A DESCRIPTIVE STUDY
OF VERBAL CASE COMMUNICATIONS
BETWEEN SOCIAL WORK AND THE OTHER PROFESSIONAL DISCIPLINES
IN A PRIVATE NEURO-PSYCHIATRIC HOSPITAL

A Thesis

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by

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"Communication is the cement that makes organizations. Communication alone enables a group to think together, to see together, and to act together."[1]

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[1]Norbert Wiener, oral communication, MIT, Feb. 21, 1951; quoted by Karl Deutsch, "Communication Theory and Social Science," American Journal of Orthopsychiatry (July, 1952).

CHAPTER I

INTRODUCTION

During the second year of graduate education in The Ohio State University School of Social Work I was placed for my agency laboratory experience in a private neuro-psychiatric hospital. During the early months of this placement I became curious about the uses of Social Service recording by the other disciplines in the hospital. This recording is quite extensive, involving patients' social histories, psychosocial diagnoses, and notes on continuing case contacts. I wondered how often this material was read, who read it, and what specific kinds of information in this recording were of interest to the other professional groups.

This interest brought further questions to mind. I was quite aware of and personally involved in the course of my work with many other media of communication in addition to social service recording. However, as I looked back over the many meetings, conferences, informal lunch table and coffee break discussions, telephone calls, and personal memos, as well as the considerable quantity of written recording by members of other disciplines, I found it impossible to make any approximation of the actual quantity

of information being passed from one discipline to another, or of what kinds of information were being exchanged more frequently than others. My ultimate question was: Do those of us engaged in services to psychiatric patients make optimum use of the case information known to the other professions in our settings, and do they of ours, in working with our respective patients and clients? Also, do existing communication structures facilitate the flow of information in the most efficient way possible?

This hospital seems to be a setting in which channels of communication between disciplines are relatively open and accessible, and in which the total quantity of communication is at a high level. Nevertheless, there were several instances in my own experience when I felt that communication had been ineffective at a crucial point in the course of the patient's treatment. There were times when patients in cases with which I had been actively working, were released from the hospital or sent home on trial visit without my knowledge of such plans. I felt, in some of these instances, that the patient and his family were placed in tenuous and frustrating situations because of this lack of knowledge, and that treatment efforts were not being used to best advantage.

In perusing the literature on the subject of mental hospitals I found much on the subject of interdisciplinary communications, but none of it anseered what are probably

the basic questions in communications: "Who communicates with whom, about what, when and how, under what conditions, and with what limitations?"[1] It was my impression that before one could arrive at any conclusions or value judgments in the area of communication between the disciplines it would be necessary to answer this more fundamental question. In his remarks immediately preceeding the above quotation, Parsons states:

> The modes and structure of communication play an important part in the effectiveness and therapeutic functioning of the mental hospital. Communication can be seen both as an intrinsic part of every social process and as a system in itself. In both these aspects, its organization and operation need much exploration before we can specify what modes of communication facilitate therapeutic processes. How people talk with each other, what they say, the opportunities for being heard and for hearing are all intimately related to the process of communication.[2]

It was my intention in undertaking this study to explore some of the aspects of the communication process as a "system in itself" in this hospital. By objectively examining and recording the flow of information existing in the present system, a foundation would be provided for further inquiry to test the value of the present system. Such value judgments, however, will have to be reserved for future researchers or other interested persons, since it is not intended that

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[1] Talcott Parsons, "The Mental Hospital as a Type of Organization," The Patient and the Mental Hospital, Greenblatt et al, eds., Glencoe, Ill; Free Press, 1957, p. 136.

[2] Ibid.

they should come within the province of this study. The only aim of this project is to provide an objective description through the use of an original method.

Due to the intrinsic limitations of this project, it seemed advisable to limit its scope to only one segment of interdisciplinary case communications. This study will, therefore, cover only those communication which directly involve the social work discipline as a participant; i.e., those communications in which a social worker is either giving out or receiving information. Because of the apparently unprecedented nature of this study, it was necessary to formulate a research method that was essentially untested. Therefore, in its limited scope, this study will also be construed as representing a pilot project by which to test the usefulness of the method.

Taken broadly, the field of communications is an exceedingly vast one. There are many important areas in this field which are not even touched upon by this study. Such topics as motives for communication, reliability and validity of information communicated, sources of information, effects of communication upon action, and psychological barriers to communication are only a few of these. There is also the area of nonverbal communication which, though posing many difficult problems to the researcher, may be as important or, under some circumstances, even more important than verbal media, especially in the communication of

feelings and attitudes. Nevertheless, all of these have been excluded from this study to keep it within appropriate workable limits.

In summary, this study has attempted to record and to organize into meaningful patterns the processes of verbal case communication between Social Work and the other professional disciplines at The Harding Sanitarium, Worthington, Ohio. It has tried to approach an answer, within this limited framework, to the general and fundamental question quoted above of who communicates with whom, about what, when and how, and under what circumstances.

CHAPTER II

THE SETTING

At present The Harding Sanitarium, in which this study was undertaken, is a one hundred-twenty bed private neuro-psychiatric hospital whose primary purpose is the evaluation and treatment of emotional and neurological disorders. Until recently it has been considered an intensive treatment center for short term patients with acute illnesses. However, with the opening of a new geriatric unit in the summer of 1960, there has been an increase in the percentage of chronically disabled long term patients. The majority of patients, nonetheless, continue to be of the acutely ill type and treatment services are focused mostly upon this type of patient.

The sanitarium is located in the village of Worthington, Ohio, which is a quiet, conservative, suburban community immediately to the north of Columbus. Although the hospital is separated from the community by natural boundaries and wooded areas, one gets the impression of a similar atmosphere permeating both: a quality of restful stability and security. The grounds of the Sanitarium are spacious (about forty acres) and naturally beautiful. The patients are housed in five small cottages ranging from ten to about forty in bed

capacity, and with varying degrees of open and closed doors. There are separate buildings for offices, maintenance personnel and equipment, and the craft shop. Architecture is English and Colonial.

Historical Development

In the early years of the twentieth century the only facilities available for the care and treatment of mental patients were state hospitals and general hospitals.[4] During that time, and before entering into the private practice of general medicine in 1908, Dr. George T. Harding, II, had been Assistant Superintendent of Columbus State Hospital. Dr. Harding continued his interest in the mentally ill patient and gradually limited his practice to psychiatry and neurology. He felt an increasing need to have hospital facilities available for his patients, and he became aware of a gap in the provision of such facilities. Dr. Harding found that many of his patients and their relatives were loathe to make legal commitment to the State Hospital, and the general hospitals were not properly equipped to care for the mental patient. The sterile routinized atmosphere of the general hospital could not long be tolerated by disturbed patients, nor could it provide a helpful environment for them. Therefore, in order to provide better care

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[4]Benjamin Wheatley, "A Descriptive Study of the Patients Hospitalized in a Private Neuropsychiatric Hospital," unpublished Master's thesis, 1957, p. 5.

for this poorly served patient group, Dr. Harding founded the Indianola Rest Home in 1915. This was an eight bed private hospital located in Columbus. His efforts proved successful and two years later this facility was moved and became the Columbus Rural Rest Home, with bed capacity expanded to twenty. Finally, in 1919, the hospital came to its present site in Worthington, and became The Harding Sanitarium.

Early treatment methods in the hospital were limited to physiotherapy, diet control, and the "rest cure" type of treatment propounded by Dr. Weir Mitchell.[5] Expansion of bed capacity continued and with the increasing impact of psychoanalytic theory and dynamic psychology upon the practice of psychiatry, treatment methods also changed. In the 1930's psychotherapy formally became accepted as an additional method of treatment.[6] In general this hospital continued as a short term treatment center; but it was also frequently used as a receiving hospital, providing evaluation services and recommendations to families and family physicians without the necessity of legal commitment. Many of the patients who were recommended for short term treatment remained in the Sanitarium, but others who were in need of

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[5]See Walter Bromberg, Man Above Humanity (Philadelphia: J.B. Lippincott, 1954), pp. 154-155 for an explanation of Dr. Mitchell's method.

[6]Wheatley, op. cit., p. 8.

long term care, moved on to the State Hospital. In the past men have been treated less frequently than women, due to the financial burden on a family of supporting such hospitalization with the breadwinner not working. However, rapidly increasing coverage by hospitalization insurance over the past years has caused this ratio of men to women to become nearly equal. In Wheatley's study of this hospital's population in 1956 he found that:

1. there were slightly more female than male patients;
2. most of the patients were between the ages of twenty-five and forty-nine, although about forty per cent were over fifty (this is probably even larger now since the new geriatric unit has been opened);
3. almost eighty per cent of the patients are married;
4. slightly less than seventy per cent of the patients reside within one hundred miles of the hospital, and about twenty per cent come from outside the State of Ohio (the number of patients from distant locations has been steadily increasing over the past twenty-five years as the hospital's reputation for excellent care and treatment has spread);
5. about sixty per cent of the patients had a high school education or more (thirty-five per cent had at least some college); and
6. occupations of patients ranged from unemployed laborers to professionals, but over ninety per cent were from families in the professional, skilled and service occupation groups.[7]

Present Staff and Services

The Sanitarium now has a professional staff numbering 93 and personnel in the supporting services of administration,

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[7] Wheatley, op. cit., pp. 16-23.

housekeeping, maintenance, clerical services, and food service totaling 42. For several years it has been a multidiscipline setting, offering the services of psychiatry, psychology, social work, activities therapies, and nursing. Each of these professional groups makes a unique contribution to the evaluation and treatment of a patient. The following paragraphs are brief summaries of areas in which each of these disciplines functions and their roles in this particular hospital, plus descriptions of their staffs.

Psychiatry

There are six senior staff psychiatrists and three psychiatric residents providing full time services to both inpatients and outpatients. Each patient is assigned to a psychiatrist primarily on the basis of the size of case loads, in an attempt to keep these relatively equal among the staff physicians. The physician, then, has complete responsibility for diagnosis and treatment plan, although he almost always makes use of the services of other disciplines both in arriving at a diagnosis and in implementing his treatment plan. A broad range of treatment methods are utilized. Among them are pharmacological therapy, electro-shock therapy, individual psychotherapy, milieu therapy (including recreational, occupational, and attitude therapies), some physiotherapy and hydrotherapy, as well as social casework services available to relatives of patients.

The medical staff is now under the co-directorship of Dr. George T. Harding, III, eldest son of the now deceased founder of the hospital; and Dr. Harrison Evans, a son-in-law of the founder. Two other members of the Harding family are also now senior staff psychiatrists: Dr. George T. Harding, IV, who is Clinical Director; and Dr. Charles Harding, brother to the co-director.

Social Work

Attached administratively to the Medical Department is the Social Service Department, made up of two professionally educated social workers as full time staff members, and, for six months out of each year, two second-year graduate social work students from The Ohio State University School of Social Work who gain their agency laboratory experience in this hospital. The social worker in this setting has three principle responsibilities: 1) participating in the accumulation of diagnostic information and impressions about the patient and his family, which are made available to the medical staff; 2) acting as a liaison between the hospital and the patient's family; and 3) providing planned casework treatment services to the family where such are indicated. At the time of the patient's admission to the hospital, an intake interview is conducted by the social worker with the patient's next of kin or any other friend or relative who might have accompanied him. The purpose of this interview

is to carry out the mechanics of admission procedure, interpret policies and practices of the hospital, and to obtain social history information about the patient. On the basis of this interview tentative diagnostic impressions are formulated and these impressions, along with other significant history material, are made available to the psychiatrist, who has meanwhile been examining the patient. This supply of information to the psychiatrist continues throughout the succession of casework contacts.

During the early part of the patient's hospitalization a decision is made by the social worker, in consultation with the patient's physician, as to whether continuing social servicecontacts with one or more relatives are indicated; and, if so, what the nature of the casework treatment plan should be. The decision is based largely upon two factors: 1) the extent to which the relative is involved in the patient's problems and 2) the need of the relative for help with problems of his own, which are often directly related to pressures resulting from the patient's illness and hospitalization. The social worker may then continue to carry the case on a casework treatment basis using primarily supportive and relationship techniques, or he may limit his contacts to the function of liaison person between the doctor-patient-hospital group and the patient's family and friends. In most cases the psychiatrist has no continuing contacts with relatives. He is, however, often called

into interviews between the social worker and a relative when there is a need for interpretation of medical information.

Psychology

This department is relatively autonomous and is financially self-supporting within the hospital. Diagnostic and treatment services are offered by the two psychologists, both of whom have a Doctor of Philosophy degree in clinical psychology. However, patients in this hospital are not routinely evaluated by the Psychology Department, but, rather, are referred for testing by the attending physician when a need for further diagnostic information is indicated. Usually such referrals are made for the purpose of obtaining answers to specific questions the doctor may have about the patient. Under some circumstancesthe psychologists undertake psychotherapy with inpatients, but this is only at the request of and consultation with a senior physician. The patient's psychiatrist continues to have overall responsibility for the management of the patient. The Psychology Department also provides outpatient evaluation and treatment services upon referral from the medical staff. Other functions of this discipline include research and participation in the training of psychiatric residents and aids.

Activities Therapies

The Activities Therapies (formerly called Occupational Therapy) Department functions through the use of a number of

activities provided for the patient at his doctor's request. These activities cover the areas of outdoor and indoor sports, handicrafts, work projects on the grounds, and cultural and social events. An activity program is planned by the physician for each patient, if the latter is able to participate, on the basis of which activities would be most helpful to him in the facilitation of his treatment plan. An appropriate attitude for the activities therapies personnel to assume toward the patient is also prescribed by the doctor. While the patient is engaged in activities, the activities therapies staff is delegated the responsibility for his management and supervision. This department is also responsible for the Day Hospital program, which is provided for patients who are able to move out of the hospital into community residences, but who still need the protected and therapeutic environment of the hospital setting during daytime hours. The activities therapies staff includes two full time registered occupational therapists, two full time untrained workers, and several part time volunteers.

Nursing

Registered nurses, practical nurses, and psychiatric aides are combined for purposes of this study because of their close work association with each other in managing and caring for patients within the cottages. Throughout the remainder of the text these three groups will all be referred to as nurses and all will be included in references to the

nursing discipline.

The nurse operates in this setting in much the same way as this profession has traditionally operated. They implement the physicians' orders in administering medication and other forms of treatment; they enforce limits on the patient; assist the patient in his needs and activities of daily living; perform limited diagnostic functions; and maintain continuous daily nursing reports on the patient's condition, attitudes, and behavior in the cottages. There is, of course, twenty-four hour nursing service in each of the cottages under the supervision of a Director of Nurses and a charge nurse in each cottage on each of the three shifts. The total staff of registered nurses numbers 23. There are 38 psychiatric aides and 15 licensed practical nurses who work under the direct supervision of the charge nurses and Director of Nurses.

Media of Case Communication

The word "media" is used here to indicate the various sets of circumstances, situations, or vehicles which make communication between the disciplines a possibility. The phrase "case communication" refers to the transmission of clinical information from one person to another.

Since the scope of this study is limited to verbal case communication between social work and the other disciplines, this section will be limited to a discussion of

media available to social work in communicating with other disciplines. The media of verbal communication have been divided into two general categories of "oral" and "written." Special media in each of these categories are enumerated and described below.

Oral Communication

Planned Meetings and Conferences

The phrase "planned meetings and conferences" will be used to denote regularly scheduled meetings between one or more members of two or more disciplines in which current cases are normally discussed. There are four types of such meetings which the social worker attends. The first is the daily Communications Staff, which is held each morning except Saturdays. This meeting is usually attended by all psychiatrists, social workers, psychologists, trained members of the activities therapies staff, representatives from the nursing staff, and a medical secretary. It is a daily meeting of all the disciplines for the purpose of reading significant nursing notes and activities therapies notes of the previous twenty-four hours, and for sharing any other information that would be of importance to the entire staff. Anticipated admissions and discharges are often mentioned, and patients admitted since the previous meeting are briefly described by the admitting physician.

Another type of planned meeting is the Intake Staff, held twice each week immediately following the morning

Communications Staff. In each of these meetings the cases of two recently admitted patients are reviewed and the patients interviewed briefly, usually by a physician other than their own. Since there is not time available to review the cases of all new patients in this way, they are presented on a selective basis, usually being those for which the psychiatrist has had some reason or desire to seek collective staff opinion in the process of arriving at a diagnosis. The procedure for presenting cases at this meeting includes the presentation of a resume of the social history and present family situation by the social worker, as well as presentations of impressions and observations from each of the other disciplines which has had contact with the patient. About fifteen or twenty minutes are allotted for the review of each case. The Intake Staff is attended by the senior psychiatrist in charge of intake and other staff members directly involved in the cases being presented.

A third type of meeting is the team conference in which each social worker meets individually with each psychiatrist to review the cases they are carrying together as a team. Conferences on cases being carried by a resident psychiatrist or student social worker are also attended by their respective supervisors. Topics discussed in these conferences include the condition and progress of the patient, current attitudes and behavior of the family, the family's response to casework contacts, and the planning of future

treatment. These conferences are held at prearranged times once each week.

The weekly Seminar is the fourth type of planned meeting attended by social workers. This is a two hour conference involving all disciplines and is used primarily for teaching purposes. One current case is presented each week and explored at length in terms of present illness, history, etiology of the problem, psychodynamics involved, treatment possibilities and prognosis. The patient involved is interviewed at length by one of the psychiatrists or psychologists and then by other staff members who wish to ask questions. They are usually patients who have been in treatment for several weeks or more; and, as those presented for Intake Staff, are usually cases in which collective staff discussion and opinion is desired by the managing psychiatrist. The Seminar is conducted by one of the Sanitarium's co-directors in a semi-didactic manner, with focus on theoretical aspects of the problem and efforts toward accumulating as much knowledge and skill as possible from the participating disciplines in the diagnosis and treatment planning for one particular case.

Informal Meetings and Conferences

Another frequently utilized medium of communication is the informal conference with one or more members of other disciplines. The principal difference between the informal conference and the planned meeting is that the

latter is regularly scheduled at specific times on specific days so that it is predictable in its occurrence and purpose, while the former is not. There is a broad range of structure around the informal meeting. This may vary from the conference that is prearranged by the participants as to time, place, and purpose, to the conference that results from a chance meeting of two or more staff members in a hallway, at the lunch table, on the hospital grounds, or elsewhere. With office facilities as closely proximate, and with a relatively small staff working together with a proportionately small number of patients, such meetings of staff members are frequent.

Telephone Conversations

The telephone as a communication medium is used in much the same way as the informal conference described above. However, it is separated for purposes of this study because it was felt by the writer that there might be unique factors involved in its use that would bear examination. There is free telephone access between all professional personnel. Because it spans distance between communicants easily, the telephone provides for at least some communication that would not otherwise exist between staff members located in separate buildings.

The foregoing communication media, it will be noticed, have all been circumstances or situations which act as vehicles for oral ar spoken communication. The following

are brief descriptions of the media for written communication.

Written Communication

Social Service Recording

Social Service recording is maintained in the same file folder as the medical chart and is considered a part of the chart in this setting. It is, therefore, accessible to anyone who is using or is authorized to use the chart. Psychiatrists, psychologists, social workers, and activities therapies personnel have free access to charts and social service recording. Nurses can use them only with special permission. The content of this recording includes the social history, notes on continuing contacts with the patient's family or other interested persons, diagnostic impressions, and social work treatment recommendations. Occasionally recorded summaries of conferences with other disciplines also appear, but these are infrequent.

Medical Charts and Psychological Records

All recording by physicians and psychologists are included in the patient's file folder and are available to social workers at any time. Medical charts include reports of all diagnostic procedures, clinical impressions, diagnoses, and progress notes recorded with varying degrees of frequency during the patient's treatment. Psychological reports are narrative summaries of test results, if a

patient has been referred for psychological evaluation. When a psychologist is seeing a patient in psychotherapy, the psychologist's progress notes are included as a part of the medical progress notes.

Personal Memos

The final media by which clinical information might be communicated is the personal memo; a personnally written note from one staff member to another. Each psychiatrist, social worker, and psychologist, as well as the Director of Nurses and the Director of Activities Therapies, has a personal mailbox where such notes can be deposited and picked up. These memos do not become a part of any permanent record.

Before concluding this chapter it should be noted that the seven media of communication enumerated above, as a part of the description of the setting for this study, will also become an important part of the method for gathering data, which will be dealt with in detail in the following chapter. It is intended that the findings of the study should illustrate, among other factors, "how" and "under what circumstances" communication takes place between Social Work and the other disciplines in this hospital. These questions will be answered mainly in terms of the comparative frequency of use of the various media of communication in this hospital.

CHAPTER III

THE METHOD OF THE STUDY

It was necessary to devise an original technique of gathering data for this study, since no previous studies of this type are available. In view of this fact, the study method will be described in detail below and definitions of terms will be provided. The successful operation of the data gathering technique in this study should make it possible to apply the same technique, with minor modifications, to other settings in which a descriptive study of inter-disciplinary communications is desired.

The Sample

One of the first problems arising in the process of devising a method was whether or not to use some type of sampling procedure; and, if so, how should this be employed. Since this study is concerned with describing the communication of clinical information, and since the patient is at the center of the clinical situation, it was considered essential that the method of this study should enable the findings to offer answers to its fundamental question (who communicates with whom, about what, how, and under what circumstances?) on a patient-centered basis. Figure 1

below illustrates, in a highly simplified manner, the possible relationships between the various disciplines and the patient in terms of direct service to him and his family; as well as the interdependent relationships among the professional groups as they assist each other through the particular contributions of each to the others.

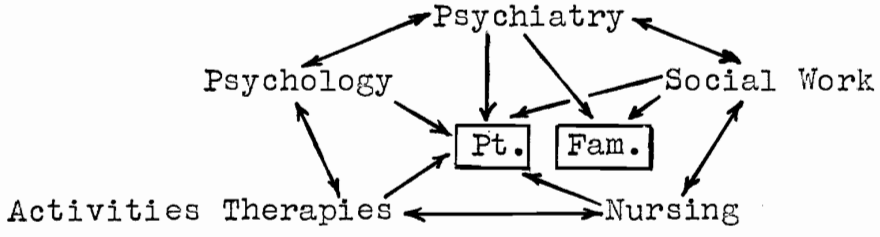

Fig. 1.--Direct service relationships among staff and patient groups.

To the end of obtaining patient-centered data, a sampling was devised by means of which a representative sample of fifteen patients could be selected from the hospital population for study. Several limits and criteria governed this procedure:

1) Only cases being actively carried by the Social Service Department on either a liaison or casework treatment basis will be selected. Therefore, those patients within the total hospital population who do not have interested relatives participating in treatment will not be represented. The reason for this limitation is on the basis of the social service caseload rather than on the basis of the entire hospital population.

2) Only those cases assigned to the two regular staff social workers will be eligible for selection. It was felt that cases assigned to student workers should not be included in the sample because of the liklihood that the students are less familiar

with and less accustomed to the use of communication media within the setting than the staff workers. Therefore, a more accurate picture can be obtained by sampling only those cases carried by staff workers.

3) In order to obtain a sample that would be representative of all phases of treatment within the hospital, the total sample included three equal groups; newly admitted patients (Group I), patients in mid-treatment (Group II), and patients who are nearly ready for release from the hospital (Group III). The average patient's hospitalization falls naturally into these three phases, each phase having a slightly different emphasis or focus, in terms of the work of the clinical team. The first phase is concerned with diagnosis and treatment planning; the second with implementation of the treatment plan; and the third with discharge or pre-release planning. Naturally, these three phases do not have rigidly trichotomous lines of demarcation or mutual exclusivity in actual practice, but rather flow together in an overlapping continuum. Separation of these phases was made arbitrarily in order to show any differences in the quantity and nature of communication between the three phases.

The average stay of a patient in the Sanitarium is about six weeks. The first two weeks were selected as comprising the diagnostic and treatment planning phase. This time period was assumed to contain the Group I, or newly admitted, patients. The second two weeks of hospitalization were likewise selected as the source for Group II, or mid-treatment, patients. However, the selection of Group III patients, those in the pre-release phase, could not be accomplished by this method if the pre-release criterion was to be strictly applied. The mere fact that a patient is in the fifth or sixth week of hospitalization could in no way be considered as an indication that he is

nearly ready for discharge or release from the hospital. Therefore, an alternate method was adopted for the selection of possible Group III patients. All physicians on the staff were asked to submit a list of patients on their caseloads whom they considered to be ready for discharge during a two-week period following the date these lists were requested. From the total number of patients considered ready for discharge within this two-week period the Group III sample was selected.

After a list of patients who were eligible for each of the three groups had been compiled on the basis of the established criteria, the actual sample of five cases in each group were selected at random. Appendix I shows a summary of the sampling procedure as it operated in each group, followed by a brief resume of clinical information fron the chart and social service recording on each patient selected for the final sample.

The Schedule

In order to provide an answer to the fundamental question being asked in this study, a schedule was devised to enable the accumulation of data that would lead to the answer to the four following questions:

1) What medium is being used in each communication?
2) What subject matter, i.e. message content, is being communicated?
3) With whom is the social worker communicating?

4) Which of the communicants is giving out and which is receiving information? (This will be referred to as "direction of information flow.")

Another requirement of the schedule was that it permit simple and quick recording of data so as not to burden excessively the recorder during the period of data gathering.

A tabular form was devised[8] with all communication media described in the preceding chapter listed on the horizontal axis and all possible message content areas listed on the vertical axis. In establishing workable limits for the content areas, it was necessary to consolidate all possible subject matter content of messages into a few all-inclusive areas. Existing communication was observed and recalled from experience to produce what would be an exhaustive list, or an nearly so as possible, of such subjects. These subjects were then categorized into broader content areas into which might be put any future communication. The following is a list of these content areas as used in the schedule, with a brief explanation.

Areas of Communication Content

Description of the Patient

This content area includes any descriptive statement about the patient's present condition, both physical and emotional, and his environmental situation at the time of his coming into the hospital; such as occupation,

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[8] See Appendix I.

family constellation, symptomatic behavior, physical appearance, and age.

Historical Data

This area would include developmental history, family history, pre-morbid personality, medical and psychiatric history, and pertinent detailed description of family members, past relationships of patient, and any other past situational or personal factors pertaining to the patient and his family.

Diagnosis and Dynamics

This would include message content pertaining to medical diagnoses, and statements intending to explain the patient's illness or trace its etiology according to psychodynamic factors involved.

Treatment Planning Decisions

Both day-to-day and long range planning for the treatment of patient and family members would come under this category. Thus, the range of content might vary from particular techniques to be used in psychotherapy to the arrangement of visiting plans.

Description of Patient's Behavior and Activities in the Hospital

Communications concerning a patient's responses to treatment, behavior in the cottage, participation in activities, interpersonal relationships, and attitudes while in the hospital would fall into this category.

Personal Needs of the Patient

Requests for clothing, cigarettes, and other personal items are included here. This category is limited to needs for physical items while the patient is in the hospital.

Description of Relatives' Current Activities and Relationships during the Patient's Hospitalization

This area is comparable to the category above which pertains to the patient's activities while in the hospital, except that here the concern is with communications about the relatives rather than the patient. Since there is considerable interest in the

way the relative relates to the patient in the hospital, as well as the frequent efforts to effect changes in this area, relationships have been mentioned specifically. Such things as current home or job situation, and the relative's response to casework treatment would also be included here.

Discharge Planning for Patient and Family

This category covers such subject matter as preparation of patient and relatives for the return of the patient to his own home, job planning, referral procedures, and planning out-patient follow-up treatment.

This tabular schedule form was set up on a single sheet of paper, with media for oral communication (planned meetings, informal conferences, and telephone converations) on one side and written media (medical charts, psychological records, social service recording, and personal memos) on the other.[9]

Use of the Schedule

The remainder of this chapter will be devoted to a description of the manner in which the schedule was utilized in gathering data about the sample. Communication between the disciplines was broken down into basic units or elements, as they will be referred to, which were used as the quantitative unit of measurement in the study. Data was collected by recording elements of communication under appropriate categories of medium and content on the schedule. An "element of communication" is defined as follows: the

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[9]See Appendix I.

transmission of one item of clinical information within one of the defined areas of message content, through one of the defined communication media, between social work and one other discipline, and with information flowing in only one direction. This definition is of great importance in interpreting the results of the study since the findings will be tabulated and analyzed on the basis of numbers of elements of communication. For further explanation, I have illustrated the use of this unit of measurement and the method of recording data on the schedule by the example below:

> Mr. W, a social worker, is walking down the hallway on his way to his office when he meets Dr. C, the psychiatrist who is treating Mr. X. The wife of this patient is on Mr. W's caseload. The following conversation ensues.
>
> Mr. W: Dr. C, I will be seeing Mrs. X this afternoon and I'm sure she'll be wanting to know how soon she can visit her husband.
>
> Dr. C: She may visit briefly this afternoon, and you can tell her that her husband has improved considerably since I changed his medication last week.

There are a total of three elements of communication in this brief conversation. The first is the social worker's statement to the doctor, which conveys information concerning the relative's activities and relationship to the patient. The second is the physician's stated decision to permit a visit, which would be considered a treatment planning decision (visiting is considered a part of treatment in this setting). The third element is the physician's report that

Mr. X has improved. The content of the latter concerns the patient's response to treatment and therefore would come under the category of descriptions of the patient's behavior in the hospital.

A system of symbols was devised for recording this information on the schedule. Initials were used to identify each profession (D-physician, P-psychologist, S-social worker, AT-activities therapist, and N-nurse), the initials representing the disciplines of the individuals communicating being recorded on the schedule with an arrow between them to indicate the direction of information flow. Thus, the three elements of communication in the informal conference used as an example above would be recorded on the schedule in the following manner.

Fig. 2.--Example of data recording.

Content \ Media	Planned Meetings and Conferences	Informal Meetings and Conferences	Telephone Conversations
Treatment Planning Decisions		D→S	
Description of Patient's Behavior and Activities in Hospital		D→S	
Description of Relative's Activities, etc.		S→D	

This information recorded on the schedule now discloses: 1) who communicated with whom, 2) about what, 3) how, and 4) which communicant gave out and which received information. The sample group or phase of hospitalization that the patient is in would indicate when the communication took place, and the sum of the symbol groups on the schedule reveals the quantity of communication. Therefore, it is now possible, by use of the above illustration, to move towards an answer to the fundamental questions in this study in regard to one example in the process of communication between social work and other professional disciplines.

As described in the preceding chapter this study utilized a sample of fifteen current hospital patients divided into three groups of five cases each. It was my intent in the adoption of this case sample method to obtain a complete record of all communications concerning each case between the social worker and members of other disciplines in the hospital for a specified length of time. A time period of one week was decided upon, since this is the minimum period in which all communication media would have an opportunity to be operative. For example, team conferences and staff seminars are held only once each week; and, therefore, the use of these media would not be represented adequately in the data if a study period of less than one week was adopted. The social worker handling each case being studied was then asked to carry out the major portion

of the data recording.

It was possible for social workers to record all the necessary data on the schedule except for those communications occurring by use of the social service recording media. An element of communication could not be considered complete until another discipline became a participant in the transmission of information. Therefore, information in social service records could not be considered communication until it had been read by a member of another discipline. In order to keep track of how much social service recording was being read, a secondary schedule was devised and affixed to the front cover of the file folder of each of the sample cases. This form requested that anyone reading social service recording identify himself, the date on which the recording was read, and the particular portion of the recording that had been read. At the conclusion of the data gathering period this information was transposed into data appropriate to this study and recorded on the schedules.

The actual data gathering for the study sample was done over a three week period, one group being studied each week. Data was collected on Group I from January 11, 1961, through January 17; on Group II from January 18, through January 24; and on Group III from January 25, through January 31. Each morning during these three weeks the social workers were given a new schedule sheet for each of the patients being studied that week. The workers kept

these schedules with them throughout the day, recording data as communication occurred. At the end of each week summaries were prepared on each individual patient as well as on the group as a whole. At the conclusion of the third week the entire sample was combined and data summarized on the sum combination of all fifteen cases. The following chapter will deal with these summaries and findings.

CHAPTER IV

FINDINGS

Quantity of Case Communications

In the total sample of fifteen cases it was found that one hundred sixty-five (165) elements of communication occurred during the one week of study. Table 1 on the following page shows the quantity of communication for each sample case plus the totals of each group. The cases are arranged in rank order within each group and are identified by the same number used in the case resumes in the appendix. It will also be noticed that there was at least some communication between social work and other disciplines on all but three of the cases in the sample. The one case in Group II on which there was no communication (case number five) involved a patient who was dismissed after three days of study without involving social work activity. The other two cases showing no activity were the cases of patients who had had several previous admissions to the hospital and were well known to the staff members. The social workers dealing with these cases felt that the situations of these patients and their families had undergone no recent changes and no communication between disciplines was necessary during the period studied.

[10]See Appendix II.

TABLE 1

QUANTITY OF CASE COMMUNICATION

Case Number		Number of Elements	
Group I (newly admitted patients)			
2	. . . . .	18	
5	. . . . .	17	
4	. . . . .	15	
3	. . . . .	13	
1	. . . . .	4	
	Total		67
Group II (patients in mid-treatment			
2	. . . . .	35	
1	. . . . .	29	
4	. . . . .	10	
3	. . . . .	3	
5	. . . . .	--	
	Total		77
Group III (pre-release patients)			
1	. . . . .	14	
2	. . . . .	4	
3	. . . . .	3	
4	. . . . .	--	
5	. . . . .	--	
	Total		21
	Total		165

Aside from these somewhat irregular cases, two facts seem to stand out boldly in the above table. First, there is a wide range in the quantity of communication among the individual cases; and, secondly, there is far less communication between social work and other disciplines during the pre-release period of hospitalization (Group III) than during the two earlier periods. If these group totals are converted into percentages it is found that forty and six tenths per cent (40.6%) of all communications pertain

to recently admitted patients (Group I), forty-six and seven tenths (46.7) per cent pertain to patients in mid-treatment (Group II), and only twelve and seven tenths (12.7) per cent pertain to patients in the pre-release phase (Group III) of hospitalization.

In an attempt to determine the reason for the wide range of variability between individual cases in the sample, a comparison was made between those patients who had been previously admitted to the Sanitarium and those who were currently hospitalized here for the first time. It was conjectured that perhaps patients who had been readmitted were better known to the staff members, as is suggested concerning cases four and five of Group III, and therefore required less communication among the disciplines. Table 2 shows the results of this comparison.

TABLE 2

QUANTITY OF COMMUNICATION ON FIRST ADMISSIONS AND READMISSION

Admission Status	Total Cases	Total Elements	Mean Per Case
First admission	8	106	13.2
Readmission	7	59	8.4

This table does show a marked difference in the mean communications per case of the two groups. It is beyond the scope of this study, however, to attempt substantiation of the

above mentioned rationale for this difference. It does seem likely, though, that whether or not a patient had been previously admitted to the Sanitarium would have a considerable effect upon the quantity of communication between social work and the other disciplines while he is in the hospital. This phenomenon suggests the further question of whether or not the readmitted patients receive optimum benefits from the multidiscipline team approach in this hospital. The implication in such a question is, of course, that there may be some direct correlation between the quality of service and the quantity of communication. However, the answer to this, too, is beyond the scope of this study.

In order further to interpret findings on an individual case basis, the following table has been prepared to indicate the mean quantity of communication for a single case over the period of one week during the various phases of hospitalization.

TABLE 3

MEAN FREQUENCIES OF COMMUNICATION PER CASE PER WEEK

Group	Mean Elements Per Case Per Week
I	13.4
II	15.4
III	4.2
All Groups	11.0

On the basis of this information it could be estimated that a social worker carrying an active caseload of forty cases

(about average for this setting) can anticipate that he will be a direct participant in about four hundred forty elements of communication with other disciplines per week (40X11.0=440).

Involvement of Other Disciplines

In examining the data for information regarding the frequency of communication with the various disciplines it is found that the majority of the social workers' inter-disciplinary communication is with the psychiatrists. Table 4 illustrates these comparative frequencies of communication with the other disciplines as they occurred in the three sample groups.

TABLE 4

FREQUENCIES OF COMMUNICATION BETWEEN SOCIAL WORK AND EACH OTHER DISCIPLINE

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	49	48	18	115
Nursing	11	14	1	26
Activities Therapies	6	5	2	13
Psychology	1	10	--	11
Totals	67	77	21	165

If the above figures for "All Groups" are changed into percentages it is found that sixty-nine and seven tenths (69.7) per cent of all communication between Social Work and

other disciplines is with psychiatrists; fifteen and eight tenths (15.8) per cent is with nurses; seven and nine tenths (7.9) per cent with activities therapists; and six and seven tenths (6.7) per cent with psychologists. These percentages remain fairly consistant throughout the three sample groups, and in only two instances does the rank order of the disciplines change. The first of these is in the column, Group II, where there are five more elements involving Psychology than Activities Therapies. This is inconsistant with the findings for the other groups. Further investigation revealed, however, that six of the ten elements involving psychology in that group were regarding one case in which the psychologist was engaged in psychotherapy with the patient. This was the only case in the entire sample in which a psychologist was acting as therapist. The second inconsistancy is in Group III where Activities Therapies is involved in one more element than nursing. There is no apparent explanation for this decrease in the quantity of communication with nurses, except that there is a sharp decline in all communication within Group III. It might be hypothesized, however, that during the final phase of hospitalization the condition of the patient is probably less critical and that he possibly requires less nursing attention and, therefore, less communication of his condition to other staff members. This situation will be investigated further later on in this chapter.

Message Content

One of the main areas of interest in this study is the subject matter or message content of the communication that social work has with the other disciplines; i.e., what kinds of information are communicated and how frequently? Table 5 illustrates this according to the content areas that were established in the preceding chapter.[11] The content areas were arranged in Table 5 according to rank order of frequency for "All Groups." The facts evident from this arrangement point out clearly two of the major responsibilities of the social work discipline in this hospital as described in Chapter II.[12]

TABLE 5

CONTENT OF COMMUNICATIONS

Content	Number of Elements			
	Group I	Group II	Group III	All Groups
Patient's behavior in hospital	23	21	4	48
Relative's current activities	13	11	7	31
Treatment planning	7	15	8	30
Historical data	7	9	--	16
Description of patient	7	8	--	15
Personal needs of patient	6	5	1	12
Diagnosis and dynamics	3	8	--	11
Discharge planning	1	--	1	2
Totals	67	77	21	165

[11] See pp. 26-28.

[12] See pp. 11-13.

The two responsibilities of the social worker emphasized by this table are: 1) the supplying of continuous information to other staff members about the family situation and 2) the acting as a liaison person between family and hospital. Communication about the patient's behavior in the hospital, the most frequent of all content areas, illustrates the important communication link the social worker must have with other disciplines to carry out the latter of these responsibilities. The second most frequent message content, relatives' current activities, likewise points up the communication process necessary in the carrying out of the responsibility for supplying information to other staff members. Later discussion in this chapter concerning the direction of information flow will give additional support to these statements.

In providing rationale for the division of the sample into three groups in Chapter III (pp. 24-25) it was hypothesized that one might anticipate a change of focus in terms of subject matter communicated between the temporal phases of hospitalization. Table 6 on the following page presents the rank order of content areas for each of the three groups to permit a test of this hypothesis.

On first glance there seems to be little evidence in this comparison of rank order content areas to substantiate the notion of changing foci. However, a minor manipulation such as drawing a line under the third item in each group,

TABLE 6

RANK ORDER OF MESSAGE CONTENT AREAS

Group I	Group II	Group III
Patient's behavior in hospital	Patient's behavior in hospital	Treatment planning
Relatives' activities	Treatment planning	Relatives' activities
Treatment planning	Relatives' activities	Patient's behavior in hospital
Historical data	Historical data	Personal needs
Description of patient	Description of patient	Discharge planning
Personal needs of patient	Diagnosis and dynamics	Historical data
Diagnosis and dynamics	Personal needs of patient	Description of patient
Discharge planning	Discharge planning	Diagnosis and dynamics

permits observations that provide at least some support for this hypothesis. It is observed that the three most frequent content areas remain the same in all three groups, although the order among them undergoes some alteration. These three areas then continue to receive the most communication emphasis throughout the patient's hospitalization. This becomes understandable, when more closely examined, since communication about "Patient's behavior in the hospital" and "Relatives' current activities" is essential in carrying out at least two of the social worker's major responsibilities in the hospital, as pointed out above. Since these are continuing functions rather than those which might be relagated to any one phase or time period during

the patient's hospitalization, it is important that communication essential to these functions be of a continuing nature also. The third of these three most frequent content areas in all groups also reflects the ongoing nature of the treatment planning process. Furthermore, "Treatment planning" was originally defined to include day-to-day decisions in the management of the patient and family; thus, by definition, including all continuing efforts to meet daily situations.

If these three content areas, which appear to be of high importance throughout the hospitalization period, are eliminated from the rank order lists (indicated by the underscore in Table 6), it is found that a slightly changing focus does exist among the groups. Communication about "Historical data" and "Description of the patient" occupy a position of relatively high importance through the first two groups, whereas these areas drop to a position of lesser importance in the third group. On the other hand, "Discharge planning" gains in relative position in the third or pre-release group, while it occupies the lowest position in the first two groups. This is hardly conclusive evidence, however, since only two elements of "Discharge planning" communication occurred in the entire study period for all groups. Communication about "Diagnosis and dynamics" seems less frequent in the Group I list than might be expected; but is understandably low in Group III, since there would be less emphasis upon diagnostic formulations when a patient

is nearing his time of release. Again, there are too few data to make these observations reliable.

Another topic of interest within the analysis of message content is the breakdown of frequencies in each content area according to the disciplines with which the social worker communicated. The next eight tables deal independently with each of the message content areas, comparing the frequency of elements between social work and each of the other disciplines in each of the sample groups.

Each of the tables below lists the disciplines in rank order according to the number of elements for "All Groups," or the total sample. In all message content areas but one, "Diagnosis and Dynamics," these rank orders remain the same: 1) Psychiatry, 2) Nursing, 3) Activities Therapies, and 4) Psychology.

TABLE 7

FREQUENCY OF COMMUNICATION: THE PATIENT'S BEHAVIOR AND ACTIVITIES IN THE HOSPITAL

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	13	8	2	23
Nursing	5	8	-	13
Activities Therapies	5	1	2	8
Psychology	--	4	-	4
Totals	23	21	4	48

TABLE 8

FREQUENCY OF COMMUNICATION: RELATIVES' CURRENT ACTIVITIES AND RELATIONSHIPS DURING THE PATIENT'S HOSPITALIZATION

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	13	7	7	27
Nursing	--	2	-	2
Activities Therapies	--	1	-	1
Psychology	--	1	-	1
Totals	13	11	7	31

TABLE 9

FREQUENCY OF COMMUNICATION: TREATMENT PLANNING

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	7	15	8	30
Nursing	-	--	-	--
Activities Therapies	-	--	-	--
Psychology	-	--	-	--
Totals	7	15	8	30

TABLE 10

FREQUENCY OF COMMUNICATION: HISTORICAL DATA

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	4	5	-	9
Nursing	1	2	-	3
Activities Therapies	1	1	-	2
Psychology	1	1	-	2
Totals	7	9	-	16

TABLE 11

FREQUENCY OF COMMUNICATION: DESCRIPTION OF THE PATIENT

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	7	2	-	9
Nursing	-	2	-	2
Activities Therapies	-	2	-	2
Psychology	-	2	-	2
Totals	7	8	-	15

TABLE 12

FREQUENCY OF COMMUNICATION: PERSONAL NEEDS OF THE PATIENT

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	1	5	-	6
Nursing	5	-	1	6
Activities Therapies	-	-	-	-
Psychology	-	-	-	-
Totals	6	5	1	12

TABLE 13

FREQUENCY OF COMMUNICATION: DIAGNOSIS AND DYNAMICS

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	3	6	-	9
Activities Therapies	-	2	-	2
Psychology	-	2	-	2
Nursing	-	-	-	-
Totals	3	10	-	13

TABLE 14

FREQUENCY OF COMMUNICATION: DISCHARGE PLANNING

Discipline	Number of Elements			
	Group I	Group II	Group III	All Groups
Psychiatry	1	-	1	2
Nursing	-	-	-	-
Activities Therapies	-	-	-	-
Psychology	-	-	-	-
Totals	1	-	1	2

In four of the content areas (Tables 9, 12, 13, and 14) it is observed that one or more of the disciplines has no communication with Social Work. These areas of non-activity seem to indicate something about the way in which these disciplines function in relation to Social Work. Table 9 shows that nurses, psychologists, and activities therapists had no communication with social workers about treatment planning. In practice, it is a fact that members of these disciplines have no responsibility for treatment planning (except in the rare instances when a psychologist is undertaking psychotherapy with a patient). They act, instead, in capacities of advising the other team members, relating information to them and implementing already formulated treatment plans. Psychiatrists always have the primary responsibility for planning the treatment approach to a patient and his family. However, much of the responsibility

for family treatment, and the planning thereof, is usually delagated to a social worker. As might be expected, considerable communication activity between social workers and pcychiatrists appears to exist in this area.

Similarly, psychologists and activities therapists have little or no responsibility for meeting or dealing with the personal needs of the patient (Table 12), whereas this is one of the primary responsibilities of the nursing staff. In Table 13 a question might be raised about paucity of communication between Social Work and Psychology in the area of "Diagnosis and Dynamics," since only two elements were reported. The use of psychological tests and the implications of test results in formulating dynamic and diagnostic information is, purportedly, the main function of the Psychology Department. One might, therefore, expect more communication with psychologists in regard to this type of information than appears in these findings. It must be remembered, however, in raising any such question, that this study is dealing with direct communication only. It is possible that information from the Psychology Department, or any other original source, may reach the social worker by a circuitous route through other disciplines.

Communication about "Discharge Planning," like "Treatment Planning" occurred with psychiatrists only, and on a limited basis during the study period. Actually discharge planning should be considered an area of treatment planning

and, therefore, does not involve the participation of members of the other disciplines except as they are needed to implement plans. The implementation of Social Work treatment plans does not require the direct participation of other disciplines since they do not deal with the family of the patient. It is noteworthy, though, that "Discharge Planning" receives so little communication even with Psychiatry, while the broader area of "Treatment Planning" is the content area in which communications with Psychiatry are most numerous. Probably one of the most significant factors relating to this phenomenon of low frequency in the "Discharge Planning" area is the practice of referring patients back to the family physician after discharge. Over ninety per cent of the patients admitted to the Sanitarium are referred there by physicians.[13] In keeping with medical ethics, these patients are referred back to their referring doctors when released from the hospital. If the physician happens to be a psychiatrist, the Sanitarium generally assumes no responsibility for out-patient follow-up. Therefore, in most cases, there is very little choice available to the Sanitarium about the nature of post-hospital treatment. This, then, might be construed as a reason for social workers not to engage in extensive discharge planning with the other disciplines.

The following four tables present the data about message content in a slightly different way from those above,

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[13] Wheatley, op. cit., p. 16.

to enable easy recognition of the content areas most frequently occurring in communications with each of the disciplines. The content areas are arranged in rank order for the "All Groups" column in each table. Percentages represent the per cent of total communication with that discipline in each of the content areas.

TABLE 15

FREQUENCY OF COMMUNICATION WITH PSYCHIATRY IN THE VARIOUS MESSAGE CONTENT AREAS

Content	Number of Elements				Per Cent
	Group I	Group II	Group III	All Groups	
Treatment planning	7	15	8	30	26.1
Relatives' current activities	13	7	7	27	23.5
Patient's behavior in hospital	13	8	2	23	20.0
Historical data	4	5	-	9	7.8
Description of patient	7	2	-	9	7.8
Diagnosis and dynamics	3	6	-	9	7.8
Personal needs of patient	1	5	-	6	5.2
Discharge planning	1	-	1	2	1.7
Totals	49	48	18	115	100.0

TABLE 16

FREQUENCY OF COMMUNICATION WITH NURSING IN THE VARIOUS MESSAGE CONTENT AREAS

Content	Number of Elements				Per Cent
	Group I	Group II	Group III	All Groups	
Patient's behavior in hospital	5	8	-	13	50.0
Personal needs of patient	5	-	1	6	23.1
Historical data	1	2	-	3	11.5
Relatives' current activities	-	2	-	2	7.7
Description of patient	-	2	-	2	7.7
Treatment planning	-	-	-	-	---
Diagnosis and dynamics	-	-	-	-	---
Discharge planning	-	-	-	-	---
Totals	11	14	1	26	100.0

TABLE 17

FREQUENCY OF COMMUNICATION WITH ACTIVITIES THERAPIES IN THE VARIOUS MESSAGE CONTENT AREAS

Content	Number of Elements				Per Cent
	Group I	Group II	Group III	All Groups	
Patient's behavior in hospital	5	1	2	8	61.5
Historical data	1	1	-	2	15.4
Description of patient	-	2	-	2	15.4
Relatives' current activities	-	1	-	1	7.7
Treatment planning	-	-	-	-	---
Personal needs of patient	-	-	-	-	---
Discharge planning	-	-	-	-	---
Totals	6	5	2	13	100.0

TABLE 18

FREQUENCY OF COMMUNICATION WITH PSYCHOLOGY IN THE VARIOUS MESSAGE CONTENT AREAS

Content	Number of Elements				Per Cent
	Group I	Group II	Group III	All Groups	
Patient's behavior in hospital	-	4	-	4	36.4
Historical data	1	1	-	2	18.2
Description of patient	-	2	-	2	18.2
Diagnosis and dynamics	-	2	-	2	18.2
Relatives' current activities	-	1	-	1	9.1
Treatment planning	-	-	-	-	---
Personal needs of patient	-	-	-	-	---
Discharge planning	-	-	-	-	---
Totals	1	10	-	11	100.0

Direction of Information Flow

It is now possible to elaborate further upon the communication process between Social Work and the other disciplines at this hospital. The tables in this section depict the quantities of clinical information transmitted from social workers to members of other disciplines, and from the other disciplines to Social Work. This is being referred to as "direction of information flow" and will be analyzed by determining in how many elements of communication during the study period the social worker gave out information and in how many he received information. Table 19 on the following page shows this data for the various message

TABLE 19

DIRECTION OF INFORMATION FLOW

Content	Number of Elements									
	Group I		Group II		Group III		All Groups			
							Number		Per Cent	
	G[a]	R[b]	G	R	G	R	G	R	G	R
Historical Data	7	-	9	1	-	-	15	1	93.8	6.2
Relatives' Current Activities	13	-	10	1	6	1	29	2	93.5	6.5
Diagnosis and Dynamics	2	1	4	4	-	-	6	5	54.5	45.5
Description of Patient	4	3	4	4	-	-	8	7	53.3	46.7
Personal Needs of Patient	3	3	2	3	1	-	6	6	50.0	50.0
Discharge Planning	1	-	-	-	-	1	1	1	50.0	50.0
Treatment Planning	3	4	7	8	2	6	12	18	40.0	60.0
Patient's Behavior in Hospital	2	21	7	14	-	4	9	39	18.8	87.2
Totals	35	32	42	35	9	12	86	79	52.1	47.9

[a]G--elements in which the social worker gives information.

[b]R--elements in which the social worker receives information.

content areas and sample groups. Percentage figures in the "All Groups" column refer to the percentage of all elements in each content area in which the social worker gave out or received clinical information.

The message content areas in Table 19 are listed in rank order of percentage of elements in which the social worker gave out information for "All Groups" (i.e., the content area in which the social worker gives out the highest percentage of elements is listed first, etc.). For all communication in the study social workers gave out information in fifty-two and one tenth (52.1) per cent of the elements, and received information in forty-seven and nine tenths (47.9) per cent of the elements. In general, then, there is a fairly even give and take relationship between Social Work and the other disciplines in this hospital.

Of the three content areas having the greatest number of total elements are examined individually, it is found that Social Work supplied information about "The Patient's Behavior and Activities in the Hospital" in only eighteen and eight tenths (18.8) per cent of the elements; but gave out information about "Relatives' Current Activities and Relationships during Patient's Hospitalization" in ninety-three and five tenths (93.5) per cent of the elements. This, even more clearly than before, points up the functions of the social worker in working with the family members and in supplying information to the other disciplines. Since the

social worker has little or no contact with the patient, it is important that he have a continuing supply of information about "The Patient's Activities and Behavior in the Hospital" in order adequately to carry out his liaison function. Table 19 shows that eighty-seven and two tenths (87.2) per cent of the elements in this content area are communications in which Social Work receives information.

The third of the three most frequently occurring content areas is "Treatment Planning Decisions." This is an area in which communication existed with Psychiatry only.

It is found that a forty-sixty ratio exists between information given out and information received by the social workers in this area. The fact that social workers gave out information in forty (40) per cent of the elements seems to suggest that, although the psychiatrist has ultimate and overall responsibility for treatment and patient or client management, the social worker is contributing actively to the planning process and is making his decisions known to the medical staff.

The one other area which deviates from a nearly fifty-fifty give and take relationship with the other disciplines is "Historical Data," wherein the percentage of elements in which Social Work gives out information is highest of all the content areas (93.8%). The reason for this is probably the fact that the social worker is responsible for gathering information about the history of the

patient and family, especially social history. Therefore, it might be expected that most communication about historical data would involve a sharing of this information by social workers with staff of other disciplines.

Table 20 presents the direction of flow for each of the disciplines. Percentages of flow in both directions remain approximately the same for all three sample groups, so only those figures for the total sample are presented.

TABLE 20

DIRECTION OF INFORMATION FLOW WITH EACH DISCIPLINE

Discipline	Given		Received	
	Elements	Per Cent	Elements	Per Cent
Psychiatry	62	53.9	53	46.1
Nursing	13	50.0	13	50.0
Activities Therapies	4	30.8	9	69.2
Psychology	7	63.6	4	36.4
Totals	86	52.1	79	47.9

In all communications with psychiatrists, social workers give out information in slightly more elements than those in which information was received. With nurses there is an even split of information flow; fifty (50) per cent of the elements giving out information and fifty (50) per cent receiving. Communications with Activities Therapies and Psychology, however, did not show these nearly equal quantities of information given out and information received.

Social workers received information in sixty-nine and two tenths (69.2) per cent of the elements involving Activities Therapies, and gave out information in sixty-three and six tenths (63.6) per cent of the elements involving Psychology.

Use of Communication Media

The final topic to be discussed in this chapter is the question about the situations or circumstances under which all this communication took place. In other words, by what media does Social Work communicate with the other disciplines? There were seven specific verbal media considered possible for use,[14] and these fell into the broad categories of written and oral communications.

Table 21 shows the frequency with which each of these media was used in each sample group and the percentage of total elements in that group occurring in each medium. The most obvious fact shown by this table is the predominance of oral communication. Eighty-one and two tenths (81.2) per cent of all elements reported in the study fell into this category, while only eighteen and eight tenths (18.8) per cent of the elements were communicated through written media. Furthermore, the oral communication is almost completely limited to meetings and conferences, planned and informal, since the amount of telephone communication is quite insignificant (2.4%). This predominance of oral communication

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[14] See pp. 16-21.

TABLE 21

NUMBER AND PER CENT OF ELEMENTS COMMUNICATED THROUGH THE VARIOUS MEDIA

Medium	Group I		Group II		Group III		All Groups	
	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Oral								
Planned meetings	24	35.8	45	58.4	6	28.6	75	45.5
Informal conferences	20	29.9	23	29.9	12	57.1	55	33.3
Telephone	3	4.5	1	1.3	--	----	4	2.4
Totals	47	70.1	69	89.6	18	85.7	134	81.2
Written								
Social service records	14	20.9	4	5.2	--	----	18	10.9
Personal memos	5	7.5	3	3.9	3	14.3	11	6.7
Medical charts	1	1.5	--	----	--	----	1	.6
Psychological reports	--	----	1	1.3	--	----	1	.6
Totals	20	29.9	8	10.4	3	14.3	31	18.8
Totals	67	100.0	77	100.0	21	100.0	165	100.0

continues throughout all three phases of hospitalization, though it does vary from seventy and one tenth (70.1) per cent in Group I, to eighty-nine and six tenths (89.6) per cent in Group II. Another fact in this table that bears note is the gradual decrease in the use of social service records, from twenty andnine tenths (20.9) per cent of the elements in Group I to zero in Group III. A likely explanation for this is the fact that during the early period of hospitalization there is an interest in gathering information about the patient and his problem. Much of this information

is found in the social history section of the social service records. The next table provides additional information about the use of these records in that the only discipline that communicated with Social Work through this medium was Psychiatry.

TABLE 22

THE USE OF COMMUNICATION MEDIA WITH INDIVIDUAL DISCIPLINES

Medium	Discipline							
	Psychiatry		Nursing		Activities Therapies		Psychol.	
	No	Per Cent	No	Per Cent	No	Per Cent	No	Per Cent
Oral								
Planned meetings	41	35.7	15	57.7	11	84.6	8	66.7
Informal conferences	44	38.3	7	26.9	2	15.4	2	16.7
Telephone	--	----	4	15.4	--	----	--	----
Totals	85	73.9	26	100.0	13	100.0	10	83.3
Written								
Social service records	18	15.7	--	----	--	----	--	----
Personal memos	11	9.6	--	----	--	----	--	----
Medical charts	1	.9	--	----	--	----	--	----
Psychology reports	--	----	--	----	--	----	1	8.3
Totals	30	26.1	--	----	--	----	1	8.3
Totals	115	100.0	26	100.0	13	100.0	12	100.0

Table 22 shows the comparative use of the various media by breaking down the total number of elements occurring in each medium into the number of elements communicated with each discipline through that medium. The accompanying percentages indicate the per cent of total elements

communicated with each discipline. In other words, the figure "35.7" at the top of the "Psychiatry" column means that thirty-five and seven tenths per cent of all elements of communication with psychiatrists took place through the medium of "Planned meetings." This table again shows the preponderance of communication between social workers and psychiatrists as compared to that between social workers and members of the other disciplines. It is also shown that although most (73.9%) communication with psychiatrists is through oral media, the "Psychiatry" column is the only one containing figures to indicate any substantial amount of written communication. Psychiatry was the only discipline that read any social service recording or exchanged personal memos with Social Work. As was indicated previously in Table 21, it was found that social workers made almost no use of medical charts as a medium of direct communication.

In communicating with nurses, oral media were used exclusively; and mostly the particular medium of "Planned meetings" (57.7%). It is also observed that Nursing is the only discipline with whom social workers communicated by telephone. The probable reason for this is that if a social worker wished a quick brief report concerning a patient he would usually call the charge nurse in the patient's cottage. In light of the frequent planned and informal meetings between the disciplines, it seems that social workers have recognized little other need to utilize telephone communication.

Communication with Activities Therapies was entirely limited to oral exchange in planned and informal meetings. This was also the case in communication with Psychology, except for the occurrence of one element through the media of written "Psychology reports."

CHAPTER V

SUMMARY AND CONCLUSIONS

This study has attempted to describe certain phenomena associated with verbal and written communications about in-patient cases between social workers and members of other professional disciplines in a private neuro-psychiatric hospital. The communications studied were limited in content to the exchange of clinical information, thus excluding such matters as policy and personnel problems and practices. The other professional disciplines involved were: psychiatrists, psychologists, nurses (including aides and Licensed Practical Nurses), and activities therapists.

The study was organized around the answering of a fundamental question in the field of communication: "Who communicates with whom, about what, when and how, and under what circumstances?" This question implies certain variables in the communication process, such as categories of message content, direction of information flow, and possible communication media. These were defined as they pertained to the various sections of the question and the setting of the study.

A schedule was designed on which elements of communication could be recorded in such a way as to indicate the variable factors present in each element. It is necessary

to stress the definition of the element-unit once again, because of its importance in the interpretation of data presented by the study. The "element" was established as the basic and smallest unit of communication between two disciplines. It is limited to one item of communicated information which falls into no more than one of the categories of message content, takes place through not more than one medium of communication, and which involves no more than one discipline in addition to Social Work as a direct participant.

The data for this study was gathered by the use of a case sample method. The sample was limited to fifteen inpatient cases that were being actively carried by either of the two regular social service staff members. In order to explore the effect of variable length of stay in the hospital, this sample was divided into three equal groups of five cases, one group from each of three phases of treatment: newly admitted patients, in the first two weeks of their hospital stay; patients in the mid-treatment phase, who had been in the hospital more than two but not more than four weeks; and patients who were considered by their staff physicians to be ready for release from the hospital within the next two weeks.

The sample, having been selected on the bases of these criteria, was then studied for one week, during which time all communication between social workers and members of other

disciplines was recorded on the schedule. This recording was done, for the most part, by the social worker assigned to each case in the sample. Each element of communication was recorded separately, by use of a system of symbols, so that the variable factors operating in each element could be determined, and so that the number of elements occurring under each variable condition could be counted. The following is a complete list of variable factors which the data collecting process determined for each element of communication.

1. Discipline with which Social Work communicated.
   a. Activities Therapies
   b. Nursing (including Registered Nurses, Licensed Practical Nurses, and Psychiatric Aides)
   c. Psychiatry
   d. Psychology
2. General area of subject matter communicated.
   a. Description of the patient
   b. Diagnosis and dynamics
   c. Discharge (pre-release) planning
   d. Historical data
   e. Patient's behavior and activities in the hospital
   f. Personal needs of the patient
   g. Relatives' activities and relationships during the patient's hospitalization.

h. Treatment planning

3. Direction of information flow between communicating disciplines.
   a. Social Work gives out information
   b. Social Work receives information
4. Phase of hospitalization during which communication took place.
   a. First two weeks of hospitalization--newly admitted phase
   b. Second two weeks of hospitalization--mid-treatment phase
   c. Final two weeks of hospitalization--pre-release phase
5. Medium through which communication took place.
   a. Oral
      1) Informal meetings and conferences
      2) Planned meetings and conferences
      3) Telephone conversations
   b. Written
      1) Social service records
      2) Medical charts
      3) Psychological reports
      4) Personal memos

By counting elements it was also possible to establish the variable of "quantity of communication" under each of the above conditions or situations.

The findings of the study indicate that all communications in the three sample groups totaled one hundred sixty-five (165) elements for the week of study. This amounts to an average of eleven (11) elements of Social Work communication per case per week. These figures changed somewhat between the three sample groups, showing an average of thirteen and four tenths (13.4) elements per case during the newly admitted phase, fifteen and four tenths (15.4) elements per case during the mid-treatment phase, and four and two tenths (4.2) elements per case during one week of the pre-release phase. Thus, communication between social workers and other disciplines seems to reach a peak during the middle part of the patient's hospitalization, and appears to be at its lowest level of frequency during the final or pre-release phase.

The following paragraphs will be given to a description of Social Work communication with each of the four other disciplines individually.

Communication with Psychiatry

The discipline most frequently communicated with was Psychiatry, by a wide margin. Sixty-nine and seven tenths (69.7) per cent of all communication during the study week was between social workers and psychiatrists. Further breakdown shows that subject matter exchanged with this discipline included all possible content areas. However, communications

in three out of the eight content areas stand out as having occurred much more frequently than the others. These areas are: "Treatment Planning Decisions," "Relatives' Current Activities," and "Patient's Behavior in the Hospital." These three areas combined, total about seventy (70) per cent of the communication with Psychiatry. Notably low among the content areas was "Discharge Planning" with only two elements or one and seven tenths (1.7) per cent of the total elements with this discipline.

It was also found that the amount of communication with Psychiatry varied between the sample groups, nearly all elements being confined to Groups I and II. Out of the total of one hundred fifteen elements occurring in all groups, forty-nine of these (42.6%) were about newly admitted patients, forty-eight (41.7%) about patients in mid-treatment, and only eighteen (15.7%) about pre-release patients.

In regard to direction of information flow in communications with psychiatrists, a fairly even balance was seen. The social worker gave out information in fifty-three and nine tenths (53.9) per cent of the total elements communicated, and received information in forty-six and one tenth (46.1) per cent.

All available media of communication, except the telephone, were utilized in exchanging information with psychiatrists. The largest portion, however, took place orally in informal conferences (38.3%) and planned meetings

(35.7%). There was some use made of social service records and personal memos, but only one element occurred through use of medical charts by social workers.

In regard to "Psychiatry," then, a general answer to the fundamental question of the study might be stated as follows: Social Work communicates with Psychiatry much more frequently than with any other discipline. All kinds of clinical information are exchanged, but the most frequent subjects are treatment planning, relatives' current activities, and the patient's behavior in the hospital. Most communication with psychiatrists takes place during the first four weeks of hospitalization by oral media in informal and planned meetings or conferences.

Communication with Nursing

The discipline with which Social Work communicated second most frequently was Nursing, accounting for fifteen and eight tenths (15.8) per cent of all communication. In communications with this discipline it was found that the highest frequency of elements was in the content area of "Patient's Behavior in the Hospital." This area accounted for fifty (50) per cent of all communication with nurses. The content area occurring second most frequently was "Personal Needs of the Patient" (23.1%). Smaller numbers of communication elements also existed with regard to "Historical Data," "Relatives' Current Activities," and "Description

of the Patient"; but there were none about "Treatment Planning," "Diagnosis and Dynamics," and "Discharge Planning."

As with psychiatrists, communication with nurses was much more frequent during the first and second phases of hospitalization than in the third. Out of the total of twenty-six elements exchanged with Nursing, eleven (42.3%) of these occurred in the newly admitted phase, fourteen (53.8%) during the mid-treatment phase, and only one element (3.8%) in the pre-release phase.

In the total communications with nurses it was found that there was an exactly even exchange of information in regard to the direction of information flow. Fifty (50) per cent of the elements contained information given out by the social worker and fifty (50) per cent contained information given out by the nurse. It was also found that all communication with this discipline was confined to oral media. Fifty-seven and seven tenths (57.7) per cent took place in planned meetings, twenty-six and nine tenths (26.9) per cent in informal conferences, and fifteen and four tenths (15.4) per cent over the telephone. Nursing was the only discipline with which Social Work communicated by telephone during the period of the study.

A general answer might now be given to the fundamental question in regard to communication between Social Work and Nursing. Nurses are the professional group second most frequently communicated with by social workers in the

hospital, and account for about sixteen (16) per cent of the total. Information exchanged with them centered mostly around the patient's behavior in the hospital and personal needs of the patient; and occurs almost entirely during the first four weeks of hospitalization. All information was communicated through oral media, the largest number of elements having occurred during planned meetings, and communication was characterized by an even exchange of information between the two disciplines.

Communication with Activities Therapies

As the third discipline in frequency of communication with Social Work, Activities Therapies participated in seven and nine tenths (7.9) per cent of all communication during the period of the study. The subject matter most frequently discussed was "Patient's Behavior in the Hospital," representing sixty-one and five tenths (61.5) per cent of the total thirteen (13) elements. A small amount also occurred in the areas of "Historical Data," "Description of the Patient," and "Relatives' Current Activities," but none in the five remaining content areas.

Most of the elements of communication that occurred between social workers and activities therapists took place during the first two phases of hospitalization. Out of the thirteen elements, six were about newly admitted patients, five about patients in mid-treatment, and two elements were about patients in the pre-release phase.

In examining the direction of information flow for this discipline it was found that social workers received more information than they gave out. Sixty-nine and two tenths (69.2) per cent of the elements contained information given out by the activities therapists, whereas the social worker gave information in thirty and eight tenths (30.8) per cent of the elements.

Media used in communicating with Activities Therapies was limited to the general area of oral communication, and specifically to planned meetings (84.6%) and informal conferences (15.4%).

In summary, then, it was found that about eight (8) per cent of all Social Work communication occurred with Activities Therapies, the third most frequently communicated with discipline in the hospital. Most communication with activities therapists was about the patient's behavior in the hospital, and occurred almost entirely during the first four weeks of hospitalization. Oral communication during planned meetings accounted for the largest part, though there was also some use of informal conferences; and Social Work received more than twice as much information from Activities Therapies than it gave out.

Communication with Psychology

Psychologists were the group least frequently communicated with; totaling eleven elements during the week, or six

and seven tenths (6.7) per cent of all Social Work communication. The largest quantity occurred in the content area of "Patient's Behavior in the Hospital" (36.4%). There was also a small number of elements about "Historical Data," Description of the Patient," "Diagnosis and Dynamics," and "Relatives' Current Activities," but none in the other content areas of "Treatment Planning," "Discharge Planning," or "Personal Needs of the Patient."

All but one of the elements of communication with psychologists occurred during the second or mid-treatment phase of hospitalization, that one element being about a patient in the newly-admitted phase. In the information exchanged between psychologists and social workers it was also found that in sixty-three and six tenths (63.6) per cent of the elements social workers gave out information, while psychologists gave information to social workers in thirty-six and four tenths (36.4) per cent of the elements.

The media of communication utilized with Psychology were, again, almost exclusively limited to oral communication in planned meetings (72.7%) and informal conferences (18.2%). The only use of another medium was in the occurence of one element through the reading of a Psychological Report.

On the basis of these findings it is possible to answer the fundamental question in regard to Psychology. Social Work communication with Psychology is less frequent than is Social Work communication with any of the other disciplines;

it is mostly in the form of oral exchange about patients' behavior in the hospital during planned meetings, with the social worker giving out information to the psychologist almost twice as often as the psychologist gives information to the social worker.

Total Communications between Social Work and Other Disciplines

By combining the information found in regard to communication with each discipline individually, it is possible to describe all of Social Work's interdisciplinary communication occurring during the period of the study. The relative frequency of communication with the individual disciplines has already been indicated, so the statements in this section will be concerned with the other variables only. Figure 3 illustrates part of the communication prelationship between Social Work and the other four disciplines. The arrowheads indicate direction of information flow, and the thickness of the lines shows the relative quantity of communication that occurred in the period of the study.

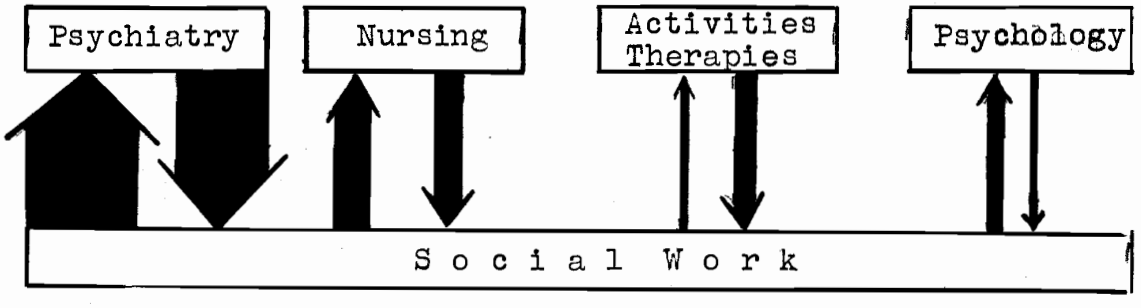

Fig. 3.--Flow of information between Social Work and the other disciplines.

The most frequent message content communicated was in the area of "Patient's Behavior in the Hospital." Twenty-nine and one tenth (29.1) per cent of the total one hundred sixty-five (165) elements occurred in this area. Two other areas also stand out as the second and third most frequently communicated kinds of information. Eighteen and eight tenths (18.8) per cent of the elements were in regard to "Relatives' Current Activities," and eighteen and two tenths (18,2) per cent were about "Treatment Planning." Other content areas accounted for between five and ten per cent each of all elements, with the exception of "Discharge Planning" which was the least frequent, occurring in only two elements out of the total.

The greatest quantity of communication took place during the mid-treatment phase of hospitalization. Seventy-seven elements, or forty-six and seven tenths (46.7) per cent of the communication took place during this phase. The newly admitted patients accounted for sixty-seven elements or forty and six tenths (40.6) per cent, while the pre-release group was least frequently communicated about with twenty-one elements or twelve and seven tenths (12.7) per cent of the total.

The overall direction of information flow was quite evenly balanced. In fifty-two and one tenth (52.1) per cent of the elements social workers gave out information to the other disciplines, and received information in forty-seven

and nine tenths (47.9) per cent of the elements. These percentages changed only slightly in the first and second phases of hospitalization. In the third, or pre-release phase, however, social workers gave out less information (42.9%) than they received (57.1%).

The circumstances or situations under which this interdisciplinary communication took place indicates a marked preference for oral media. The most frequently used medium was the planned meeting, in which forty-five and five tenths (45.5) per cent of all communication occurred. Thirty-three and three tenths (33.3) per cent came about through informal conferences, and two and four tenths (2.4) per cent over the telephone; accounting for a total of eighty-one and two tenths (81.2) per cent occurring in the oral media. The written communication, then, amounted to eighteen and eight tenths (18.8) per cent of the total; most of which occurred through the use of social service records (10.9%) and personal memos (6.7%). Use of medical charts and psychological reports was limited to only one element of communication each. The relative use of these media did not change markedly between the three phases of hospitalization, except in two instances. First, there was a steady decrease in the use of social service records from twenty and nine tenths (20.9) per cent on the newly admitted phase to zero in the pre-release group. Second, there was a sharp rise in

the use of the informal conference medium in the pre-release phase accompanied by a decline in the use of planned meetings.

In summarizing the response to the fundamental question of the study in regard to all communication between Social Work and the other disciplines, it might now be said that social workers communicate with all disciplines, but primarily with psychiatrists and, in decreasing amounts, with nurses, activities therapists, and psychologists. Most of this is oral communication taking place during the first four weeks of a patient's hospitalization, and most frequently involves the exchange of information about the patient's behavior in the hospital, the relatives' current activities, and treatment planning. The information is exchanged on an almost equal give and take basis, with social workers giving out a slightly larger amount of information than they receive from the other disciplines.

Other Factors

During the course of the study there was some attempt made to identify certain factors which may have an effect upon communication activity. One of these attempts was concerned with the amount of time a patient has spent in the hospital. It was hypothesized that at different points during hospitalization there would be different foci in the subject matter communicated about any one patient. The sample was divided into three patient groups for this purpose; one group representing newly admitted patients, another

representing patients in the middle phase of treatment, and a third group representing patients in the final or pre-release phase of hospitalization. It was found that the three areas of subject matter communicated most frequently remained the same in each of the three sample groups. These were the areas of "Patient's Behavior in the Hospital," "Relatives' Current Activities," and "Treatment Planning." However, the less frequently communicated subject matter areas did show some shift in focus. "Historical Data" and "Description of the Patient" were in relatively important positions during the first two phases, but became less important during the pre-release phase. Communication about "Diagnosis and Dynamics" also shows up as more important during the first two phases, whereas "Discharge Planning" gains proportionately in the final phase.

Another question was raised concerning the comparative frequency of communication about patients admitted to the hospital for the first time and patients who had returned for one or more readmissions. It was found that a significant difference did exist; since there was an average of thirteen and two tenths (13.2) elements per patient among the first admissions, but only eight and four tenths (8.4) elements per each readmitted patient during the week of study. It was concluded that this factor plus the practice of referring patients back to their family physician after discharge, probably were major contributing factors to the

infrequent communication about the pre-release group and the content area of "Discharge Planning."

Intrastaff Attitudes and Possible Bias of the Study

I feel that some final comments should be made, which are admittedly subjective impressions, about the general atmosphere of interpersonal relationships amongst the staff personnel of this hospital. The staff relationships and attitudes should be taken into consideration when interpreting the findings of this study, or when attempting to compare them with findings of any similar future study undertaken in another setting.

My dominant impression of this staff is that it operates at a particularly high level of maturity. There is much warmth and acceptance among the staff members, both toward each other and in their relationships with patients. There is little of the interdisciplinary competition and hostility seen in many psychiatric settings. For these reasons the communication in this hospital is probably more efficient and free flowing than in most other hospitals, especially the larger governmental institutions. These factors plus the small size of the hospital would then be expected to introduce a bias into the findings of this study as compared with a similar study in a psychiatric hospital of another type. This bias is probably especially significant in the media of informal meetings and conferences,

which are relied upon to a large extent in this setting.

Some Final Observations

It is the impression of the writer, based upon several months' experience as a student member of this hospital staff, that the results of the study represent a fairly accurate picture of communications between social workers and members of the other disciplines. However, it is also felt that the total frequency of elements was probably too low to guarantee a high degree of reliability. Since no other studies of this type were found available for comparison purposes it is impossible to present the findings of this study in light of an established set of findings on other patient groups or other hospitals. However, suggestions for further study in this area would include the use of a larger sample and longer period of study to promote greater reliability of findings.

One of the purposes of this study was to devise a study method and test its use. The method was particularly satisfactory in permitting the amassing of a large amount of data with relatively little effort on the part of the recorder. This was due to the type of schedule used and the use of symbols in recording, which enabled all aspects of an element of communication to be noted by merely writing two letters and an arrow in the proper place on the schedule. On the other hand, it was necessary for the recorder to use

subjective judgments in many instances, mostly in assigning an element of communication to one of the established message content areas. It was impossible to predict in advance the content of all communications during the study period, so when elements occurred that were of borderline or questionable content the recorders were told to use their own judgments. Perhaps revision of the content areas, themselves, would correct this difficulty.

The unit of communication referred to as the "element" seemed to be a useful and accurate measuring device; although it was necessary for a recorder to be very alert in order to prevent overlooking some elements.

This study has described only one small segment of case communication within a small neuro-psychiatric hospital. Before a complete description of interdisciplinary communications could be obtained it would be necessary to also study the exchange of information between other disciplines in the hospital, and between the disciplines in other settings. Even if this were accomplished, the result would be only a superficial quantitative description of communication processes in the psychiatric setting.

In the development of any measurement technique it is necessary to begin on an elementary level. First, the presence or absence of variables must be determined; followed by a classification process and further refinement to determine such things as significant qualitative value

judgments, and propriety in the use of variables being studied. This study has covered the basic steps, methodologically speaking, by establishing the presence or absence of variables, classifying variables according to type and rank order, and by indicating certain relationships between disciplines on the basis of these classifications and quantitative values. Further refinement of the measuring technique would be necessary, however, before data could be obtained on which to base interpretations of the significance and qualitative value of the communication practices described in this study. It would be erroneous to attempt any such interpretations on the basis of a quantitative analysis alone. There are no data in this study, or anywhere else, to substantiate a conclusion that ten elements of communication are necessarily better than one.

On the other hand, it is a truism that communication is essential to the effective functioning of any multidiscipline effort. This study does show that communication exists between Social Work and the other disciplines in this hospital. This basic finding in itself, then, assigns some positive value to the way in which the disciplines relate to each other in this setting.

It is a much discussed fact in social work practice that wide variations in frequency and content of interdisciplinary communication exist between agencies or institutions employing more than one profession to operate in a teamwork

approach. It is probable that frequency of communication between two disciplines is dependent to a large extent upon the particular roles and responsbilities of those disciplines within their setting. This study of The Harding Sanitarium, for example, has demonstrated a large volume of communication contacts between social workers and psychiatrists as compared with communication between social workers and members of other disciplines. In a setting where these disciplines operate differently or have different responsibilities the relationships and communication between them would be expected to vary from those found by this study. However, it does not seem too presumptuous to assume that in settings where responsibilities of the disciplines are similar, similar patterns of interdisciplinary communications would also exist. Thus, one of the accomplishments of this study is the establishment of some objective basis for comparing communications in this hospital with those of other settings where roles of the disciplines are similar. Further inquiry and refinement of measuring techniques may then lead to the ability to determine an optimal or ideal communication system.

A high degree of importance has been assigned to communication in this field. In 1952 Dr. James M. Cunningham made the following statement in his presidential address to the American Orthopsychiatric Association:

> We have been concerned as an association with the problems of integration and coordination in the teamwork approach to psychiatric problems. This has been a matter of committee study for several years. . . . One of the difficulties has been that there are organizations which provide the services of people on their staffs representing the three professions, but there is lacking adequate coordination and integration of their various activities, The problem is primarily one of communication between the professional persons concerned.[15]

It is well nigh impossible to arrive at an adequate solution to a problem without fully understanding the problem. Therefore, it seems that studies such as this would provide an essential framework or foundation on which to base further inquiry, research, and qualitative judgments so that the psychiatric patient may reap the maximum possible benefits from the most effective and efficient operation of the multidiscipline team practice.

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[15]James M. Cunningham, "Problems of Communication in Scientific and Professional Disciplines," American Journal of Orthopsychiatry (July, 1952), p. 446.

APPENDIX I

THE SCHEDULE

SCHEDULE

Oral Communication

Medium / Message Content	Planned Meetings	Telephone Conversations	Informal Conferences
Description of Patient			
Historical Data			
Diagnosis and Dynamics			
Treatment Planning Decisions			
Patient's Behavior and Activities in the Hospital			
Personal Needs of Patient			
Relatives' Current Activities and Relationships			
Discharge Planning			

SCHEDULE

Written Communication

Medium / Message Content	Medical Charts	Social Service Records	Psychology Reports	Personal Memos
Description of Patient				
Historical Data				
Diagnosis and Dynamics				
Treatment Planning Decisions				
Patient's Behavior and Activities in the Hospital				
Personal Needs of Patient				
Relatives' Current Activities and Relationships				
Discharge Planning				

APPENDIX II

SUMMARY OF SAMPLING PROCEDURES AND RESUMES OF SAMPLE CASES IN EACH GROUP

GROUP I

Total patients hospitalized for one week or less		11
Patients eliminated by selection criteria		6
Not active social service cases	2	
Active cases not carried by staff worker	4	
Total cases eligible for Group I		5

1) Description of patient: Thirty-seven year-old married male with two children
Time in hospital: seven days
Present problem: acute anxiety reaction with schizoid trends
History: one previous hospitalization at another hospital, plus outpatient treatment--similar problem
Social service contact: wife

2) Description of patient: Thirty-two year-old housewife and mother of two children
Time in hospital: four days
Present problem: Schizo-affective disorder
History: one previous hospitalization at the Sanitarium two years ago--similar problem
Social service contact: husband

3) Description of patient: Seventeen year-old male high school senior, living with parents
Time in hospital: two days
Present problem: acutely agitated manic state with thought disorder
History: first admission and first episode
Social service contact: mother and father

4) Description of patient: Twenty-nine year-old housewife and mother of two
Time in hospital: two days
Present problem: rapid and profound mood swings, with feelings of inadequacy
History: first admission to Sanitarium, previous hospitalization and outpatient treatment elsewhere
Social service contact: husband

5) Description of patient: thirty-eight year-old married physician with three children
Time in hospital: one day
Present problem: agitated depression with uncontrollable temper outbursts and destructive behavior
History: first admission to Sanitarium, several prior hospitalizations elsewhere, plus outpatient treatment
Social service contact: wife

GROUP II

Total patients hospitalized for at least two but not more than three weeks		17
Patients eliminated by selection criteria		8
Not active social service cases	4	
Active cases not carried by regular staff	4	
Total cases eligible for Group II		9
Random eliminations		4
Total sample		5

1) Description of patient: thirty-four year-old married physician and father of three
Time in hospital: seventeen days
Present problem: schizophrenic reaction with depression and paranoid ideas
History: first episode and first admission
Social service contact: wife

2) Description of patient: twenty-one year-old single female college student
Time in hospital: twenty-one days
Present problem: acting out behavior, character disorder, suicide attempt one year ago
History: three previous admissions to Sanitarium in past year--similar problem
Social service contact: mother and father

3) Description of patient: forty-seven year-old married nurse with no children
Time in hospital: sixteen days
Present problem: acute anxiety reaction associated with long term neurotic adjustment and marital conflict
History: five previous admissionsin past eighteen months--similar problem
Social service contact: husband

4) Description of patient: Twenty-nine year-old housewife and mother of four
Time in hospital: twenty-one days
Present problem: depression with paranoid trends and mood swings
History: first admission to Sanitarium, two prior hospitalizations elsewhere in past two years
Social service contact: husband

5) Description of patient: sixty-three year-old housewife and mother of three
Time in hospital: twenty days
Present problem: recurrent schizophrenic episodes with depressive elements
History: seven previous admissions to Sanitarium in past six and one-half years, plus three admissions to other hospitals prior to 1954.
Social service contact: husband

GROUP III

Total patients considered ready for discharge within two weeks		9
Patients eliminated by selection criteria		2
Not active social service cases	1	
Active cases not carried by staff worker	1	
Total cases eligible for Group III		7
Random eliminations		2
Total sample		5

1) Description of patient: forty-six year-old married businessman
Time in hospital: twenty-eight days
Present problem: manic depressive illness
History: first hospital admission, outpatient treatment one year ago
Social service contact: wife

2) Description of patient: sixty-six year-old single businesswoman
Time in hospital: fifteen days
Present problem: depressive reaction
History: first admission and first episode
Social service contact: nephew

3) Description of patient: sixty-seven year-old married retired tradesman
Time in hospital: forty-one days
Present problem: depressive illness and suicide attempt
History: four previous hospitalizations during past five years--similar problem
Social service contact: wife

4) Description of patient: forty year-old housewife and mother of two
Time in hospital: twenty-three days
Present problem: long term neurotic admjustment, alcoholism, marital conflict
History: eight previous admissions to Sanitarium in past two years
Social service contact: husband

5) Description of patient: fifty-four year-old housewife and mother
Time in hospital: twenty-two days
Present problem: recurrent depressive episodes, long term neurotic adjustment with somatic complaints, marital conflict
History: ten previous admissions to Sanitarium in past seven years
Social service contact: husband

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