and controversy has, I believe, obscured a rather important point. It is my understanding that the framers of the Report favor self-contained treatment units of 150 to 300 beds, in which a patient may

receive any necessary psychiatric treatment throughout his entire period of hospitalization. This would help insure continuity of staff-patient relations rather than the discontinuity that now so frequently results when patients are transferred from one section of the hospital to another for the benefit of the overburdened staff, and at substantial psychological cost to the patient.

#### **Experiment Wisely**

The 1,000-bed upper limit simply indicates the Commission's belief that there should be no more than three to six of these relatively self-contained units on a single campus. I heartily agree with the concept of small, relatively self-contained units, but we should have further experimentation in this direction in *existing* large hospitals before establishing an absolute upper limit on total hospital size. It may well be demonstrated that certain specialized services, such as general medicine and surgery, recreation, and vocational training, can be developed more efficiently and economically in a 1,500- or 2,000-bed hospital than in one of 1,000 or fewer beds, and still retain the advantages of the small unit ward treatment program. Further, all types of patients cannot be treated in these small general psychiatric units, since some require differing programs. More later about the needs for various kinds of spe-

cialty programs, both in and out of the hospital.

#### **Controversial Recommendation**

Other direct services to patients include rehabilitation and follow-up. In this general area, the Joint Commission has put forward another rather controversial recommendation. It recommends that existing large hospitals, remote from other medical facilities and from the population they service, be converted into chronic disease hospitals for mental and other types of patients.

Members of the Joint Commission say they have been misunderstood about this recommendation. They did not mean by chronic disease hospitals, the "transfer hospital" of the past, where chronic patients who failed to recover in the acute hospital, were sent, only to be neglected.

Minnesota had transfer hospitals some years ago. It is to the credit of my predecessor in the Minnesota mental health program that these transfer hospitals were abolished and all were converted into receiving hospitals. I am afraid that many people have read the Commission Report to mean a "transfer hospital" and neglect when the term "chronic disease hospital" was used.

However, the framers of the Report really meant a rehabilitation hospital, a place where the chronic or long-term patient is the most important patient present — where his

treatment and rehabilitation is not neglected by the staff in the interest of taking care of more acute patients. They recognized the need for a different and specialized program for the long-term patient as compared with the acute patient. Only, they believe, when special hospitals are set up for this special rehabilitation function is the program likely to be successful.

There have been some successful efforts in this direction in other states, but frankly I am troubled by the recommendation. If implemented on a broad scale, it would mean that professional personnel in these rehabilitation hospitals would not have the opportunity to see, and deal with, the full course of the disease process from the time of its acute onset to the time of completed rehabilitation. It is my belief that in order properly to understand the process, one must see it in its entirety.

#### **Adequate Field Trials a Must**

In support of the chronic disease hospital concept, some individuals point out that really good treatment of tuberculosis patients was not generally available until special hospitals equipped to deal with their long-term rehabilitation needs were established apart from general hospitals. Note, however, that tuberculosis hospitals were never precluded from treating acute tuberculosis patients.

I believe the Commission would

have been wiser, at this point in time, had it recommended extensive experimentation with different modes for providing rehabilitation services rather than to make the flat recommendation it did. The conversion of large mental hospitals into chronic disease hospitals should not be adopted as policy without adequate field trials.

Aftercare and rehabilitation are essential parts of all services to mental patients. These services must be fully integrated with hospital services to achieve the maximum possible continuity of therapeutic relationships. Outpatient services in connection with mental hospitals are essential to this function.

Having discussed some of the direct service to people, let us consider some of the supporting services essential to good treatment and preventive programs. There is, as you well know, a shortage of personnel, particularly professional. Thus, it follows that there must be increased training activities to provide the needed personnel.

#### **One-to-One Not Always Essential**

The usual pattern of treatment in many hospitals and certainly in private practice, is a one-to-one relationship between patient and therapist. While this is certainly necessary for many patients, particularly those with relatively recent illnesses, it is not essential, and in some instances,

not even indicated, for the proper treatment of many long-term patients. Besides, it just simply is not feasible to expect that we shall have enough trained persons to provide this type of therapy for all of the patients in our mental hospitals within the foreseeable future.

#### **Varied Treatments the Answer**

This means that we must utilize psychiatrists and other mental health personnel in ways that will allow them to provide treatment by methods other than on a one-to-one basis. To this end, many of us would recommend that: (1) All general residency programs in psychiatry must give training in (a) the treatment of patients with major psychoses; (b) the utilization of group processes and milieu factors; and (c) the methods of treating patients through other personnel and agencies in the community. Such training can be achieved only in properly supervised experience in hospitals that treat psychotic patients on a long-term basis.

The Joint Commission recommends that the mental health *professions* launch a national manpower recruitment and training program, expanding on and extending present efforts in seeking to stimulate the interests of American youth in mental health as a career.

The Joint Commission has something to say about financial support in the field of education. "The phi-

losophy that the federal government needs to develop and crystallize is that science and education are resources — like natural resources — and that they deserve conservation through intelligent use and protection and adequate support—period. They can meet an ends test but not a means test and not a timetable or appeal for a specified result.

#### Science Profits Everybody

"Science and education operate not for profit but profit everybody; hence, they need adequate support from human society, whether this support comes from wise public philanthropy or private."

The Joint Commission further believes the mental health professions must participate actively in the support of constructive legislation in the field of education in general, as well as in medical and other scientific areas. Of the upper 10% in intelligence among high school students, only 25% finish college. There must be adequate educational resources and a scholarship program, so that competent students may enter various professions, regardless of their financial ability. Further, there are special problems in the field of medical education since the facilities for the production of physicians are growing at a less rapid rate than the population to be served and there is relatively little financial aid available for students in medical schools.

Another very important supporting aspect of a complete medical health program is research. The Joint Commission's book, *Action for Mental Health*, recommends that 21/2% of all operating budgets for the mentally ill be expended in the field of research and another 21/2% in the field of training. Actually, these percentage figures are typographical errors and should have read 5% each in the training and research fields. Very few states are approaching this level.

The Commission also recommends an increased emphasis on long-term Versus short-term project activities, and federal support for the development of research institutes or centers for mental health research operated in collaboration with educational institutions and training centers or established independently. It is interesting to note that the Report does not specifically recommend the establishment of such centers within mental health programs or within mental hospitals. It would have been better, it seems to me, had this recommendation been made.

#### Patients and Environment

Research on mental illnesses needs at least two things: The study of *patients* suffering from mental illnesses and the study of the *environment* from which they come. This is not to minimize the need for studying normal persons as well. Since we must study sick people and their im-

mediate and larger environment, it is self-evident that many of these recommended research institutes must be established in our mental hospitals.

Incidentally, the establishment of research and training activities in service-oriented facilities such as our large mental hospitals, usually produces a very important secondary gain — improved service. This is occasioned by the professional and intellectual stimulation afforded the staff by virtue of the presence of these activities. Treatment-oriented activities cannot afford, in their own self-interest, not to engage in research and training activities for this stimulating value, to say nothing of the opportunity to produce more personnel and new knowledge. To this end, many of us believe that every federal and state mental hospital for the mentally ill or retarded should have a research program. In more fully developed hospitals this should include some basic research as well as clinical. There should be a special budget for the research activities.

#### **Must be Public Demand**

Let us now turn to a third supportive element in a community mental health program, public support. The financial resources necessary for an adequate mental health program probably will not be forthcoming unless the public understands and wants it. Among the understandings needed, as viewed by the Joint Commission,

is the recognition that mental illnesses are disorders with psychological as well as physiological, emotional, organic, social, and individual causes and effects.

#### **Many Lack Appeal**

Society tends to reject the mentally ill who are often singularly lacking in appeal. It needs to be made clear that individuals suffering from mental illness are far from the popular stereotype of "raving maniacs" or "berserk madmen." Such individuals do exist but, according to Dr. Ewalt, "in somewhat similar proportion as airplanes that crash in relation to airplanes that land safely."

We need also to overcome the pervasive defeatism that stands in the way of effective treatment. It is true that we have serious gaps in our knowledge, but there are many effective treatment tools available. With intensive application of existing knowledge a much better job could be done right now.

While commenting on attitudes of the public, let me offer a comment on the attitude of professionals. Most such persons believe it wise to avoid and political involvement. In so doing they fail to distinguish between partisan issues and questions of broad public policy. This may be due to the fact that in some states *partisan* political activity has seriously interfered with the proper operation of professional programs. However, it is the

obligation of every professional and non-professional worker in the mental health field to make his voice heard on issues of broad public policy, for only in this way can other members of the public and their representatives and officials be informed of the problems and needs in the field. Only when this information is available can members of the legislature and other important bodies have the necessary data upon which to make appropriate value judgments. Too many of our colleagues have remained aloof from "politics" because they do not discern the difference between politics in its finest sense — the questions of broad public policy — and politics in its, sometimes rather ugly, partisan sense. Of course, mental health programs and particularly state hospitals must be free of partisan political interference. All mental health activities of the given state should be under a competent medical leader.

Time does not permit me to more than mention some of the specialty programs that must be included in a comprehensive mental program. Among the types of patients requiring special services are children. Specially trained personnel are required for their treatment. If hospitalization is necessary, separate hospitals or units must be provided. It is crucially important that children's facilities be readily available to the families of the children served, since they must usually be involved in the treatment process.

The mentally retarded also require special facilities, many of which should be comparable to those required by mentally ill children. Consideration should be given to the integration of the program for the retarded into the over-all mental health program, as is the case in Minnesota, since the disabilities of the retarded are in most instances due to medical problems.

We are experiencing an actual and relative increase of older individuals in our population. Therefore, the problems of the geriatric patient are looming ever larger. Further, most geriatric patients with mental disorders are multiply handicapped, having not only psychiatric symptomatology, but very often cardiac, cerebrovascular, arthritic, pulmonary, and other difficulties.

#### Separate Geriatric Program?

I am not at all sure that the psychiatrist is the person best able to cope with the total health problems of all geriatric patients with some mental symptoms. It is my feeling that a separate geriatric program under the leadership of a gerontologist should be established. Very careful medical and social screening should be carried out before patients are admitted to facilities for definitive rehabilitative, or long-term treatment. Only those individuals whose *major* symptomatology is psychiatric in nature should go to mental hospitals.

The majority of multiply handl-

capped oldsters, even when they present minor to moderate mental symptoms, should be cared for in nursing homes or other special facilities for the aged under the supervision of geriatricians, but with psychiatric consultation available. It will be necessary to develop many additional community resources for the aged before it will be possible to treat the many geriatric patients now housed in mental hospitals in more appropriate facilities.

Programs for alcoholic, narcotic, and barbiturate addicts, and also for sociopaths, and so-called sex psychopaths, need to be developed within the framework of the mental health program. The proper treatment of these individuals requires special programs and facilities and the availability of specially trained personnel.

Leaving the needs for specialty programs, let us examine a few clinical and administrative principles of importance in implementing a community mental health program. Among these are the following:

#### **Importance of Continuity**

1. *Continuity of service.* One of the most important tools in conducting therapy with many psychiatric patients is the development of a meaningful, human relation between the therapist and patient. It is self-evident that the maintenance of such a relation is made difficult if there is a continual change of therapists during the treatment. Further, many patients

have particular difficulty in establishing human therapeutic relations because of their illnesses. To call upon them to shift this relation from one therapist or group of therapists to another several times during the course of treatment, complicates rather than facilitates the process. Only rarely is it necessary to shift a patient from one treatment group to another for therapeutic reasons. In most large mental hospitals, including the majority of those in Minnesota, only the patients who remain on the "receiving service" during their entire period of hospitalization have continuity of patient-staff relations. The numerous patients who do not return to the community directly from the "receiving service," are often the victims of much discontinuity of service. In addition to continuity of patient-staff relations, continuity also involves family and friends. Thus, hospital and other types of service to patients should be reasonably accessible to the families and friends of patients, preferably in the home community.

2. *Responsibility for Treatment of Patients Must be Clearly Defined.* This principle is closely related to the first discussed, but it certainly is not identical. It indicates that one physician and his treatment team should maintain responsibility for the treatment of the patient throughout his entire hospitalization. In this sense it is the continuity principle. When a physician and his team know

they need not necessarily keep the responsibility for a given patient throughout his entire period of hospitalization, it is relatively easy for them to recommend transfer to another service when the patient's behavior becomes somewhat troublesome. The usual comment is, "We do not treat patients with such behavior on our service." When a transfer is made on this basis, the physician and his colleagues have been able to divest themselves of responsibility for coping with the problems of this particular patient. When the possibility for divestment of responsibility exists, responsibility in the truest sense does not exist. The opportunity to transfer a patient more or less routinely, undoubtedly has an influence on the way in which the currently responsible personnel treat him. They often leave to their successors necessary action — to be more restrictive, less restrictive, more imaginative in helping the patient to find meaningful and acceptable modes of expression — and in other ways abrogate their responsibilities to the patient before transfer.

3. *Patients and Employees Tend to Respond to the Environment and Expectations of the Place in which They Live and Work.* For this reason, the organizational structure of the hospital and the placement of patients in various living units should be such as to foster improved behavior. If a hospital has wards which are officially or unofficially designated

as "disturbed ward," "regressed ward," or "untidy ward," to give only a few examples, there results an expectation on the part of employees working in these units that the patients housed there will present the described behavior. Since it is expected, and in some instances fostered, many employees do not try to modify the behavior when it is presented. Further, when a patient moves into a situation where the modal behavior is "disturbed," "regressed," or "untidy," and where the other patients as well as the personnel seem to tolerate such behavior quite readily, it is not surprising that the patient tends to conform to the modal behavior pattern. On the other hand, if a patient who is presenting disturbed or disturbing behavior is placed on a ward where the modal behavior is *not* "disturbed," where it is not expected by the employees, and where it is poorly tolerated by the other patients, most patients will accommodate you by behaving in a much less disturbed fashion. This is not a statement based on theory alone, but rather on repeated observations in different hospitals by many various observers. One of the places where this observation was made was in Hastings state hospital, in Minnesota. Many of the changes made in the organizational structure of that hospital during the time I was in Minnesota, were predicated on the three principles just enumerated. The responsiveness to environment prin-

ciple seems to argue for some admixture of patients with varying behavioral patterns, i.e., the establishment of living groups in which the members present *relatively* heterogeneous behavior, rather than the creation of groups with very similar behavior. The latter has been the pattern in most large hospitals in the past. Further, the establishment of groups of patients within which varying behavior patterns are presented is often useful not only to the "poor patients" in the grouping but to those who are "better" since the latter seem to help the less able patients, to the benefit of both.

4. *Commonly Accepted Operating Assumptions Should be Repeatedly Queried.* In a field where our knowledge is limited, we must operate our programs on the best current assumptions. It is important that we not become deluded into accepting assumptions as facts. We often tend to do things a certain way because that is the way they have been done for years, not realizing that new knowledge has been acquired which would indicate the need for a change in assumptions and procedures.

5. *Manpower Should be Utilized at its Highest Level of Competence.* The Joint Commission has a great deal to say about this. There are, of course, certain kinds of general medical, psychiatric, and neurological examinations and treatment that must be carried out by or under the immediate direction of profes-

sionally-trained people. However, it is wasteful for individuals competent to do this type of work to find it necessary to perform less exacting, short-term therapy, counseling, or even secretarial duties. The Joint Commission recommends that non-medical mental health workers with aptitudes, sound training, practical experience, and demonstrable competence be permitted to do general short-term psychotherapy — namely, treating persons by objective, permissive, non-directive techniques of listening to their troubles and helping them resolve these troubles in an individually, insightful and socially useful way. Such therapy combining some elements of psychiatric treatment, planned counseling, "someone to tell one's troubles to," and "love for one's fellow man," obviously can be carried out in a variety of settings by institutions, groups, and individuals, but in all cases should be undertaken under the auspices of recognized mental health agencies.

In addition to better utilization of the individuals available in official programs, there is an urgent need to utilize the very substantial resources of the private practicing psychiatrists and other physicians in the community for the benefit of the many patients in mental hospitals. It is therefore recommended that psychiatrists and many other medical personnel accept it as their responsibility to devote a significant portion of their time to the treatment of patients

at the hospital level. It is also recommended that there be substantial experimentation with the treatment of private patients by private physicians in public hospitals. If this were done, it would not only provide additional psychiatric resources for the benefit of hospitalized patients, but it would also tend to foster continuity of care and treatment.

Hire Doers!

6. *Progressive Personnel Should be Employed.* This refers to the importance of recruiting individuals, both medical and administrative, who are devoted to "seeking a way to get a job done" in contrast to those point out why "it cannot be done." The latter type individual is useful in helping one keep out of legal, administrative, and fiscal difficulties. However, about one per organization is all you really need and can tolerate if you are to get on with program development.

We now come to the problem of financing mental health programs. The Joint Commission recommends that "expenditures for public mental patient services should be doubled in the next five years — and tripled in the next ten." This is not a comment on financing, but a standard of care statement. It would have been better had the Commission recommended that the long-range goal of public services be to provide a quality of psychiatric and other medical treatment comparable to that provided in well-managed general hos-

pitals. It could then estimate the cost. A first step toward this goal may well require doubling or tripling the aggregate expenditures within the next five to ten years.

The Joint Commission concludes that "the states cannot afford the kind of money needed to catch up with modern standards of care without revolutionary changes in their tax structure," and therefore recommends "that the states and the federal government work toward a time when a share of the cost of state and local mental patient services will be borne by the federal government, over and above the present and future program of federal grants-in-aid of research and training."

The tax issue is one upon which I am not competent to comment. However, there is an important philosophical issue in this recommendation beyond the tax base problem, viz., grant-in-aid. If federal financing is accepted because of the tax base issue, we are also accepting the grant-in-aid principle. This means the nation would have decided, in its own self-interest and out of regard for the dignity of its individual citizens, that it cannot permit certain of its citizens to be provided for at less than some minimal standard of care. If some states either cannot or will not provide this minimal care, then the federal government, in the national interest, must step in and assure that some sort of floor of minimal care is established. In order to do

this, those parts of the country that are more able or willing to pay will have to support those parts of the country that are not as able or willing.

This philosophy, which is only implicit in the Report, must be accepted before it is necessary to even consider the tax issues and financial formulas such as those discussed at some length in *Action for Mental Health*. It is with the problem of the states or communities that apparently *will not* pay for services, as well as those that apparently *cannot*, that we sometimes get bogged down. Actually, these are moral and economic issues and not medical ones. The medical issues are to be found in the explicit standard of care statement and the implicit grant-in-aid philosophy. Should grants-in-aid be established, we really do not have to differentiate between the "*will not*" and the "*cannot*" states as much as we sometimes think. There is a long history of federal grants-in-aid in health and other fields that shows such grants-in-aid usually stimulate increasing state and local programs and financial support.

Now for some comments on admission procedures versus commitment laws. This goes back to the assumption that mental patients have a right to easy access to treatment facilities available, including mental hospitals. Many of the criminal-like procedures now extant in many states for the "commitment" of patients

to mental hospitals have been established presumably to protect the individual from wrongful deprivation of liberty. This is a quite proper concern and should be kept constantly in mind. However, I submit that the type of procedures set up to protect the individual's right to freedom very often invade other rights of the individual, namely, his right to privacy and his right to be treated with the dignity due a human being. It is quite possible within our Constitution to provide for admission procedures which will take account of all these individual rights. By far the vast majority of patients should, and would under proper state laws, be able to enter a mental hospital voluntarily on the same basis as he can now be admitted to a general hospital.

We sometimes become discouraged with the slow rate of improvement in our field, and perhaps a little envious of the substantial expenditures in other areas, such as defense and luxuries, as compared with expenditures for the promotion of mental health and the treatment of the mentally ill. But we must remember that man has been "defending himself" and "pleasuring himself" since time immemorial. Only recently has he undertaken mental health activities on a new conceptual framework. Then, too, man tends to make expenditures of his time and substance in his own self-interest and  
(Please turn to Page 48.)

# Family Courts

GEORGE T. FROHMADER

**I**N THE AREA OF FAMILY social problems, as they relate to the law and consequently court proceedings, there is evidence today of a more unified and effective approach. There is evidence of an increasing interest and activity in a judicial agency known as the Family Courts.

The principle of unity being maintained in court proceedings, in treatment, and in the family itself, as it relates to justiciable family problems, is not new. In 1913, Dean Pound discussed the weakness of piecemeal justice as follows:

Two signal cases of waste of judicial power, the multiplicity of independent tribunals and the vicious practice of rapid rotation, which prevails in the great majority of jurisdictions, whereby no one judge acquires a thorough experience of any one class of business, may only be noticed. As an example of the possibilities of the first, it has been observed that in Chicago today, at one and the same time, the juvenile court, passing on the delinquent children; a court of equity, entertaining a suit for divorce, alimony, and the custody of children; a court of law, entertaining an action for necessities furnished an abandoned wife by a grocer; and the criminal court or domestic-relations court, in a prosecution for desertion of wife and child —may all be dealing piecemeal at the

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**Mr. Frohmader**

same time with different phases of the same difficulties of the same family.<sup>1</sup>

Some real family courts do exist today. They are effectively handling all justiciable family problems in a single court. Jurisdiction includes the gamut from divorce through juvenile delinquency, every conceivable family problem.

Adult jurisdiction in family courts should go only so far as it is equipped and able to deal with certain aspects of family problems. Generally, the law does not go too far in this area.

The following types of cases are usually considered within the desirable area of adult jurisdiction in fam-

MINNESOTA WELFARE

ily courts: (1) offenses against children when an adult is accused of a crime against a minor, when an adult has failed to fulfill a duty toward a minor, and when an adult causes juvenile delinquency or dependency; (2) cases of non-support and desertion; (3) the establishment of paternity; (4) cases of adoption and guardianship; and (5) divorce cases.

Offenses against children by unrelated adults are best handled outside of family courts. The functions of a juvenile court and of a domestic relations court would be combined in a single family court.

Let's look at the evolution of the law. Due to the rigidity and injustices of the common law, there developed courts of equity based on what ought to be done and what should be done in good conscience, rather than on what might be done legally. This was the forerunner of individualized justice.

The substantive law relating to families concerns itself with husbands, wives, parents, guardians, and children. Without doubt, the technique of the specialized juvenile court involving a social investigation, among other things, can more closely attain the ideals of justice than can purely legalistic techniques.

#### **Legal Lagging**

Even before 1900 there developed a realization among legal experts that there existed a gap between the methods of law and that of other

social sciences. There was a feeling that law should put more emphasis on its results rather than on the theoretical accuracy of its philosophy. Such an attitude led ultimately to some of the specialized social problem courts, as they are known today.

#### **Changing Procedures**

Three of the important requirements which insure individualized justice are the judge, the facilities, and the protection of legal rights. The judge and his staff must believe in an individualized justice and be able to carry out a non-punitive service.

Facilities and personnel must be available in the community to carry out court dispositions. Differences in procedure between the old courts and the new specialized courts indicate that the former relied on the learning of lawyers whereas the new courts rely on the learning of psychiatrists and social workers. Evidence used to be brought in mainly by the parties; now it is brought in by the court itself. Much of today's justice is based on social engineering rather than legal science.

The distinct function of the court is to adjudicate and dispose. A social treatment facility of the court derives its authority from the court's disposition but should be an administrative organ exercising its own discretion in the actual treatment of adjustment problems. Unfortunately, the traditional image of justice is that of a blindfolded goddess treating all per-

sons alike and disregarding extenuating circumstances.

William Seagle, writing in *Encyclopedia of the Social Sciences*, asserts that the extension of the juvenile court idea effected a relaxation of the ordinary criminal and civil procedure in family cases; and that the family court is the logical evolutionary product of the juvenile court movement.

#### **Psychiatry's Broadening Scope**

The validity of treating the family as a unit is gaining ground. The agreement that individual problems are often only parts of family problems has long been recognized by those in the helping professions. Psychiatry, however, has not kept pace with social work in the approach to treating an individual problem as part of a family problem. Recently, there has been evidence of psychiatry broadening its conceptual frame so as to examine human behavior in the context of the individual's social environment rather than in the isolation of his internal processes.

Nathan Ackermann, psychiatrist, states that "any attempt to study social phenomena must make use of a definition of personality which emphasizes its orientation to social participation."<sup>2</sup> Ackermann re-emphasizes that the functions of personality are oriented to both internal processes of the organism and toward the social environment. The inner self and the outer self must be considered together and not apart. The individual and so-

ciety can be analogized to the relation between mother and child. Sometimes they complement each other and other times they are in conflict.

Ackermann extends his thesis in a later article in which he states that although there have been momentous advances made in understanding the individual personality, we have arrived at a point of diminishing returns.<sup>3</sup>

He states that if significant additions to the knowledge of personality are to be made now we must broaden our conceptual frame so as to examine human behavior "not in isolation, but rather in the context of comprehensive evaluation of the group structure of the family."

In speaking of current interest in the importance of considering the family and other social inter-relations as an important part of the total personality, Ackermann states: "Recently a wave of fashion has, in fact, asserted itself which once again emphasizes the relations of individual personality with family and wider society."<sup>4</sup>

#### **Treating the Family**

Ackermann sees not only the possibility of inadequate treatment from treating individuals in isolation from their social setting, but also possible dangers. For example, the treatment of just one marital partner could precipitate divorce. In summary, Ackermann implies that persons should be treated as members of a family, in

other words it is the *family* which is treated.<sup>5</sup>

The medical field, in general, is taking hold of this concept of treating the family as a unit. Henry B. Richardson, M.D., states:

The application to the family of the concept of homeostasis, by which living organisms maintain a balance between their internal and external environment, is new to doctors in general, but is inherent in the approach to the social sciences. The members of the family may be compared to the organs of the body, in spite of obvious differences. Although the intra-family relationships are not often essential to life, each individual is profoundly affected by the others and by the family as a whole. It is necessary here to use a set of concepts taking advantage of developments in the social field and to devise working tools by which the family equilibrium can be understood.<sup>6</sup>

Richardson hopes that his material, illustrating the importance of and the fact that patients' personalities include their family inter-relationships, will be of interest not only to the medical profession but to those in the broad field of social and family welfare. His hopes are being realized.

#### **Changing Horizons**

The legal field, which is necessarily slow and cautious about moving ahead, is showing some highly positive signs by certain interested and social-minded judges. Judge Melson, in writing about the establishment of the family court in New Castle county, Delaware, states:

FALL, 1962

In 1945, however, it finally became evident to the people of that county that a juvenile court cannot effectively work with a child as an isolated unit, for the very simple reason that a child does not live as an isolated unit, but as a part and parcel of his family environment. So quite logically these people proceeded to establish the family court . . .<sup>7</sup>

#### **Social Work Has It!**

The concept of the family as a unit of treatment has been utilized advantageously by the social work profession. The literature suggests that other professions in the broad field of social welfare can effectively enhance their effectiveness by the adoption of this sound concept.

Can families be served effectively in the authoritarian setting of a family court? A negative answer to this question is seldom heard today. Authoritarian agencies have quite well proved their effectiveness. It is recognized today that all agencies represent psychological authority.

Then, what about families that don't want help? Alice Overton, who until June, 1959, served as director of the Family Centered Project of St. Paul, wrote in an article entitled: "Serving Families Who 'Don't Want Help'" that first the family needs to gain a positive feeling toward authority through close contacts with a worker who shows the family members great respect. Next, there must be some exploration into how and why the family feels their animosity toward authority. Then, the worker

should help the family develop the realization that it is themselves that they are hurting through their hostile behavior. Finally, the worker, together with the family, helps them to decide on some more appropriate ways to get along with authority figures.

### **Children Caused the Change**

The first family court in the United States to exercise jurisdiction over both domestic relations and juvenile cases appeared in 1914 in Ohio. The family court was created in response to a recognition that problems coming before a juvenile court were problems of the family; and that the court's dealing with domestic situations often involved children, although children's cases were not within their jurisdiction.

There has been confusion over what is meant by the name "family court." Domestic relations courts are frequently called family courts. A general definition of domestic relations courts is made difficult by their great variety of jurisdiction, organization, origin, and inspiration. Social workers prefer to call the socialized court with jurisdiction over both juvenile and adult family problems a family court. Therefore, some so-called family courts with only adult jurisdiction are in reality domestic relations courts; and also, some so-called domestic relations courts with broad jurisdiction are actually family courts. An example of the name family court being mis-

leading is evidenced by a court in New York City called the family court and, despite the resounding breadth of its title, has a narrow jurisdiction, having mainly to do with financial support cases.

The underlying philosophy of the family court is to the family what the juvenile court is to the child. There is a need to extend the philosophy of the juvenile court into a unified court known as a family court with broad domestic relations powers. A unified court is the other side of the same coin with unified treatment.

*Standards for Special Courts Dealing with Children*, published by the U.S. Children's Bureau in 1954, indicates that specialized courts on a state-wide system have certain advantages. They are: more uniform practices, better selection of judges fitted for the task, and a wider choice of qualified personnel. A state-wide system of specialized courts would allow greater flexibility of districting and re-districting according to need.

### **Divorce Cases?**

There is controversy regarding the handling of divorce cases. It is suggested that when it appears in a divorce case being heard that it might possibly be adjusted by the conciliatory process, it would be proper to transfer the matter to the family court forthwith on the court's own motion. The family court can help those who want to make the marriage succeed.

*(Please turn to Page 31.)*

# A Rose by Any Other Name

ARTHUR S. RUSTERHOLZ

FIVE YEARS AGO I wrote an article for this publication in which I undertook to criticize social workers for what I believed was an undue use of jargon. My main point was that in dealing with the public, social workers should talk in language that the public can understand—that if social workers wished to use fancy terminology in talking to their own kind, well, that was "no skin off my nose." I am now inclined to question my earlier liberality on this last point, but I'll get to that later.

As might have been expected, my article (entitled *Let's CM It a Spade*) produced mixed emotions on the part of the social work "profession." The reaction, insofar as it came to my attention, was considerably more "pro" than "con" but the "cons" were fairly insistent that I had omitted a form of heresy. My heresy was not that I had descried the use of jargon; almost every social worker thinks social work, in general, should speak and write more understandably. No, my sin, as I see it, was that I actually tried to put into practice the thing that I was preaching. In short, I attempted to write my message in such a way that ordinary

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FALL, 1962



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mortals could understand it. Apparently, I succeeded.

Do you remember Abraham Lincoln's reported answer to his wife's question about a sermon he had heard? He said, "The preacher talked about sin." Further questioning brought forth the laconic answer that he (the preacher) "was against it." Most of us are against sin in the abstract; it is only when the preacher gets around to talking about *your* sin and *mine*, that we begin to bristle. The same goes for jargon, with some

25

people. It's bad except for some specific pet phrase or term of yours (or mine).

### Obscure Language—Bah!

I score the use of obscure language—language that tends to make meanings unclear. The Bible is a veritable compendium of figures of speech that are rich in color and in highly expressive (and meaningful) imagery, as are the writings of Shakespeare and those of most of our great poets; and I would be the last to criticize them on that account. When, for example, I assailed social workers for "muddying the waters of public understanding," I made the metaphor so obvious that my meaning was unmistakable.

Having said all this by way of introduction, I wish to reaffirm my faith in the method I previously used by applying it to a few more terms that somehow missed inclusion in my earlier article.

Social work, in common with other fields, is greatly concerned about in-service training and staff-development programs designed to help its practitioners "grow on the job." Aside from pregnancy this might conceivably be best achieved by the use of rich desserts, olives, nuts, potatoes, gravies, etc. For the adherent of basic English, however, what we really mean is that we want social workers to improve in their work. Ridiculously simple, isn't it? But it sounds



so impressive to say it the other way—we think.

Nowadays, when we have conferences, which, as one wag has put it, is whenever we get lonely, somebody is likely to "throw out" a suggestion of some kind. The citizen uninitiated in the ways of social workers, and of some of their compatriots in allied fields, might pardonably suppose that this means that the suggestion is discarded (which is often the fate it deserves). But to the initiated it means that the proposal is presented for study and/or consideration, which is a meaning about as opposite to that usually conveyed by the words "throw out" as you can possibly get. This shows how "cockeyed" this jargon business can become. If the first person who used this expression in this new way had himself been thrown

out of whatever group he was in, perhaps our social work terminology would not now be so "loused up." Incidentally, if we must "hurl" our suggestions, why don't we "throw them in?" This is more in line with the terminology used by the average American.

Let's get back to this business of loneliness. Not only do we have conferences to avoid loneliness, but we show our fear of it in our verbal descriptions of what ought to be a purely intellectual process. When the first "genius" has "thrown out" a suggestion, frequently a second one "goes along with him" on it, like two clerical workers on a trip to the washroom, where, as some humorist once put it in poetic language, apparently grave dangers lurk. To those, who justify and defend the use of many of these new-fangled terms and phrases on the ground that they are



FALL, 1962

convenient shortcuts, let me ask what word is shorter and more appropriate in this context than the word "agree?"

Even when we use a relatively basic word, we sometimes find it necessary to employ a comparatively complex form of it although the simplest form would suffice. Hence, we say that a family "is accepting of" service when we could better say that it "accepts" service.

### Fickle Phraseology

When an agency provides fairly regular service to a family for the purpose of solving some problem or other, the worker may record the fact that she is "active with the family." The public should not be misled by this phrase. While this could take the form of participation in a square dance, a family game of croquet, or setting-up exercises, it seldom does. Nor does "facing up to the problem" involve having the client lie on his back and gaze in rapt admiration at the social worker. It just means that he realizes what the problem is, and it may imply, further, that he is ready to consider taking appropriate action toward solving it, at least in part.

Incidentally, social workers must be fond of this little word "up." They also use it as a part of a colloquial verb form; namely, "point up." They are constantly observing things that "point up" needs or problems. They really mean that those things "em-

27



"... active with the family."

phasize" such needs or problems, but they seem loath to use this perfectly respectable and clearly defined word.

The above illustration about the *active* social worker does have one virtue; namely, that it ascribes the activity to the worker. The phrase "active case record" lacks this advantage. All the case records I have ever seen have been inactive; in fact, they have been inert. (I admit that this is rather technical and that no social worker would be confused by this convenient short cut, but I recommend using a few more words to clarify the meaning when one is writing or speaking for or to the public.)

In curious contrast to many of the illustrations I have previously given, in which many social workers and others use complex language when simple words and expressions would suffice, is a current practice of taking short, readily understandable

words but compounding them instead of employing single words that have just as precise meanings. Perhaps this is due to the influence of the German language, which forms words of extraordinary length by combining several words into one. In German this device produces an exactitude that is most useful, particularly in scientific writing. In English, however, the results are often less advantageous.

Probably the most commonly used example of these compound adjective forms is the term "on-going." At first glance this looks like a good term made up, as it is, of two short words known to everybody with only the most rudimentary knowledge of our language. Yet, in a literal sense it is a misnomer, and at best it is a colloquialism. It is usually used to describe a process or a procedure, which strictly speaking, isn't "going" anywhere. A word that is only a little longer, much more appropriate, and as readily understood is the word "continuing." Why social workers have begun to shun it in favor of "on-going" is a mystery to me.

Incidentally, if this trend toward manufacturing compound adjectives out of prepositions or adverbs and present or past participles (with or without hyphens) continues, we may expect to see some exceedingly cumbersome case recording involving such terms as:

up-coming	for	rising
around-turning	"	rotating

before-happening	previous
down-sitting	seated
after-happening	subsequent
down-lying	reclining
out-filled	completed
up-climbing	ascending
down-climbing	descending
back-coming	returning
about-facing	turning around

It should be recognized, of course, that a few terms of this general type are in common use and are appropriate. Thus, "incoming" is a suitable substitute for "arriving" as are "outgoing" for "departing" and "incoming" for "approaching." "Up-standing" is a well-established synonym for honorable, but this is not the meaning that would be attached to the word if it were hyphenated.

How many times have you said, or heard, in answer to a forthright question a sentence or paragraph prefaced with the phrase "I would say?" In most instances this form of speech is wholly inappropriate and probably stems from one or more of three causes: (1) ignorance of grammatical rules governing the use of the subjunctive mode, (2) lack of the courage of one's convictions, or (3) an attempt to appear disinterested and scholarly.

Peculiarly enough, however, although the general public commits many grammatical errors, this one is perpetrated almost entirely by representatives of the various professions (not just social workers).

Although this is not the place for  
FALL, 1962

an extended dissertation on grammar, understanding of the examples given does call for some knowledge of the subjunctive mode. This mode is properly used in expressing views that are doubtful, hypothetical, or conditional. Characteristic signs of it are such auxiliary verbs as would, could, should, may, might, etc. The next time somebody begins a sentence with the words "I would say that. . ." ask yourself (or him, if you dare) the question "would *if what!*"

The condition under which he would say whatever he would say should be expressed before the end of the sentence. Would he say this *if* he had all the facts? Who knows? The implication is that he doesn't or he would presumably make a more forthright statement. Or would he say this if he weren't "gutless" and were able to accept some responsi-



"... facing up to the problem."

bility for having opinions and being willing to express them unequivocally?

### Say It Succinctly!

I suspect, though, that this timid way of speaking is the outgrowth of the schoolman's effort to make his statements sound profound, studied, objective, non-judgmental tentative, and open minded. This approach may be valuable in the research laboratory or even in the classroom, but it is not particularly helpful in the everyday business and professional world in which decisions and commitments must be made on the basis of whatever facts are available. (I sometimes wonder how so many of the devotees of this approach ever managed proposals of marriage.)

I said in the beginning of this article that I am no longer willing to accept the propriety of social workers' using jargon even among themselves. This conclusion stems from my fundamental belief that unclear terminology is often a reflection of obscure thinking. It is obvious that no social worker can plan intelligently with and for a client whose problem he cannot clearly state and record. Nor can the agency he represents achieve any continuity in its relationship with that client in the event that the worker leaves and his successor must depend on past case recording for his knowledge of the situation.

Let me illustrate this point with two excerpts from one of our coun-

ty agencies' ADC case records. (Some day I hope to publish a compendium of all such "gems" that have come to my attention.) The first of these makes the worker look like a confused athletic coach.

"This worker has not been able to discover what defensive pattern the client uses. The strengths observed: the tendency to move towards help. Weaknesses: dispersion of her efforts in trying to reach a goal for particular problems."



I don't know about you, but I get the idea that the client is pretty shifty in a broken field—rather hard to catch. In the second excerpt I don't get any idea at all except that somebody knows a number of big words.

"She uses denial intellectualization to defend herself against a disabling amount of anxiety."

If only I knew what this meant, I should be happy to tell all my breathless readers whether it was good or bad. As it stands, I can only marvel

MINNESOTA WELFARE

## FAMILY COURTS

(Concluded from Page 24.) Even after court action has begun, the conciliatory procedure can help a large number of cases.

Family courts can be created by awakening the public to the shortcomings of existing court organization. Once that has been accomplished, the next step is enacting enabling legislation and appropriation of necessary funds. The returns will be in the form of less divorce, delinquency, dependency, relief, and crime.

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at the erudition that enables some social workers to assemble such an imposing array of words into one short sentence. I feel like some of the illiterate characters in Al Capp's comic strip *Li'l Abner* who look at anything printed or in writing and exclaim, "Ain't it purty? What do it say?"

I am going to close this article with a story currently making the rounds that illustrates forcefully one of the more drastic results of the inability of human beings to communicate with each other.

FALL, 1962

A man out for a drive picked up a hitchhiker who turned out to be a beatnik. As the latter sat snapping his fingers, the car approached a busy highway. Finding his visibility blocked, the driver asked the beatnik whether anything was coming. The beatnik looked and then replied, "Nothing but a big dog, Daddy-O."

As the car entered the intersection, there was an ear-splitting crash, and people began flying in all directions.

Three days later, the driver awoke on his hospital bed and, looking across the room at the other bed, saw his beatnik companion swathed in bandages from head to foot.

He addressed him thus: "I thought you said nothing was coming but a big dog!"

The beatnik answered, "That's right, man, nothing but a big Greyhound."



## *Minnesota Lions Eye Bank*

Since August, 1960, 25 Minnesotans have been looking into happiness through others' eyes.

It was two years ago in June that Dr. John E. Harris, head of University of Minnesota's department of ophthalmology, told a Minnesota Lions clubs convention of the dire need of an eye bank in this state. He stressed the need for a place where persons wishing to donate their eyes could be put in touch with men, women, or children whose sight could be restored through a cornea transplant.

The delegates responded with typical Lions' vigor, enthusiasm, and

generosity. They voted to establish a Minnesota Lions Eye Bank at the University, with costs to be borne through voluntary contributions from their clubs throughout the state. Ten directors were appointed for two-year terms. In August, 1960, the first board of trustees met and the program was launched.

Each Lion in Minnesota is asked to fill out a donor card which in effect wills his eyes to the Eye Bank. Shipping cartons and containers are made available to all accredited hospitals. Executive approval allows the Minnesota Highway Patrol to speed  
(Please turn to Page 39.)



*This is the Minnesota Lions Eye Bank committee, helping to bring happiness through others' eyes. Seated: Secretary Rita Konkel, Robert G. Davidson, Chairman George R. Dugan. Standing, left to right: Dr. Thomas Hagen, F. C. Bayard, Dr. Peter Lommen, Frank E. Murphy, Wally Lambert, and Dr. John E. Harris.*

*Are They Providing Adequate  
Care and Services?*

## Nursing Homes in Minnesota

ALBERT T. HUEBENER

THERE HAVE BEEN MANY Opinions about nursing homes\*—pro and con.

Newspapers showing nursing homes in flames or telling of irregularities in their administration and treatment do much toward creating a negative impression. Needless to say, such incidents do not pertain to *all* nursing homes.

There are, however, reality-based complaints from relatives and county welfare departments regarding homes that mistreat patients—by not feeding them sufficiently, limiting them to their rooms all day and not allowing them to socialize with others or to watch TV in the living room, not allowing them to go outside for a walk or to sit in the yard, by leaving them alone without anyone in attendance, and never having a doctor come when they are ill. It is admitted that such stories may give impetus in bringing about improvement in such facilities by authorities; but, the original harm done in creating fear and distrust in the minds of the public is often irreversible.

Nursing homes can and do serve

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\* General term for all similar facilities—homes for the aged, rest homes, boarding homes, or foster homes.



Mr. Huebener

a useful and important purpose in society. The problem of aging (geriatrics) is continuing to become a more outstanding problem each year—not only in society where medicine is learning to lengthen the life span, but especially in institutions where protective care and treatment seems to lengthen the life span.

The growing need for long-term care for persons over age 65 makes

it imperative that nursing homes be carefully examined. Elderly persons who are unable to live alone—because they are not able to shop for food, cook adequate meals, look after the heating system in checking for fuel, doing the laundry, house-cleaning, taking out the garbage—and who are ill and often require some bed care—find the facilities of a nursing home adequate in meeting their needs. Many older citizens can live alone because they have close friends or relatives nearby to look in and to help with the minor problems—changing a fuse, changing a light bulb, fixing a faucet or an electrical connection, helping to nail up fixtures for curtains or drapes, repairing a torn shade, etc.

However, many senior citizens are too proud to ask for help—going so far as to try to do everything themselves—thereby straining their physical being to a point where they endanger their health and making them more susceptible to illness or accidents. These latter persons are the ones who require some supervision. The newspapers are filled with items concerning elderly persons living alone who have fallen and broken their hips or legs and are unable to reach a phone, only to be found later—too late. There are those who become ill with pneumonia and don't receive medical or nursing attention—and also are found too late.

In many instances, the family physician or the county social worker

know of such situations but are powerless to do anything about it until something happens. Then it may often be too late—an accidental fire, injury, illness, insect-infested home (health hazard)—causing irreparable damage.

If nursing homes were more highly thought of, many more persons would not hesitate in partaking of their services and in turn enjoy life instead of using all their efforts to recover from some damaging or traumatic episode. There are numerous instances where persons entering nursing homes have improved due to the atmosphere of friendliness, kindness, and comfort provided by the personnel there.

#### Many Types of Homes

Naturally, there are many different kinds of nursing homes—some desire only ambulatory patients, others only bed patients, others no diabetics, and still others no mental hospital patients. The latter are unable to see that the elderly mental patients are generally the same type of elderly persons that the nursing homes already have. Perhaps it is just as well in such instances that the mental patients are not placed where there is a lack of understanding of the problems of the aged. Today, mental illness is being recognized as being no different than any other illness, as is evidenced by the rise of psychiatric wards in general hospitals, along with

their O.B. wards, surgery wards, contagious wards, etc.

Many of the better nursing homes have learned that patients from mental hospitals are easier to care for, as they are "routinized" from years of institutional care. They do not offer the problems of adjustment as the person who has been at home and who now has to give up some of the freedom and independence he was used to. Most mental patients are dependent on routine and feel secure and comfortable under such conditions.

Many nursing homes give patients experiences in additional independence and freedom than was available in the institution. Patients from state institutions also have the benefit of controlled medication after having been under observation for a period of time, whereas those persons from a private home are usually sent off to a nursing home or a general hospital at the first sign of being cantankerous or obstreperous—which brings up another point.

### **G.P.'s Out of Step**

With the sudden flood in recent years of many miracle drugs and medicines—especially of the tranquilizing variety—many general practitioners have been unable to keep step with their uses, effects, and dosage. The average general practitioner does not get enough experience in treating all sorts of depressions, anxieties, psychosomatic ills, hysterics, etc.

Granted he has many such clients, he generally doesn't have time to observe the reaction of his clients to the many possible drugs and medicines available, and their possible side effects. Those physicians who have had some experience in a mental hospital and become acquainted with the new drugs and medicines can treat every one of their patients in the community, while other physicians send every senile or nervous person to the hospital or state institution. There should be close communication between hospital physicians and community physicians in meeting the medical problems of the population. The hospital physicians stand ready as consultants to assist the community physicians at any time. The Department of Public Welfare's division of medical services is setting up programs for community physicians to assist them in becoming better acquainted in recognizing various mental ills and in meeting their needs—preventive-wise and treatment-wise.

Many county welfare departments place former hospital patients in nursing homes in their own county, thereby limiting the variety of placements and the time element in releasing the patient from the hospital. In other words, although there may be a suitable vacancy in a nursing home nearby, but in another county, the patient is not released from the hospital until there is a vacancy in the "home" county. This may be feasible administratively, legally, and eco-

nomically, but not from the humanitarian point of view. The best (therapeutically) placement should be chosen for a person, regardless of location.

### **Dollar Dictation?**

Although from the humanitarian point of view financial considerations would not enter in, we would have to admit that is a consideration. Many patients are therefore placed, not in the best placement possible, but merely as the vacancies occur and the patient's name appears at the top of the waiting list for the placement.

This whole question could be revised by having the hospital social workers place patients in the community. Someone might say, "What of the philosophy of the community responsibility?"

True enough, although some hospitals may be many miles from certain communities, technically the hospital is still part of the community—it serves the community, and stands ready as consultant to the community, and feels a sense of responsibility toward the community as a whole. That is why our hospitals are now trying to release many of the chronic patients who can get along in the community so that there will be beds available in the hospital for the treatment of acute cases. It is recognized that the quicker the illness is treated, the better chance for improvement. (This does not contradict a previous

statement regarding the control of illness in the local community by the general practitioner.)

We realize that there will be instances that can be treated only in a residential hospital setting. What we did refer to is the heavy flow of aged patients to the state institutions that could be cared for at local nursing homes. The hospital social workers, in the placing of patients in the community, become acquainted with the resources of the entire geographical area and would be in a better position to meet the individual needs of the patient. The hospital social worker would also follow up on the patients on provisional discharge status. The social worker knows the patient, and the patient feels secure and comfortable in seeing the familiar face of the hospital social worker. The hospital social worker is more experienced with establishing rapport with patients and in understanding their needs.

### **Leave It to the Worker**

Some of our leading states, such as California, New York, and Illinois, have the hospital social workers make the placements for hospital patients in the community, and also are responsible for the follow-up. In this way, the hospital is able to coordinate the release plans more efficiently—having an idea when the vacancy will occur, and in preparing the patient for this. Another advantage is the ability of working out foster home

programs with the patients with certainty—and not have to be dependent on an intermediary for coordination. The hospital can also sponsor ex-patient groups, without having to work through the county agency, hoping that the county will accept the idea and facilitate the planning.

If the counties had mental health social workers just as they have child welfare workers or probation officers, then the whole program of returning patients to the community would be more successful. Many county social workers do not have the slightest understanding of mental illness—prevention, treatment, and resources.

Unless there are more trained (in understanding mental illness) social workers, the whole program may fail. Already many nursing homes close their doors to former mental patients—due to past experiences which may have been unsuccessful—either because the home was not suited to the patient; or at a time when the patient or nursing home needed consultation, no experienced person was available.

#### **They Missed the Hospital**

The return rate of chronic patients is no higher than the return rate of acute cases. Of those chronic patients returning, most of them have returned because they wanted to—they didn't feel comfortable in the nursing home. This has been observed: that although they may have

acted out while in the nursing home, as soon as they return to the hospital setting, they behaved as they did before leaving—with no acting out symptoms.

#### **Timing is Important**

The annual reports requested from the county social workers in many cases serve as only impetus for visiting the former mental patients in their homes. This is not right. When a patient first leaves the hospital, a visit within the first two weeks should be made—then each month, as the situation requires. Many counties never send the hospital a report, others send it too late—although the requests are sent to the county two months before the anniversary date of the provisional discharge occurs.

One final point: although nursing homes are inspected and licensed by the Minnesota Department of Health; in addition to many relatives, a few of the county welfare departments are also dissatisfied with conditions in some of the nursing homes. Perhaps standards should be revised so that they are kept up with the times. Although physical facilities do not always indicate the best caliber of treatment, at least it would be a positive indicator to relatives.

To maintain a high caliber of personnel for the care of persons, yearly physical examinations should be required, as well as a psychological testing to weed out the undesirable. Personnel who have sadistic, im-

moral, or hostile tendencies should not be permitted to work with or handle nursing home residents. Barbers, beauticians, as well as other persons (doctors, nurses, dentists, chiropractors, oculists, chiropodists) who "touch" others are required to have permits or licenses. New personnel in hospitals are required to go through a training program and are hired on a probationary basis until they successfully complete this training. Would it therefore be unfair to require such standards of persons working with "helpless," "aged," or "infirm" in nursing homes? Would working a week or two in a mental hospital be impossible?

A recently study<sup>1</sup> of nursing homes in Detroit, Michigan, area brought out some suggestions regarding the training of personnel—that a period of "on the job training" should be spent in a state institution—while another idea was that the state should run a school for new operators and personnel and give an examination at the end of the training period.

#### **Raise the Standards!**

The nursing home situation is an important one, and the state hospitals should take more active participation in bringing the standards for the care of the aged and infirm to a maximum level. It is admitted that the state hospitals cannot provide an example of adequate living conditions

—due to the continual overcrowding. Even in the area of activities, the state hospitals are unable to provide concrete examples—due to lack of sufficient personnel. But, in the area of care and treatment, the state hospitals in Minnesota are utilizing the most advanced and progressive methods, and can therefore provide excellent leadership for nursing homes.

#### **Quick to Improve**

Overcoming the handicaps of overcrowding and insufficient personnel, the state hospitals have instituted "therapeutic community" programs<sup>2</sup>, "intensive treatment" programs<sup>3</sup>, and "open hospital" programs. Well-known authorities from other states have visited Minnesota with progressive ideas, which Minnesota has been quick to adapt to local hospital facilities.

Unless the present need for adequate nursing home facilities are met by private local facilities, the government may take a hand in providing such facilities. It is a known fact that when private or voluntary agencies do not meet the needs of the people, the government then steps in.

In the 1959 Minnesota State Legislature, a bill was considered to provide subsidy to persons wishing to build nursing home facilities. Although the bill was not passed, it could be considered again in the future, if sufficient nursing home facili-

1. "Proprietary Nursing Homes," Thomas E. Mahaffey, Health Information Foundation, Wayne State University, Detroit, Michigan, 1961.

2. "The Therapeutic Community in a State Hospital," Minnesota Welfare, Fall 1960.

3. "Nurses and Psychotherapy" Mental Hospitals, May 1961.

MINNESOTA LIONS EYE BANK

(Concluded from Page 32.) donor eyes to the University hospital in Minneapolis with minimum delay.

As a restoration of sight, when possible, is the first consideration in rehabilitation, the Lions Eye Bank is a valuable resource for rehab clients in Minnesota State Services for the Blind; and since the Bank's establishment, many patients have been registered whose sight can be helped through replacement of a donor cornea for one damaged as the result of injury or infection.

The Lions today are striving to extend this service. Through an education-publicity program, they want the public to know that any person—Lion or not—can have the opportunity to let his or her eyes become a living memorial through the gift of sight.

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ties are not provided by private or voluntary sources. This then, with state influence, may be the only method of having adequate nursing home facilities—with trained personnel.

Society is now very conscious of the aged, because those over 65 are becoming an increasingly larger portion of our population. Legislation to aid in housing and caring for aged persons has been passed on both federal and local levels. If the role of government continues to grow in these areas, it will naturally have a greater impact on the nursing home situation and its future unless nursing home proprietors act in discon-

tinuing substandard nursing homes, and raise the standards of the remainder.

*Summary:*

1. There are some negative comments of nursing homes and other related facilities.
2. Nursing homes serve an important role in our society.
3. Aging is becoming an ever-increasing problem.
4. The releasing of mental hospital patients also points out the ever-increasing need for understanding of mental illness.
5. Professional persons need to keep up with the latest studies, statistics, and results in the problems of the aged and mentally ill.
6. Mental hospitals can be leaders in educating their communities with a better understanding of the aged and mentally ill.
7. Bring the facilities of the aged and mentally incompetent up to date by revising standards.
8. Personnel who work with the aged and the mentally and physically infirm should be qualified and competent.
9. Nursing homes are necessary in lightening the state hospital load so that more facilities can be brought to bear on the rising problem of prevention and treatment of the acutely mentally ill.

# LET'S LOOK AT A BOOK



THE CHURCH CHILDREN'S HOME, IN A CHANGING WORLD. By Alan Keith-Lucas. The University of North Carolina Press, Chapel Hill, N.C. 1962. 92 pp. \$1.25.

This book is a collection of 14 papers presented by the author to regional or denominational groups interested in care of children away from home. The author is on the faculty of the school of social work, University of North Carolina, and has been associated with a number of children's homes through his assignment as director of the Group Child Care Project and other organizations.

The task of the children's home has become much more complex since there are few pure-orphaned children. Today children do not come to institutions because they need a home. Instead they are disturbed children who are having problems relating to their own home or community.

The focus no longer is on long term custodial care, but is on treatment and return home. This requires a more highly trained and diversified staff, with higher costs and with less visible results. These children need a setting where they can learn to "trust" again; for many have lost faith in parents, in themselves, and in God.

This short book gives us a refresher course on the child in group care, and also redefines the role of staff members.

I would like to include this quote from the author that applies to training of staff members: "It is how one helps them want to learn and how one helps them put not only what they know but what they are into practice. Proficiency in the job is so largely a matter of what one thinks about one's job, what it expects of one, the kind of support one gets in it, and in the last analysis what discipline one is willing to acquire to become proficient in it."

He touches on the importance of work with families, spiritual training in group care, and handling of children's sexual growth in group care. Around this last point, he quotes a boy as saying, "The crime in this institution is not what one does with a girl. It is being with her. If they caught us together and didn't see us smooching, they'd assume either that we had just finished or hadn't had time yet to begin." The author's remarks about co-educational facilities are enjoyable.

Whereas my first reaction was to classify this book as just another dull production, my conclusion was that you'll seldom get more out of 92 pages—across-sectional book on institutional life and problems.—*Paul H. Gruber*, consultant to private child placing agencies, Minnesota Department of Public Welfare.

COTTAGE SIX—*The Social System of Delinquent Boys in Residential Treatment.*  
By Howard W. Polsky. Russell Sage Foundation, 505 Park Ave., New York 22, N.Y. 1962. 193 pp. \$3.25. Although

Mr. Polsky is assistant professor in the New York School of Social Work, his book focuses largely on sociological phenomena, rather than on social work methods.

Based on observations made while actually living in a cottage, housing the "toughest" boys in a residential treatment center, it is a study of the power structure developed and perpetuated by delinquent boys in a group living situation with little or no staff intervention in group relationships. In the final chapter, Mr. Polsky does briefly suggest some possible solutions to the problems which he has very graphically portrayed; but he seems largely to ignore what social workers have learned about working with groups, and individuals in groups.

The institution supports the theory of therapeutic milieu; but in practice there is strong emphasis on individual therapy, while apparently ignoring group living relationships. There seems to be little or no communication between so-called professional staff and house parents. The latter, living with the delinquent boys and cut off from administration and professional staff, are forced to accommodate to the crude and cruel power structure of delinquents. The strongest, most aggressive boy, with the aid of his subordinate leaders in the power pyramid, controls all of group living, even to the extent of withholding food. Kangaroo courts are winked at. Cruel forms of punishment, baiting, and incessant degrading remarks and commands from the high status boys, keep the low status boys in their subservient position.

House parents, lacking skill and help in influencing group relationships, can only give tacit support to this kind of control, in order to maintain some semblance of harmony and order in the cottage. Thus, every boy in the cottage is trapped. In the interest of self-preservation, he must necessarily accept the standards, values, and attitudes of a delinquent culture. His self-concept, also, is certainly strongly influenced by the role assigned to him by a hostile group.

This is a very revealing study of the relationships and control system developed by

delinquent boys in the absence of adult intervention. Living with the boys in their cottage facilitated extensive, continuing, and intimate observation, which should contribute to our understanding of street gangs.

Obviously, the book cannot be recommended as a description of a good institutional program; and it is not intended to serve that purpose. It *can* be recommended, without reservation, as a very graphic portrayal of problems to be solved and pitfalls to be avoided in working with delinquent adolescents.—*Marjorie McFeters*, consultant, children's institutions, Minnesota Department of Public Welfare.

FAMILY CASEWORK DIAGNOSIS, Alice L. Voiland and Associates. Columbia University Press, 2960 Broadway, New York 27, N.Y. 1962. 369 pp. 88.50. Make no mistake about it—so far as general development of the social work field is concerned, this is the book of the year, and then some! In importance and ultimate effect this book will be compared to Bradley Buell's *Community Planning for Human Services* which came out in 1952, and even now—10 years later—continues obviously to have more than historical importance to the field. Like Buell's, Miss Voiland's book came out of research done by Community Research Associates (CRA), and represents another germinal contribution to the field which will stimulate further research, probably at least a fair amount of argument, and will help to bring changes in day-to-day professional practice.

It is necessary for any prospective user of this book to be clear about what the book is, and what it isn't and does not do. Especially in Minnesota public welfare, readers will have diverse expectations of what a CRA-sponsored book will give them. So at the outset, this is *not* a book about casework process, or a casework text in the same way the standard books by Hamilton, Perlman and others are; you won't get here (at least directly) a how-to-do-it book about interviewing and differential use of self in the treatment relationship.

This book as it stands is a "first" book, not a book of the last or final word, and it's hard to compare it with anything else. An enormously ambitious and encompassing

book, I see at least seven major parts to it. Any one of these parts could well have been the subject for sustained, book-length attention in its own right.

First, Miss Voiland reports on the case research back of this book—how the research came to be done, its outgrowth from earlier CRA work, how they went about it, the numbers of cases selected, sampling procedures, how the data was analyzed, and so on. (Of interest here is the fact that Family Service of St. Paul was one of the 7 agencies nationwide which participated.) Here in this first chapter and at other places in the book the Minnesota county Welfare staff members will realize there are some differences between the Minnesota method and some of the terms Miss Voiland uses. The most important of these differences, and a *caution* to Minnesota users, is that when she writes "level A disorders" she means existing (or official) disorders and "level B disorders" are what the Minnesota method would call symptoms of potential disorder.

Second comes a long chapter, "The Determinants of Social Behavior." Here Miss Voiland discusses cultural influences on behavior in American society, but largely in its main lines, with little reference to sub-cultural determinants (occupational, social class, ethnic). Then into changes in American population structure. Finally she describes the psychodynamics of individual growth and development, and the psychodynamics of the relationships involved in family living (child-rearing, marital, financial, etc.).

The third major part is a chapter on "Healthy Family Functioning." Here Miss Voiland writes about normative expectations of behavior and we have the advantage that she follows essentially the same outline or construction we've become familiar with in the Case Planning and Classification Schedule (CPCS). Thus she writes in terms of the socialization aspects of child-rearing functioning, the self-identity patterns in marital functioning, and so on. This chapter has probably a more direct and immediate usefulness to us than some of the others.

What logically follows is the fourth major part of the book, a chapter on disorders or breakdowns in functioning. The disorder idea itself is described, and the terms prohibited behavior, restricted behavior, and

behavior subject to protective intervention are discussed; Miss Voiland adds another, "therapeutic exploration" about which as she says there may well be disagreement (in the public welfare program we haven't so far used the term therapeutic exploration in an operating way). The separate disorders are described, and the same caution is necessary to the Minnesota reader: where Miss Voiland writes level B disorder, translate into symptoms of "potential disorder" in our method, and do not confuse this with levels of service (A, B or C) to be given to a case.

In my own mind I see the next chapters assembled together as the fifth major part of the book. These chapters describe the four family types: perfectionist, inadequate, egocentric and unsocial. This is the most striking and the most completely developed part, and has to be considered as the heart of the whole book. For it's the claim of this research that families using our agencies are one or another of these types, or combinations or shadings of these types. Miss Voiland tells us what each type looks like—the disorders and potentials for disorder which are characteristic of each type, the etiology of breakdown, how the family functions in the same five areas of functioning we consider in case analysis: financial, child-rearing, marital, child development and adult adjustment. All this she does in considerable detail, although little case vignettes or illustrations of some kind would have helped a good deal.

Chapters IX and X make up a sixth part, a conception of a total framework for family diagnosis and its interpretation and elaboration.

Finally we have a regrettably all too short treatment of the application of all these ideas in social agency practice so far as case-worker, supervisor and administrator are concerned; this is presented largely in terms of a working method for diagnosis, prognosis, treatment planning and evaluation.

A bibliography is appended (some 160 items) for the reader who wants to follow out lines of special interest.

This book will always, I think, be recognized as a pioneer book. It will stimulate work by others. How well it will hold up over the years will probably depend mainly on how well the four family types stand up to examination and use in case practice by

advanced practitioners. There's a huge difficulty in moving from language and conceptions of *individual* type to those of a distinctively *family* type.

The words Miss Voiland uses to describe family types all have prior uses in describing individual persons. Indeed a reader's first impression might be that all she has done is to take words for individual types and make them into family-sounding types.

If you talk about a family as the inadequate type or the unsocial type, are you talking about a distinctive *family* type? Or are you still type-casting in individual terms? If one or both parents are perfectionistic as individual types, will the functioning of their family be well summarized and typed by the term "perfectionist family" as Miss Voiland describes this? When you first think about this, you're apt to be doubtful. On the other hand you come to realize that after all is said and done, what parents are as individual types has a large and powerful impact in shaping the final cast or kind of functioning of the whole family.

If Miss Voiland and her associates have in fact given us a *sound* family typology, we have something that is more than a theory breakthrough; there would be some fairly immediate benefits to social work practice as well: sharper diagnostic understandings and prognostications, treatment plans more attuned and less naive, and a better, differential "fit" of ongoing treatment effort to families of the several types. There are management implications also—in terms of the investment of staff time, case assignments to staff and the caseworker evaluation process.

The conceptual and the empirical issue here is whether Miss Voiland has met the requirements for an effective ideal typology: does she in fact distinguish with economy and precision those main types or general tendencies of family functioning that we actually find in social agency practice? I don't know; the field will give its answer. And in Minnesota we have through our use of the new method the opportunity to make important contributions to these answers.

This book will be widely available and used in our state. Any dangers there are in relation to this book are not mainly in the book itself but in attitudes we might have toward it. We can react to the book but

FALL, 1962

## Definitions

**FOOL:** A person who doesn't agree with you.

**PESSIMIST:** A person who, given the choice between two evils, chooses both of them.

**PSYCHO-CERAMIC:** A crackpot.

**HONEYMOON SALAD:** Just lettuce alone.

**PEACE:** Short pause between wars for nation identification.

**DIARY:** Penned up emotions.

**TOURISTS:** People who travel thousands of miles to get a kodak picture of themselves standing by the car.

**SEWING CIRCLE:** Where women go to needle each other.

keep our distance from it. This could take several forms: we can regard it as "interesting" and "important" and so on but yet somehow irrelevant on the job of "providing services," "developing programs," "meeting needs," etc.; or we can carp and criticize the book from the sidelines, so to speak. These would be unfortunate reactions, I think, leaving us the poorer. We shouldn't, in other words, admire the effort but make an insufficiently studied and argued response to the content. Neither should we (because we admire the effort) in any way seem to put the book out of reach of responsible criticism, either.

One last word: this is a sophisticated book which demands a good deal of its user. It's not a padded, discursive writing which makes for easy, fast reading. I think you don't so much read this book as study it, go over parts more than once, stop to think about it, to question, etc. Not all prospective readers will have the interest, the energy and the prior understandings to get full use out of it; for those who do, however, I think work with this book will be an exciting venture.—Web *Martin*, assistant to the director, division of field services, Minnesota Department of Public Welfare.

Ignorance of the law excuses no man; not that all men know the law, but because 'tis an excuse every man will plead, and no man can tell how to confute him.—John Selden.

Most of the greatest evils that man has inflicted upon man have come through people feeling quite certain about something which, in fact, was false.—Bertrand Russell.

We have too many people who live without working, and we have altogether too many who work without living.—Charles R. Brown.

When we fill our hours with regrets over the failures of yesterday, and with worries over the problems of tomorrow, we have no today in which to be thankful.—Henry Ward Beecher.

A little more devotion, a little more love, and less bowing down to the past, with more confidence in ourselves and more faith in our fellow men, and the race will be like a burst of light and life.—Elbert Hubbard.

The greatest thing in family life is to take a hint when a hint is intended — and not take a hint when a hint is not intended — Robert Frost.

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THE CHURCH AND THE OLDER PERSON.  
By Robert M. Gray and David O. Moberg. William B. Eerdmans Publishing Company, 255 Jefferson Ave. S.E., Grand Rapids 3, Mich. 1962. 162 pp. \$3.50.

Much has been spoken and written about the role of the church in meeting the problems of the elderly in our society. In the early stages of this book, I felt I was rereading some familiar work with only the word *church* substituted for the word *social agency*, the *community*, or *society*. However, as one moves through the first two chapters, it becomes obvious that the authors are making a new contribution to the literature. The core of the text is a verbatim reporting of attitudes of older persons toward religion, the church, and church membership. Fortunately, the authors have not attempted to select only those statements that concur with a preconceived notion of how the older person should feel. Thus you find a series of interviews indicating the church has great meaning, and then you find interviews indicating bitterness on the part of older persons with respect to the church. The authors do not attempt to analyze the validity of the statements but do attempt to point out the significance of such statements by older persons. No one can take issue with this approach.

It should be remembered that the authors are presuming the reader will be sufficiently sophisticated in psychology to recognize that some of the responses are more defense mechanisms than accurate reporting of the older person's relationship with the church. Should the unsophisticated reader accept the statements at face value, any effort at improving conditions for the older persons in the church might be disastrous or at the least, unproductive.

The book does more in reporting symptoms of the older persons' defenses to the aging process than it does to understanding of the causes; hence, any church program for the aged, based on the problems reported in the book, would only serve to treat the symptoms rather than the causes of isolation and uselessness in later life.

The book does provide an excellent bibliography of all the major works and some of the lesser known studies in its field. Actually, the authors point out that the book was written as a survey of present knowledge about the church and older people in contemporary society. This it does well.

The one criticism that might be raised is that the authors, both professors, step out of their academic roles and recommend certain types of activities for the church and for the older members of churches.

While most of the recommendations are

valid, they do not go deep enough. The involvement of older members in the church is much more complex than participation in its business and religious ceremonies. More attention must be given to such needs as: a pastor assigned only to work with the neighborhood's elderly population; or that the design of new churches take into account the elderly; or that large print hymnals and prayer books be purchased.

The purpose of religion is far more than bringing satisfaction and joy to society. The tenets of religion can be painful as well as rewarding; therefore, the church needs to be looked upon as more than an instrument for providing joy to the aging. It should provide experiences that prove the meaning to life is found in deeper values and relationship than between man and his church per se or the members of his church.

The studies reported are excellent guide posts to ministers, social workers, nursing home operators, and others who work with the elderly. For this reason, I would recommend the book for those responsible for counseling with persons in the retirement years. Emphasis is placed on the church's function in satisfying basic social and psychological needs of older persons which assists them to face fears, anxieties, loneliness and impending death.

The book is highly recommended reading for church boards, as it clearly points out the conflict between the older and the younger members of the church. While the tradition and heritage of religion are usually carried on by the older members, it is basically the younger generation that supports the parish. This raises conflicts that can be avoided by intelligent planning on the part of church boards.

The suggested topics for further research at the end of the book are excellent.

Clearly acknowledging that the studies to date have raised more questions than answers, the authors have outlined issues that should be pursued as soon as possible.

To that plea I would add a sense of urgency for the churches making use of the knowledge already available. They have a primary responsibility in reshaping the attitudes of our society with respect to the aging and the aging process. Too few are fulfilling this responsibility.—*Bernard E. Nash*, director, center for community devel-

opment, University of Missouri, Columbia, Missouri (formerly special consultant on aging, Minnesota Department of Public Welfare).

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HOUSEPARENTS IN CHILDREN'S INSTITUTIONS. By Alton M. Broten. The University of North Carolina Press, Chapel Hill.

1962. 90 pp. \$1.25. It may seem a little saccharine to say, as Alton Broten does, that "The unsung heroes and heroines of our generations are those men and women who, without pomp and circumstance, without status or adequate return, give daily of themselves to tasks involving the up-bringing of the youth of our land."

Nevertheless, when you consider that there are more than 54,000 children in institutional care in the United States (as reported by the Children's Bureau, 1962) the role of the house parent as a kind of parent surrogate is tremendously important.

This booklet does not purport to be a free-flowing narrative account of all of the virtues and attributes to be found in the model house parents' bag of tricks. On the contrary, it is, as it declares itself to be, a discussion guide for house parents, child-care workers, group workers, and counselors. It grew out of discussion groups which met from 1956 to 1961 on the campuses of some 30 child-caring institutions in 6 southeastern states: Virginia, North Carolina, South Carolina, Georgia, Alabama, and Florida. These institutions, affiliated with the group child care project under sponsorship of the University of North Carolina and the Southeastern Child-Care association, were involved in a considerable program of in-service training. Ninety pages in length, this book is divided into six sections:

- I. The House parent and the Job
- II. The Child—His Past and Present
- III. Relationships with Children
- IV. Training and Discipline
- V. Children in Groups
- VI. Activities and Other Problems

Its strong points are that it can help a house parent to assess his own attitudes and standards in terms of what he brings to the job of helping children who have come from broken homes and highly volatile child-parent relationships. The first chapter contains a very valuable section to the house-parents on making a self-inventory of their

## Credits

Cartoons for *A Rose by Any Other Name* (Pages 25–31), by special arrangement with Glen Holscher.

Cartoon, Page 47, courtesy *The Clark Contactor*.

Cartoon, Page 48, courtesy TRUE, *The Man's Magazine*.

own attitudes and background (the Personal Factor).

The part of the booklet I dislike is the chapter on Training and Discipline. This seems to me to be a heavy-handed treatment of discipline with undue emphasis on its part in institution setting. Despite this weakness, I think that this booklet could well be part of the in-service training portfolio of every children's institution, along with our own DPW *Manual for Child-Care Workers*, Eva Burmeister's *The Professional House parent*, and Fritz Maier's *Guide for Child-Care Workers*.

A copy of this booklet is available in the DPW library; additional copies can be secured through the University of North Carolina Press.—Arthur. C. Jauss, consultant to private facilities for retarded, Minnesota Department of Public Welfare.

A MINNESOTA DOCTOR'S HOME REMEDIES FOR COMMON AND UNCOMMON AILMENTS. By John E. Eichenlaub, M.D. Prentice-Hall, Inc., Englewood Cliffs, New Jersey. Seventh printing, 1962. 252 pp. \$4.95.

This book is much more cleverly contrived than its disarmingly homespun title would indicate.

Somehow we got the idea, reading the publisher's promotional flack, that this book would tell how you could sally out into the woods, gather a handful of prickly ash berries and make a witches' brew to stave off minor ailments. It does nothing of the kind. Instead, it is soothing and reassuring as it emphasizes how —with common sense treatment and proper rest — the ailing body heals itself (something the chiropractors have been telling us for decades!).

Dr. Eichenlaub's style is breezy. He has

the gift of being able to chummily josh the reader — even promising that many of the measures and remedies suggested will save trips (and money) to the doctor's office. Yet time and again, he shrewdly recommends that the reader consult his family doctor.

It appears to this reviewer that Dr. Eichenlaub tiptoes the tightrope very skillfully between the public and his fellow medicine men. Neither side can be angry with him after the book has been digested and its lessons learned. He sends you trotting to the doctor here — and (for some ailments) saves you money there.

The writing is easy, unlabored, chatty. No doubt about it, this book contains much sense. Nothing objectionable about the price (\$4.95), either. That's a shade under most doctors' fee for one office call —and you'll save that amount over and over, if you'll just mind the Eichenlaub advice.

When you've finished reading this book, you will somehow feel less frightened of the germ potential: the little bugs won't get you if you'll just (reasonably) watch out.

We'd say that buying this book for the average family to consult when necessary would be money sensibly spent.—Walt Raschick, publications editor, Minnesota Department of Public Welfare.

## Teenager, Go Home!

Too many teenagers complain: "What can we do? Where can we go?" The answer: *Go home!*

Hang the storm windows, paint the woodwork, wash the car. Rake the leaves, mow the lawn, shovel the walk. Curry the dog, feed the cat. Help the minister, the Salvation Army, the Humane Society—visit the sick, the poor, *study your lessons!* And when you're through—if you're not too tired, read a book.

Your parents do not owe you entertainment; Your city doesn't owe you a recreation center. The world doesn't owe you a living.

MINNESOTA WELFARE

## Reorganization Story

THE UNITED STATES is full of well-intentioned people who are eager to reorganize industries and government agencies. The way some of them are going about their tasks reminds us of a report a reorganization expert is alleged to have made on a symphony orchestra after attending one of its concerts.

The report, author unknown, follows in part:

"For considerable periods the four oboe players had nothing to do. The numbers should be reduced, and the work spread evenly over the whole of the concert, thus eliminating peaks of activity.

"All the 12 first violins were playing identical notes. This seems unnecessary duplication. The staff of this section should be drastically cut; if a large volume of sound is required, it could be obtained by means of electronic amplifier apparatus.

"Much effort was absorbed in the playing of demi-semi-quavers. This seems an excessive refinement. It is recommended that all notes should be rounded up to the nearest semi-quaver. If this were done, it would be possible to use trainees and lower grade operatives more extensively.

"There seems to be too much repetition of some musical passages. Scores should be drastically pruned. No useful purpose is served by re-

FALL, 1962

peating on the horns a passage which has already been handled by the strings. It is estimated that if all redundant passages were eliminated, the whole concert time of two hours could be reduced to 20 minutes, there would be no need for an intermission.

"The conductor agrees generally with these recommendations, but expresses the opinion that there might be some falling-off in box office receipts. In that unlikely event it should be possible to close sections of the auditorium entirely, with a consequential saving of overhead expense—lighting, attendance, etc.

"If the worst comes to the worst, the whole thing could be abandoned, and the public could go elsewhere."  
—From the Jerry Klutz column, *Washington Post*.



"Did you get the raise?"

### A PYRAMID OF MUSIC

*(Concluded from Page 5.)*

professional music teachers have heard of music therapy, are somewhat fascinated by it, and may be willing (with encouragement) to begin doing some volunteer teaching in the institution.

A trained musician on the hospital staff would naturally become acquainted with the over-all treatment program, and in the case of a volunteer music teacher he should also be acquainted with the treatment program as well as identified with the recreation program. The value of the program for the patient depends largely upon the person-to-person relationship of the employee and patient. Whether the patient is playing a game, making a plastic project, playing an instrument or singing, these activities are tools used by a person to bring about a social situation which is meaningful and satisfying to the patient, and this person can be another patient.

Even though music is a highly developed art, music in the institution need not be restricted to the select few, but rather should become a part of the patients' daily life just as music is a part of our daily life.

Music is considered a fundamental activity in our schools and is very often considered a part of the basic education of the pupils. Many of us play an instrument or sing in a choir, sing to ourselves, or simply regret that we haven't continued our music education.

48



*"Now who left the front door open?"*

### COMPREHENSIVE MENTAL HEALTH

*(Concluded from Page 19.)*

we have not long been in a position to demonstrate that it is to his enlightened self-interest to support treatment and particularly the prevention of mental illnesses.

The Report of the Joint Commission is a very valuable document. It has identified a number of major problems and most of us can identify with many of its recommended solutions. Most of the methods proposed to solve the problems identified are not controversial. We should get on with these. As for those that are controversial, we simply need a little more experimentation with methods of solution. The Report is a major contribution to the development of programs for the mentally ill in this country.

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Music should be a part of the community life of our patients. Music is as normal and natural an activity in the hospital setting as any other kind of hospital activity.

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