RELATIVE VISITING FOR MENTALLY-ILL PATIENTS;
ITS POSSIBILITIES AND VALUES AS A TREATMENT RESOURCE

A study based on experience at the Provincial Mental Hospital, Essondale, British Columbia, and Saskatchewan Hospital, Weyburn, Saskatchewan, 1962.

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Until recently, there has been only limited interest in the role of the family in the treatment and rehabilitation of the mentally ill. Although it is generally conceded that the interest and support of the family, except in some unusual cases, is of considerable help in the patient's treatment, little attention has been devoted to the subject of visits to mental hospital patients by relatives and friends. As a consequence, little is known about the specific effects of such visits and the types of patients who receive visitors. The present study examines mental-hospital visiting in terms of the therapeutic value of visits for patients, with attention directed to how visits by relatives assist social workers in providing treatment services to patients, and what determines how frequently a patient is visited.

The material required for this investigation was obtained by a questionnaire distributed to Social Workers in the psychiatric facilities at Essondale and Weyburn Saskatchewan. This information was supplemented by conducting personal interviews with a small sample of patients and another of visiting relatives in the Provincial Mental Hospital, Essondale. Reference has also been made to a previous study of mental hospital visiting conducted at Weyburn, Saskatchewan.

Terms such as "disculturation" and "disocialization" have been used to describe the submissiveness, loss of interest and deterioration of personal habits which may result from prolonged institutional residence. The introductory chapter reviews these effects, points up the need for maintaining the patient's contact with the family to help counteract these unintended consequences, examines the social worker's investment in maintaining the support of the family, and demonstrates how the hospital has changed its attitude from one of limited acceptance of visiting relatives to a much greater realization of their potentialities. The core material compiled from the questionnaire interviews, and reference to other surveys is analyzed under three headings: (a) visits of questionable value, (b) positive contributions, and (c) social worker's utilization of visits (Chapter II). The determinants of visiting are assessed by reference to (a) the causes of infrequent visiting, (b) the characteristics of frequently and infrequently visited patients, and (c) other comparable surveys of visited and unvisited patients (Chapter III).

The conclusions are that visits can make a positive contribution to the patient's treatment. However, there are some situations in which their value is questionable; for example, visits may not be indicated when the patient is acutely ill, not accustomed to living in hospital, the relatives are unable to accept mental illness, or there is a tenuous relationship between patient and relatives. More often, visits contribute to the patient's treatment by reassuring him that he has not been forgotten by loved ones; helping him to overcome feelings of being an anonymous member of a large community of patients; reassuring him about home and family matters. Visits indirectly benefit patients through the efforts of social workers to employ their contacts with relatives to obtain social information, determine family resources, plan for discharge, prepare for follow-up, communicate information, alleviate stresses in the family situation, discuss treatment, and help the relatives to accept the patient.
The study also demonstrates that visiting frequency is dependent upon a variety of factors, such as, the distance relatives must travel, the misconceptions, fear or shame about mental illness, unwillingness to accept the patient's return home, feelings of anxiety and guilt connected with the patient and his illness, loss of interest in the patients, pain or embarrassment connected with visits, the hospital's visiting facilities and regulations, and the attention given to visitors by staff. Infrequently visited patients spend more time in hospital, have fewer previous admissions, are older, and have relatives further removed from hospital. In conclusion, a number of recommendations are made for improving a hospital's visiting program.
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CHAPTER I

THE HOSPITAL EXPERIENCE: THE NEED FOR COMMUNITY CONTACTS

In Canada there are approximately 56,000 patients in mental hospitals and psychiatric units.\(^1\) It is highly probable that the majority of these patients have relatives and acquaintances. If it is assumed that on the average each patient claims the interest of at least three persons outside the institution, it is conceivable that a total of 168,000 people may at one time or another pay a visit to a mental hospital. Yet this very sizeable group of people is often neglected by our hospitals. Greenblatt writes: "The average mental hospital is so involved with the care of patients that it pays little attention to the great flow of relatives, although from many standpoints the patient-relative dyad may be considered two aspects of visiting, inseparable in health and disease."\(^2\)

In the present investigation the writer proposes to examine, how visiting relatives may contribute to the hospital's therapeutic program, what determines the frequency of visiting, and the steps which can be taken to improve mental hospital visiting.

Institutionalization: Its Effects Upon Patients

It is now generally conceded that the informal organization of the hospital, the social relations, and the social structure within the hospital affect the personal condition of patients and can retard or facilitate their improvement. As a custodial and treatment centre, the mental hospital can help the patient in a number of ways. First, it serves to remove the

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\(^1\)Mental Health Statistics Supplement: Patients In Institutions 1959 Dominion Bureau of Statistics Health and Welfare Division Institutions Section, Queen's Printer, Ottawa, May 1961, p. 17.

\(^2\)Greenblatt, Milton et al, From Custodial to Therapeutic Patient Care in Mental Hospitals, Russell Sage Foundation, New York, 1955, p. 224.
individual from the sources of conflicts and agitations which may have precipitated his illness or aggravated his non-conforming behaviour.\(^1\),\(^2\) Stern writes

> Even in the poorest mental institutions, which offer little or nothing in the way of scientific treatment, numbers of patients recover largely because they are removed and protected from the stresses, strains and entanglements of life among their own people, and have a chance for an emotional breathing spell in an impersonal atmosphere.\(^3\)

Secondly, hospitalization protects many patients from self-directed, as well as outer-directed violence. Similarly, they are protected from punitive measure the community might impose upon them were they not hospitalized.\(^4\)

Thirdly, the patient is usually accepted by the hospital milieu. Possibly he has been rejected by others in the community before entering hospital. He may feel burdened by the stigma of commitment but he is heartened and encourage to discover that other patients and staff accept him as a person.\(^5\)

Fourthly, the hospital milieu provides the benefit of group suggestion. The routinized procedures may rouse the patient from his apathy and disrupt his former distorted perspectives. For example, a restless patient may be encouraged to go to bed at a certain time when he sees others doing so.

\(^1\) Cumming, Elaine and Cumming, John, Closed Ranks and Experiment in Mental Health Education, Harvard University Press, Cambridge, Mass., 1957, p. 132


\(^4\) Cumming, op. cit.

\(^5\) Weinberg, op. cit., p. 385.
Good habits essential for changing the patient's outlook and restoring normality may be better acquired through following the group than through threats, nagging or disciplinary measures which the family may employ.\(^1\), \(^2\)

Fifth, within the hospital, patients place a high value upon leaving the hospital. They compete for this and rate one another on their potential for being discharged. Consequently, the patient acquires a desire to leave. In line with his desire for discharge, he tends to view the outside community more favourably. Since he is anxious to leave as soon as possibly, he looks upon his personal improvement as a means to this end.\(^3\)

However, although hospitalization has these distinct advantages, it also has a number of disadvantages. "Hospitalization under any condition involves surgery - social surgery". The patient is severed, in some degree, from the social unit in which he functions and is transplanted to a new and unfamiliar world.\(^4\) The hospital environment is often one to which even normal persons would have difficulty adjusting. Among other things the patient must face the prospect of a loss of liberty. Doors may be locked and windows barred. Personal and sentimentally-valued objects, such as wedding rings and wrist watches, are often taken from the patient, who is oftensafe keeping.\(^5\), \(^6\) In addition, the patient, who is often a highly sensitive person desiring only safe, quiet and private surroundings, is placed in a situation in which his every act and utterance come under the

\(^1\)Weinberg, op. cit., p. 385.
\(^2\)Stern, op. cit., p. 25.
\(^3\)Weinberg, op. cit p. 385.
\(^4\)Ingle, Dana, L., Editor, Social Service Responsibilities In After Care, Proceedings of Regional Institute, Louisville, Kentucky, October 1955, Kentucky Department of Mental Health, p. 26.
\(^6\)Dunham, H. Warren, and Weinberg, S. Kirson, The Culture of the State Mental Hospital, Detroit, Wayne State University Press, 1960, p. 4.
public scrutiny of fellow patients and staff. Dressing, eating, toileting, sleeping and talking are carried out under the surveillance of persons charged with his care. These highly sensitive and emotional people must come to terms with this constant public evasion of what, for normal people, constitutes much of their privacy.¹

A re-education takes place within the hospital whether or not it is consciously intended. "The longer the patient's residence in hospital, the greater his susceptibility to whatever conditioning the hospital culture imposes and the more complete his amputation from society".² In the past few years a number of writers have begun to concern themselves with the effects of institutionalization upon long term inmates.

The theory has been advanced that there is an active phase in mental illness with a subsequent attempt to achieve an equilibrium between residual symptoms, the patient and his environment. If the patient is kept in hospital during the second phase, the equilibrium he reaches is in the adjustment to a hospital environment, not to the environment in which he has normally lived. This gives rise to symptom patterns due, not to the advance of this disease, but to adjustment to the abnormal institutional environment.³

Sommer and Osmond, in citing a study by Johnson and his colleagues, indicate that the "greatest part of a mental hospital population is a residual one which consists of 'psychiatric failures', patients who have not responded to treatment enough to leave a hospital and who give no promise

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¹Dunham, H. Warren, and Weinberg, S. Kirson, The Culture of the State Mental Hospital, Detroit, Wayne State University Press, 1960, p. 4.
of responding in the foreseeable future". The residual nature of the patient population may be further borne out by the fact that in Canada 59 per cent of the patients on the books at the end of 1959 had been in hospital over five years.

Sommer and Osmond describe a number of phenomena associated with institutionalization of more than two years duration. They use the term "de individuation" to depict a condition involving a lessening of the individual's capacity for independent thought and action. "The inmate becomes a so-called mass man, capable of little spontaneous activity". There is an unquestioning acceptance of routine and a tendency to allow others to make important decisions.

A second phenomenon they distinguish is "disculturation". The individual acquires institutional values and attitudes unsuited to his previous culture. The writers found that the longer a patient had been in hospital, the more his values differed from those of the normal group. Physical needs such as eating and sleeping tended to take on more importance, whereas social needs (families and friends) tended to decline in importance.

Another symptom which may result from continuous institutionalization is "psychological or physical damage". In the case of mental patients, the damage can be the stigma which prevents the ex-patient from leading a normal life or finding a satisfying job outside. "Estrangement" is a term the authors use to indicate how outside conditions change over time, leaving the patient unprepared to face the changes. Patients frequently find that their

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2 Social Mental Health Statistics Supplement; Patients in Institutions, 1959, op. cit. p. 13
3 Sommer and Osmond, op. cit. p. 255
4 Sommer and Osmond, op. cit. p. 256
families have moved away or even died. Also, after years in an institution a patient may not be able to get work because the skills he possesses are lessened or obsolete.

"Isolation" depicts the loss of contact with the outside and the tendency to be forgotten by family, friends and community. The present study will be concerned with investigating how a loss of outside contacts affects patients, and the reasons for a decline in the number of visits a patient receives after spending some time in hospital. Sommer has found that: "After about a year there is a sharp drop in the number of letter and visitors, and the decline becomes steeper the longer a patient has been in hospital".¹ Finally, the authors suggest that persons who have been institutionalized for long periods usually undergo "stimulus deprivation". During his stay in a hospital the patient has to accustom himself to a life that's tempo is quite different from that of the outside. Leaving the hospital may require that the patient quickly adapt to the rapid pace of the outside. As an example of how the inmate's world may be limited, the writers note that his visual experiences may be restricted to a few colours such as buff or dull grey. After a time the inmate may come to prefer the heavily saturated colours, which suggest that their senses may be somewhat deadened by prolonged institutionalization.²

Various labels such as "hospitalitis", "depersonalization", and "desocialization" have been given to the process brought on by prolonged institutionalization.³ Barton goes one step further than labeling it as a

¹Sommer and Osmond, op. cit. p. 256.
²Ibid. p. 258
³Ibid. p. 254.
process and claims that the type of symptoms mentioned are indicative of a
disorder which he has given the name "institutional neurosis". According
to his definition:

Institutional neurosis is a disease characterized by apathy, lack of initiative, loss of interest, more marked in things and events not immediately personal or present, submissiveness, and sometimes no expression of feelings of resentment at harsh or unfair orders. There is also a lack of interest in the future, and an apparent inability to make practical plans for it, a deterioration in personal habits, toilet, and standards generally, a loss of individuality and a resigned acceptance that things will go on as they are - unchangingly, inevitably, and indefinitely.¹

Thus, Barton concludes that after four years in a mental hospital most patients are suffering from two illnesses, schizophrenia and institutional neurosis. He maintains that institutional neurosis should be considered a disease in its own right for the following reasons: it occurs not only in mental hospitals but in other institutions as well, for example, prisons, orphanages, and prisoner-of-war camps; mental illness, regardless of type, does not produce an end state similar to institutionalization; the symptoms may be resolved by rehabilitation; hospitals in which the staff are aware of the entity are ceasing to produce it; and a schizophrenic who is cared for by his relatives does not regress or deteriorate to the same extent as a schizophrenic who remains in the mental hospital, particularly if he is kept in a large ward.²

Barton distinguishes a number of factors commonly associated with institutional neurosis. The first four which include bossiness of medical and

¹Barton, Russel, Institutional Neurosis, John Wright and Sons Ltd., Bristol, 1959, p. 12.
²Barton, op. cit. p. 53.
nursing staff, the ward atmosphere, enforced idleness, and the effect of drugs pertain more particularly to the routine within the institution. The last three are more closely related to the present investigation - visiting and the maintenance of contact with relatives and friends. They include the following:

(a) loss of contact with the outside world. It may be difficult for relatives to visit because of distance, time, and expense. His separation may be maintained by detention behind locked doors, systems of parole and difficulty in getting leave.

(b) loss of personal friends, of possessions and personal events. At first friends may visit, but very soon the combination of transportation difficulties, expense, and possibly little welcome from the hospital or the patient make visiting less frequent until it eventually ceases.

(c) loss of prospects outside the institution. It has been observed that as a patient's length of stay in hospital is extended, his prospects of locating employment, finding a place to live, and friends to mix with, diminish rapidly.¹

Contacts With Family And Friends: A Link With The World Outside

As previously noted, hospital-family relationships have for the most part been sadly neglected. The hospital staff is often so overburdened by the problem of caring for the patients and so hampered by shortages of personnel and inadequate facilities that the patient's relatives are not a major object of concern.² There is apt to be much more emphasis placed upon improving the patients immediate therapeutic milieu. However, important as inter-personal relationships within the hospital may be, perhaps a patient's inter-personal relationships with his family are of equal or more importance.

¹Barton, op. cit. p. 16-22.
Kaplan and Wolfe point out that for the patient who will recover the hospital "is only a transition between a past and a future in the community". They emphasize that "no matter how successful the inter-personal relationships within the hospital, it is his links with the outside world that must be strengthened".\(^1\) For the patient, the family is the embodiment of his unique subcultural heritage, personality development and way of life.\(^2\) In fact, the family plays such a significant role that the idea is fast gaining acceptance that "mental illness is not a one-person problem but a family problem". Indeed Federn has ventured to say that "no patient can be cured unless his family wishes it".\(^4\) According to Proehl a denial of the patient's existence by the family may even accomplish his "institutional death".\(^5\)

In general, it has been felt that the interest and support of the patient's family during the time of his hospitalization is positively related to his rehabilitation. The continuing interest of relatives and friends brings to the patient a feeling that not only someone in the hospital but somewhat equally important in the community cares about his welfare. He becomes less cut off while in hospital so that upon discharge he will have less ground to regain and will find it easier to become re-established.

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\(^1\) Kaplan, and Wolf, op. cit. p. 639  
\(^2\) Ibid, p. 634  
\(^5\) Ibid. p. 47.
Social workers have long recognized that the family is one of the most important resources in the total treatment and rehabilitation of the mentally-ill patient. The very prominent influence which the family exerts over the fate of the patients has been commented on by Hollingshead and Redlich. They contend that the family's attitudes towards its psychotic member are responsible, to a significant degree, in determining "who goes to a hospital, who stays home, who improves in hospital, who deteriorates, and eventually stagnates in a chronic ward". They also emphasize that

Patients are not discharged just because they are well; neither are they retained in hospital just because they are sick. Their discharge is the result of many factors and events, among them being the nature of the illness, whether adequate benefit resulted from hospitalization, attitudes of the family toward the patient and the patient toward the family, relationships of the patient with the hospital staff and of the hospital staff with the family.  

Social workers play upon the patient's family to a great extend for gathering diagnostic material about the patient and his social situation. In fulfilling their traditional role of helping the patient face the problems of adjusting back into the community, finding employment and making living arrangements, social workers utilize the family in planning for the patient's rehabilitation. More often than not, the patient returns to the family after treatment in hospital. Social workers must also reckon with the fact that many patients will return to isolated communities where few social resources exist. It may be impossible to give adequate follow-up services. In such instances the family may have to be depended upon almost exclusively for maintaining

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1 Hollingshead, August, B, and Redlich, Frederick, G. Social Class and Mental Illness, Wiley and Sons, New York, 1958, P. 343.
the patient's improvement. Therefore, it is vital that the relatives maintain the interest in the patient. It is equally important that during their visits to hospital, the family be given as much therapeutic assistance as possible in order to prepare them for carrying out your recommendations for further care of the patient.

Changing Attitudes Towards the Patient's Family

Although at times present hospital staffs may be ambivalent toward visitors and relatives of patients, visitors are probably more welcome than in former days. Early hospital administrators, particularly psychiatrists, saw no therapeutic role for the patient's family. One of the original founders of the American Psychiatric Association, Isaac Ray, in 1863 wrote:

It is now a well-settled principle, that, to treat the insane with the highest degree of success, the surroundings of the patient should be entirely changed so that he will see no face nor other object familiar to him in the previous stage of his disease ... Another duty encumbent on the friends is to refrain from all interference with the medical or moral management of the patient ... It is hard to believe, no doubt, that those who are nearly related to the sufferer should refrain from visiting him when he seems to be in most need of comfort and consolation; but a little reflection on the subject will show what it should be a sacred duty under ordinary circumstances, may be a source of serious mischief here.¹

Such ideas as Ray's held sway for many years. As recently as 1940, Harry Stack Sullivan made this statement: "It is natural, but not so objectionable that relatives should be firm in their conviction that their visits to patients are wholly beneficial while they are often precisely the opposite". Since it is realized that some visits are particularly upsetting for patients and relatives alike, one of the objects of the present study is to explore the conditions which visits may be considered beneficial or non-beneficial. Chapter III has

been devoted, in part, to an examination of this subject.

More recently there has been a greater recognition of the therapeutic value of the patient's family. Frieda Fromm-Reichmann (1950) demonstrates this further development in psychiatric thinking. She writes:

The sense of belonging, the heightening of their self-respect and the increased prestige in the eyes of other patients caused by visits from relatives and friends means so much to the hospitalized psychotic that he should not be deprived of them although at times patients do react with what appears to be a temporary set-back in their progress.

In the contemporary situation it would appear to be much more generally accepted that working with the patient's family is one of the most important ways of providing a continuum between hospital and community. It is becoming clear that it is one of the hospital's responsibilities to strengthen patient-family relationships, to interpret the family to the patient and the patient's illness and treatment to the family. Rees demonstrates this pronounced change in attitude with the following statement: "It is just as important that the relatives be prevented from being allowed to forget the mental hospital patient as it is to prevent the patient from losing touch with the world outside the hospital".¹ According to Greenblatt and others, the modern therapeutic process requires in particular the understanding of relationships between relatives and patients, and a re-education of the attitudes of one to the other. The authors stress the "working through" of conflicts rather than their avoidance. They maintain that "in the modern hospital it is reasonable according to present conceptions to encourage visiting, to study visitors, and to accept the challenge of the problem of both visitors and patients. For the hospital, in accepting responsibility for the treatment of mentally ill patients has, in effect, taken on responsibility for education of the family members".²

²Greenblatt, op. cit. p. 234.
It might be confidently stated that never in the history of our race have the community and the hospital been so close together as they are today. However, although the hospital has become much more accepting of visitors and the vital role they can play in the patient's treatment and rehabilitation, there is still a long way to go. Hospitals are only beginning to realize the potentialities of visiting relatives and friends of the patient. As a topic for research, the visiting of mentally ill patients by relatives has received only very limited attention. Greenblatt writes that "the psychiatric hospital finds itself in the sorry plight of having no well-defined theories about the desirability of integrating relatives into the treatment programme, and recognizing them as controlling factors in the patient's attitudes and his strongest link with the outside world".\footnote{Greenblatt, op. cit. p. 224.} Sommer makes the statement that "far more has been written about community volunteers and visiting entertainers than about visits by the patient's own family and friends".\footnote{Sommer, Robert, "Visitors to Mental Hospitals, A Fertile Field For Research", \textit{Mental Hygiene}, Vol. XLIII, No. 1, January 1959, p. 8.} It is partly in response to the paucity of research in this important subject area that the present investigation has been undertaken.

**Method and Scope of the Study**

The present investigation has been designed to meet the following purposes:

(a) to examine the situations in which visits are of questionable value in the patient's treatment;

(b) to define the positive contributions of the relative's visits;

(c) to examine the ways in which visits assist social workers in providing treatment services to patients;

(d) to investigate the conditions which appear to be related to visiting frequency;
(e) to explore and evaluate some of the major techniques which a hospital may employ to increase visiting and to enhance the therapeutic value of visits.

To obtain the information presented in chapters II, III, and IV, questionnaires (see Appendix A) were designed and distributed to a total of twenty-five social workers in the Crease Clinic, the Provincial Mental Hospital at Essondale and Saskatchewan Hospital, Weyburn. It was anticipated that the workers' views and experiences would be influenced by the settings of these hospitals.

Crease Clinic is a psychiatric hospital designed and equipped to serve as a diagnostic and treatment centre for the early cases of mental illness, chiefly early psychoses and psychoneuroses. The average stay in Crease Clinic is six weeks and the maximum stay by statutory provision is four months. Patients who are thought to require longer hospitalization are referred to the Provincial Mental Hospital.

The Provincial Mental Hospital is composed of a number of separate buildings and social service departments are located in three of these buildings. Centre Lawn is the admitting unit for male and female patients. Here patients receive active treatment and may be discharged or, if they require further treatment, may be transferred to one of the longer term units. East Lawn houses the long term female patients. West Lawn is the counterpart for male patients.

Saskatchewan Hospital, Weyburn is one of the two public mental hospitals in Saskatchewan. It serves the south-eastern section of the province, roughly one third the surface area of the province. In contrast to the Provincial Mental Hospital, the Weyburn Hospital is not divided into separate
units for admissions and longer term cases. Admission and longer term male and female wards are contained in the same building.

In addition to obtaining information by questionnaires, personal interviews were held with a selection of patients and relatives. The five male and five female patients interviewed were chosen by the charge nurses on Five Centre Lawn wards. The nurses were requested to select any patients whom they thought would be able to talk about visiting experiences and would be willing to answer a few questions about the visitor programme. To obtain a selection of visitors for interviews, an equal number of male and female visitors were randomly chosen from among those visiting Centre Lawn and Crease Clinic on three afternoons. In most instances the visitors were quite willing to discuss their views on visiting and the hospital programme. A few did not find it possible because of limited time. Since the writer found it more convenient to conduct interviews at Centre Lawn, the final selection of visitors was comprised of eight Centre Lawn and two Crease Clinic visitors.

Thus, it was the writer's intention to examine mental hospital visiting from the perspectives of three groups of people very much interested and concerned with visiting. It was thought that these three sources should be authorities on the subject. The latter two groups are of course, most directly affected by the visiting experience. The decision to include social workers was made on the basis that social works, by the nature of their involvement with both patient and relative, are in a strategic position to observe how visits affect both, and are able to provide relevant information about the various aspects of visiting.
CHAPTER II
THE SIGNIFICANCE OF VISITS IN THE PATIENT'S TREATMENT

In the following chapters the data which has been reported was obtained by assembling a questionnaire which was then distributed to the social workers in the Crease Clinic, the Provincial Mental Hospital, Essondale, and Saskatchewan Hospital, Weyburn. However, since the replies to the questionnaire were not considered sufficient by themselves to provide a rounded picture of the nature and value of visiting, the material was supplemented by conducting personal interviews with a selection of patients and visiting relatives.

The direction taken in the following sections is first, to define the situations in which the value of visits is questionable. This discussion will be followed by an exploration of the positive contributions of visits with attention directed to an examination of how social workers employ the relatives' visits in providing treatment services to patients. The emphasis throughout will be to examine visiting from the standpoint of what is best for the patient.

Negating Situations

(a) Social Workers' Viewpoint:

The observations to follow are based on the replies to the questionnaire. Of the twenty five questionnaires distributed, twenty-four were returned. The number of respondents reporting from each of the three settings were as follows: Crease Clinic, seven; Centre Lawn, West Lawn and East Lawn, units of the provincial Mental Hospital, five, four and three respectively, and Weyburn, five.

Although the respondents were in complete agreement that visiting relatives have an important part to play in the treatment of patients, they were also unanimous in affirming that there are some situations in which visits
should not be encouraged. For the sake of convenience and clarification, the examples cited have been classified as follows:

1. **State of Patient:** Approximately one-half of the respondents made reference to the patient's illness or frame of mind. It was generally agreed that visits should not be encouraged when the patient is acutely disturbed. Others commented that visits should not be encouraged when the patient is "abusive", "physically threatening", "hostile", or "paranoidal" towards visitors. Still others took the patient's wishes into consideration. These persons indicated that visits should not be encouraged if the patient is not interested.

2. **Behaviour of the Relatives:** About one-half of the respondents made some reference to the relatives' behavior. There was general consensus that visits can be damaging when relatives are extremely "over-protective", "over-anxious", "demanding", "rigid", "guilt-ridden", or "smothering". Visits were also thought to interfere with the patient's treatment and progress when the relative displays "unhealthy views toward the patient or towards mental illness", or when the visitor is "unable to accept or understand mental illness".

3. **Type of Patient-Visitor Relationship:** A few respondents listed an unhealthy relationship between patient and visitor as a possible reason for not encouraging visits. One person specified that visits should not be encouraged if a patient is attempting to break from parental, or authority ties, or a damaging marriage, an ill-considered engagement, unwanted religious ties, or if a patient wishes to have a temporary break from a close personal tie in order to have time to think things through.

4. **Stage of Treatment:** Two respondents thought that visits should not be encouraged during the first few days of hospitalization when a patient
requires time to settle in to the hospital routine. A few others thought that visitors should not be encouraged if the visit causes more than a temporary setback in the patient’s recovery, complicates, or interferes with the treatment process; or unduly upsets the patient.

(b) The Patients’ Viewpoint:

Turning now to the interview with the patients, it was found that the final selection of patients displayed the following characteristics. In marital status, seven were single, two were separated and one was married. They ranged in age from 20 to 48 years. The average age was 33.9 years, the median 33.5 years. One male patient had never been admitted to a mental hospital before, while seven others had each been admitted on one previous occasion. One patient had two previous admissions and another three. The duration of the present admission to the date of the interview ranged from two days to 3.4 months. The average duration was 1.47 months, the median 1.43 months. The frequency of visits for these patients was as follows: one patient, who had been in hospital only two days, had not been visited and the other nine had each been visited an average of 1.42 times per week.

In general, these patients made very few comments regarding what might be considered the less desirable features of visits. Only one patient admitted that he had sometimes found visits to be upsetting experiences. This patient, a 24 year old single male, admitted to hospital for the second time, stated that when he first entered the hospital, he sometimes found that visits from his parents were upsetting. He thought this was partly due to the inability of his parents "to understand his problem". "At times they become too over-anxious".

In the majority of instances, comments concerning the doubtful value
of visits were made in conjunction with comments which emphasized the more favourable effects. One forty-five year old, separated male, admitted to the hospital for the second time indicated that visits, if they are to be helpful "should be from responsible people, not just casual acquaintances". A somewhat similar view was expressed by a thirty-eight year old, married, female, admitted for the second time. It was her experience that visits from the "right people" tended to cheer her up. In addition, she expressed the view that "if a patient doesn't want to see certain people" he or she "shouldn't be required to". Nevertheless, she maintained that she had never found visits upsetting, but indicated that in several cases she had seen "girls drying" after visitors left.

(c) Relatives' Viewpoint:

Referring now to the relatives interviewed, it was found that one-half were husbands. There were three wives, a mother and a sister making up the other half. Four of the relatives came from Vancouver and the remainder from surrounding municipalities. They ranged in age from 26 to 63 years. The average age was 40.2, the median 41.5. Each had visited an average of 2.45 times per week since the admission of their patients.

The patients they visited ranged in age from 17 to 58 years. The average age was 39 years, the median 39.5. All were married with the exception of one 17 year old Crease Clinic patient. The length of present hospitalization ranged to date of interview, from 4 days to 1.63 months. The average duration was .74 months, the median .63 months. Four of the patients had not been admitted to hospital before, four were second admissions, one was a fourth admission and one patient had been admitted on seven previous occasions.

As was found in the case of the patients interviewed, a survey of the relatives' visiting experience revealed that they too were prone to emphasize the positive rather than the negative features of visiting. Only
two of the relatives interviewed would not definitely say that they thought their visits were helping the patients to get better. One of these, the husband of a forty year old patient admitted for the second time, did not think that he was in a position to say whether his visits were helping his wife to get better. However, he did think that his wife liked him to visit, but apparently she did not seem to like other people to visit.

Three of the relatives expressed the view that visits are not as helpful in the early stages of treatment as they are in the later. One husband, whose wife had been admitted to the hospital on seven previous occasions, commented that in the early stages of treatment his wife was usually "too doped up" to really appreciate his visits. Another husband, whose twenty-four year old wife had been admitted to hospital for the second time only four days prior to the interview, indicated that he thought his visits would be more helpful to her after some improvement in her condition had taken place. Two relatives revealed that they were not allowed to visit more than twice a week due to the doctor's restrictions. Evidently their visits were not regarded by staff to be entirely beneficial. Nevertheless, one of these relatives, a mother of a seventeen year old schizophrenic girl who had been admitted to Crease Clinic for the first time, thought that her visits were helping her daughter to get better. She indicated that her daughter looked forward to her visits. Along with the other two relatives mentioned above, she thought that her contacts with the patient would be more helpful when her daughter received weekend privileges. Another relative, whose visits had been restricted, indicated that she was uncertain as to whether or not her visits were helping her twenty-nine year old husband. She commented that her husband "seemed to be happy" when she visited. She also indicated
that her husband expected her to come. The one example of an upsetting visit was offered by this woman. She mentioned that, on a few occasions, she brought along her three year old child and her husband felt badly when the baby had to go home.

A number of relatives were asked if, during visits, the patients ever requested to be taken home. A few revealed that sometimes requests were made. One husband commented that in the early part of treatment his wife would generally ask to be taken home, but with improvement in her condition her demands would become less frequent.

Positive Contributions

(a) Social Workers' Viewpoint:

In attempting to determine the specific benefits patients may derive from "successful" visits, the respondents were presented with four possibilities. On the basis of their choices, it would appear that the most outstanding benefit of visits, in the eyes of the social workers, is the reassurance a patient gets in knowing that he has not been forgotten by loved ones. Twenty-two respondents checked this item. Another important benefit of visits, according to social workers, is the re-establishment of the patient's identity as an individual with his own unique family background, while at the same time lessening his feelings of being an anonymous member of a large community of patients. Eighteen persons responded to this item to make it the second most frequently checked benefit.

Fifteen persons thought that successful visits result in a stimulation towards recovery. Other responses to this item were "questionable", "doubtful", "sometimes" and "not always". One person thought that a patient is more likely to be stimulated towards recovery if the visitor receives case-work services.

The least important benefit of visits according to social workers, is
the confidence a patient may gain from a feeling that he is getting along better with his family. Only eleven respondents checked this item. Another six responded with such comments as "questionable", "hopefully", and "Not necessarily". Another commented that "the hospital is an unusual setting for family relationships to develop". When asked if they thought whether the four possibilities referred to above are the major treatment benefits patients may be expected to derive from successful visits, nineteen respondents replied in the affirmative and two persons were not sure.

Other treatment benefits of visits were suggested by eleven respondents. These benefits included: enhanced feelings of self-worth, feelings of belonging, keeping in contact with the outside world, keeping in touch with the family affairs, and allaying anxieties which patients may have in this area. One respondent commented that successful visits confront the patient with reality and afford him the opportunity of coming to terms with it gradually while still protected by the hospital setting.

It is recognized that not all visitors come to hospital voluntarily. Some may require inducement. A further purpose of this study was to try to establish the effects on both types of visits on patients.

In giving consideration to the effects of voluntary visits, the majority of respondents (twenty one) thought that the effects were either possibly or definitely beneficial. When asked whether they had experience with relatives who had to be induced to visit, six of the respondents indicated that they had not had such experience. In estimating the effects of such visits, the majority (nine) of those who had experience thought that the effects are either possibly or definitely beneficial. Five others thought that the effects are possibly detrimental. Three persons did not reply to this item.

The responses to the above questions suggest that voluntary visits are more apt to be viewed as beneficial than induced visits. However, as one
respondent pointed out, if hospital personnel urge relatives to visit, it may be presumed that a decision has been reached as to the potential visitor's suitability. Therefore, it may well be that in such cases, induced visits could have as much therapeutic value as voluntary visits, and in some instances might even be more valuable.

(b) Patients' Viewpoint

By and large, the patients in this survey viewed with favour their visiting experiences. All patients indicated that they looked forward to visits. Four made qualifying comments such as "yes, but I don't anticipate visits", "in a way", "in general, but not the first day", and "yes, I really enjoy them".

All patients thought that visits helped them. A few required no prompting in order to expand on how they thought visits were able to do this. One thirty-three year old single male, admitted for the second time, commented: "If a person feels alone, visits can help, but if he is in for different things, they could be a hindrance". He went on to say, "It helps to know I haven't been forgotten, that people think enough of me to visit". He also thought that since the hospital is a protected setting "there is a tendency to let outside cares drift". One advantage of visits is that "they keep you in touch with outside ties". Another patient, a forty five year old separated male, admitted for the second time, commented that visits "Hold you to your previous background". He continued: "The first couple of weeks in hospital you are really cut off. Your thinking and emotions are out of wack. You're more sensitive and imaginative. If things don't turn out the way you like, there is a slight feeling of being cast off". It was this patient's experience that a visit from people who mean something is an important feature in helping to
allay such feelings. He concluded: "Certainly you find out who your friends are. As it turns out, nobody is really against you". Some of the other comments made were: "It helps to know someone is thinking of you. Visits relive tension, get your mind off the present"; "when you get a visit, it's more like you're not away, more at home"; and finally "Visits are a real morale builder".

Not all patients were able to readily define how they thought visits helped them. To ascertain such information, it was necessary to ask other questions. As a result, all patients stated or implied that they liked to get news from home. One thirty-eight year old married woman, admitted for the second time, commented, "It concerns most people what their family is doing". Another female stated that "when you know everything is okay at home, it is better than a lot of medicine".

A few patients were asked if visits resulted in them feeling confident that they were getting along with their families as well as, or possibly better than, they did before hospitalization. One patient said she always got along well with her family, while another indicated that her response to her family was much the same as ever. A third did not think visits resulted in changing her own or her family's views. Another replied that she did "not necessarily" feel more confident that she was responding to her family as well or better than before hospitalization. One male patient indicated that he did think visits helped him in this respect. In his opinion, relatives, through visiting, are able to talk over problems with doctors and other staff. They "see the nature of the illness" and their "ideas change for the better".

Dunham and Weinberg, in their study of the culture of the state
mental hospital, observed that among "hopeful" patients - a term they use to describe a short term or acutely ill patient - "the value accorded most prestige is leaving hospital and going home". They further state that such patients "await family visits as welcome respites and as instruments of discharge". The findings of these authors suggest that if leaving hospital is a value accorded most prestige and that if visits are regarded as instruments for discharge, then it might be assumed that the more frequently-visited patients would be looked up to or envied by other patients.

In an effort to test whether there might be some basis to this assumption, all patients interviewed were asked if they thought patients who receive visitors are envied or looked up to by ones who do not. Six patients expressed the view that there was possibly some envy or feeling akin to it. Comments such as the following were made: "Yes, at times, there is envy", "Maybe a little, not really envy", and "They may be a little envious". Three patients made no specific comments, but simply answered in the affirmative. One patient thought that these feelings depended upon mood. Another maintained that visiting hours are sometimes hard on patients who don't get visitors because it may leave them "a vacant hour" without company. One patient did not feel he could speak for other patients, but as far as he was personally concerned, there was no envy on his part.

In view of the above, there is probably some justification in assuming that, in addition to the other benefits patients receive from visits, they may also gain a certain amount of prestige or status.

(c) Relatives' Viewpoint

Returning to the relatives, it was found that, in general, they too were favourably impressed with their visiting experience. More than half indicated that they definitely thought that their visits were helping the patients to get better. The comments made by the remainder have already been noted in a previous section. All the relative thought that the patients looked forward to their visits. One husband remarked that his wife liked him "to be on time". Another visitor in referring to her husband said, "I think he expects me to come". As might be expected, all visitors indicated that their patients appreciated receiving news from home. One example of how visits are sometimes of immediate help to patients was given by the sister of a forty-five year old woman admitted for the second time. The sister recalled one instance where the patient had been "bad" (noisy) prior to her visit but "quieted right down" when she arrived.

The Social Workers' Utilization of Visits

Most hospitals keep a record of the patients visited, date of the visits, and the names and addresses of visitors. Thus, when one refers to the records in order to discover what relatives visit and how frequently, it is possible to get some indication of the patient's family resources and their degree of interest in the patient. Then, too, if a staff member leaves word in the visitor's register, he can be notified when a relative he wishes to see makes a visit.

In this survey, as a first step in determining the social workers' employment of visits, they were asked if, upon receiving a referral, they checked whether the patient received visitors. The fact that nearly all respondents (twenty-three) replied in the affirmative and only three of these made qualifying comments such as, "sometimes" or "if desirable" would indicate that social workers regard the attaining of this information as an
important function. An analysis of their reasons for making such a referral revealed that the same number (twenty three) checked for the purpose of determining the relatives' interest in the patient. Two of these commented that they checked for this purpose "in some cases".

Arranging to meet the relatives was the second most frequently-cited reason for checking on whether a patient receives visitors. Twenty respondents replied affirmatively to this item. Two of these commented that "in some cases" they checked for this purpose. Another indicated that he only checked for this purpose if follow-up services were to be provided. The least cited purpose for checking was to determine the family's resources. Fourteen respondents indicated that they checked for this reason.

Thus, it would appear that the majority of respondents checked for all three purposes. This is to be expected since these purposes often go hand in hand. However, determining the relatives' interest in the patient seemed to be regarded as the most important of the possibilities mentioned. Arranging to meet the relatives was of secondary importance, whereas determining the patient's family resources was looked upon as the least important reason for checking.

Seven respondents listed other purposes for checking on whether a patient received visitors. Most of these did not specifically answer why they checked, but indicated what the respondents were likely to do after meeting the relatives. Their responses included "helping the relatives with their feelings about the crisis of hospitalization", determining the adequacy of "financial support for immediate family living", determining the relative's "capacity to accept the patient", and discussing "possible discharge plans".
Two of the Crease Clinic respondents indicated that they also checked to determine whether a patient has relatives who might be interested in relative group meetings.\(^1\) One of the Weyburn respondents indicated that he also checked for the purpose of locating prospective foster homes for patients.

More and more it is being recognized that total treatment should include the interest and support of the family throughout the patient's illness. It is also being acknowledged that after-care thinking should begin upon the patient's admission and continue throughout his hospitalization. Although giving the patients' family some interpretation of mental illness and the role of the hospital is a task shared by the whole hospital, social workers, because of specific skills and specific areas of competence, may assume greater responsibilities in this area and may assume a larger part of the work of modification of family attitudes and the modification of environmental factors affecting the patient.\(^2\)

In view of the foregoing consideration, another aim of the present study was to discover to what extent social workers take advantage of visits in carrying out such responsibilities. In an attempt to elicit this information, the respondents were asked if they followed the practice of trying to see the relatives of referred patients at least once during their visits. In response to this question, fifteen respondents answered in the affirmative. Four others made the following comments: "not necessarily", "only if necessary", "this is not always possible" and, "this depends upon the patients needs and is done in about one-third of the cases". Of the four persons who indicated

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\(^1\)Meetings in which relatives come together with a social worker to discuss concepts and attitudes towards mental illness, the hospital and patients.

\(^2\)Ingle, Dana, L., Editor. Social Service Responsibilities In After Care, Proceedings of Regional Institute, Louisville, Kentucky, October 1953, Kentucky Department of Mental Health, pp. 25-40.
that they did not try to see relatives at least once during their visits, and two persons commented: "relatives are often seen by appointment not necessarily during a visit", and relatives are "only seen when some specific information or problem is involved". One person possibly misinterpreted the question: The response read "I usually see relatives after several visits".

From the above data it may be concluded that not all social workers try to see the relatives of referred patients at least once during the course of their visits to hospital. Although no provision was made for determining why this was so, it can be seen that there may be a variety of reasons. For example, they may simply have not had time. Also, some do not perhaps regard the practise as part of their role, while other cases may be left to the doctor. Whatever the reasons may be for not following such a practise, the important consideration here is that if the visiting relatives fail to receive the proper attention from hospital personnel, central problems can remain unsolved and as such may not only interfere with the patient's treatment and progress, but may also influence his acceptance into the larger community when he is ready to leave hospital.

To ascertain how visitors may contribute to the hospitals therapeutic program through contacts with social workers, the respondents were asked to give their reasons for trying to see relatives when they visit hospital. A number of possibilities were itemized. Although a fair proportion of the survey group checked all the possibilities mentioned, it would appear that social workers regard the following as the major reasons for trying to see the
visiting relatives: (a) "to discuss pre-discharge plans", (b) "to obtain social history information", and (c) "to help the relatives accept the patient". The number of respondents checking each of these items was nineteen, sixteen and sixteen respectively.

The other possibilities mentioned were apparently regarded as being of lesser importance. Thirteen respondents indicated that they tried to see the relatives "to discuss aspect of treatment". One person commented that he did not arrange appointments specifically for this purpose, but he would discuss treatment if the relatives inquired about it. Eleven respondents indicated that they tried to see the relatives "to encourage continued visiting". Five of these persons made qualifying comments, such as, "this depends upon the family situation", "depending upon the patient's condition" and "if indicated - the contrary may be true". One Crease Clinic worker indicated that lack of continued visiting is a very minor problem in that unit.

Finally, the evidence suggests that social workers are least likely to try to see the relatives "to interpret how visits benefit the patient." Only ten respondents checked this item. Two of these qualified their responses with the comments, "as circumstances indicate" and "this is necessary only in some instances at Crease Clinic".

In listing additional purposes for seeing the visitors, two Crease Clinic respondents indicated that they also tried to see relatives in order to plan discussion groups for relatives. The value and method of implementing discussion group for relatives will be elaborated upon in Chapter IV. Another mentioned that he tried to see relatives as part of an admission interview. Four Crease Clinic respondents specified that they would sometimes interview relatives in order to discourage too frequent visiting if it was thought to
be in the best interest of the patient. On the basis of this information and that supplied above, it would appear that in Crease Clinic lack of visiting is not such a problem as it may be in the other units.

Rather than simply establishing whether social workers try to meet visiting relatives and their motives for doing so, an attempt was made to discover if they also saw value in meeting with the patients and visiting relative (even briefly) on the ward. It is evident that social workers do see merit in such practice. All but three replied in the affirmative. Seventeen were able to comment on circumstances in which they thought it might be desirable to do so. For purposes of clarification and interpretation their comments have been classified as follows:

(1) For Assessment Purposes: It was considered by eight respondents that it might be desirable to see the patient and relative together on the ward for the following reasons: to observe interaction; to determine the type of relationship which exists between patient and relative by looking for such things as leadership, dominance, support; to clarify the mutual degree of understanding of the patient and his illness; to clarify the mutual expectations of relatives and patient; and to "establish certain facts previously unclear".

(2) For Treatment Purposes: It was further estimated by seven respondents that seeing the patient and relative together on the ward might be valuable in the following instances: when there is a need to save time in transmitting information both the patient and the relative should know; when immediate planning is necessary and relatives live a long distance from hospital; when the worker wishes to convey the idea that he is a "link"—somebody whom both the patients and relatives can trust; When the worker
wishes to establish a relationship in preparation for follow-up services; when the worker wishes to emphasize the family focus and demonstrate his interest in the welfare of the family; when it is thought that a patient could benefit by a demonstration of the worker's positive attitudes and respects for the patient in the presence of the relatives; and finally, to work out problems when a patient is confined to the ward.

(3) For Other Considerations: The following comments are representative of other contingencies which five respondents thought could make a meeting with patient and relatives profitable: if it is a patient's first admission; if the patient seeks it; if it is thought that the relative can offer support to the patient, and if the patient is returning to the family.

The respondents were also asked to comment on circumstances in which it might be desirable to meet with the patient and relative (even briefly) on the ward. Fourteen persons responded. As in the foregoing, analysis revealed that these comments could be grouped into separate categories:

(1) Condition of the Patient: According to the respondents, meeting with the patient and relatives on the ward was seen to be undesirable when the patient is too disturbed and his illness is likely to create scenes impossible to handle.

(2) Type of Interaction Between Patient and Relative: Five respondents estimated that it is undesirable to meet with the patient and the relative on the ward when there is negative interaction between patient and relatives and the relatives are hostile to the patient or vice versa; "when relatives interfere with the patient's psychological state"; or in circumstances in which the "relative is involved in the patient's illness and is incapable of understanding".
(3) Other Considerations: Finally four respondents thought that meeting with the patient and relatives on the ward is not desirable if the situation is such that the patient does not want to be seen by relatives; the patient and relatives want to be alone; the worker has little prior knowledge of the visitors; the worker does not have a specific therapeutic goal in mind; or the meeting is likely to damage the worker-patient relationship.

From the above material it may be concluded that social workers think it is useful to see the patient and visiting relatives together on the ward in carrying out certain aspects of assessment and treatment. However, there are some circumstances in which they think it is undesirable to do so. These may be briefly summarized as follows: if the patient is in a very disturbed condition; if there is negative inter-action between patient and relatives; if the patient doesn't want to be seen by relatives; or if the patient and relatives want to be alone. The writer would question whether social workers, by making such exceptions might not be ruling out opportunities to carry out necessary assessment and treatment which could result in the modification of negative inter-action between patient and relatives.

In exploring another possible way in which visits assist social workers in providing services to the patients, the respondents were asked if they thought patients were more accessible to a discussion of their relationships with their families following visits. In response, thirteen persons replied in the affirmative. Nine of these same persons took the opportunity to comment on their observations regarding the matter. Their comments may be summarized as follows: visits very often promote the renewal of either positive or negative feelings (these feelings are sometimes revealed to the
worker following a visit by relatives); and patients are more particularly accessible to a discussion of relationships if there is some conflict or a breakdown in relationships between patient and relatives or when the patient is responding to treatment. Finally, one respondent thought that the question of whether patients are more accessible to a discussion of relationships following visits is dependent upon "degree of acuteness of the illness and the patient's symptoms". This person went on to say, "The very withdrawn schizophrenic is little moved by pleasant or unpleasant experiences".

A few persons indicated that the answer to the question of whether patients are more accessible to a discussion of their relationships following visits depends on many factors, including the type of patient, the degree of illness, what transpired between the patient and family during visits, and whether the worker has been included in preparing for the visit. Another respondent commented that, in about fifty per cent of cases, the patients are more accessible to a discussion of relationships following visits. This person thought that such a discussion is more apt to occur "if the relationship is near the surface" but if it is "deeper lying, the feeling may be a cover-up", however, she thought that "one is able to make useful observations in either case". The respondent concluded by saying that "an even better opportunity for this sort of thing is provided when a patient has spent a weekend at home".

The evidence gathered here suggests that, following visits, patients may be more willing to discuss their relationships with their relatives. The comments of the respondents pertaining to this observation would seem to indicate that it is the resumption of the patient's contact with the
relatives which is the important determiner of this reaction. A visit may bring about a renewl of patients' positive or negative feelings towards his relatives. The expression of such feelings not only provides the social worker with a better knowledge of the family background and the social factors which are so vital in attaining a total picture of the patient's illness, but it also gives him a better idea of where to focus his energies in alleviating the stresses which may exist between patient and relatives.
CHAPTER III
THE DETERMINANTS OF VISITING

In the foregoing chapter, effort was devoted to delineating the favourable and the unfavourable effects of visits upon patients. The evidence suggested that, although visits are sometimes upsetting, they are much more apt to facilitate the patient's treatment. However, not all patients receive regular visits. For example, at Saskatchewan Hospital, Weyburn, which has a patient population of approximately 1,530, an average of 1,400 relatives and friends visit each month. 1 This means that a patient, on the average, receives less than one visitor per month. In view of the above, it would seem important to ascertain what determines how frequently the mentally ill patient is visited.

Causes of Infrequent Visiting

(a) Social Workers' Viewpoint:

Why are some patients visited infrequently? In order to determine the main factors involved, the social workers participating in this study were presented with a list of possible factors responsible for infrequent visiting. The list was culled from the literature dealing with the topic, and the purpose was to determine the relative degree of importance which the respondents attached to each of the variables.

These variables were as follows: (a) misconceptions, fear, or shame about mental illness; (b) anxiety and guilt about the patient and the illness (relatives may feel that they are to blame for the patient's condition); (c) discouragement with the patient's slow progress; (d) pain

1 General Statistics, Saskatchewan Hospital, Weyburn Saskatchewan, unpublished statistical information, 196.
or embarrassment connected with visiting; (e) a desire to sever contact with
the patient in order to offset the changes of his return home; (f) decisions
of the relatives that their visits are not benefitting the patient; (g) lack
of communication, especially in the case of severely regressed patients;
(h) rejection of the relatives' visits or denial of the relatives' existence;
and finally, (i) other demands upon the relatives' time which make it difficult
for them to visit more often.

Since social workers function as a liaison between patients and the
community, they are afforded numerous opportunities for coming into contact
with the patient's home situation. Therefore, they are quite often in a
favourable position to discover why the relatives do or do not visit.

In this survey, the respondents were first asked whether they had
found the above listed items to be causes of infrequent visits by relatives
(living in reasonable proximity to hospital without transportation difficulties).
The results indicated that the majority of social workers had encountered,
in varying degrees, all of the listed causes.

From the examination of the frequency with which each of the items
was checked, it would appear that the respondents had had the least amount of
experience with relatives who limited their visiting because they did not
think their visits were benefitting the patients. Fourteen respondents checked
this item, as compared to twenty respondents who indicated that they had had
some encounter with relatives who limited their visiting because of pain or
embarrassment connected with visits.

The respondents were then asked to select what they considered to be
the three most prevalent reasons for infrequent visits. The following variables
were regarded as such by twelve, ten, and thirteen persons, respectively: (a) "misconceptions, fear or shame about mental illness"; (b) "a desire to sever contact, to avoid the patient's return home"; and (c) "anxiety and guilt about the patient". The fact that "misconceptions, fear or shame about mental illness" was placed among the three most prevalent causes suggests that social workers are continuing to find that the community's understanding and acceptance of mental illness has not reached a high level.

"A desire to sever contact to avoid the patient's return home" may be regarded as the reason which is more particularly relevant to long-term patients. Families generally adapt to a long period of absence of any of their members with the result that resistance may be encountered at the prospect of a patient returning home. In some instances, the patient's return may necessitate difficult person and financial adjustments which the relatives are unwilling to make.

The other items which were listed may be considered less important reasons for infrequent visits, but five are worthy of mention. The number of times each was included as one of the three most prevalent causes of infrequent visits is as follows: loss of interest in the patient (8); other demands forcing the relative to visit less often (7); pain or embarrassment connected with the visits (7); discouragement with the patient's lack of progress (6); visits not considered beneficial by the relatives (5).

Some notable differences arise in the frequency with which certain of the above items were listed by the social workers in the five hospital units included in this survey. Proportionately, more East Lawn and West Lawn
respondents considered loss of interest in the patients to be one of the three most relevant reasons for infrequent visits. An unpublished survey of the male population of West Lawn carried out between February 1960 and July 1961 indicates that forty seven percent of the patients had been hospitalized for more than ten years since the dates of their most recent admission. In view of this, it is not difficult to understand why loss of interest in the patients was so frequently itemized by these respondents.

Crease Clinic respondents, on the other hand rated "other demands forcing relative to visit less often" as one of the three most prevalent causes. Although the "demands" were not specified, employment obligations and family responsibilities may be taken as important factors in this.

(b) Patients' Viewpoint:

Although it may sometimes appear that patients are merely passive recipients of visits, more often than not they are, in fact, active participants who share much of the responsibility for the outcome of the encounters. Moreover, the degree to which patients are affected by visits is substantiated by the experiences of nursing staff. It is frequently noted that patients (particularly those who have had few visits) vividly recall and make numerous references to any visit received, weeks and even months, after their visitors have come and gone.

To ascertain what factors patients regard as playing a part in determining how often they are visited, one of the questions asked of them was whether or not they were satisfied with the number of visits they received.

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Five patients stated that they were, while four made it clear that they would have liked their relatives to visit more often. One patient could not properly comment since she had been in hospital only a few days.

In accounting for their lack of visits the four "dissatisfied" patients gave the following interpretations: three specified that their relatives lived too far away, and one of these three maintained that his relatives could not afford to visit more often and that they did not have their own car; another explained that his relatives had young children to look after and found it difficult to get away; and one more indicated that, although he would have preferred his friends to visit more often, he realized that their own problems took precedence over his own. (It should be mentioned at this point that it was the writer's impression that these four patients who would have preferred more visits seemed only mildly dissatisfied with the number of visits they received).

The hospital's physical facilities and its policies regarding visiting must also be looked upon as influences which affect visiting frequency. For example, one might question the part which visiting hours play in determining how often a patient is visited.¹ When the patients were asked whether they thought the visiting hours were long enough, all but two maintained that they were fairly well satisfied with the length of time allotted. However, it was evident that most were answering the question in terms of how the length affected them personally. They tended to overlook whether or not relatives found it convenient to visit within specified times.

¹Visiting hours in both Crease Clinic and Provincial Mental Hospital are 1:30 to 4:00 P.M. daily, and 7:00 to 8:00 P.M. on Tuesdays and Thursdays.
Also, in expressing their views, several of the patients made comments such as: "The hours are almost too long if they visit often", or "There is not much more you can say after that long". One patient thought that the length of visits should be limited to one-half hour per person, because "after that, the conversation starts to get too personal, and if a patient tires easily, it may be too much of a strain on him".

Only two of the patients questioned whether or not there was sufficient time allowed for visiting. One suggested that the evening hours "may be a rush". Another specified that evenings "should be left open for extenuating circumstances". With respect to the location of the visits, half the patients said that they were usually visited in the ward corridors; three with ground privileges, were frequently visited outside; one woman found it pleasant to take her visitors to Pennington Hall, and another mentioned that he and his parents sometimes used the visitors' room.

When asked whether they would prefer more privacy when visited, five were fairly well satisfied with the existing arrangements. Some of the comments were as follows: "It's all right under the circumstances"; "it's all right as long as there is a place to sit down", and "I think there is enough privacy, although the corridor has been quite full at times". The remaining five indicated that they were not satisfied with the existing facilities for visiting. One patient expressed the view that there should be additional reception rooms for visiting. One wished to see a "more comfortable atmosphere, with soft chairs - not hard chairs" and "a visiting room where patient can forget the hospital". Two expressed their dissatisfaction with corridor visits. One female made the following criticism: "Anything would be better than the corridor, where doctors and staff walk by and the chairs

-Pennington Hall is a combined recreation centre and coffee shop for patients-
are lined up in a row". She thought that "there should be some way to group off chairs, to allow people to talk about personal matters without others overhearing".

(c) Relatives' Viewpoint:

As previously mentioned, all the relatives interviewed were from Vancouver and surrounding municipalities. All were able to reach the hospital in less than an hour and the majority travelled with their own, or the family car. The exceptions were two persons who usually came with friends or relied on public transportation, and one who lived within walking distance. The one travelling by bus remarked that this made it more difficult to visit.

On the basis of these statistics, it would appear that distance and problems of transportation did not play a significant role in determining how often this particular selection of relatives visited. However, it should be noted that the psychiatric facilities at Essondale serve almost the entire population of the province. Therefore, it may be assumed that a large percentage of patients have their visits curtailed due to distance and transportation difficulties encountered by relatives living in outlying areas.

To discover what other factors the relatives regarded as being influential in determining visiting frequency, they were asked if they visited as often as they would have liked. Seven replied in the affirmative and of these, two husbands indicated that they visited as often as their work would allow but did not say that they would like to visit more often. Another husband, whose wife was a recent admission, commented: "Right now, I don't care to visit too often. It will be better when my wife improves and has ground privileges". Thus only three of the visitors indicated that they would like to visit more often. As mentioned earlier, two of these had been
advised to limit their visits to twice a week and in addition to these restrictions, one woman commented that it was not always easy to find a babysitter. This same difficulty was experienced by another visitor who would have like to visit more frequently.

As in the interviews with patients, an attempt was made to discover how the relatives viewed the hospital's visiting program in order to ascertain whether it might have an influence on the frequency of their visits. Inquiries regarding visiting hours revealed that the majority of relatives (8) found the length satisfactory. Only two sometimes found it difficult to visit within the allotted time with one man explaining "It makes it hard when I'm working because I can only get out two nights a week unless I take them off." The second relative, a woman, had found that evening visiting hours were not coordinated with the bus schedule, which meant that after the conclusion of a visit she had to sit some time before she was able to return home.

As discovered with the patients, most of the relatives revealed that they usually visited in the ward corridors. Occasionally, a few used the visitors' rooms, Pennington Hall, or visited on the grounds. When asked whether they felt that they had sufficient privacy during visits, the writer was surprised to discover that the majority of the relatives did not voice any major complaints about the amount of privacy. It was evident that they had accustomed themselves to the hospital's overcrowded conditions and realize the difficulties which would be encountered in expanding the visiting facilities. In most instances, the relatives found it possible to
obtain some degree of privacy, except for the occasional busy day or weekend when there were more visitors than usual. Thus, only two of the relatives indicated that they would have appreciated more privacy. One person, who generally visited in the corridor, commented: "People are sitting on top of you now."

In addition to the above factors, it was also thought that the attention which hospital staff give to visitors might have some bearing on their willingness to visit. In view of this, the relatives were asked if they would appreciate having more opportunity to talk to doctors, social workers, or other staff. Their replies clearly pointed up the fact that relatives did not feel that they had sufficient access to staff (particularly the doctors). All but two wanted more opportunity to talk to staff directly concerned with their patient's care. Some of the comments made were as follows: "I would like to see the doctor more often without waiting for an appointment"; "I would like to talk periodically to someone involved"; "I would like to see the doctor more often if possible, but at least there should be someone on the ward to talk to - preferably the head nurse". Another two relatives said that they "would like to see someone" in order to talk about the patient's condition. One of these was anxious to find out if what her husband had been telling her was actually true.

A few relatives made other comments which would appear to tie in more directly with what the social workers estimated to be the cause of infrequent visits. At least three indicated that they had been or still were, discouraged with the lack of progress of their patient. One husband, whose wife had been admitted for the first time, remarked that visits were "not bright looking at first". Another commented: "Visits shake you up a little
at first". A wife whose husband had only been in hospital a few days was rather dismayed because she didn't think the hospital seemed "to be doing anything for him". Several relatives made other comments which indicated that there may have been some pain or embarrassment connected with their visits. One gentleman admitted quite frankly that he "hated" the idea of his wife being in the mental hospital. He would have preferred that she go to Crease Clinic. Along with another relative, he expressed a distaste for the locked doors, which he thought "bothered" his wife.

The Characteristics of Frequently and Infrequently Visited Patients

Although the evidence to this point has been more successful in raising questions that providing conclusive answers, it suggests that the frequency with which a patient is visited is a complex matter related to a variety of factors. Although a number of determinants have been discussed, there are probably many others. To clarify what they might be, further investigation was undertaken to ascertain whether there was any relationship between visiting frequency and such variables as the patient's age, sex, marital status, length of hospitalization and previous admission to hospital.

It has already been noted that five of the patients were satisfied with the number of visits they were receiving, whereas four indicated that they would have preferred their relatives to visit more often. The five "satisfied" patients were visited an average of 1.84 times per week, compared with an average of .84 for the four "dissatisfied" patients. Moreover, the patients with female relatives were visited more frequently than those visited by male relatives. The average number of visits per week for those two groups was 2.66 and 2.19 respectively.

Thus, there are two groups of frequently visited and two groups of less frequently visited patients. Rather than dealing with four separate groups, the data was combined to yield one larger group of ten frequently visited
patients (Group A) and a second group of nine less frequently visited patients (Group B).

Table 1. A Comparison of the Characteristics of Frequently and Less-Frequently-Visited Patients

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>(Group A) Frequently-Visited Patients</th>
<th>(Group B) Less-Frequently-Visited Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>30.3 years</td>
<td>43.1 years</td>
</tr>
<tr>
<td>Percentage of Female patients</td>
<td>50 %</td>
<td>66 %</td>
</tr>
<tr>
<td>Percentage of Unmarried patients</td>
<td>50 %</td>
<td>33 %</td>
</tr>
<tr>
<td>Average Length of Present Admission (months)</td>
<td>1.30 months</td>
<td>1.03 months</td>
</tr>
<tr>
<td>Percentage of Patients with Previous Admission</td>
<td>80 %</td>
<td>66 %</td>
</tr>
<tr>
<td>Average Number of Previous Admissions</td>
<td>1.62</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Source: Adapted from Crease Clinic and Provincial Mental Hospital records.

A comparison of the characteristics of these two categories shows a marked difference in the average ages of the two groups. (See Table 1). The frequently visited patients were, on the average, almost thirteen years younger than the less frequently visited. Also, a comparison of the number of unmarried patients in each category shows that there were proportionately more unmarried patients in Group A than in Group B. One-half of the frequently visited patients were females, whereas two-thirds of the less frequently visited were females. There is little difference in the lengths of hosp-
italization for the two groups. The frequently visited patients had been in hospital approximately eight days longer than the less frequently visited. Approximately the same proportions of both groups of patients had been admitted to the hospital on previous occasions. The average number of previous admissions for patients who had been previously admitted to hospital was less for Group A than for Group B. Most of the previous admission in the latter group were accounted for by one patient who had been admitted on seven previous occasions.

It had been noted that distance from hospital did not appear to influence the frequency with which the interviewed relatives visited. However, among the patients interviewed, three of the less frequently visited mentioned that their relatives were unable to visit more often because they lived too far from hospital.

In view of the limited size of the groups under survey, the findings of this portion of study cannot be taken as conclusive evidence for the existence of relationships between visiting frequency and the characteristics in question. However, since a number of more extensive studies have been concerned with investigating these same relationships, their finding will be reported here in an attempt to determine as accurately as possible the nature of such relationships.

Comparable Surveys

(a) Sommer's Study:

A study undertaken by Sommer at Weyburn Mental Hospital compared the characteristics of patients who received visitors during a three-week criterion period with the characteristics of a random sample of equal size from the total hospital population. He neither found a relationship between the age of a
patient and whether or not the patient received visitors, nor a relationship between visiting and distance of the patient's home residence from hospital. Patients who received visitors had lived proportionately the same distance from hospital as the random sample of patients. However, there was a marked relationship between length of hospitalization and whether or not a patient received visitors. The average length of hospitalization for the patients who received visitors was 7.4 years, whereas the average length of hospitalization for the random sample was 16.6 years. He also found that female patients received proportionately more visitors than male patients.\(^1\)

(b) Groth's Study:

A study of unvisited patients undertaken by Groth and others at the V A Hospital in Fort Lyon, Colorado, further confirms the existence of a relationship between receiving visitors and length of hospitalization. The average length of hospitalization of all unvisited patients was 14.7 years, whereas for all patients (as obtained from a 20 percent sample of the hospital), it was 9.9 years. The findings of these investigators differed from those of Sommer in that they discovered that the unvisited patients were significantly older than the visited. Their data also indicated that the farther a relative lives from the hospital, the less likely he or she is to visit. On one of the wards studied, they found that 47 percent of patients never having a visit had relatives living more than 500 miles from the hospital, while only 15 percent of the patients having visits during the year had relatives living this distance. They also discovered that "a surprisingly large percentage of the unvisited patients (58 percent) had never been married."\(^2\)

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\(^1\) Sommer, Robert, "Visitors to Mental Hospitals, a Fertile Field for Research", Mental Hygiene, Vol. 43, No. 1, January, 1959, pp. 8-15.

(c) The Weyburn Study:

In addition to the aforementioned studies, a previous investigation of a similar nature was conducted by the writer at Saskatchewan Hospital, Weyburn. Utilizing the opportunity provided by a "Family Day" (a special event set aside by the hospital to encourage visiting), invitations were sent to the relatives of a large selection of patients (one relative per patient). Accordingly, out of a total of 418 patients whose relatives received invitations, 120 were visited on Family Day. Eighty-eight were visited in response to the written invitations, while thirty-two were visited by relatives who may have come in response to radio and newspaper advertising.

An analysis was undertaken to compare the characteristics of those who were visited on Family Day with the characteristics of those who were not. On the basis of age, it was found that the average age of the unvisited group (51.26 years) was 3.38 years less than the average age of the unvisited group (54.64 years). This data lends some support to both the findings of the present study and those of Groth, that is, unvisited patients tend to be older than visited patients, but the difference in age is not substantial. However, in terms of marital status, 56.66 percent of the visited and 69.42 percent of the unvisited patients had never been married. These findings somewhat more convincingly confirmed the existence of a relationship between receiving visitors and the patient's marital status. It would appear that married patients are more apt to receive visitors than unmarried patients.

The average length of hospitalization for the visited patients (12.26 years) was nearly five years less than the average length of hospitalization for the unvisited (17.25 years). This marked difference supports the argument that the effectiveness of employing "Family Day" to encourage visiting is explored more fully in Chapter IV.
that the longer a patient remains in hospital, the fewer visits he is apt to receive. However, although this argument would appear to hold true for long-term patients whose hospitalizations run into years, it cannot be assumed that a similar relationship exists for short-term patients whose hospitalization may be counted in months.

Table 2. Previous Admissions of Visited and Unvisited Patients

<table>
<thead>
<tr>
<th>Sample</th>
<th>Percentage of Patients With Previous Admissions</th>
<th>Average Number of Previous Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Visited (N = 120)</td>
<td>43.33</td>
<td>1.57</td>
</tr>
<tr>
<td>Patients Unvisited (N = 298)</td>
<td>32.21</td>
<td>1.51</td>
</tr>
</tbody>
</table>

Source: Adapted from Saskatchewan Hospital, Weyburn records.

A comparison of the two groups on the basis of previous admissions to hospital, as shown in Table 2, reveals that a greater percentage of the visited patients had been admitted to hospital on previous occasions. Both groups had approximately the same average number of previous admission.

Although the other studies mentioned were not concerned with exploring whether there is a relationship between visiting and previous admissions of a patient, the differences noted here between the proportions of visited and unvisited patients with previous admissions suggest that patients who have been admitted to hospital on previous occasions are more likely to be visited than patients who have not had previous admissions.

Table 3 shows the percentage of visited and unvisited Family Day patients who received visits during the year prior to Family Day, as well as the average number of visits they received. It may be seen that proportionately
more of the patients visited on Family Day also received visitors during the year. They also averaged a greater number of visits than the unvisited Family Day patients. Thus, the evidence would seem to suggest that patients with relatives who have been visiting regularly are more likely to be visited on a special occasion than are patients whose relatives have not been visiting or have visited less regularly.

Table 3. Patients Visited During Year Prior to Family Day

<table>
<thead>
<tr>
<th>Patients Hospitalized One Year or More</th>
<th>Percentage of Patients Visited During Previous Year</th>
<th>Average Number of Visits Received During Previous Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visited on Family Day (N = 114)</td>
<td>81.57</td>
<td>5.60</td>
</tr>
<tr>
<td>Unvisited on Family Day (N = 290)</td>
<td>50.34</td>
<td>3.41</td>
</tr>
</tbody>
</table>

Source: Adapted from Saskatchewan Hospital, Weyburn records.

In comparing the frequency of visits for male and female patients, it was found that proportionately more females (32.96 percent) than males (25.42 percent) were visited on Family Day. Here again the findings substantiate the hypotheses that there is a relationship between frequency of visits and the sex of the patients. It would appear that females are more apt to receive visitors than male patients.

As previously indicated, 88 of the patients visiting on Family Day were visited by relatives who came in response to written invitations. All but six of this group of patients had been in hospital over one year or more since their most recent admission. Table 4 shows the number of
relatives who visited on Family Day, as well as the average number of times they visited in the previous year as classified by distance from hospital.

Table 4. **Visiting Frequency as Related to Distance of Relative's Home**

<table>
<thead>
<tr>
<th>Miles From Hospital</th>
<th>Relatives Visiting on Family Day in Response to Invitations</th>
<th>Average Number of Visits in Previous Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 50</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>51 - 100</td>
<td>40</td>
<td>3.3</td>
</tr>
<tr>
<td>101 - 150</td>
<td>11</td>
<td>1.7</td>
</tr>
<tr>
<td>151 - 200</td>
<td>11</td>
<td>1.8</td>
</tr>
<tr>
<td>201 - 250</td>
<td>5</td>
<td>3.0</td>
</tr>
<tr>
<td>over 251</td>
<td>3</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Source: Adapted from Saskatchewan Hospital, Weyburn, records.

The correlations between distance and frequency of visits as shown by the data would appear to support Groth's finding that the more distant the relative lives from hospital, the less frequently they visit. The observation that almost 50 percent of the relatives lived within 51 to 100 miles from hospital may be accounted for by the fact that these boundaries encompass the two largest metropolitan centres in south-eastern Saskatchewan, namely Regina and Moose Jaw cities.

**Comparison and Discussion**

In comparing the results of the other three studies mentioned with those of the present, it will be noted that similar relationships have been observed between visiting and the patient's age, previous admissions and relative's distance from hospital. However, the findings of the present study differ from those of the other investigation in that they do not show the same types of relationships between visiting and the patients' sex, marital
status and length of hospitalization. In view of the limited size of the survey groups in this study, the findings of the other investigations should be given more weight. However, two points should be kept in mind.

First, the present study did not undertake to compare the characteristics of visited and unvisited patients, but was instead concerned with comparing the characteristics of frequently and less frequently visited patients. This distinction is important since the difference between visited and unvisited patients is absolute, whereas the difference between frequently and less frequently visited is relative. Therefore, it cannot be definitely asserted that the same factors which operate to determine whether a patient is unvisited, necessarily operate to determine whether a patient is visited less frequently.

Secondly, the present study was comprised of patients who had been in hospital for short periods of time, while the other studies mentioned were concerned with patients who had a history of both recent and long-term admissions. If relationships do exist between the visiting frequency of short-term patients and the characteristics in question, then, they are perhaps less marked and more difficult to detect. Nevertheless, the findings of these other studies do bear special significance for the present investigation regarding the determinants of visiting.

To recapitulate, it was found that visited patients tended to spend less time in hospital than unvisited patients and that female patients received proportionately more visits than male patients. Married patients were visited more frequently than unmarried ones, and the visited patients tended to be younger than the unvisited. Also a previous study undertaken by the writer seemed to indicate that patients with previous admissions were more apt to be visited than first admissions; and that patients with relatives
who had visited in the one-year period prior to Family Day received more
visits on that day than patients whose relatives had either not visited,
or had visited less regularly, during that time. Finally, both the findings
from the Groth study and the writer's previous investigation indicated that
a relative who lives further from the hospital will visit less frequently.

Sommer points out that the variables he examined, the length
of the patient's hospitalization was most closely related to whether or not
the patient had visitors. However, he was not able to infer a casual relation­
ship between the two variables. In speculating on the significance of the
relationship, he states:

One might think of the large isolated mental hospital as a
grossly disculturating social institution; the longer the
patient is in hospital, the more dissocialized he becomes
and the more likely his relatives are to consider him incap­
able of living outside again. In this case, the relation­ship between visiting and length of hospitalization would be
a by-product of the disculturating effect of the hospital,
rather than a casual connection.

Added to the comments of Sommer, Groth formed the impression
that most relatives are reluctant to visit a chronic patient. He notes that:

After the patient has been in hospital for some years, his
family establishes an adjustment without him. Frequently
the relatives and their neighbors find this new situation
less anxiety-producing than the condition prevailing when
the patient was at home. The relatives tend to think their
family would be safer and happier if the patient were 'written
off'. They: rationalize that the patient is getting better
care in the hospital.

The apparent relationships between visiting and the patient's sex
and marital status may both be partially due to the same underlying factors.
In the writer's previous investigation, it was found that only 33 percent of
the females, as compared with 80 percent of the males, visited on Family Day

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1 Sommer, op. cit., p. 14
2 Groth, op. cit., p. 216
were single. It was also noted that of the 88 patients whose relative visited in response to written invitations, 62 percent of the females and 71 percent of the males who had been, or still were, married were visited by spouse or children. Thus, it would appear that marriage increases the patient's chances of being visited due, no doubt, to the fact that the patient is partially ensured of receiving visits from his family if his other relatives should vail to visit. Then too, it has been noted that married patients, as a group, tend to leave hospital sooner and stay our longer. Since it has already been established that patients with shorter hospitalizations tend to receive more visits, it may be seen that this is another possible reason for married patients having more frequent visits.

The following explanations might help to account for the finding that younger patients receive more visits than older patients. Generally speaking, the older the patient, the greater the likelihood that his relatives will also be advanced in age. Age increases the possibilities that the relatives may be unable to visit because of sickness or difficulties in travelling. Length of hospitalization may also play a part and, indeed, Groth found a significant correlation between patients, ages and length of hospitalization. Here again the evidence points to the significant role that length of hospitalization seems to play in determining whether or not a patient is visited. In addition to such factors, there remains the possibility that our "youth-oriented" culture conditions people to pay less attention to their aging relatives.

1 Groth, op. cit., p. 211

2 Loc. cit.
The possibility of a correlation between the patient's length of hospitalization and previous admissions could also help to explain the finding that, proportionately more visited patients had had previous admissions. Although the writer did not look into such a possibility, in his previous study, it is evident that patients who have been continuously hospitalized are not as likely to receive visits as those who have, during the same period, been in and out of hospital on a number of occasions. For one thing, the patient who has been out of hospital has had more of an opportunity to renew acquaintances and build up relationships than has a patient who has been constantly hospitalized during the same period. Then, too, previous admissions may service to accustom the relatives to think in terms of the patient's recovery. Whereas they might otherwise relinquish all hope, a time out of hospital, even though temporary, might well serve as reason for optimism. As a further speculation, it might be argued that previous admissions serve to more fully acquaint the relative with the hospital, its personnel and its functioning. Perhaps such experiences help to create healthy attitudes towards patients and mental illness. In short, the relatives may be more willing to co-operate in doing what they can to facilitate the patient's return to the community. They may see visiting as one step in this direction.

The finding that, proportionately, more of the patients who received visits on Family Day had also been visited during the previous year is as might be expected. It may indicate that relatives who make a regular practice of visiting establish closer relationships with patients than do those who rarely, if ever, come. For this reason, regular visitors may make a greater effort to visit on special occasions so as not to disappoint the patient.
Traditionally, there has been a tendency to locate mental hospitals away from the major population centres and this has unfortunately increased the problems of communication between hospital and community. The apparent relationship between visiting and the relative's distance from hospital is thus what might be expected, and numerous reasons could be cited to explain the corresponding decline in visits which investigators have found. In many cases, it may not be possible for relatives to make a trip to and from the hospital in one day, for as already noted in the present investigation and the other studies mentioned, many relatives have to travel over two hundred miles to make a visit. In such cases, or even in those in which visitors have much shorter distances to travel, employment demands, family responsibilities, expenses and difficulties in obtaining transportation, and inclement weather causing poor driving conditions may combine to make it impossible for relatives to visit more than a few times during the patient's hospitalization.
CHAPTER IV

A "NEW LOOK" FOR MENTAL HOSPITAL VISITING

The necessity of incorporating the patient's family in the treatment program has been the theme of this study of mental hospital visiting. It has been argued that, although hospitalization most often promotes recovery from mental illness, prolonged institutionalization in a large, crowded and remote mental hospital may be accompanied by a number of undesirable phenomena which deter from the effectiveness of treatment. The longer a patient remains in such a setting, the more "dissocialized" he tends to become. Most important from the standpoint of this thesis is the fact that he loses contact with the outside world - family, friends, and community. Barton suggests using the term "institutional neurosis" to describe the condition of patients who have spent considerable time within the type of institution in question. The patient accepts routine without question. He becomes less capable of independent thought and action. He acquires the values of institutional living, which, may differ markedly from those of larger society. He loses interest in the future and in events not immediately personal or present. In addition, there is usually a deterioration of personal habits.¹

The role of the patient's family is exceedingly important in neutralizing these unintended, unfavourable consequences of hospitalization. Since most of a patient's life is spent in the community and since the goal of the hospital is to return the well patient to it, hospitalization should

¹Barton, Russel, Institutional Neurosis, John Wright and Sons Ltd., Bristol, 1959, p. 12.
not be looked upon as more than a temporary phase in the patient's treatment. Therefore, in addition to concentrating on the formation of therapeutic relationships within the hospital, emphasis should be placed upon strengthening the patient's ties with the world outside the hospital. Generally the family is the principal mediating agent between the hospital and community. Without the relatives' continued interest and participation in the patient's treatment and progress, the lines of communication between the patient and community are far more difficult to maintain. Visiting is only one aspect of the relatives' participation in the patient's convalescence, but it occupies a place of strategic importance. The patient's recovery very often rests upon a recultivation of human companionships. There can be no substitute for personal contact with loved ones. By encouraging relatives to visit on a regular basis hospital authorities may help to fulfill this basic human need.

The Utility of Visits

Although it can be affirmed that, as a general rule, the arguments for encouraging visiting hold true, there are some situations in which the value of visits must be questioned. Possibly the most significant discovery from this survey is that visits are not as likely to be as therapeutic during early phases of treatment as when the patient has made some progress towards recovery. Perhaps this is so because neither the patient nor the relative is apt to appreciate a visit when a patient is still acutely ill or not yet
accustomed to the experience of being in hospital. Visits may not be indicated if a patient is hostile, threatening or abusive towards visitors. On more rare occasions, visits may have little beneficial effect because the patient is not interested in seeing anyone. A tenuous or strained relationship between the patient and relatives can also limit the value of visits, particularly if a visit upsets the patient's equanimity. At times the type of behavior which the relatives display can undermine the beneficial effects of visits. Extremely anxious, over-protective, or guilt-ridden visitors can communicate tensions which disturb the patient and perhaps even cause a temporary setback in his recovery. Visitors can also interfere with a patient's progress if they are unable to accept or understand the patient and his emotional difficulties.

Turning to the positive contributions which visits can make to the patient's treatment, it has been shown by this survey that one of the most outstanding benefits a patient may receive is the comfort of knowing that he has not been forgotten by the people most important to him. Perhaps this is so because, like most people the mentally-ill patient is searching for constancy in his human relationships, and wants to feel that he still "belongs" to society.

In view of the fact that the pattern of life within a large, strange, mental hospital is generally quite different from anything the newly
admitted patient has even known before, there is danger that he will will feel lost and overwhelmed. Visits can help him to overcome his feelings of anonymity. During visits he emerges once again as an individual with his own unique background and pattern of relationships. He is reminded that, in spite of hospitalization, he still occupies an accepted place within the family setting. Another beneficial derivative of visits is the satisfaction a patient gets in knowing how his family is managing in his absence. Patients enjoy receiving news about their homes and relatives. Quite often, they desire some reassurance that their children or others who depend upon them are not suffering unduly as a result of the patient's admission to hospital. Also a visit can reassure the patient that in spite of any disagreements or conflicts which may have arisen between himself and his relatives, the family is still concerned about his welfare and do not think any less of him because of his illness and hospitalization.

In addition to the direct contributions which the relatives' visits can make to facilitate the patient's recovery, visits benefit patients indirectly through the efforts of the hospital staff (notably, social workers) to utilize their contacts with the visitors in providing better treatment services. For example, by noting how frequently a patient receives visitors and the relatives' reasons for visiting or not visiting, one can make some determination of the patient's family resources. Such information is required for the
purpose of assessing to what extent the family can be relied upon to provide
the patient with constructive support throughout the treatment period and
following separation from hospital. Contacts with visitors can provide social
workers with opportunities to formulate discharge plans and involve the
relatives in creating desired modifications in the patient's home environment.
In the majority of cases, the family is called upon to assume most of the
responsibility for the patient's continuing care. On the basis of their know-
ledge/the patient and his condition, the relatives are quite often in a favour-
able position to make recommendations and proposals regarding his rehabilitation.
They can be instrument/in helping the patient to locate employment, take a
special training course, or perhaps find a suitable place to live.

Another useful concomitant of visits is the opportunity which they
provide social workers to acquire relevant data about the patient's social
background. In order to obtain a complete picture of the patient's illness and
to make a proper assessment of his situation, it is essential to have an
appreciation of his daily environment, the totality of his problems, and the
people most important to him. Understanding the patient's family life implies
having some idea of what it has been and some perception of its strengths and
weaknesses. Through individual or joint interviews with the family and the
patient, social workers are able to learn something of the interplay of relation-
ships and how the family functions as a group. The information acquired is also
valuable in providing clues to the patient's personality and typical behavior pattern. Then, too, the relatives are frequently in a key position to provide accurate accounts of the patient's interests, capabilities, and skills. Without the relatives' assistance, staff must depend on the patient to give this information. However, a patient is sometimes reluctant or unable to reveal such matters. Also there are times when their interpretations cannot be completely relied upon. Delusions, hallucinations, and other symptoms of their illness may cause them to give a distorted picture.

Joint or individual interviews with patients and relatives, during visits, can be of mutual benefit to both parties in that they may offer the social worker an opportunity to form a relationship in preparation for follow-up services. If the patient is to receive full benefit from after-care service, it is necessary that both he and his relatives accept the social worker's intervention and relate positively to him. The relatives' contacts with hospital personnel can help patient's through the increased understanding the relatives get regarding the patient's condition and what part they may play in facilitating his recovery. At times, families require much support and careful interpretation of mental illness in order to appreciate the patient's difficulties and accept him as someone who needs their sympathetic understanding and assistance. A visit by relatives can result in a more expeditious use of time in communicating information which would ordinarily be communicated by
correspondence. Information regarding the type of treatment, the patient’s progress and discharge proposals can sometimes be transmitted quickly and effectively in person.

Still another beneficial effect of visits arises out of the social worker’s contact with the patient following the visitor’s departure. It frequently happens that, after a visit, patients verbalize more freely and express previously hidden anxieties, resentments, and other pent-up feelings regarding their relationships with their families. This expression gives the social worker a better idea of where to focus his energies in order to alleviate the stresses and settle any conflicts which may exist.

Why So Few Visitors?

Having established that, as a general rule, visits by interested relatives can make a positive contribution to the treatment of the mentally ill, a second major objective in this study was to discover what determines how frequently a patient is visited. It would seem to be a reasonable assumption that patients in mental hospitals receive fewer visits per capita than patients in general hospitals. The difference is perhaps due, in large measure to the long distances which relatives of mentally ill patients must travel in order to reach the hospital. Since most larger communities boast adequately-equipped general hospitals within easy reach of the populations served, distances present few problems to their visitors. However, in a province such as British Columbia or Saskatchewan there may be only two mental hospitals serving the
entire population. This, of course, means that hundreds of miles may separate the mentally-ill patient from his home and relatives. Such distances make visiting vastly more complicated and subject to a number of variables over which neither the family nor the hospital has much control. Inclement weather and poor driving conditions can easily discourage relatives from attempting a long trip. Relatives may encounter difficulties in getting transportation. Travelling can be expensive, particularly if the visitors have to stay over, because they cannot visit and return home the same day. Visitors who rely on public transportation facilities may discover that schedules are not coordinated to suit their needs. In such instances visiting can be very time consuming. Relatives with family responsibilities or employment obligations may find it impossible to get away for the time it takes them to visit. It is understandable that under these circumstances, visiting may gradually decrease and perhaps eventually stop. Although the family may feel guilty for not coming more often, they may come to the conclusion that brief and infrequent visits are more heart-rending than none at all.

A second group of variables influencing visiting frequency is more directly related to the patient's condition and the cultural acceptance of mental illness. According to the respondents in this survey, misconceptions, fear, or shame about mental illness is a foremost determinant of infrequent visiting. It would seem that there is still a large gap between the general
public's knowledge and understanding of the disease and that which is publicized by the mental health educators. Undoubtedly there is still some stigma attached to mental illness. Despite widespread reports to the opposite, some people look upon it as an incurable condition. Others hold to the belief that the mentally-ill are often violent or dangerous people. This belief may be perpetuated to some extent by sensationalism in the movies, newspapers, and other mass media which frequently portray the psychotic person as being vicious and dangerous to be at large. In actual fact the majority of mentally-ill persons are passive withdrawn individuals who would not harm anyone. Nevertheless, the public is apt to have a certain amount of fear of people whose behavior is unpredictable or irrational and at times the mentally-ill person's behaviour may be both.

Another important reason for not visiting stems from the relatives' efforts to avoid being called upon to assume responsibility for the patient, following his release from hospital. To circumvent this contingency the relatives may decide to sever contacts with the patient. Very often they may be unwilling to accept the patient's return home because he represents a financial burden. As a result of his incapacitating condition the patient may go through long periods in which he is unable to assume normal employment responsibilities and thereby earn his living. Families, especially those living on marginal incomes, may feel that they cannot afford to support a non-contributing member. Some relatives may not visit because they are convinced
from past experiences that the patient even when considered well enough to leave hospital will continue to present difficulties for the family. In other cases, where the patient has been in hospital for a period of years, the relatives may think that he is too dissocialized to assume a normal pattern of living within the community. It is conceivable that in some instances, the relatives feel ashamed of the patient's less-socially-accepted behavior and do not want to have him around.

The anxiety or guilt relatives may have in connection with the patient and his illness can have a very pronounced influence on their willingness to visit. Relatives who have been closely associated with a patient sometimes blame themselves for his illness and admission to hospital. They tend to think, that if they would have handled the situation differently the patient would not have become ill. Rather than face a reactivation of guilt feelings they prefer to visit as little as possible. Guilt feelings can also interfere with the relatives' incentive to visit in cases where the patient has been rejected or not wanted at home, especially if family members realize that they should have tried to make arrangements for him to leave hospital.

The family's interest in a patient is another prominent determinant of visiting frequency. A loss of interest is most marked when the patient has been hospitalized over a long period of time. As the patient's length of stay is extended, the relatives are apt to lose interest because they think that he
will never recover sufficiently to leave hospital. Unless there is an appreciable improvement in his condition they may cease visiting on a regular basis.

Visits can be painful and embarrassing experiences for relatives, particularly, if the patient is agitated or very actively psychotic. The patient may threaten the relatives or accuse the family of betraying him by having him placed in hospital. In certain circumstances, relatives who are in a position to visit regularly do not choose to do so because they become dejected when the patient demands or pleads to be taken home, but is not well enough to leave hospital. It can be painful when the relatives visit for the first time and discover that the surroundings of many of the patients are crowded and inadequate and do not meet the standards of care set by general hospitals. In still other situations, relatives may not visit regularly because they do not feel that their visits are benefitting the patient. If a patient is negativistic, fails to recognize the visitors or acts inappropriately towards them, it is natural that the relatives will question the value of their visits. It is for such reasons as those mentioned that a number of the respondents in this survey estimated that visits during the initial stages of treatment are not as helpful as when there has been some improvement in the patient's condition.

The hospital's regulations, its accommodations for visitors, and
the general atmosphere may be said to comprise a third division of variables governing the frequency of visiting. In this survey it was discovered that only a small proportion of the respondents considered that the hours allowed for visiting had a restrictive effect on visits. However, it was noted that all the relatives interviewed lived reasonably close to the hospital. For relatives living at more distant points it is highly probable that times allowed for visiting might prove insufficient to suit their convenience.

Perhaps it is of more significance that several of the respondents felt that the visiting hours were "almost too long". Both the patients and relatives interviewed, express the view that they found it difficult to maintain conversations for extended periods. If a patient is withdrawn or uncommunicative a visit can be an uneasy experience for both parties, especially if the visitor feels obligated to stay for an arbitrary length of time.

The hospital's visiting facilities must also be considered as one of the important determinants of visiting. It is evident from this survey that the facilities available for visiting purposes are sometimes not conducive to a pleasant and comfortable visit, or a constructive one. Corridors are highly unsatisfactory for visiting, especially on busy days when it is difficult to find a place to sit. In some of the corridors, the tables and chairs may be lined up against the walls to permit the wide thoroughfare, but such an arrangement makes it awkward for patients and visitors to face one another. It also
results in a limitation of their privacy.

Privacy is a luxury in the mental hospital where so many of a patient's daily activities are carried out in full view of staff and other patients. Nevertheless, the patient and his visitors should be able to expect a minimum of privacy. Also to be considered is the fact that the majority of patients, although mentally ill, are still quite physically healthy. They may desire the same intimate relationships with spouse or fiance as they previously enjoyed.

The amount of explanation, encouragement, and assistance visitors receive from hospital staff also has a bearing on their motivation to visit. Relatives are apt to have many questions and anxieties regarding the patient's treatment, progress, and discharge. They want to know such things as: What should a person talk about during a visit? Should one always agree with the patient? When the patient comes home is it advisable to invite other people to the house? Some questions can be best answered by staff who are directly involved with the care and treatment of the patient. For example, the doctor is often the only person who can say how long the patient will likely require hospitalization. The important consideration from the standpoint of this survey is that if the visitors fail to receive a reasonable amount of attention from hospital personnel, they may feel that their participation is not appreciated and that there is no place for them in the treatment program.

Occasionally visits may be counter-indicated. If a patient becomes
becomes very upset or disturbed by visitors, the doctor may recommend that relatives visit less frequently or perhaps discontinue for a while. However, such action taken by staff may be considered one of the least important determinants of visiting. In most instances, the problem is one of encouraging rather than discouraging more frequent contacts between patients and relatives.

The Infrequently-Visited Patient

As a final concern of the second portion of this survey, frequently and infrequently-visited patients were compared on the basis of a selected set of characteristics. The results demonstrated that the infrequently-visited patients tended to: (a) spend more time in hospital, (b) have fewer previous admissions, (c) have relatives who lived further from hospital than the relatives of the frequently visited patients. They were also: (d) likely to be older, and (e) likely to be unmarried.

As previously mentioned, the longer a patient remains in hospital the more "discultured" he tends to become, and the more his relatives are apt to consider him incapable of living outside the hospital. The patient becomes estranged from his family and as a consequence the relative take less interest in him. A patient who has been continuously hospitalized does not have the opportunity to re-establish meaningful relationships and become re-socialized through living outside the hospital. Older and unmarried patients are apt to receive fewer visits because they very often have fewer relatives and
friends who could visit them. Many of the older patient's relatives are also advanced in age. Death, sickness, and the inability of the relatives to make long trips results in a loss of potential visits. Since unmarried patients do not have families of their own they also have fewer potential visitors. The finding that patients whose relatives live long distances from hospital are visited infrequently is not unexpected in view of the previous discussion regarding the difficulties relatives encounter in making long trips to hospital.

A "Strategic Retreat"

The therapeutic value of visits has now been amply demonstrated. The fact that there are situations where visiting is counter-indicated does not detract from the validity of the thesis. It has also been shown that close relationships between patient, family, hospital and community are dependent upon a variety of factors, possibly one of the most outstanding being, the dislocation a person undergoes when he enters a mental hospital for treatment. A patient is removed from his job, family, home and community, to begin a changed way of life in the strange surroundings of a distant institution. Such dislocation argues strongly for the utilization of alternative treatment resources for the mentally ill.

McNeel recommends that

the patient should only reach the hospital after a strategic retreat by stages, as intermediate steps in treatment are found inadequate. The aim should be early treatment with a minimum
of dislocation of his life pattern. This requires all facilities
to be readily available and within easy reach. (In this way
community resources and the mental hospital would become so inter-
linked that the stigma now associated with public mental hospitals
would gradually disappear). 1

Perhaps, more emphasis should be placed upon the establishment of
outpatient departments, as well as day and domiciliary care programs. If
removal from the home is indicated, it might not necessarily imply removal
from the community, if a psychiatric unit in a general hospital can be used.
Then if the intermediate steps have proved inadequate and the person must
be hospitalized, he still should be able to maintain contacts with his
community. Provision must be made for visits with relatives and friends and
the maintenance of the community pattern of life, as far as possible. 2 The
size and location of mental hospitals is an important consideration here.

Small, regional hospitals, providing for 150 to 300 beds, serving
areas with a radius of about eighty miles, might well be the type of facilities
required. The chief advantage of such facilities, from the point of view of
this survey, is that patients would be cared for close to their homes and their
relatives. The effect would be two-fold. Patients would benefit from the
support of home and relatives so that they would become less cut-off while in
hospital and have less ground to regain; families and relatives would not lose
connections with the patient and would be in a better position to help him
become re-established after discharge. Also the location of regional hospitals
would permit the community physicians more ready access to the hospital and
would permit staff and patients to community services and resources. 3 Nonetheless,
until such facilities have been developed the present type of hospital will

1 McNeel, B.H., Discussion Leader, "A Therapeutic Community, From
Custodial Care to Modern Therapy". Mental Hospitals, Vol. 9, No. 5, May 1958, p. 27
2 Loc. cit.
3 Lawson, F.S., "The Saskatchewan Plan". Ten Giant Steps, Strides in
Mental Health, Saskatchewan Division, Canadian Mental Health Association,
continue to face the problem of bridging the gap between itself, its patients, and the community of which they are a part. In the concluding section, attention is directed to the steps a hospital might take to improve its relations with the community and facilitate its services to patients, through a development of the visiting program.

**Recommendations For Improving Mental Hospital Visiting**

To cast more light on measures which a hospital administration might adopt to encourage visiting, the social workers, relatives, and patients taking part in this study were asked for their views on the merits of a number of proposals for improving the visiting program. Some of these are already in effect in several of the hospital units included in this survey. For example, Crease Clinic has been experimenting with group meetings of relatives.

(a) **More Access to Staff:**

First, is the proposal to give visitors more interpretation of the patient's illness and a fundamental understanding of what to expect in the patient's behaviour. From the present survey there was almost unanimous endorsement of the proposal. Twenty of the respondents also saw merit in staff-relative conferences as a means of insuring that relatives get a proper interpretation and understanding of the patient and his illness. Since the majority of the relatives interviewed wished for more opportunities to meet with staff, particularly the doctors, it is clear that they also would like to see the above practices extended.
The need for giving visitors information, reassurance, and guidance is especially important during the initial phases of a patient’s treatment. In this survey, it has been shown that patients are not likely to appreciate visits at this time. Therefore, to insure that the relatives will not become discouraged from making further visits, it is necessary that they be helped to understand that their visits will be more appreciated when the patient’s condition has improved and he has become more accustomed to the hospital. Perhaps it might be feasible for staff to recommend that the relatives visit less during the initial stages of treatment and encourage them to visit more after the patient has made some progress towards recovery.

An important consideration is, how are visitors to be given such necessary attention by a hospital staff often overburdened with other vital responsibilities? Lidz and others note, as was discovered in this survey, that "initially, it is the physician that the family turn to for help and guidance". In their estimation, the physician cannot simply refer the relatives to the social service department. "Unfortunately, there pervades a stereotype of social workers which makes it difficult for the family to turn to this source for help. The existence of the stereotype must be recognized, as must the fact that the social worker cannot discuss the patient’s illness with the same confidence as the physician can!".

Although one might argue with the statement that the physician cannot refer the family to the social worker because of the existence of a stereotype, it is quite true that the social worker cannot discuss the patient’s illness with the same confidence as the doctor. This is not the social worker’s area of competence. Even if social workers were able to do so, the questions might still be raised: are there sufficient psychiatrists and social workers to

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supply the needs of all relatives requiring attention? Secondly do all visitors require the specialized services of medical or social services personnel? One possible way of partially meeting the relatives' demands for more attention may be to encourage other members of the treatment team to take more interest in the relatives and to provide them with whatever assistance can be given.

The need for more staff is apparent. For example, if social workers had smaller case loads they would be able to spend more time in tracing families of unvisited patients and encouraging them to keep in touch with the patient. An increase in nursing staff is equally important. Nurse are often in the best position to answer the relatives' questions - questions such as how the patient sleeps, is he homesick, or needing anything. Yet, nursing staff pressed with other responsibilities, may have little time to answer these questions.

A proposal to educate staff regarding the importance of involving the patient's family in the treatment program was viewed by all respondents as being an effective practice worth developing further. However, the implementation of such a practice is not necessarily simple and might meet with resistance. There may be an attitude that time spent with relatives is wasted. Staff look upon this as time taken away from the treatment of the patient. They may have to be convinced that this part of treatment is as essential as anything which contributes to the patient's welfare.¹

¹Yonge, Meith, Discussion Leader, "Consolidating Relationships with the General Community", Mental Hospitals, Vol. 9, No. 5, May 1858, pp. 11-14.
(b) **Group Meetings of Relatives**

Another possibility in enhancing the value of visits, while at the same time making better use of technical personnel, may be to deal with relatives in groups. The majority of respondents (22) were very favourably disposed to the idea of group meetings of families to discuss mental illness, the patient's hospitalization and common problems they might be facing with respect to aiding the patient's recovery. To determine how receptive relatives and patients might be to the idea of group meetings, they were also asked for their views on the proposal. A survey of the opinions of the relatives revealed that five thought that group meetings could be beneficial. Generally it was felt that such meetings might result in a better understanding of their individual problems. One relative interviewed happened to be a participant in the Crease Clinic group meetings. It was her feeling that such meetings were valuable. She indicated that "relatives come out with questions and advice" which she found useful. She also thought it was "less embarrassing" to get such advice and help from other relatives than to get it from professional staff. There were some dissenters: two indicated that they would not be interested in such meetings; one woman maintained that in coping with mentally-ill relatives, each person has his own particular problems which are best worked out individually.

Of equal interest were the patients' comments regarding group meetings of relatives. Seven favoured the idea. Some of the comments were: "I think it would be a wise idea"; "I imagine it would be educational"; "It might help to eliminate the stigma of going into a mental hospital and the ignorance of the public". Two patients were dubious. One declared: "I don't think much of the idea. Each problem and each patient is different".
Another didn't think that "people would want to get close to other patient's relatives because of the stigma". A special case was a woman who contended that she was "violently opposed" to any discussion of common problems in which the patient is not included. She thought that, without the patient, there would be more chance of confusion on the part of the relatives and the possibility of "coming up with the wrong opinions". However, she was not opposed to staff members talking about mental illness to groups of relatives.

Thus, it may be concluded from this survey that, although there were dissenting views, the majority of social workers, relatives and patients expressed approval of the idea of group meetings of relatives, as one of the means of increasing the value of visits. However, the fact that several of the patients expressed dissenting views would seem sufficient reason to warrant consulting with patients and interpreting the purposes of the meetings before getting the relatives to participate.

Group meetings of relatives have been part of Crease Clinic's visiting program for some time. In that unit, they take the form of weekly one-hour meetings held in the social workers' office on the ward. Tea and cookies may be served, records of the meeting are kept. Relatives are selected on the basis of availability and upon referral from nurses, doctors, and social workers. Topics discussed are usually in the nature of individual cases, with major attention being paid to mental illness, recognition, cause, treatment and prognosis. The social worker encourages group interaction, guides the discussion and offers information. Some of the gains which have been noted as a result of these meetings are: better understanding of mental illness and the hospital and an increase in the
relative's involvement in the treatment program.¹

A number of hospitals throughout North America have experimented with group meetings of relatives and it would appear that, in the majority of instances, they have met with success. Some writers report that family members are usually eager to share experiences which have proven successful in assisting patients to cope with their mental disorder. It has been noted that group sessions increase communications between patients and relatives. Other writers report that group sessions resulted in relatives changing attitudes deleterious to the patients, through discussion of parent-child relationships, sibling rivalries, dependence-independence conflicts, and marital hostilities.²,³,⁴

(c) Guide Books For Visitors:

Providing visitors with a handbook to help orient them to the hospital's program may be another means of giving the relatives guidance and a basic understanding of the hospital's routine and care of its patients. At the same time, it may free staff from the necessity of covering similar ground with each relative and thereby allow more time for dealing with the unique problems and difficulties the visitors may be encountering. In this survey, fourteen of the respondents estimated that providing visitors with handbooks is an effective practice. Another seven thought that the practice merited development. Only three thought that it was of doubtful value. In

¹Thompson, James, B., Crease Clinic Relative Groups East III Preliminary Report, unpublished report presented to Crease Clinic Social Workers Staff Meeting, November 30, 1961.
questioning the relatives, it was found that all but one had received copies of the [Visitors Handbook].¹ Their comments indicated that they had found the booklet helpful in acquainting them with hospital regulations and procedures. One relative had also make a special effort to get a copy of the handbook, Mental Illness, a Guide for the Family.² She found this book particularly helpful in putting her "mind at ease" for she was "unable to follow the course of the illness". She suggested that "it would be much simpler and would save anguish if the book were make available at the hospital.

(d) Extending Visiting Hours:

In a previous discussion of the determinants of visiting, it was noted that only two of the patients and two of the relatives thought that the existing visiting hours sometimes made it more difficult to visit. The comments of the social workers would indicate that they too, saw little to be gained by a proposal to extend the hours would be of little value. Another six thought that it was a proposal worth developing. One person thought that more allowance should be made for evening visiting, particularly to encourage more visiting by relatives who are normally employed during the daytime. This would seem to be a very appropriate proposal especially for psychiatric facilities such as those at Essondale, which are located so near to a major metropolitan centre. It is doubtful whether a lack of provision for evening visiting has much effect on the frequency of visits in a facility such as Saskatchewan Hospital, Weyburn, which is much further removed from the larger

¹A booklet which is available at the hospital. It contains information regarding: visiting, (location and hours), correspondence with patients, the hospital facilities, the function of various departments, administration of patients' affairs, hospital fees and discharge procedure.

metropolitan areas.

Although the majority of persons taking part in this survey evidently thought that an extension of the visiting hours was unwarranted, the practice still may be worth consideration. A number of other hospitals have adopted the measure with success. Barton reports that, in an English mental hospital, it was found that visiting could be made much easier by encouraging visiting at any time, any day, between 9 a.m. and 9 p.m. He found that the usual objections regarding matters such as, interference with nursing routines were proved to be groundless. In several centres on this continent, visiting hours have been increased without undue stress upon staff. Some of the advantages of this practice have been noted by Greenblatt and others who observed that instead of visitors coming all at once, they tend to come throughout the longer period in smaller numbers and are easier to handle. There was less compulsion noted on the part of relatives to stay the full time. They were free to stay for a "natural period". Also, unvisited patients appear less conspicuous and were not as apt to feel hurt or rejected.

(e) Transportation Clubs:

The need for better transportation services and possibly paying the fares of relatives who cannot afford to travel, was emphasized by three

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1 Barton, Russel, *Institutional Neurosis*, John Wright & Sons Ltd., Bristol, 1959, p. 29.
respondents. Barton has made similar proposals. He recommends the formation of "transport clubs" for relatives. In some cases he feels social workers might arrange for fares to be paid. He also mentions that it would be helpful if relatives could be persuaded to form a "rota of visits", so that the patient has someone to look forward to regularly. At the same time, relatives would be spared from frequently having to make a long, tedious, and expensive journey.¹

(f) Baby-Sitting Services:

A few persons proposed that the hospital set up babysitting service for the convenience of relatives with young children. When it is considered, that at least one-fifth of the relatives and patients included in this survey indicated that the responsibility of looking after children sometimes made visiting more difficult, this suggestion does appear to have some merit. Of course, even with babysitting services, not all relatives would be able or willing to bring their young children with them and those living further away might prefer to leave their children at home rather than take them on a long trip. Nevertheless, for a fair proportion of the relatives with young children, babysitting services might be a welcome proposal.

Another factor which is often overlooked is the positive effect which children may well have upon patients. It would seem to be a reasonable assumption that patients derive as much satisfaction from their company as anyone does. However, the absence of children among the visitors is quite noticeable, particularly in the long-term units where it is possible for a patient to go on for a number of years never having close contacts with children. A babysitting service might encourage more relatives to bring their children, thereby helping to establish a trend to more visiting by family units.

¹Barton, op. cit., p. 29
(g) Freer Access to Patients:

One respondent suggested that giving relatives more opportunity to see and visit with patients other than their own might be another way of increasing the visitors' therapeutic potential. In connection with this proposal, Greenblatt has observed that, in several hospitals that he has studied, relatives are free to visit in any part of the building. Such a practice allows the visitor to see a wider range of the patient's activities, to observe patients and at times join with them in their daily life. "The next step is for the visitor to become a social and recreational partner". In this way, he may acquire a more positive feeling for the hospital while assisting the patient to feel more "at home". In his estimation, "a relative may be a happier relative and a healthier link between the patient and the outside".¹

(h) Improving Visitor Facilities

In the previous chapter, it was noted that several of the patients and relatives were not satisfied with the hospital's physical facilities for visiting. The chief grievance seemed to centre about the lack of privacy. A review of the moments made would indicate that a hospital administration might do well to carefully examine its physical facilities and policies respecting the location of visits, to ascertain whether they can be modified to improve visiting. Some modifications in the physical features would not necessarily be expensive or imply reducing the already limited bed space. As one patient pointed out, even a rearrangement of chairs and tables could result in a more relaxing and more private visit. Also portable screens could be utilized to separate groups from one another.

¹Greenblatt, op. cit. p. 66.
Another feature of hospitalization which an administration might do well to examine is its precautionary measures. It was noted that several of the relatives found the locked doors disturbing. In commenting upon this feature of the mental hospital, Rees writes, "It is unfortunate that the various safety precautions used in mental hospitals (locked gates, high walls, locked and barred windows) not only service to keep patients in, but are just as effective in keeping the public out". He asks, "Are all these precautions really necessary, or do they merely service to irritate the patient, alienate the public and help to convince both that the mentally-ill patient is a thing apart and needs to be 'put away'".¹

(i) "Open House":

A recent innovation which many hospitals are now beginning to employ for stimulating visiting, is "open house" day when all may visit and see the various treatment programs. Weyburn Hospital held its second annual Family Day in July 1961. The event had several purposes, namely to provide an occasion in which patients, their families and their friends could enjoy themselves; to give relatives a wider acquaintance with, a broader perspective of, the hospital program; to create an atmosphere in which visiting would be more frequent; and to improve the hospital's relationships with the communities served. A few of the day's activities included hospital tours with the help of "volunteer" guides and visiting and entertainment in the form of law games and a ball tournament. As well, picnic facilities and snack booths were set up on the grounds and doctors, nurses, social workers and other personnel were on hand to provide general information and

answer the questions of visitors about specific patients and the hospital program. In addition to radio and newspaper advertising, some 1550 invitations were sent to the relatives and friends of the hospital's 1517 patients.

One measure of the success of the event may be gained from examining the statistics for the day. Three hundred and fifty-nine patients (which includes the 120 in the study mentioned) were visited by approximately 1200 relatives and friends. For 22 patients included in the project group, it was the first visit they had received in at least a one-year period. Although the greatest number of visitors came from within a one-hundred mile radius of the hospital, many came from points up to three hundred miles away. A few came from out of the province. Many of the relatives were lavish with their praise of the physical improvements in the building, the homelike atmosphere on the wards, and the high standard of nursing care given to the patients. Several relatives were able to remain in town to continue their visiting and some patients were able to return home for recreational leaves.

"Bridging the Gap"

The enormous potential value of the family in the patient's treatment has now become more firmly established. It has been shown that the relatives' contacts with patients and staff are vital in assisting the patients' transition from home to hospital and in supporting the patient throughout the treatment period. Such contacts are also useful in aiding the patient's transition from hospital to home, in preparation for after-care and in the prevention of relapse.

1 These figures include only those who registered. It was estimated that some patients were visited by relatives who did not register.
It is readily apparent that a strong treatment program rests upon a minimizing of gaps between the hospital, its patients and the community. The most effective way of insuring the patient's return to the community is to "keep the lines open" while he is in hospital and to build bridges before he is discharged. It is to this end that visits by relatives can make a unique and important contribution.
APPENDIX "A"

Questionnaire Used For the Study

Relative Visiting For Mentally-Ill Patients

I am seeking your views and experiences in this important area as part of a study of patient-family-hospital interrelationships. I am particularly concerned to evaluate the pros and cons of visits and to assess them as definitely as possible, as a treatment resource.

Your cooperation in this inquiry is greatly appreciated.

Ronald Petersen (Master of Social Work student)
University of British Columbia, Vancouver, B.C.

I. Purposes and Procedure

A. Do you think that visiting relatives have an important role in the treatment of patients? Yes ..... No ..... Not sure ..... 

B. In your opinion, how much time is devoted to such visitors by social workers? Not enough .......... Sufficient .......... More than necessary ...

C. When you receive a referral:

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<th>QUESTION</th>
<th>Yes</th>
<th>No</th>
<th>Explanatory Comments</th>
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<tbody>
<tr>
<td>1. Do you check on whether the patient receives visitors?</td>
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<td>2. If so, why do you check?</td>
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<tr>
<td>(a) To determine family resources</td>
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<td>(b) To determine the relatives' interest in the patient</td>
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<td>(c) To arrange to meet the relatives</td>
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<td>(d) Other (Please specify)</td>
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<td>3. Do you try to see the relatives at least once when they visit?</td>
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Explanatory Comments
### Purposes and Procedure cont'd

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<tr>
<td>4. For what purposes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) To obtain social history information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) To discuss aspects of treatment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(c) To encourage continued visiting</td>
<td></td>
<td></td>
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<tr>
<td>(d) To interpret how visits benefit the patient</td>
<td></td>
<td></td>
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<tr>
<td>(e) To help the relatives accept the patient</td>
<td></td>
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<tr>
<td>(f) To discuss discharge plans</td>
<td></td>
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<tr>
<td>(g) Other (Please specify)</td>
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<td></td>
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</tbody>
</table>

D. Do you see value in meeting with the patient and relative (even briefly) on the ward? Yes No

E. Could you comment on circumstances in which this might or might not be desirable?
   Desirable
   Undesirable

F. In your opinion, are patients more accessible to discussion of their relationships with their families following visits by relatives? Yes No
   Comment

II Results

A. What benefits may the patient be expected to derive from "successful" visits?
   1. More awareness of identity and a reduction of feelings of anonymity
   2. Satisfaction that he hasn't been forgotten
   3. Confidence that he is able to get along better with his family
   4. Stimulation towards recovery

B. In your estimation, are the above the major treatment benefits patients derive from "successful" visits? Yes No Not sure

C. Would you suggest others? (Please specify)
### APPENDIX "A" (cont'd)

#### III.

**A.** Have you had experience with relatives who were urged to visit, but didn’t come? Yes ..... No ..... 

**B.** Indicate if you have found the following to be causes of infrequent visits by relatives (living in reasonable proximity to the hospital without transportation difficulties):

<table>
<thead>
<tr>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Misconceptions, fear or shame about mental illness</td>
</tr>
<tr>
<td>2. Anxiety and guilt about the patient</td>
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<tr>
<td>3. Discouragement with the patient's lack of progress</td>
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<tr>
<td>4. Pain or embarrassment connected with visits</td>
</tr>
<tr>
<td>5. Visits not considered beneficial by relatives</td>
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<tr>
<td>6. A desire to sever contact to avoid the patient's return home</td>
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<tr>
<td>7. Other demands forcing the relatives to visit less often</td>
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<tr>
<td>8. Loss of interest in the patient</td>
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<tr>
<td>9. Other (Please specify)</td>
</tr>
</tbody>
</table>

**C.** From the above, select what you consider are the three most prevalent reasons for infrequent visits, and list them according to the corresponding numbers 

**D.** Have you had experience with relatives who had to be urged to visit, but did come? Yes ..... No ..... 

**E.** From your experience, what are the effects upon patients when:

<table>
<thead>
<tr>
<th>Effect</th>
<th>Definitely Beneficial</th>
<th>Not Sure</th>
<th>Definitely Detrimental</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relatives do not visit despite urging</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Relatives only visit with urging</td>
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</tr>
<tr>
<td>3. Relatives visit of their own accord</td>
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</tbody>
</table>

**F.** In your opinion are there some situations in which visits should not be encouraged? Yes ..... No ..... If your answer is yes, can you give an example
IV. Possibilities for Exploration
A. What are your views regarding the following practices:

<table>
<thead>
<tr>
<th>PROGRAM ITEMS</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educating staff regarding the importance of involving the patient's family in the treatment program</td>
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<tr>
<td>2. Extension of visiting hours</td>
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<tr>
<td>3. Giving visitors more interpretation of the patient's illness and some fundamental understanding of what to expect in the patient's behavior</td>
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<tr>
<td>4. Providing visitors with a handbook to help orient them to the hospital program</td>
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<tr>
<td>5. Staff-relative conferences to clarify treatment goals</td>
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<tr>
<td>6. Group meetings of families to discuss common problems arising out of the patient's illness</td>
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</tbody>
</table>

A - Very Effective  B - Worth Developing  C - Doubtful Value

B. Have you any other suggestions for improving the visitor program?

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APPENDIX "B"

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