AN INVESTIGATION INTO THE IMPLEMENTATION OF GROUP WORK, AS A METHOD OF SOCIAL WORK INTERVENTION, IN HEALTH SETTINGS IN SOUTH AFRICA

by

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ABSTRACT

This research aims to discover whether social workers employed in health settings in South Africa use group work as a method of intervention with patients. It attempts to explore in which hospitals (or particular patient populations) group work is considered possible, and to discover to what extent social workers in health settings consider group work to be beneficial to patients. It also attempts to discover some of the potential difficulties experienced in initiating group work in medical settings. An effort is also made to establish, from social workers active and experienced in the field of medical social work, what place group work might have in the broader context of health services in the future.

Data was obtained through the use of mailed questionnaires, which were sent to 186 health settings, across South Africa. These settings were chosen according to the following priorities:

i) those known to have social workers
ii) services offered (e.g. oncology, psychotherapy)
iii) size of the setting
iv) geographical location (both urban and rural in all nine provinces).

The sample included general public and private hospitals, psychiatric hospitals (both public and private), mining hospitals and other health settings such as old age homes and facilities for the mentally retarded and for alcohol and drug rehabilitation (accompanied by a medical facility).

Responses were received from 90 health settings, with 64 of these being completed questionnaires. The majority of responses came from public hospitals, and the least from the mining hospital category.

Findings of this study indicate that group work is used by 50% of the health settings in South Africa. Groups are most often therapeutic or educational in nature, are run on average once a week for an hour, and are usually of open membership. Group work is not used in some health settings, most commonly due to insufficient time (on the part of the social worker).

From the findings, it seems that many more social workers would like to run groups for patients than they do presently. The benefits of group work are acknowledged by the majority of this study's sample of social workers, and if solutions could be found to problems such as heavy caseloads and insufficient time, more social workers would choose to use group work than are doing so currently.

Group work is considered to be a feasible method, both in the hospitals and at primary health care level. With South Africa's growing emphasis on primary health care, and the proposed inclusion (by the Department of Health) of social work services at this level, it is important that social workers find a way in which to meet the needs of patients at both levels. With group work, this may be possible.

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LIST OF ABBREVIATIONS

d.f.	Degrees of Freedom
EC	Eastern Cape
fam	Family
FS	Free State
G	Gauteng
genpri	General Private Hospitals
genpub	General Public Hospitals
inc	Include
insuf	Insufficient
KZN	Kwazulu-Natal
mem	Membership
min	Mining Hospitals
MP	Mpumalanga
NC	Northern Cape
NP	Northern Province
NW	North West Province
ot	Other
other	Other Health Settings
PHC	Primary Health Care
pripsy	Private Psychiatric Hospitals
pubpsy	Public Psychiatric Hospitals
ref	Refer
sep	Separate
WC	Western Cape
χ^2	Chi-square statistic

CHAPTER 1:

INTRODUCTION

1.1. BACKGROUND TO THE STUDY

Conducting research in South Africa, especially socio-economic (and related) research, such as this study, necessarily involves some awareness, on the part of the researcher, of the legacy with which South Africa has been left following the Apartheid era. Although this study is not based in or concerned with this era in particular, the effects can none the less be felt in all activities within this country. While in some areas action to redress the inequalities of the past is being taken in leaps and bounds (as in the building of new primary health clinics and the provision of free medical care to pregnant women and children under 6 years), in other areas, progress is slow (as in the loss of funding for essential welfare services, and the lack of adequate resources for all sectors of the South African population).

Along with many other African countries, health services in South Africa were originally designed to cater to the needs of the European administrators, miners and others who came to the country. From these early days, therefore, health care was distributed along racial lines (Iyun in Phillips & Verhasselt 1994: 250). With the entrenching of racial attitudes in the laws of South Africa (since 1932), this discrepancy in the distribution of resources worsened.

Health in South Africa

The Department of Health's Annual Report (1996) states:

> South Africa is pre-eminently a society in transition, and this is reflected in its disease and death profiles. Mortality due to diseases of poverty (upper respiratory infection, perinatal causes, diarrhoeal diseases) co-exist with diseases of affluence (stroke, ischemic heart disease and neoplasms). The high mortality rate due to violence is a reflection of a society in transition and change (Department of Health 1997: 5)

In trying to correct the inequalities of resource distribution, standards of health care, and the services offered, South Africa is currently investing a great deal of money into the building and/or upgrading

of public clinics to function at primary health level. This is an attempt to provide people with easier access to medical facilities and to treatment that is less costly.

Wilson & Ramphele (1989: 337-338) sum up the condition of South African health services as they knew them in 1989:

> [i]f health care in South Africa is to be judged in terms of heart-transplants or dialysis, then it probably ranks amongst the top five or six in the world. But, if it is to be judged in terms of its children or the incidence of tuberculosis, then it plummets.

Sadly, this situation has not been significantly altered. At present, health services in South Africa are facing diseases both of poverty and of affluence (as previously mentioned). Many of the diseases of poverty are related to the conditions of the past, and are almost non-existent in other more-developed countries. With a marked lack of practical resources such as housing, finances, and education, there is a greater scope for services to the South African public, and social work has the opportunity to meet these needs.

Social Work in Health Care in South Africa

According to the Department of Health's White Paper (1997: 224), the primary health care (PHC) approach is defined as:

> [t]he underlying philosophy for the provision of health care that includes curative, preventive, promotive and rehabilitative care within the context of, amongst others, community participation and intersectoral collaboration.

Although PHC in South Africa will be focussed on later (see Chapter 2, Section C), it is important to realise the necessity behind the introduction of a model such as this.

The use of social work is planned at PHC level (Department of Health 1997: 37) in South Africa, especially in areas such as: mental health and medical social work (see Appendix B for a complete PHC services plan). This will enable social workers to experience greater community contact, and will hopefully go some way to removing the stigma or feeling of intimidation, on the part of the patients, which is attached to visiting a hospital.

However, many of the primary health clinics stand empty and unused after completion. Although built and fully equipped, many do not have access to water, electricity or telephones. Others lack essential medicines or trained professionals (SA Survey 1997: 485). Thus, although South Africa is attempting to move towards an emphasis on PHC, the fact that comparatively few of these clinics

are successfully operational (in all provinces across South Africa) means that the hospitals still need to play a primary role in health care.

Social work possesses the awareness and skill to offer possible solutions to these complex issues, and is able to support other professions in their attempts to improve the quality of life of South Africans. Anstey (1983: 12) states that:

> ... groups allow for feelings of commonality, belongingness and support, they provide powerful means of attitude and behaviour change, and supply important perspectives, resources and support systems.

The use of group work allows social workers to reach a greater number of people. This is especially important in health settings where the turnover of patients is rapid. In an environment that is characterised by the clinical relationship between medical staff and patients (which will be explored in Chapter 2), social work is able to offer a supportive facet to the hospital experience. Where patients become involved in groups in the hospital setting, support becomes available from a number of individuals, who share common problems.

> ... the group process is well suited to ameliorating the emotional stress felt by many patients and their families who have feelings of isolation, loneliness, guilt, stigmatization, depression, helplessness and hopelessness. In a successful group, these feelings are counteracted by a sense of belonging to a group in which a person feels understood and accepted, a powerful dynamic in the process of change (Northen 1990: 10).

With these changes in health care in mind, this research hoped to investigate the place of social work in health care in South African health settings. Social workers' use of the group work method has been identified as particularly useful in health settings, for instance in long-term wards, in waiting rooms, with cancer patients, and with burn victims. "Groups have special values in helping clients and their families to cope with the emotional distress and changes in living occasioned by the medical event" (Northen 1990: 10).

In the researcher's personal experience, group work provides many benefits to individuals (which will be discussed in later sections). With the effects of the hospital environment in mind, and the impact of this on patients, these benefits would assist patients in health settings. And yet groups were not used in five of the settings which were approached concerning the running of groups (see Chapter 3). As the benefits of groups are acknowledged by so many e.g. Johnson & Stark 1980: 336-337; Longeran 1980: 53; Northen 1990: 9-11 (amongst others), it seemed relevant to discover

why group work is used in so few of South African hospitals. This research attempts to discover the role of social work (and of group work especially) in South African hospitals.

1.2. OBJECTIVES OF THE STUDY

This study attempts to gain an understanding of the use of group work in health settings across South Africa. Within this context, the following objectives were considered to be important:

- To discover the extent to which group work is used in South African hospitals.
- To determine whether social work professionals consider group work a beneficial and feasible method of intervention in health settings.
- To attempt to discover the conditions under which group work is considered most beneficial in the health settings in South Africa, for example in particular settings, using a particular type of group, or with particular patient populations.
- To determine whether South Africa could be making greater use of group work in health settings, given the medical conditions that are prevalent in South African hospitals.
- To attempt to determine the willingness of social workers in South African health settings to work at primary health care level.

1.3. ANTICIPATED VALUE OF FINDINGS

It is expected that this study will lead to a greater understanding of the use of group work by social workers in health settings. It is further hoped that this understanding will serve as a starting point for further research.

A greater understanding of the use of group work in general, of problems that inhibit this use, and of the benefits that group work offers, will allow for improved planning of health services, and may lead to a wider acceptance of social workers' ability to meet the needs of individuals in society, and in the hospital environment in particular. Since the ultimate aim of any research is to be able to offer a better service to clients, it is hoped that this project will contribute to this.

1.4. RESEARCH DESIGN AND METHODOLOGY

1.4.1. Design

This research is exploratory-descriptive in nature. This design was chosen since little is known about the use of group work in health settings, especially in South Africa. Grinnell & Williams (1990: 139) state that:

> [i]f a great deal is known, we will be in a position to ask specific and complex questions in an attempt to *explain* data previously gathered. If less is known, our questions will be of a more general *descriptive* nature. If very little is known, our questions will be still more general, at an *exploratory* level.

It is hoped that the study will generate some understanding of how social work in health settings across South Africa is carried out, and describe more completely the use of group work in these settings, including the reasons why group work is not used.

This study is thus an exploration of the field of medical social work. An attempt has been made to place social work within the context of a health setting; to explore how social workers spend their day and what relationships they form within the setting. Once the context is supplied, and some aspects of the environment examined, the study goes on to focus on the use of groups. The study looks at which types of group are used most frequently in health settings, at their structure and perceived benefits. Reasons why group work is not made use of are also investigated, as well as attempting to explore possible avenues of development, leading to alternative practices or solutions.

1.4.2. Methodology

In order to explore the use of group work in health settings adequately, a literature search was conducted. This was essential in order to understand the origins of social work in health settings and to gain an understanding of how the practice of social work is affected by its presence in a secondary setting (and in particular, in a health care setting).

From the literature, it was also possible to explore the use of group work in overseas countries, and to examine research findings conducted in this area. An attempt was made to include South African literature (especially recent journal articles), but most relevant literature is from the United States of America or the United Kingdom.

Through familiarity with the literature, it was possible to draw up a questionnaire regarding the role of the medical social worker, and the use of group work. This questionnaire was pre-tested on 9 subjects and was then distributed to a final test sample of 186 health settings in all nine provinces of South Africa. A total of 90 responses were returned, with 64 containing completed questionnaires. These were then analysed - both qualitatively and quantitatively.

1.5. SCOPE AND LIMITS OF THE STUDY

1.5.1. Scope

This study has focussed on medical social workers' use of the group work method of intervention, in health settings across South Africa. Questionnaires were sent to social workers in various areas around the country, with the aim of determining to what extent they made use of groups in working with patients, what forms of group work were favoured, and their reasons for not using group work (if this was the case). Some description of the average day of each social worker was also obtained, and social workers were asked for their opinion regarding the future of medical social work, and the use of group work in this area of practice. The scope of the study was thus wide, and attempted to incorporate possible variables such as type of hospital and geographical location.

1.5.2. Limitations

This research is limited by the number of responses received. Although an effort was made to include in the sample a wide range of settings and of geographical locations, the response rate from many of the categories was too low to allow any of the findings to be generalised to settings beyond those of the sample, especially in the case of private and mining settings. The low response rate means that the findings may not accurately reflect the circumstances of all health settings across South Africa. Although valid for the population they are comprised of, these results may not be reproducible should the study be repeated.

This study is further limited by the method of data collection used. While questionnaires were considered the best method to use for this study, the weaknesses of the method in general, and the

population that resulted, may have made an impact on the findings. In addition, the use of mailed questionnaires relies on the motivation of subjects to reply. Those that were sufficiently motivated might also be those who are motivated enough to run groups in health settings, thus not being representative of those not running groups.

The limitations of this study will be discussed in more detail in Chapter 3.

1.6. PROBLEMS EXPERIENCED

The following problems were experienced during the course of this research project:

- Due to reasons outlined in Chapter 3, the researcher was unable to personally enter the health settings. This meant that data gathered was of necessity second-hand, with a resulting decrease in objectivity since the data was gathered by those running the groups.
- There was a lack of literature surrounding the use of group work in health settings in South Africa. This made it difficult to compare the findings, and to place them in a real context.
- The use of questionnaires as the method of data collection may have influenced the data obtained, as stated above, and will be further explored in Chapter 3.
- There was a low response rate, which may have been due to the lack of follow-up of the mailed questionnaire.
- The quantifying of results to enable accurate measurement proved problematic, as a result of the fact that findings were both qualitative and quantitative. Although measurement is not the primary aim of this research study, lack of accurate measurement affects the overall value of the study.

1.7. DEFINITION OF CONCEPTS

For the purposes of this study, the following definitions will apply unless otherwise specified:

1.7.1. **Health Settings**

Health settings shall be a broad term used to refer to hospitals, clinics and any other institution that is involved in the care of individuals' health needs. This will include public and private hospitals; psychiatric hospitals (both public and private); old age homes; facilities for the mentally retarded; and alcohol and drug rehabilitation centres, if these are accompanied by a medical facility (although it is realised that the latter are not always considered 'health settings' in the strict sense of the term).

1.7.2. **Patients**

A patient is considered to be anyone who has received a diagnosis from a medical professional (usually a doctor), and who is receiving medical treatment, through a hospital or other health setting. Both in-patients (people staying overnight on a ward), and out-patients (people who have single appointments or who attend regular clinics, are not admitted to a ward, and who return home on the same day) are included in this definition.

1.7.3. **Membership**

Membership of groups is described as either open or closed. According to Ziller (cited in Henry 1992: 231),

> [a]n open group is one that people enter and leave at their individual pace of growth; a closed group is one in which persons begin their experience together as a set of people convened by a worker, move through their experience together, and end their experience together at a predetermined time.

1.7.4. **Size**

Many authors have speculated about the most appropriate size for effective group work. Without being able to provide a steadfast number, all agree that the appropriate number of group members will be best decided by the nature of the group (Corey & Corey 1982: 74-75; Douglas 1976: 86; Henry 1992: 9). Henry claims further that groups with an odd number of members usually report higher levels of harmony and cooperation than groups with an even number of members (which are usually characterised by higher levels of hostility and an inability to agree). "Perhaps people unconsciously want an odd number in case someone is needed to break the tie between opposing factions within the group" (Henry 1992: 9).

1.7.5 **Co-leadership**

Co-leadership is used in many cases of group work due to the many advantages that are attributed:

- an inexperienced group worker can gain in confidence and experience by being placed with someone with more experience
- the presence of two leaders means that the group can benefit from the combined experience, skills and feedback of two people
- co-workers provide the opportunity to model interpersonal relationships within the group
- co-leaders offer one another support within the group, and also provide security in the event of loss of direction or confusion on the part of one of the co-leaders i.e. relieves pressure on the leaders
- involving two leaders with differing skills means that while one worker focuses on an individual, the other worker can observe the group members. Thus, individual and group dynamics can be observed

(Henry 1992: 223; Corey 1990: 77).

These advantages often result in the use of co-workers in group situations. Co-workers may come from the same discipline, or from different disciplines that frequently work together e.g. in the hospital setting, co-workers may be social workers and nurses, or social workers and physio-therapists. Konopka (1983: 197), however, does not advocate the use of more than one group leader, except in the training of group workers, or for research purposes.

For the sake of convenience, patients and doctors shall be referred to in the masculine and social workers in the feminine. Unless stated differently, this will apply throughout the study.

1.8. ORGANISATION OF THE STUDY

In this chapter, the study is briefly introduced, by placing it into context, describing the aims and anticipated value of the project, and examining the scope and limitations thereof.

The literature review can be found in **Chapter 2**. This chapter is divided into three sections, which focus on different aspects of the literature consulted. Section A examines the development of social

work as a profession, focussing on its development in South Africa. The development of group work and the use of this method will be included here. Section B focuses on the presence of social work in health settings. The historical origins of social work in these settings and an exploration of the effect that this environment has on the patient, will provide a context for the discussion of the role of the social worker in these settings. Section C provides some data as to the present situation of health care in South Africa, focussing on some common health issues, and the development of primary health care.

The empirical aspects of this study can be found in the next chapters. **Chapter 3** will describe fully the research design and methodology, including the problems encountered. **Chapter 4** will present the findings of this study. These will take the form of tables, graphs and some statistical analysis, as well as qualitative data. The findings will also be discussed in this chapter.

The conclusions and recommendations for further research can be found in **Chapter 5**. These will draw the study together, and provide some indication of future research questions suggested by this study.

Finally, the **Bibliography** and **Appendices** will follow the main body of this project.

CHAPTER 2:

LITERATURE REVIEW

2.1. INTRODUCTION

This chapter examines the literature consulted, and is divided into three sections to facilitate clarity:

Section A will report the development of social work as a discipline, focussing on its development in South Africa. The impact of the South African environment on social work will also be considered. The development of group work as a method of social work practice will then be traced, followed by some description of its flexibility (i.e. range of possible group structures and goals), as well as documented benefits and dangers.

Section B places social work in the health setting. The origins and development of medical social work form the basis of this section. Thereafter, the impact of the setting on the patient, and thus on the provision of social work services, will be reported. This section will also include an exploration of the social worker's role in the health setting, including the use of groups in these settings.

Section C offers data relevant to the provision of health care services in South Africa. After providing a brief context to health care in South Africa, this section will examine some South African health concerns, as well as the future plans for health care in South Africa, viz. PHC. This section will also attempt to offer some motivation (through the sources consulted) for the use of group work at PHC level.

As a whole, this chapter contains both old and recent literature pertaining to the topic.

2.2. SECTION A: DEVELOPMENT

2.2.1. Development of Social Work in South Africa

In South Africa, social work could perhaps be said to have originated in the year 1652, when the Dutch East India Company used the Cape of Good Hope as a place to obtain fresh supplies en route to India. Adverse weather conditions, which resulted in the failure of crops, brought poverty to the area. The Dutch Reformed Church (in Holland) was responsible for poor relief in the Cape colony, and continued this role when it later established itself in South Africa. People in town were assisted by the Church, however for both the Boers (White farmers, initially Dutch) and for the African people (Khoi and San) who did not live in the town, family was the main means of meeting basic human needs (McKendrick 1987: 6-7, Patel 1992: 35).

The years 1801 - 1902 were a period of British occupation of South Africa. The Boers resented the interference of the British, and moved inland to escape it. As the Boers 'conquered' the new land, they grew in independence; and the family grew in strength as the primary organisation of meeting needs. However, for the Africans, this move inland resulted in a breaking-down of tribal society. So, as the Boer family grew stronger, the African family was weakened. At the same time, institutional welfare was created in the town - focussing on white people (McKendrick 1987: 8-9).

Urbanisation and industrialisation in South Africa began in response to the discovery of diamonds in 1870, and of gold in 1885. With each discovery came a rush of migrant workers (many of whom were overseas immigrants who possessed industrial skills). White migrants did not possess the skills of these immigrants, but did not wish to compete with Africans for unskilled jobs. This was the beginning of the 'poor white problem' (de Kiewiet 1941: 88-114). For the African migrants, low-paid employment was available in the urban areas, which paid cash earnings, but denied permanent residence. Cheap, unskilled labour thus became available to townspeople, but brought with it migrant labour problems, due to the perceived need to maintain racial segregation (McKendrick 1987: 9-10). Migrant labour was also considered advantageous to the White farmer as it was cheaper i.e. employees only supported the worker and not the family; subsistence farming was considered ample to support the families left behind (Patel 1992: 36).

> "Because the nineteenth century created a great class of black workers upon the farm and in industry, the impression was easily created that white society had won a special position for itself, elevating all of its members beyond the reach of the forces which governed the life of the members" (de Kiewiet 1941: 180-181).

As a result of this, racial differences lead to segregation of the people of South Africa, which was entrenched by laws which gained support from the Bible and from the theories of Darwin.

Poverty became widespread amongst both Whites and Africans in the years after 1903. The Department of Labour was created in 1924 in an effort to provide work for poor whites. This enabled them to improve their economic standing over the Africans (Matthews 1986: 4). Africans were forced to live on reserves, which rapidly became overcrowded. Some Africans were attracted to the White farms. Although the jobs were low-paid, they offered permanent residence, and an escape from the crowded reserves (McKendrick 1987: 10-11).

Formal social work in South Africa has its roots in the report of the Carnegie Commission of Inquiry, which investigated the poor white problem in South Africa in 1932. As a result of this report, the Department of Social Welfare was established in 1937, and courses in social work were rapidly developed at South African universities (Helm 1962: 68; Patel 1992: 37).

From this time, the racial attitudes of White South Africans (as already entrenched in the laws) were reflected in the social welfare programmes. Services focussed on Whites, and benefits were distributed along a ratio of 3:2:1 (Whites, Coloureds, Africans), even though the population was made up of 20.9% Whites, 10.3% Coloureds and Indians, and 68.8% Africans (McKendrick 1987: 13). This continued for many years, under South Africa's Apartheid regime, only changing in the 1990's.

South Africa is now moving towards the use of developmental social work, having recognised the desperate need for services that meet the needs of the community. Gray (1996: 10) defines developmental social work as a form of social work which:

1. Affirms the social work profession's commitment to the eradication of poverty,
2. Recognises the link between welfare and economic development,
3. Construes welfare as an investment in human capital rather than a drain on limited resources,
4. Includes non-remedial forms of intervention.

Thus, developmental social work in action should: use a people-centred approach; view welfare as a

human right; and work toward the prevention of social problems, and equality in the distribution of resources and services. Gray goes on to say that the most effective ways of using developmental social work include: community development; the inclusion of the community in all stages of planning; and multisectoral involvement in the development (Gray 1996: 10-11). This form of social work can be implemented on a practical level, in the use of PHC. This is the aim of South Africa's Department of Health (Department of Health 1997: 36).

2.2.2. Social Work - the Discipline

At the heart of social work, as practised today, lies the following definition:

> [s]ocial work seeks to enhance the social functioning of individuals, singularly or in groups, by activities focussed upon their social relationships which constitute interaction between individuals and their environments (Boehm 1958 cited in Compton and Galaway 1994: 5; Skidmore, Thackeray & Farley 1991: 5).

Skidmore *et al* (1991: 8) go on to give a more current definition:

> [s]ocial work may be defined as an art, a science, a profession that helps people to solve personal, group (especially family), and community problems and to attain satisfying personal, group, and community relationships through social work practice, including casework, group work, community organisations, administration, and research.

The emphasis of social work is thus on improving the social functioning of individuals - which may be done through helping them to solve personal problems, or by improving their ability to interact with others in society. In doing this, social work makes use of the three methods of practise, viz. casework, group work and community work (Shulman 1992: 19).

This work can be done with a variety of people and problems. Hepworth and Larson (1990: 3) mention the following:

- People who are homeless.
- Families, including single-parent families and those that have serious conflicts manifested by runaways, delinquency, violence, learning difficulties, and the like.
- Couples and families that have problems of child or spouse abuse.
- Couples that have serious marital conflicts.
- Individuals and families whose income is inadequate due to unemployment, absence of a wage earner, physical incapacity, lack of job skills, and other such factors.
- Individuals and families whose lives have been disrupted by physical or mental illness or disability.
- Substance abusers and their families.
- Foster parents and children whose parents are deceased or who have abandoned or neglected them.
- Immigrants and minority persons who lack essential resources or opportunities or who have been victims of racism, sexism, or other forms of discrimination.

- Developmentally disabled (mentally retarded) persons and their families.
- Aging persons no longer able to function adequately.
- Migrants and transients who lack essential resources.
- Children (and their families) who have school-related difficulties.
- Persons who experience extreme stress related to traumatic events or to major life transitions such as retirement, death of loved ones, children who leave home, and the like.

In order to improve social functioning, social work makes use of an ecological model in which each individual is seen in relation to his situation, and the needs engendered by the uniqueness of his environment. Social work directs its attention to the interface of the individual and his situation (Compton and Galaway 1994: 4), and a balance is sought between the individual and the characteristics of his environment (Morales & Sheafor 1989: 18; Zastrow 1990: 52). This emphasis can be seen in the following diagram:

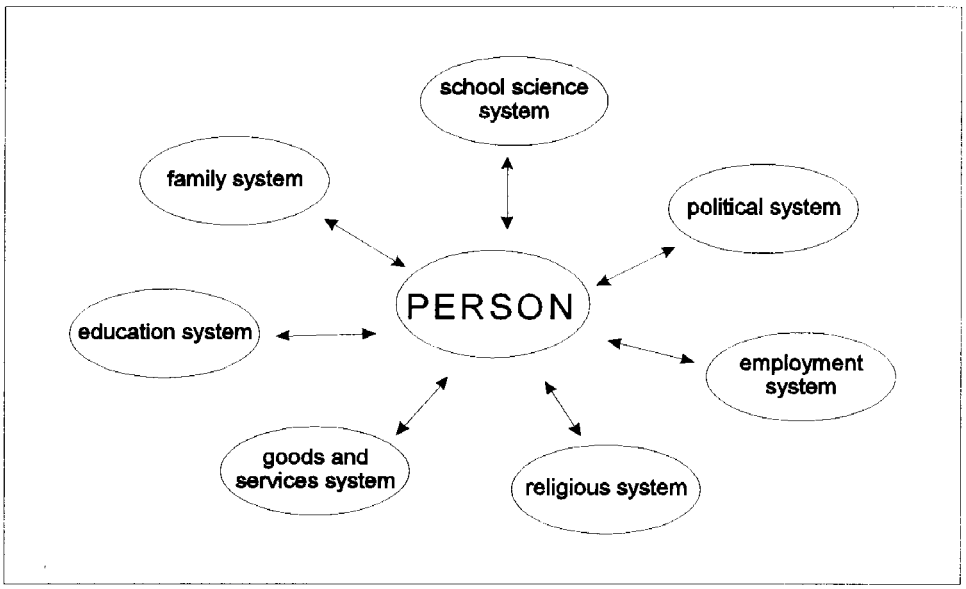

Figure 2.1 Person-in-Environment (Zastrow 1990: 53)

Awareness of the importance of this person-in-environment concept enables group work to relate to both the individual and his environment, and to facilitate improvements in this interaction. This study will focus on the use of group work by social workers in the specific environment of hospitals or similar health care facilities.

2.2.3. Development of Group Work as a Method

The Industrial Revolution in the United Kingdom brought with it slums, overcrowding and generally

bad social conditions (du Preez 1972: 50). Students from Oxford and Cambridge universities organised recreational groups in underprivileged neighbourhoods. Settlement houses were begun in 1884, and recreational groups were used there too (Reid 1981: 23-37). Although these houses were initially of a religious nature, aimed at encouraging attendance at church and "...protecting members from the moral dangers of city life" (du Preez 1972: 50), many people were attracted by what they hoped to gain in terms of education and material assistance. The homes may not have been successful in reaching their own objectives, but they did fulfil a need - that of allowing individuals to interact with others, and to gain in support and knowledge.

Settlement houses were established in the United States of America from 1886 (Balgopal & Vassil 1983: 3; Reid 1981: 53-62), and also offered educational and recreational facilities to the underprivileged. In addition, they enabled immigrants to learn the American way of life. Settlement houses allowed for a better understanding of the problems of the poor through participation in their community life. Activities included things such as "... kindergartens and preschool services, adult education, leisure time and cultural groups, social action committees and neighbourhood concerts - all group-oriented activities" (Garvin 1981: 31). After this successful beginning, people with similar interests began to group together, forming organisations such as the Young Mens Christian Association and the Boy Scouts.

Around 1905, social workers became focussed on casework (helping individuals), but realised the importance of working with individuals, families and groups of both. By the 1930's, group work had become part of social work education and training in some institutions (Garvin 1981: 31; Levine 1990: 3). According to Levine, group work was initially used most often in community settings, the major emphasis being on the disadvantaged (Levine 1990: 3), with goals such as the improvement of living conditions and the advocating of change in social conditions (Middleman & Wood 1990: 4-5). By the 1940's, this interest resulted in group work being practised predominantly with children and army veterans, and in 1946 group work emerged as an established method in its own right (Garvin 1981: 35). Since 1975, there has been a rapid increase in literature concerning group work, showing evidence of a growing interest in this method (Northen 1990: 8).

Group work in South Africa originates from the desperation that existed after the Second World War. Poverty was widespread, along with overcrowding, slums, unemployment and the gradual

disintegration of family life. The Dutch Reformed Church (as before) played an important part in offering relief, along with various women's organisations. Initially groups met over needlework classes, but as their potential became obvious, the groups became more educational, offering subjects such as hygiene, child care, etc. (du Preez 1972: 58).

Once the value of these classes was acknowledged by the Department of Social Welfare, subsidisation of qualified social workers to facilitate the groups was offered. Social workers took on these tasks, with no previous experience in group work. In 1961, the first course in group work was offered to the 'Suid-Afrikaanse Vroue-federasie' (*South African Women's Federation*) by the University of Pretoria (du Preez 1972: 59).

2.2.3.1. **Theoretical Framework of Groups**

According to Skidmore *et al* (1991: 76), group work is today defined as:

> ... a method of working with people in groups (two or more people) for the enhancement of social functioning and for the achievement of socially desirable goals... based on the knowledge of people's needs for each other and their interdependence.

The effect of group membership (and the influence of others) on behaviour has been under study for many years (Anstey 1983: ix; Chesney, Rounds & Chesler 1990: 121; Johnson & Stark 1980: 336-338; Northen 1990: 7-9). Being part of a group allows for comparisons of beliefs and behaviours, and gives individuals the chance to get to know themselves in relation to others. As human beings, we are strongly dependent on interaction with others, as most activities involve some form of group interaction (Anstey 1983: 3; Johnson & Johnson 1982: 1; Northen 1990: 9; Skidmore *et al* 1991: 74). As Carlton (1984: 11) notes:

> ... the person is an essentially social being with physical, psychological and social attributes, who derives a sense of identity, personal autonomy, and meaning from relationships with other people. Group membership is the essence of human life. Within groups, the person acts and is acted upon, creates and is created, cares and is cared for, uses and is used to learn and master the autonomous tasks of daily living. Through membership in groups, the person engages in activities that lead to a sense of worth, accomplishment, well-being, and fulfilment.

Thus, in making use of groups, social work attempts to provide this aspect of human nature to individuals experiencing problems.

Zastrow lists some types of groups that social work may make use of in achieving its aims. These include: "... recreation; education; problem-solving and decision-making; self-help; ...and therapy ..."

(1990: 584). It is pertinent at this point to look at some of these forms of group work.

i. Therapeutic Groups

Perhaps the most easily recognisable and well-known form of group work is that of therapeutic groups. The aim of these groups is "to help members identify and change aspects of psychosocial and family functioning that are interfering with the progress of patients or family members toward health" (Northen 1990: 12). Therapeutic groups go beyond the support of patients, and facilitating an adjustment to the hospital experience. These groups arise from the knowledge that the interpersonal relations of the patients' have been disrupted by the hospitalisation, and that any problems that existed before this, may have been aggravated further (Northen 1990: 12).

According to Northen (1990: 13), the majority of therapeutic groups are semi-closed, only permitting new members at particular times, and they meet most frequently once a week, with group sessions lasting between one and two hours.

ii. Self-Help Groups

Another well-known group format is that of self-help. These groups deal with a wide range of "... psychological, social, medical, environmental and political problems" (Toseland & Hacker 1985: 232). Self-help groups are composed of people with common problems, who meet for extended periods of time. These groups are most often not lead by professionals (i.e. social workers, psychologists, or medical personnel, amongst others), and are not usually government funded (Toseland & Hacker 1985: 232).

iii. Support Groups

Support groups (which have much in common with self-help groups) are also very popular.

> Social support has been defined as "... an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy); (2) instrumental aid (goods or services); (3) information (about the environment); or (4) appraisal (information relevant to self-evaluation) (House 1981 cited in Taylor, Falke, Shoptaw & Lichtman 1986: 608; Smoczyk, Zhu & Whatley 1992: 267).

Support groups are often made use of by agencies or institutions who recognise that many clients or patients experience common problems. Support groups are very popular with people suffering from

many forms of cancer, or other medical conditions such as Alzheimer's, as well as with their family members. In examining the existing literature, it is evident that support is something that cancer patients are in special need of (Daste 1990: 69-71; de Bocanegra 1992: 347-352; Gitterman in Lurie, Rosenberg & Pinsky 1982: 12-13; Johnson and Stark 1980: 336; Taylor *et al* 1986: 608-609; Vugia 1991: 89-104). This may be due to the fact that improved medical treatments (resulting in extended periods of remission) mean that there are a greater number of people requiring support in coping with the daily problems of living with cancer (de Bocanegra 1992: 347). Hospices make wide use of various support groups. They see the support system (Hospice), and the client system (patient and family), also functioning as groups (Richman 1990: 171).

Support groups are most commonly open-ended, and often involve the co-leadership of nurses, "... who are responsible for the medical aspects of the presentations or discussions" (Northen 1990: 16).

According to Northen (1990: 15), the goals of most support groups (especially those situated in hospitals) are:

> ... to reduce stress and social isolation; to enhance capacity to cope with diagnoses, hospitalization, and treatment regimens; to generate a sense of belonging; to provide opportunities for ventilation and universalization of feelings and concerns; to provide opportunities for socializing with persons with whom one has something in common; to enhance self-esteem and lessen feelings of being stigmatized; and to learn about the medical condition and its treatment and about available resources in the hospital and community.

iv. **Educational Groups**

Many support, self-help and therapy groups include an element of education in their group programmes, informing clients of the hospital routine, teaching them about medical conditions or diseases, or teaching patients new coping skills. Northen (1990: 16) goes on to explain that some groups can focus totally on the educational aspect, thus becoming educational groups e.g. in helping patients and family members to learn about the process of hospitalization, the role of medical personnel, resources available in the hospital setting, and about the disease - its etiology, treatment and consequences for future life. These groups are very often co-led by other professionals.

2.2.3.2. **Range of possible groups**

Douglas (1979: 20) provides us with a list of possible fields of social work practice, in which group

work can be used:

1. In work with the elderly
2. Crime and delinquency
3. Education and training
4. Family and child welfare
   - (a) work with children
   - (b) work with adolescents
   - (c) work with parents
   - (d) foster parents and foster children
   - (e) adoptive parents and adoptive children
   - (f) unmarried mothers
5. Family group work
6. Marital group work
7. Health and medical care
8. Mental health and subnormality
   - (a) adolescents
   - (b) psychiatric patients (i) in hospital (ii) in the community
   - (c) community mental health
   - (d) subnormality (i) in hospital (ii) in the community
9. Recreation and leisure
10. Residential work

Groups can be short- or long-term, and may be of open or closed membership. This list attempts to illustrate the range, flexibility and usefulness of group work. A more complete list can be found in Appendix C.

2.2.3.3. **Benefits and Dangers of Group Work**

The variety of benefits (relating to group work) to group members is well-documented. Many practitioners have investigated the group process, noting the experience of the members, the effects (both short- and long-term), and noting what groups of clients gain most from what sort of group work. A number of authors have also paid attention to the dangers involved in using the group work method. Dangers vary for the population of the group, the problems being worked on, the personalities of the individual group members, as well as that of the group facilitator. These benefits and dangers will be briefly discussed.

i. **Benefits**

Recognised benefits range from those experienced by most group members (e.g. the creation of an

atmosphere of well-being; the formulation of a network of relationships; and the comparison and feedback that is experienced when in contact with others), to those that are specific to certain groups (e.g. the counteracting of 'dehumanising' experienced by patients; and the education of people with erectile dysfunctions). Benefits are experienced in a number of areas for the members:

Personal

Members seem to gain most in personal areas of their life from the group experience. The "sense of well-being, worth and fulfilment" that Carlton noted (1984: 11) is reported by many others. Individuals in groups are given support, and realise constantly that they are not alone in experiencing difficulties. This is noted especially in the use of groups with patients (both mental and physical), with a predominance of reports concerning work with cancer patients (Alberts 1993: 157; Kitto 1989: 32; Worden & Weissman cited in Massie, Holland & Straker in Holland & Rowland 1990: 460).

In addition, the use of group work fills in the gaps left from the casework relationships that clients might be simultaneously involved in (Coughlan & Suluman 1995: 15). This means that questions raised in individual interviews can be explored and tested with a wider range of people (other than family members). This is then helpful in reducing (or even perhaps preventing) and increase in psychological stress on the part of the client (Taylor *et al* 1986: 608; Telch & Telch 1986: 802; Vugia 1991: 90).

Groups also provide an arena for the expression of tension and/or anger to people other than family members (whose relationship with the client is often already fraught with feelings of guilt, denial, anger or fear). Thus the family are not overwhelmed by too many feelings they have no idea how to deal with, and the client retains the freedom to share his concerns. He is also able to gain a more accurate understanding of himself, an the support of others enables him to feel stronger in dealing with the difficulties encountered (Robinovitch & Ransohoff 1982: 61).

Group work facilitates the development of empowerment - both personally and socially. Individuals often form groups through the need of support. Although this is often for support needed to cope, support and encouragement is also often needed to confront or improve existing situations. In this way, clients learn how to "take control" so that instead of passively enduring what happens to them,

they determine the effect of the situation on their own lives (Boyd & Skittrall in Carter, Jeffs & Smith 1995: 117).

Social

Being a member of a group leads naturally to gains in the social aspects of individuals' lives. Gottlieb (1988: 23) notes the following social benefits to group members:

Firstly, members gain a network of support, rather than needing to rely on only one individual for support. This has benefits for the individual who was providing the primary support too, since being called on constantly to be supportive can be very emotionally and energy-draining. For the client, this means that should the individual not be available, there are a number of options of others he could turn to for support.

Secondly, group consensus is much harder to ignore than the opinion of a lone individual. This can be used to constrain the behaviour of group members. so that individuals learn to behave in socially acceptable ways, or it can be used to affirm changes in members' behaviour that meet with approval, but that the client is unable to accept from individuals. For some group members, being faced with this sort of consensus would allow them to trust the approval more because of the number of people involved.

Thirdly, a sense of alliance is created with the other members of the group. Through the nature of the group experience, the feedback received from the members of the group will be very meaningful to the members, and comparisons with other members will allow clients to gauge their own development and learn from other group members.

Logeran (1980: 53) notes that groups are able to counteract the effect of hospitals on patients - "dehumanising". She believes that group work unites the patients so that they feel some sense of belonging even while they are cut off from most of their circles while in hospital. Membership in groups in hospitals increases communication (both between patients and between patients and hospital staff) allowing both the patients and the staff to see the "others" as individuals, decreasing existing prejudice. Communication leads to further involvement in the hospital and the ward, so that hospitalisation is not an experience that has to be endured and then just put aside as an unconnected

experience in life.

This benefit is also experienced by Orten, Allen & Cook (1989: 75) in the use of group work with the elderly. Groups aim at the improvement of social behaviour, communication and even frequent socialisation outside group hours. This is also the aim of groups for individuals suffering from Alzheimer's Disease and other forms of dementia (Gonyea 1989: 69).

Education

Since many groups aim at the education of members, it is clear that this must be a recognised benefit. Groups obviously address the concerns of the group members so that there is some value to their attendance. In addition to learning facts about the issue / condition under discussion, members also learn that they are not alone in their experience e.g. mentally ill gay and lesbian clients investigating issues relating to the fact that they are stigmatised both as mentally ill and as homosexuals (Ball 1994: 109).

The opportunity for the sharing of personal experience that is provided by group membership means that many of the members gain in knowledge (whether or not that is the aim of the group) as well as not having to openly participate (Johnson & Stark 1980: 336-337). This is also indicated by Chesney *et al* (1990: 119), by Gottlieb (1988: 28) and by Macaluso & Berkman (1984: 21).

Education also results in decreasing repeat admissions to hospitals. Group members learn facts they weren't aware of, pick up helpful hints from other members, and gain in understanding so that they are able to take preventive or precautionary steps before needing hospitalisation (Subramanian & Ell 1990: 101).

There is an increased use of group work in hospital waiting rooms. This is beneficial in a variety of ways. Firstly, since many patients simply sit in these rooms unoccupied for hours, group work makes valuable use of the fact that many have nothing to do (thus keeping people occupied, decreasing boredom and not allowing too much time for introspection or depression). Secondly, using group work in the waiting room means that it is possible to reach many people who would not ordinarily seek help of any sort. From the research (Arnowitz, Brunswick & Kaplan 1983: 397), it appears that both education and therapeutic work is possible in waiting rooms.

Financial

The use of one or two facilitators to run groups for many clients means that group work is considered to be a very cost-effective method (Gilbert 1990: 28). This is often the motivation for using group work e.g. where resources are limited and the need for services great - 5 social workers to 1 053 beds (Leratong Hospital 1988: 28). This view is supported by both Drum & Knott (1977: 21) and Rotholz (1985: 60).

Rotholz goes on to note that the use of group work in waiting rooms (which necessitates a single session and not an on-going group) means that groups are time-limited, each complete in themselves. Thus, groups do not involve a long-term commitment by either the worker or the patients, providing a very practical solution in a time of limited resources (1985: 146).

ii. Dangers

Potential disadvantages of group work are not as thoroughly investigated as the benefits, but those that are recorded do require consideration when planning group work. Much of the literature emphasises this careful planning, and the dangers associated with the use of the group work method often reflect inadequate planning.

Facilitators

Group leaders should be responsible for determining the membership of groups. This means that the facilitator would be aware of the personalities making up the group, of the problems being brought into the group and have some idea of the homogeneity of members. If this does not happen, it might mean that the institution is not really supportive of the group, or that the group leader (and so the group) has so little status in the organisation, that very little therapeutic change will actually take place. Thus, the benefits of support, empowerment and "dehumanising" can not be experienced (Friedman 1994: 234).

Galinsky & Shopler (1977: 90) suggest that facilitators need adequate training that they can bring to the group for the benefit of the members, as well as having the ability to assess constantly throughout the group experience to gain some understanding of how individuals are participating, developing or not holding their own. Part of this, is the need for the leader to be constantly aware

of group behaviour so that destructive behaviour doesn't occur e.g. judging, hostility, condemning of members, etc (Davies 1975; Toseland & Rivas 1984; Yalom 1975 cited in McKendrick 1987: 81).

Members

In planning for group work, it is essential that the facilitator keep in mind that group work is not suitable for all individuals nor for all problems. The need of the individual member must be carefully considered before entry to the group is permitted. Members' problems may become destructive to the group, as each member receives only limited attention from the group leader, and sessions cannot be taken up with only one member's problems. Certain individuals are more suited to individual casework (Davies 1975; Toseland & Rivas 1984; Yalom 1975 cited in McKendrick 1987: 80).

It is also necessary that before entering groups, individuals should have a clear understanding of what will be involved in the group experience e.g. be willing to comply with the rules; be interested in the purpose of the group, and be able to interact with others (Galinsky & Shopler 1977: 89).

Issues

Although group consensus was noted as a benefit of group work earlier, the power of group work to 'control' individuals so much that they deny their own beliefs (or to some extreme points, even their senses!) if group opinion is different, is considered a major danger of this method. Thus, although individuals gain support from other group members, group consensus can lead to other problems for members (Galinsky & Shopler 1977: 89).

Yalom (1975), Davies (1975), and Toseland & Rivas (1984) note the following areas of concern in the use of group work:

Firstly, confidentiality may be something that all groups profess, but in reality it is not always possible to ensure this. Thus, there may often be delays in establishing trust amongst the group members, and in therapeutic groups the ability of the group to reach its goals.

Secondly, it was noted that the sharing of information allowed members to learn new coping techniques from others - it is possible that members learn maladaptive behaviours as well as positive

improvements.

Thirdly, group problem-solving obviously takes longer than individual problem-solving as there is a greater amount of information to consider, and the consensus of more people is required. In addition, the use of the entire group to solve simple problems may be inappropriate, causing members to feel frustrated, bored and angry (cited in McKendrick 1987: 80-81).

Henry (1992: 2) believes that the lower costs of group work should not be the reason for offering groups. Although some time-saving may be experienced, she notes that groups require as much time and effort per individual (in terms of record keeping and following up information) as individual clients do. Thus, cost as a motivation is considered to be both a benefit and a danger.

iii. Summary

Thus, group work can be a method that offers many benefits, yet also entails some risk, both for the group member, and for the group leader. The benefits of groups that have been reported in this section however, offer a powerful encouragement, especially to social workers in health settings. The hospital environment (as will be demonstrated in Section B) provides many opportunities for social workers to assist patients, which can be done increasingly well through use of the group method.

2.3. SECTION B: SOCIAL WORK IN HEALTH SETTINGS

2.3.1. Historical Origins of Medical Social Work

Social work in the field of health care has its roots in the English hospital almoners of 1895. Although almoners were present in the hospital primarily to prevent the abuse of the hospital and its resources by patients, the value of 'social work services' in this setting was demonstrated so significantly, that almoners became accepted members of the hospital staff. This acceptance however, relied on a confused expectation of the role of the social worker, and thus laid the groundwork for the present relationship between doctors, social workers and patients - one which still has difficulties today, and which will be discussed in later sections (Butrym 1967: 6-8 & 22-27; Caires 1994: 18-23; Keen 1988b: 1-7; Mizrahi & Abramson 1985: 33-48).

In the late 1800's, Dr Richard Cabot of the USA became aware that the outcome of the patients' physical treatment was greatly affected by the social situation of the patient. He saw the medical social worker as fulfilling both an advocacy role for the patient, and acting as a liaison between the hospital and the wider community (Butrym 1967: 26; Keen 1988b: 2). Due to his insight, the first formal Social Work Department was established in 1905 in Boston Massachusetts General Hospital.

The hospital almoner of 1895 was often called upon to fulfil an administrative function (e.g. compile medical records of patients), was responsible for organising transport, and also needed to be available to perform other functions. Sadly, this was not because of any major contribution in these areas, but mostly because no one else existed who would perform these functions. Almoners gratefully took on these responsibilities as a way of gaining the goodwill of the medical staff, which was very necessary to enable the almoners to obtain access to patients with social problems that might benefit from their particular skills (Butrym 1967: 23).

Medical social workers however, became increasingly discontented with this view of their function. The tasks they were assigned were often time-consuming and did not utilise the professional skills they possessed.

> If one accepts the reality of the stresses of illness and hospitalisation, one would expect a larger portion of the social worker's task to be concerned with the acute and relatively short-term

> problems arising out of illness and hospitalisation, and less time to be spent by the social worker in providing help with long-term rehabilitation, resettlement, and support for which most of the necessary resources exist within the community (Keen 1988b: 2).

Over the years, hospitals have become increasingly aware of the need to consider the social and emotional needs of patients, in addition to their physical needs, in order to offer effective treatment. This has led to the use of inter-disciplinary teams in an effort to deliver holistic care. According to Germain (1984: 212),

> ... the aim of the interdisciplinary team is to integrate ... the concepts, methods, and data of diverse disciplines in order to provide better health care for the individual, family, community, or population.

This team reflects a bio-psycho-social approach and considers the total person-in-environment concept, as mentioned in Section A (Germain 1984: 212). In this way, the team aims to meet all the needs of the patient (be they physical, social or psychological) in offering the most effective care. Holistic health care also acknowledges the concept of self-determination. This is done by including the patient in the planning of any treatment and decisions made concerning his case. It is in this area that medical social workers make their most important contribution.

Thus, as Carlton (1984: 8) says:

> [h]ealth social work seeks to help the ill or disabled people to maintain, attain or regain a mode of living that is satisfactory to them and help them make a socially positive contribution to the human groups and communities of which they are part.

Health social work acknowledges that illness and disability are social events that take place in the lives of those experiencing disease or a handicap, and that the social phenomenon of 'being ill' makes certain demands on the lives of the individuals concerned (Carlton 1984: 14).

2.3.2. **Hospital Environment**

Many individuals are unfamiliar with the hospital environment. Although almost all people will experience hospitalisation at some point in their lives, be it directly or indirectly, it is an extremely stressful event (Keen 1990: 293). Hospitals are seen as alienating environments (Longeran 1990: 53), and hospitalisation can be for many, the beginning of a crisis (Robinovitch & Ransohoff 1982:

59-60). Both the alienating environment and the crisis situation will produce feelings of anxiety, depression, emotional isolation and even passivity and dependency in patients. Hospitalisation is a statement that medical attention is necessary, a separation from the familiarity of routine existence, a loss of independence and also a loss of control. The confusion, and accompanying anxiety, produce behavioural changes in patients.

2.3.2.1. **Medical Model versus Social Model**

A medical social worker is caught between what are acknowledged to be two separate fields - medicine and social work. Although both these fields share common goals such as helping people who are experiencing problems in social functioning; preventing unnecessary pain or suffering and promoting health and well-being (Butrym & Horder 1983: 8), the ways in which doctors and social workers think, is sufficiently different to necessitate different approaches.

> Medicine is concerned with classification in order to produce knowledge which will be effective in the course of healing...; social science is concerned with the meanings and behaviours that organise the experience of illness for the individuals involved... (Radley 1994: 5).

The development of the Medical Model as a frame of reference for health professionals can clearly be seen, and the motivation understood. Along with the accidental discoveries of medicine (such as penicillin, anti-depressive medication, etc.), came a need to be able to prove scientifically what was occurring. Over many years, medicine moved from an 'art' to a 'science', with doctors focussed on laboratories and specialisation rather than on individuals with emotional, social and psychological needs. Their training and education have come to reflect these priorities (Butrym 1967: 24-25).

Medical doctors are trained to provide a diagnosis, based on facts supplied by the patient or detected more directly in a physical examination. The ability to diagnose accurately is one of the most important responsibilities of medicine. In diagnosing, a label is applied to the patient's symptoms and signs, and this label then suggests the treatment of the patient (based on scientific knowledge) (Butrym & Horder 1983: 10; Caires 1994: 10).

This responsibility led to doctors focussing exclusively on the physical biology of individuals. As the doctor was the person with the understanding of the illness and with the ability to treat the illness, it became natural to defer any decisions concerning patients to the doctor. Thus, with medical treatment as the primary goal, and the doctor as the person most able to benefit the patient, the

Medical Model became the frame of reference in dealing with patients (Bond & Bond 1986: 10; Butrym & Horder 1983: 20-23).

As well as providing a way of viewing the patient and his condition, the Medical Model also afforded a doctor a certain status. This has determined much of the functioning of health settings, especially in areas such as inter-disciplinary teams being led most often by doctors; doctors referring patients to the social worker; and physical treatment being of primary importance (Abramson 1990b: 46-47; Mizrahi & Abramson 1985: 46).

On the other hand, social work does not have the same scientific knowledge base as medicine. It is grounded far more firmly in the social sciences, and conclusions and approaches are "... often impossible to verify and hard to defend in the face of scepticism or challenge" (Butrym & Horder 1983: 21).

The Social Model of health care, to which social work ascribes, sees the patient holistically. Social, psychological and emotional aspects are taken into consideration when assessing patient health, and treatment is not limited to the biological sphere.

The World Health Organisation (WHO) describes health as "... a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Skidmore *et al* 1991: 151; Schlesinger 1985: 78). The Social Model (also known as the Holistic Model of health care) is much more able to attend to the health needs of individuals, as described by WHO. As Bowling (1991: 1) says,

> ...the therapy has to be evaluated in terms of whether it is more or less likely to lead to an outcome of a life worth living in social and psychological, as well as physical, terms.

Mizrahi & Abramson (1985: 35-36) have examined the sources of strain that exist between social workers and doctors in an effort to describe the use of these models, and they note that the socialisation of doctors and social workers is fundamentally different. Whereas social workers are trained to be aware of their reactions to others and are taught how to deal with this, doctors are trained to be sympathetic to patients, but are not given any time to be aware of their own feelings. Again, whereas social workers are taught the importance of the relationship between patient and professional, doctors are not. Doctors participate in rotations of wards, and once the rotation is

completed, patient files are transferred to the next intern. However, it is common for the same social worker to follow patients from one ward to another so that relationships are maintained.

2.3.2.2. **Adjustment to Hospitalisation**

At this point, it is necessary to consider the process of hospitalisation. This process is important because of the manner in which it impinges on the individual.

Upon admission, patients are questioned extensively regarding their condition, and other relevant data. A name tag is attached to the patient's arm. Patients are compelled to don hospital gowns (which are revealing, and in themselves serve to threaten a patient's 'dignity'). Patients admitted to general wards are compelled to share accommodation with strangers, whom they have not chosen to be with, and which can also be seen as lacking in privacy (despite the curtains which can be drawn around beds in many hospitals). Prior to surgery, patients are exposed to intrusive staff (all wishing to become acquainted with the designated surgical area); intrusive medical procedures e.g. uncomfortable or painful tests; and surgical preparations e.g. shaving of hair and the administering of enemas.

Patients are expected to follow instructions from medical personnel as to the taking of medication or permitted exercise. Patients are awakened in the early hours of the morning, and persuaded to go to sleep early in the evening, which for many is not the normal routine. Information about the condition or prognosis of the patient is often withheld, for reasons ranging from "protecting the patient from bad news or worry", to "not wishing the patient to lose heart and become depressed". Often medical personnel will inform the patient's family, in the hope that the family will tell the patient when he is better able to receive the news, or that the patient will take the news better from someone they know (Carlton 1984: 16; Germain 1984: 45-51; Jones 1991: 255; Keen 1990: 293-294; Parsonnet & O'Hare 1990: 37).

As Germain (1984: 20-21) notes:

> [i]n all health care settings ... patients biological, social, psychological and cultural orientations to time and space - together with the facility's spatial arrangements and the tempo, rhythms, and timing of its activities - bear heavily on coping tasks and resources.

There are thus many adjustments that individuals are required to make in order to fit into the

hospital environment. Regensburg (cited in Keen 1990: 294) provides a list of common adjustments that patients are required to make due to illness and hospitalisation:

- Patients encounter changes in their self-image and in others' perception of them. This is often due to the use of labels, wearing of hospital gowns, etc.

- A patient's sense of authority, responsibility and freedom of choice is threatened. Patients are under the control of medical staff to some extent, resulting in compliance with the staff's instructions, and the handing over of decision-making powers to staff members. Patients often become passive in their thoughts and behaviour.

- Change also occurs in patients' social and environmental pressures and supports. Being relieved of roles and responsibilities removes certain pressures, such as handing in reports and performing family duties. But it also removes supports, for example being hospitalised far from home so that family are unable to visit.

- By being hospitalised, patients are also unable to follow their normal routine. Instead, patients are expected to follow the routine of the hospital. This means things such as eating meals at certain times, and seeing visitors in prescribed visiting hours only.

- Patients also face the possible loss of significant others, personal possessions and control over their environment. In addition to the stress caused by the pressure of illness, patients are unable to influence their own environment (including people and things) from a hospital bed. Other family members may be delegated to make decisions, and in an attempt to allow the patient to rest and recuperate, distressing information is often not shared, causing the patient to feel alienated and 'helpless'.

- Patients are separated from the things that mean security for them, e.g.

familiar objects, routines and roles - all these create personal security.

- Patients are surrounded by uncertainty: in not knowing what is happening, what to expect, how to cope, whether the illness will recur, etc.

- Patients will also experience pain, be it illness-related, treatment-related or long-term chronic pain.

These adjustments are supported by Jones (1991: 254-255), and Schlebusch and Lasich, who go on to add that the patient experience is influenced by the attitudes, reactions, and behaviour of medical staff (in Schlebusch 1990: 332-334).

2.3.2.3. Relationship between Staff and Patients

There are three main areas which emerge when exploring this relationship:

i. Power Imbalance

In most doctor-patient relationships, the patient lacks the knowledge and skill of the doctor. This results in a power imbalance between patients and doctors that exists even before the relationship is initiated. This imbalance of power means that the doctor is placed in a dominant role, and the patient in a submissive one, and all interactions are structured from this frame of reference. This power is reflected in many ways through the relationship: the doctor has control over whether patients have any right to the sick role; doctors decide on the discharge date of patients; and doctors decide on the course of treatment or care, including whether the patient is fit to walk or drive, etc. (Germain 1984: 50; Jones 1991: 124; Shulman 1992: 390).

ii. Social Interaction

Jones notes that, "... becoming a patient involves surrendering one's role as an independent adult as well as one's body" (1991: 124). The patient often responds to hospitalisation by becoming withdrawn, tense and anxious. Normally, individuals are able to maintain some control over their

access to others, but in a medical setting such as a hospital, this becomes more difficult as patients are constantly monitored by staff. If a patient is faced with too little social interaction, he feels socially isolated; if there is too much interaction, he feels crowded. Patients feel a loss of autonomy, and often begin to act like children, seeking permission to perform certain activities that otherwise would have been decided on and performed independently (Germain 1984: 49).

iii. **Information Control**

The aspect in the doctor-patient relationship which receives the most attention, is the patient's access to information. One suggestion as to why this filtering of information occurs is the idea that people are reluctant to convey bad news to others, particularly information that might cause further anxiety, depression or loss of hope (Germain 1984: 47; Jones 1991: 124-125). Another possible reason is that amidst a doctor's busy schedule, there is no time to provide the information, answer questions that arise, or to attend to any feelings that are triggered (Germain 1984: 48). This control of information has negative effects on the patient. Because of the patients' lack of understanding of medical terminology, diagnosis or prognosis, doctors frequently deem it unnecessary to explain or even inform patients of what is occurring. The withholding of information from the patient results in feelings of uncertainty, anxiety or unimportance for the patient. "Instead of informed cooperation as a competent adult, she is expected to conform to orders on the basis of faith" (Germain 1984: 47).

This lack of information also contributes to an inability to participate in decision-making, which contributes to the patient's lack of autonomy and feelings of isolation, and forces the patient to adhere to the submissive role, according the doctor the respect of knowing what is best, and conforming to decisions made for them (Germain 1984: 47; Shulman 1992: 390). Without information regarding his physical condition, the illness, treatment or prognosis, patients become unable to judge for themselves what is being done, why they feel the way they do, what more to expect, and whether changes are due to an improvement in their health, errors in treatment, or a decline in health.

These three areas focus on the way in which the patient experiences the relationship. Some note should be taken of the staff's experience of patients. It appears that patients are often classified by staff members as 'good' or 'bad', with criteria such as physical condition and behaviour being used

to categorise the patients. For some staff members, 'bad' patients could be those who are responsible for their condition, for example drunks and over-dosers, and 'good' patients be those who are compliant, non-complaining, and generally passive (Radley 1994: 102). Jones (1991: 132) gives us a similar system of classification:

> 'Good' patients were considered to be those who were co-operative, uncomplaining and stoical, although staff expected to be informed if they were needed medically. 'Problem' patients were those who were unco-operative and overemotional and complaining, although they were categorised as such only by the staff who had to bear the brunt of their time-consuming requests. These were generally patients who did not respond to sedatives or tranquillisers (the chief methods of dealing with pain or discomfort) and who, instead, required lengthy verbal reassurances and explanations.

A patient is thus considered a 'good' patient if they perform according to the expected behaviours. The treatment of 'problem' patients depends on their condition, but possible consequences include premature discharge, neglect and referral to a psychiatrist (with the accompanying stigma) (Germain 1984: 52).

2.3.2.4. 'Sick Role' and the Patient Career

Upon admission to a hospital or other medical setting, people are observed to go through changes in their perception of themselves (Jones 1991: 254). Various explanations can be given for this. Talcott Parsons, a sociologist, identifies the 'sick role' that is played by people once they become patients (Germain 1984: 35; Harding, Nettleton & Taylor 1990: 36; Jones 1991: 94).

According to Parsons' theory (Harding *et al* 1990: 36), fulfilling the role of 'patient' properly, perpetuates the order of society (i.e. the role is sanctioned by society), thus allowing the patient certain rights if his obligations are fulfilled. The patient has the right to assume that day-to-day expectations and responsibilities will be set aside to allow time to restore his health e.g. being able to stay at home instead of going in to work, or not having to perform certain functions such as doing chores around the house (this depends on there being someone else able to take over these responsibilities temporarily). The patient is also given the right to seek assistance from, and to be dependant on others e.g. obtaining leave from work, being admitted to hospital or simply relying on family and friends for support (Bond & Bond 1986: 212; Germain 1984: 94-95; Harding *et al* 1990: 36).

In return, patients are expected to fulfil certain obligations. Patients must want to get well and realise that their being sick is only temporary (obviously a chronic condition such as haemodialysis is not viewed in the same light), and they must act appropriately e.g. co-operate with the competent help, that is the medical staff (Bond & Bond 1986: 212-213; Germain 1984: 94-95; Harding *et al* 1990: 37). Parsons thus demonstrates the social meaning of illness, so broadening the biological focus (Carlton 1984: 32; Harding *et al* 1990: 36).

Germain (1984: 51) points out that there is evidence to suggest that the role of patient, as perceived by both patients and staff, actually contributes to the stress experienced by the patient:

> [p]atients believed they should accommodate their demands to the needs of sicker patients and to the pressures on physicians and nurses. They saw themselves as subject to rewards and punishments, assuming that essential services could be withheld unless they made themselves acceptable to their caretakers.

By adapting behaviour, individuals become patients. Patients leave behind their adult independence, and often ask permission to do things such as take a shower. Independent behaviour is often reprimanded, for example taking medication without a nurse to watch and doing exercise before being informed of limits (Bond & Bond 1986: 197). Observation of other patients' behaviour leads to socialisation:

> [t]he process of adapting or being socialised into the role of patient involves beginning to accept restrictions of freedom and movement, to accept community living arrangements and to conform to ward routines (Bond & Bond 1986: 199).

The sick role is influenced by the staff's reactions to the medical label applied e.g. surgical patient, psychiatric patient, ICU patient. The use of a label contributes to the patient's identity, letting it be known which behaviours are expected, and which not. The 'helplessness' that Parsons says is part of the 'sick role', is not always considered to be of benefit to the patient (Walmsley, Reynolds, Shakespeare & Woolfe 1993: 237). These feelings of powerlessness are further aggravated by the seeming lack of continuity - patients are "... first encouraged to participate and then excluded from the therapeutic process" (Bloor & Horobin cited in Harding *et al* 1990: 41). Thus the patient is forced to adjust to the hospital environment, without being given any assistance from hospital staff, and often without any indication as to what to expect and to how to deal with what does occur.

2.3.3. Limitations of the Hospital Setting

The limitations of this setting revolve around numerous factors - all of which impact on the role of the social worker. the nature of the setting itself, i.e. the use of the medical model, and the fact that social workers in medical settings are essentially caught between the needs of three clients simultaneously, makes the role of the social worker very difficult. Changes in health care also impact on the social worker, with less time being spent doing what social workers consider essential, so that work is experienced as more superficial and less gratifying.

2.3.3.1. Nature of the setting

For Gilbert, one of the major limitations to the use of group work in health settings is the fact that hospital personnel are often familiar with the medical model. Because of this, they retain a bias towards long-term therapeutic groups and are distrustful of open-ended or short-term support groups. In addition, some professionals fear a lack of experience in using group work, and feel safer in the less visible individual counselling relationships (Gilbert 1990: 28-29).

Mbandazayo believes that a 'top-down' leadership approach is destructive. In an attempt to resolve this issue, she encourages social workers to make use of communication in their techniques with patients and with other staff members. She suggests 4 basic principles that social workers should follow (Mbandazayo 1988: 2):

a. respecting the individuals worth and dignity;
b. encouraging self-determination;
c. accepting people as they are in spite of their weaknesses; and
d. avoiding being judgmental.

In this way, she hopes to avoid the clinical relationship that is experienced between patients and staff members, and in the hospital environment itself.

Weiner points out the difficulties that arise when social workers are faced with patients, wards and the hospital itself as clients, and with trying to meet the needs of all three 'clients' simultaneously:

> A hospital is a formalised, routinised, and hierarchical organisation... many of the features that make for efficiency and better medical care serve simultaneously as obstacles in development of teamwork. Medical authority necessary in order to save patient's lives may run counter to the need for a democratic atmosphere in teamwork (Weiner 1959: 64).

2.3.3.2. **Changes in Health Care**

One of the most obvious limitations of offering services to patients in health settings is the need for rapid discharge. As noted earlier, this pressure to discharge patients occurs due to financial constraints, for both the patients and the hospitals and institutions. This pressure has resulted in a corresponding impact on the practice of social work in these settings.

Farley writes of the impact on in-patient psychiatric settings in particular. In these settings, a long-term stay of 3 - 12 months in 1989 had been cut to 2 - 4 weeks in 1991. A short-term stay of 7 - 45 days in 1989, had become 24 hours - 14 days in 1991 (Farley 1994: 209). For the 27 social workers interviewed, the shortened length of stay required a change in their approach, and dictated the use of a different technique. Whereas with the long-term approach, techniques usually centred around observation, interpretation and behavioural modification, short-term work had to be made more focussed, directive and confrontational, so that social workers concentrated on education, cognitive rehabilitation and direct problem-solving (Farley 1994: 208).

Social workers in Farley's study complained that the relationship with family members was also suffering. Although there was more scheduled contact with families, the relationship was considered more shallow. Social workers could not wait for families to feel comfortable in the relationship, or to attain rapport with the worker, before they had to seek needed information (Farley 1994: 209).

Increased difficulty was experienced regarding discharge of the patients.

> Most patients are discharged with a list of resources, and the pressure is on families to follow through on their own... Social workers expressed frustration with this process, predicting that rehospitalisation is more likely to occur when the disposition plan is not firm (Farley 1994: 210).

The fast pace of the work has also meant that social workers are no longer able to engage in therapy, and many say that this makes it difficult to feel any sense of accomplishment concerning improvements in the patient's condition (Farley 1994: 210).

This change in the nature of the relationship affects the commitment of the worker to the patient and to the service being rendered to the patient. The attitude towards the patient would appear to be less caring because the social worker is unable to devote as much time and effort to each client as would usually occur. This results in the social worker gaining less satisfaction from the job, leading

to frustration and possible burnout.

Friedman (1994: 231) believes that a reduced length of stay is needed, and supports the use of group work to identify and plan for life circumstance changes that will facilitate an early discharge. Gilbert states that group work offers a cost-effective option. In addition to the benefit to the social workers involved, she also believes that "... groups increase exponentially the possible number of supportive relationships among members who share a common problem" (Gilbert 1990: 28). She goes on to suggest that some patients will react more favourably to group therapy rather than individual therapy, and that the stimulation of an alternative method may protect the social worker from possible burnout.

2.3.4. Role of the Social Worker in Health Settings

Lewis describes medical social work as the "... art of helping and caring about people whose social and emotional problems complicate their illness, and ... also complicate the treatment of the illness..." (cited in Keen 1988a: 10).

Zastrow (1990: 499) gives some suggestions as to possible client populations within the health setting:

- helping terminally ill patients and their families adjust
- counselling women who have had a mastectomy
- helping a low-income wife from a distant area find lodging in the community while her husband undergoes heart surgery
- counselling patients who are so depressed they are contemplating suicide
- helping an unwed mother plan for the future
- providing genetic counselling for a young couple who gave birth to a mentally retarded child
- helping an executive of a large company to make plans for the future following a severe heart attack
- counselling a woman about her emotional reactions following a miscarriage or a stillbirth
- being a support person to a hospitalised person with AIDS and to his or her friends and relatives
- finding living arrangements that will provide some medical attention for people who no longer need to be hospitalised
- counselling alcoholics and drug addicts or making appropriate referrals to other agencies
- counselling patients about their apprehensions of undergoing surgery
- helping someone suddenly struck with a permanent disability adjust and make plans for

the future
- meeting with relatives and friends of patients to help interpret the nature of the medical condition and perhaps solicit their help in a treatment plan to facilitate recovery
- counselling someone with emphysema on how to stop smoking
- counselling a rape victim on her psychological reactions
- informing relatives about the medical condition of someone who has just had a severe automobile accident

From this list, it is obvious that there is a wide scope of activities available to the social worker in the medical setting. Medical social work is involved in soothing patients' anxiety about hospital admission, circumstances at home, forthcoming surgery or treatment, and future prognosis. Skills are therapeutic, educational and task-oriented in nature, amongst others. Most work is done in consultation with others (for input or referrals), and is directed towards both patients and family members.

As the hospital (or other health setting) is a secondary setting for the practice of social work, a medical social worker is responsible to the patient; to the hospital itself; and also to the community in which she works. Brock (cited in Keen 1988a: 11) describes three relationships through which the medical social worker functions:

a. The relationship between the social worker and the patient involves direct services to the patient and relevant family members; collaboration with other hospital personnel who may be working together as a team in treating the patient holistically; referral to other disciplines or outside resources if considered appropriate; and research relevant to the patients' needs and concerns.

b. Responsibilities to the hospital include working with other medical professionals in educating them about the social and emotional issues of patients; recommendations to the relevant authority concerning services and policies that may have negative effects on patients; and offering oneself to assist all personnel in difficulties with patients or in determining the necessity of social work intervention.

c. Community involvement may comprise educating social work organisations on the effects of hospitalisation on their clients and their families; in liaising with resources about referrals; and in the planning of services and programmes that might improve the social functioning of individuals at a communal level (Keen 1988a: 11).

In a study conducted by Brandon (1970: 10-16) in the UK, the role of the social worker as seen by doctors was investigated. Of the study sample (n=30), no doctor mentioned a role for social workers in helping patients who were facing major surgery or who were in any way afraid. Referrals from physicians were mainly concerning the home environment of the patient, which included home helps, job opportunities, interpersonal relationships, housing difficulties or (in the case of obstetrics) the care of the family.

From this study, Brandon (1970: 13) derived a classification of the tasks of the medical social worker, according to the expectations expressed by this sample:

- *Enabling patients to use hospital services* e.g. problems with the admission process (7% of the sample)
- *Diagnosis* e.g. discover significant psycho-social information that will enable the understanding of the patient (23% of the sample)
- *Treatment* e.g. assisting the patient and family in coping with the illness (10% of the sample)
- *Rehabilitation* e.g. assistance to improve the quality of life after treatment i.e. a wheelchair in the case of disability (27% of the sample)
- *Disposal* e.g. clearing of the hospital bed (allowing for a new admission) (33% of the sample)

These tasks are very general, and do not take into account the social workers' possession of skills and wide range of knowledge. In addition to the knowledge base essential to all social workers, medical social workers are also required to possess knowledge in the following areas:

> ... illness factors and their relationship to personal, environmental, and cultural factors; ... the health care system and the health care organisation; ... patienthood and the patient role; and familiarity with medical terminology, routine tasks and procedures, organ systems, syndromes, technological developments, and forms of treatment pertinent to the practitioners' particular setting or service (Germain 1984: 72-73).

Since these tasks reflect the view of other professionals, they also do not make allowance for the input which the social worker might wish to make, but which is not expected of them.

From the results of Brandon's study, it is obvious that the majority of the sample see the 'disposal' of the patient as the primary focus of the medical social worker. The use of the term 'disposal' as

opposed to that of 'discharge' gives some indication of the opinion of the sample concerned, regarding the patient's future plans, their present situation, and the role of the social worker in discharge planning (as discussed later in Section B).

Another study, conducted through the Department of Health and Security in the UK in 1978, found that the pressure to discharge patients promptly upon completion of medical treatment resulted in the inability of the social worker to do more than offer practical assistance where possible. Very few social workers were required to have specialist knowledge concerning patients' reactions to hospitalisation, to being ill or to being discharged (Keen 1988b: 3).

Two studies conducted in Durban (South Africa) produced similar results. In 1978, Edwards determined that only 26% of hospital personnel (n=123) saw social workers as assisting patients in adjusting to illness, and 89% saw social workers rather as resource finders and solving problems *for* the patient (cited in Keen 1988b: 3). In a more recent study, less than 15% of the research sample (n=93) saw the social worker as participating in the treatment of the psycho-social aspects of hospitalisation. Practical aspects were focussed on by 85% of the sample, which they saw as solving domestic problems, and being a friend and comforter to the sick (Keen 1988b: 4).

2.3.4.1. **Teamwork in Health Settings**

Collaboration in health care settings is not a new concept. When Dr Cabot brought social workers to Boston Massachusetts General Hospital in 1905, he wanted them to collaborate with physicians in improving the social conditions of patients (for which the physicians did not have the time or inclination). At this stage, collaboration was informal. Team collaboration made its appearance after 1945. The rehabilitation team worked with disabled veterans and needed a range of knowledge and skills. In the 1960's, meetings between patients and professionals in psychiatric institutions "... were designed to encourage self-management and system change by the patients" (Germain 1984: 198). The use of collaboration in medical care continued to grow, despite problems such as role confusion and ambiguity of function, which are still experienced today (Keen 1988b: 4; Mizrahi & Abramson 1985: 47).

Collaboration is defined by Germain (1984: 199) as:

> ... a cooperative process of change involving communication, planning, and action on the part of

> two or more disciplines (or, in some instances, on the part of two or more individuals from the same discipline). Its purpose is to achieve specific goals and tasks related to health care that cannot be achieved as well, by one discipline (or individual) alone.

Within the health setting, collaboration occurs in three main ways:

- *Conferring* requires respect and trust from colleagues. Views are exchanged, opinions given, and each individual is free to agree or not. Greater clarity is achieved and possible solutions are determined.
- *Cooperating* results from previous conferring. The large group may decide to cooperate on a particular issue in the treatment of the patient. This is a temporary agreement, but means that professionals will work together, with a common goal.
- *Consultation* is the most structured and formal of the three. This does not involve a reciprocal exchange of ideas. Instead, a consultant is called in because of the fact that he possesses knowledge and skills needed by the team. Consultation is advisory in nature, and lasts only until the concerns of the consultee are dealt with.

(Germain 1984: 204-205)

Collaboration often occurs in the form of teams. Multi-disciplinary teams are hierarchical, with control, decision-making powers and leadership usually given to the physician, due to his medical expertise and legal responsibility for the patient (Abramson 1990b: 46-47). Team members are chosen according to the needs of the team in achieving its function i.e. according to the specialisations needed to offer the patient the best treatment (Germain 1984: 209).

Interdisciplinary teams however, instead of having an illness-focussed approach, use a bio-psycho-social-cultural approach. This approach depends on the concept of the person-in-environment (see Section A). The aim of this team is to integrate (not only coordinate) the concepts, methods, and data presented by the diverse disciplines, in offering the patient better health care. This use of collaboration also encourages the participation of the patient, so that the needs of the patient are the central issue, and not the specialised function of the team. As this form of team integrates all knowledge, and does not weight the information according to the status of the individual team member, it is therefore not hierarchical in nature (Germain 1984: 212).

> All forms of collaboration require particular knowledge, skills, and attitudes in working with others to meet patients' needs, solve problems, and carry out clinical tasks (Germain 1984: 224).

It is thus essential for the social worker working on any team to have a thorough understanding of her profession, to know what functions she can fulfil, and in what ways she may benefit the patient. As Konopka (1983: 206) states,

> ... social group workers must responsibly share information with other members of the team and, in turn, make responsible use of the information team members share with them. They also may be asked to pass on to other team members their specific knowledge and skills, which they may have been taught by others.

Being aware of the ease with which role-blurring and -overlapping occurs in teams is imperative. Regensburg (cited in Keen 1988b: 7) states that collaboration:

> ... requires of each member of a unit a strong sense of belonging to one's profession, self-reliance coupled with interdependence, willingness among personnel to learn from one another, and the ability to work together with respect for the difference in knowledge, skills, and specific objectives that characterise different professions or functions within a profession.

Thus, in order to offer patients holistic care, teams need to collaborate responsibly, both to the benefit of the patient, and to avoid overlapping of roles.

2.3.4.2. **Discharge Planning in Health Settings**

Earlier, it was mentioned that in the study done by Brandon (1970: 13), the majority of the sample saw the discharge of the patients as being the most important function of social workers in health settings. Keen (1988b: 3) also mentions a study done in the UK by the Department of Health and Security in 1978 wherein the pressure to discharge patients was so intense that little more than practical assistance on the part of the social worker was possible. Research reveals, however, that the social workers' role in planning for discharge is very important (Abramson 1990a: 53-54; Frankental & Stevens 1995: 10; Nightengale 1990: 92).

The average length of stay of patients in health settings seems to have decreased, partly due to financial constraints (Abramson 1990a: 53). As a result of this, patients have been forced to look at rehabilitation outside of the hospital environment, but where one is still adequately cared for. This necessitates planning, both for the patients and for their kin/caregivers. However, the pressure to discharge rapidly is often instrumental in the incomplete assessment of patients' health or treatment needs (Abramson 1990a: 54). Discharge becomes focussed on medical or physical stability, without taking into account the psychological or social aspects of patients' health.

It is a realistic concern of medical professionals that beds are occupied when all that can be done

(medically and physically) has already been done. It is important that beds are made free to treat the increasing number of individuals seeking medical treatment. It is however, also realistic that if the patient is discharged to an environment where adequate care is not assured, the chances of the patient being readmitted to hospital are increased (Frankental & Stevens 1995: 9-10).

For Frankental & Stevens (1995: 9), the entire period (from the onset of the condition to the placement of the patient after treatment) is part of a continuous process. To ease this, they advocate that discharge planning should begin on admission, or as soon as a diagnosis is available. This is considered important as treatment is designed around the diagnosis, which will in turn influence the planning for discharge.

Having previously noted the effect of hospitalisation on patients (e.g. childlike obedience, passive behaviour and lack of information concerning what is happening), it is likely that allowing patients some control over the outcome (in order to effect the patients' desired recovery) will improve general health levels, sense of well-being, and mortality rates (Abramson 1990a: 54-55).

There are various ways in which patients can be given control over their environment, without interrupting treatment. Nightengale writes of the use of a discharge planning group in an inpatient psychiatric facility. This group arose out of the need to discuss discharge issues more thoroughly. With a philosophy of encouraging "... patient responsibility, involvement, and decision making" (Nightengale 1990: 85), patients are encouraged to attend the group when they have reached a certain level in their treatment. There, they assist in the review of other patients by discussing problem areas, by making suggestions as to how the patient can make better progress and by supporting the patient in progress already made. In the group they are also encouraged to begin considering their own plans for discharge. This sharing between patients encourages much closer helping relationships, and results in patients typically becoming more responsible. These behavioural changes in patients are due to their opinions being respected and acted on by the facility. It is documented that from the hundreds of discharge planning sessions conducted, only a handful of the group's recommendations were overturned - these due to incomplete information, or a change in the patient's condition (Nightengale 1990: 89).

Thus, patients may be enabled to make informed decisions and adequate plans for their futures by

allowing them to express opinions which will be taken seriously by staff members. The patients' participation in areas usually denied them, should be encouraged by staff members.

Abramson (1990a: 56) notes that social workers can develop practices that increase patient control, such as:

1. involving the patient when working with families;
2. reaching for underlying conflict;
3. providing a sense of choice within existing parameters;
4. preparing patients for discharge;
5. enlisting families and hospital caretakers to assist in these processes.

These practices are supported by Frankental & Stevens (1995: 10). In their opinion, it is only possible to make decisions that best serve the patient if the psychosocial domain is also considered. This includes:

> ... the patient's need to understand his/her condition and its implications; the patient's right to be respected as an adult capable of making personal decisions, and therefore to be consulted; patient - kin/caregiver relations, and relationships within the support network.

Thus, effective discharge planning relies on collaboration between the team members so that the patient is considered holistically. With input from all concerned disciplines, the patient benefits from a treatment and plan for the future that incorporates all aspects of his life. The need for support does not however end after discharge. Many patients continue to depend on medical staff for support, as well as family members. To this end, Bauman and James (1990: 168) note that many burn victims endure a long period of adjustment (accompanied by depression, anxiety and alcoholism) after discharge, and therefore a referral to groups outside the health setting is essential to these patients.

2.3.5. Groups in Health Settings

The use of groups in the field of health care has slowly grown in popularity. Although groups have existed in health settings since the turn of the century, they have been rather marginalised by a health system that is more familiar with individual intervention (Robinovitch & Ransohoff 1982: 59; Schopler & Galinsky 1990: 1). Increasing interest in the group work method however, has encouraged professionals to make greater use of it, which has in turn lead to a wider range of group work services.

As discussed in earlier sections in this chapter, improvements in health care have lead to a fragmented and impersonal service to patients and their family members (Holmes-Garrett 1990: 144; Keen 1990: 293; Longeran 1980: 53; Schopler & Galinsky 1990: 1), as well as an emphasis on rapid discharge (Abramson 1990a: 53; Keen 1988b: 3). Group work aims to minimise the negative effects of these factors on patients, by offering patients the opportunity to share with others, to gain in support individually, to assist patients in the adjustment to illness and disease, and to bring the patient holistic care.

Groups can be used for support of people with similar problems e.g. obesity and haemodialysis patients with sexual dysfunction (Gottlieb 1988: 28; Halpern & Dlugacz in Lurie *et al* 1982: 117; Longeran 1980: 54; Macaluso & Berkman 1984: 20; Taylor *et al* 1986: 610; Vugia 1991: 97). Groups can also be used to support the family/caregivers and staff that live with and care for patients with similar problems e.g. family members caring for frail elderly and staff support groups (Gonyea 1989: 62; Richman 1990: 173-174). Groups may aim to educate patients or family e.g. information groups about living with cancer, and about the facility or setting, teaching new skills such as stress activity management and assertive communication (Halpern & Dlugacz in Lurie *et al* 1982: 117; Heinrich & Schag 1985: 445; Johnson & Stark 1980: 339; Telch & Telch 1986: 807). In addition, groups may be used to achieve certain tasks such as fund-raising (Chesney *et al* 1990: 127). Groups can also be used as a "... vehicle for change within the hospital" (Shulman 1992: 390).

Longeran (in Lurie *et al* 1982: 30-31) notes that in order for groups to become established in health settings, they need to be directly related to the physical recovery of patients. She suggests that prospective group workers attempt to discover how they can best assist the hospital in improving the health care it offers to patients.

Having done this, it is easier to convince other staff members of the value of groups. Longeran states that:

> [t]he rationale for medical groups includes the following:
>
> 1. they can offer an opportunity for the patient to be viewed in a combined physical, emotional, and social perspective;
> 2. they can facilitate interdisciplinary team work;
> 3. they can elicit information that is useful in diagnosing and treating the patient medically;
> 4. they can give administration a feedback mechanism from patients;
> 5. they are useful in educating patients about their disease;

6. they can treat patients wounded self-esteem resulting from illness; and
7. they can humanise the hospital experience

(Longeran in Lurie *et al* 1982: 31)

There are thus many ways in which the use of groups can assist both the medical profession in treating patients, and the patient in achieving optimal recovery. But many group workers acknowledge the difficulties experienced in developing group programmes that are beneficial to patients and to the hospital as an organisation. Support from medical personnel has also often been lacking (Gilbert 1990: 27-28).

Longeran believes that:

> [i]f groups can help medical staff with such problems as patient compliance, patient management, and health education and help administration with cost containment, the hospital may be quick to sanction the groups (in Lurie *et al* 1982: 32).

Therefore, once the use of groups in health settings has been successfully negotiated, it is dependent on the individual social workers to deliver services that benefit the patients in these many different ways (as mentioned earlier).

2.4. SECTION C: MEDICAL SOCIAL WORK IN SOUTH AFRICA

2.4.1. Brief South African Context

As mentioned in Chapter 1, the development of health services in South Africa is linked very closely to the social, economic and political development of their country. It is important to note the impact that was made on the spread of disease by the system of migrant labour which was predominant in South Africa, as well as the neglect of employees health by the urban employer. In addition, public health was only noted as a concern when the health of White South Africans in the urban areas was threatened (Lund 1987: 36-37). Delays in the introduction of public health care for all South Africans have a legacy that is increasingly relevant today.

Until recently, South Africa has had a reputation of excellence in the areas of research and technology e.g. first heart transplant in South Africa in 1967. Simultaneously however, the majority of the population was unable to afford (and in some cases even access) what minimal health services were available for them. Little attention was paid to the prevention of disease (Lund 1987: 37).

2.4.2 Some Current Health Issues

According to the Department of Health's Annual Report of 1996, the top 20 health problems and/or diseases faced by the South African population, as identified by the Essential National Health Research (ENHR), are as follows:

1. Injury / trauma / violence (including rape)
2. TB
3. Nutrition
4. HIV / AIDS
5. STDs
6. Cancer (all types)
7. Diarrhoea
8. Respiratory infection ...
9. Mental health (excluding substance abuse)

10. Malaria
11. Drug abuse
12. Cardiovascular disease
13. Diabetes
14. Hypertension
15. Measles
16. Teenage pregnancy
17. Perinatal mortality
18. Non-intentional injury
19. Smoking
20. Women's health

(Department of Health 1997: 37)

Most of these health issues could involve some aspect of social work services. Many are echoes of the possible services which Zastrow lists (see Section B). However, some are unique to the South African environment, and present conditions.

The South African Survey 1996/1997 (1997: 466) notes that in 1996 there were 159 000 cases of tuberculosis (TB) (27% also HIV positive). TB is further aggravated by poor living conditions, and the stress of poverty and overcrowding makes the underprivileged a prime target for this disease. In the same year, there were 29 160 cases of malaria (158 of these resulting in death) (SA Survey 1997: 463).

The Department of Health's White Paper (1997: 119) states that it has declared TB a top national health priority. Extensive TB control programmes have been planned, aimed at preventing 1.7m cases of TB and 50 000 deaths (SA Survey 1997: 468).

In August 1995, there were a reported 8 405 cases of AIDS in South Africa. However, it was estimated that the reality was closer to between 40 000 and 80 000 cases. AIDS is not a notifiable disease in South Africa, and is reported on a voluntary basis only (which might account for the discrepancy in the figures). By the year 2000, it is estimated that South Africa will have 250 000 AIDS orphans. Dr Clive Evian (Director of Alexander Forbes AIDS Consulting and Support Unit) estimates that there are 2 000 people infected daily in South Africa, giving a total of 4.8 million infections in South Africa by the year 2000 (SA Survey 1997: 458 - 461).

The value of group work with cancer, mental illness, substance abuse, terminally ill, etc. has been

recorded in Section B of this study. However, groups for people with medical conditions such as respiratory infections (e.g. TB), malaria, heart disease, hypertension, etc. are not well-documented in South Africa.

2.4.3. **Primary Health Care in South Africa**

According to the South African Survey 1996/1997 (1997: 483), in 1995 South Africa had 3 830 health facilities. This included 2 953 clinics, 425 hospitals, 153 community health centres and 8 academic health services, as well as 217 hospitals and 74 clinics in the private sector.

The national average hospital density in 1994 was 3.6 (per 1 000 people). Five provinces (Western Cape, Northern Cape, Free State, Gauteng, Northern Province and North West Province) had hospital densities above the national average (SA Survey 1997: 484).

Kloos (in Phillips and Verhasselt 1994: 210) notes that there are three major problems which are experienced by Western Medicine in the 'Least Developed Countries'[1]. These are a failure on the part of health policies to focus on the health of the population as a whole and not only on the privileged, 'urban-based elite'; a lack of resources, such as community participation and the fact that in the middle-income countries, the health expenditure absorbs 6% of the total budget, but in low-income only 3-4%; and also difficulties in implementing the primary health care programmes.

In the provision of PHC, 4 'cornerstones' are promoted (Lund 1987: 39):

"
- Regular monitoring of children's growth, for the early detection of ill health
- The promotion of oral rehydration for gastro-enteritis - one of the chief killers of children in less developed situations
- Immunisation programmes to eradicate preventible diseases
- The promotion of breast-feeding."

These are all dependent on the assumption of responsibility for health, which must be taken by

[1] Least Developed Countries (LDC's) are "... characterised by the highest incidence of communicable diseases and malnutrition" (Kloos in Phillips & Verhasselt 1994: 210).

communities themselves, in areas such as sanitation, water and nutrition.

Problems in the above areas are present in South Africa, and may offer some explanation for the fact that many of the PHC clinics are not operating, despite favourable location and community support.

2.4.4. The Use of Group Work in the South African Context

It is evident then that attempts are currently being made to offer improved health care to South Africans. However, the ubiquitous poverty of this country means that this provision is very different in rural, underdeveloped areas - especially when it is realised that health care includes the use of electricity, water and sanitation.

PHC and the proposed inclusion of social work services as a part of this, becomes not only a viable option, but also an essential one. As mentioned earlier in this chapter (see Section A), group work is considered by many to be a cost-effective method of social work (Gilbert 1990: 28; Leratong Hospital 1988: 28). In South Africa, where poverty strikes at every foundation, cost-effectiveness is a primary concern.

Thus, the use of group work in servicing many people offers benefits, not only to the patients themselves, but also to South Africa and the PHC model by reaching clients before they need be admitted to hospitals or spend large amounts of money on complicated medical treatments.

CHAPTER 3:

RESEARCH DESIGN AND METHODOLOGY

3.1. INTRODUCTION

This chapter outlines the design of this study, and the methodology used in obtaining the data. The sampling procedure and the method used to collect the data will then be explained, followed by the techniques used to analyse the data. An assessment of the limitations of this study, and the problems encountered in conducting it will complete this chapter.

3.2. RESEARCH DESIGN

This study is exploratory-descriptive in nature. As such, it encompasses two forms of research design, aimed at different forms of data, that can be combined to produce a more accurate analysis.

3.2.1. Exploratory Research

According to Collins (cited in McKendrick 1987: 257), "[t]he main condition for exploratory research is imperfect knowledge or research about a phenomenon". Since this form of research, by its nature, involves a small sample, generalisation of the data is limited (Marlow 1993: 24). Exploratory research is however a starting point for further research (Grinnell & Williams 1990: 150).

It is noted by Babbie (1992: 90) that exploratory research has three main purposes, ie:

1. to satisfy the researcher's curiosity and desire for better understanding,
2. to test the feasibility of undertaking a more careful study, and
3. to develop the methods to be employed in a more careful study.

For Babbie, exploratory research seldom produces definitive answers when used alone. Therefore, once familiarity with the topic is achieved via the use of exploratory research, it is possible to search for more definitive answers using a more scientific form of research e.g. experimental (1992: 91).

This research aims to discover whether social workers employed in health settings in South Africa use group work as a method of intervention with patients. It attempts to explore in which hospitals (or particular patient populations) group work is considered possible, and to discover to what extent social workers in health settings consider group work to be beneficial to patients. It also attempts to discover some of the potential difficulties experienced in initiating group work in medical settings. An effort is also made to establish, from social workers active and experienced in the field of medical social work, what place group work might have in the broader context of health services in the future. Having explored these areas, this research lays the grounds for a more thorough study.

Some statistical data are also necessary in order to support the conclusions of the study. This leads to the second facet of this research design.

3.2.2. Descriptive Research

Royse (1991: 44) notes that "[d]escriptive statistics can provide precise information on the characteristics of a group of respondents", while Collins goes on to say that descriptive research "... includes both quantitative and qualitative descriptions of the phenomenon under investigation" (cited in McKendrick 1987: 257).

To this end, precise information concerning the running of groups e.g. frequency, length, and structure, was sought. This precise data allowed for the use of statistical procedures as well as assessment of the qualitative data. The inclusion of statistical data resulted in the information being reflected as objectively as possible (Marlow 1993: 25).

The use of both types of research design was necessary so that the area of medical social work could be explored to some degree, and that this exploration would provide a context for the descriptions of group work used in heath settings in South Africa. An understanding of the complexities of social work in health settings enables better understanding of the use of group work as a method of social work.

Methods of data collection were designed to elicit both qualitative and quantitative responses. This will be discussed more completely in section 3.5.

3.3. RESEARCH METHODOLOGY

When this research was first conceptualised, the researcher had hoped to run a group in a hospital setting, and to use that experience as a base for assessing if groups in medical settings could generate positive outcomes for patients in three particular areas viz. improvements in self-esteem, compliance with medical advice and in the patients' successful adaptation to the hospital environment. The group was to be therapeutic in nature. In the process of trying to gain entry into a hospital, the researcher met with a great deal of resistance.

Five hospitals were approached for assistance with this project, among which were a burn unit, a renal unit, an orthopaedic ward, a radiotherapy ward, a ward catering for geriatrics (all areas which were considered by the researcher to demonstrate particular need of social work intervention), and a private hospital. For practical reasons (e.g. the inexperience of the researcher and time constraints of the study) and due to the nature of the group, it was necessary to establish criteria as to the membership of the group. These criteria consisted of the following: the group should consist of 6 - 8 members. According to Douglas (1991: 131), 7 - 8 members is optimal. Less than 8 does not make adequate allowances for absentees, and more then 8 makes it difficult for any leader to observe members closely. This is supported, for weekly groups with one leader, by Corey & Corey (1982: 75). Further conditions were also applied for the purposes of the study: members should be able to converse adequately in one of the two languages spoken by the researcher; members should not have organic brain damage that would prevent group involvement; members should be in-patients of a medical facility; and members should be sufficiently mobile to move to group venues.

Unfortunately, it proved impossible to locate a medical setting that fulfilled the necessary criteria (as above). The following were identified as the reasons for the collapse of this attempt:

- Insufficient group membership - sufficient patients could not be found on any of the wards approached to warrant running a group. Groups of 3 or 4 were not considered optimal for research purposes, although it subsequently became apparent that this is

realistic in health settings.

- Language difficulties - the group facilitator i.e. the researcher, was not familiar with the languages spoken by many of the patients who would have been potential group members.
- Stigma against social work - this was especially strong in the private hospital. It was felt that patients would be insulted if approached by a social worker, for any reason.
- Physical/organic condition prevented group involvement - e.g. people in Intensive Care Units (ICU's) or suffering from conditions such as Alzheimer's Disease were not considered for group membership, for research purposes.
- Difficulties were experienced in obtaining staff support for the group, in locating suitable venues for meetings, in obtaining assistance in moving patients, and in mobilising those who wished to attend.
- Temporary intrusion into the hospital environment was not welcomed, as it was felt that the running of groups for the purposes of research would be to the benefit of the researcher, and not to the patients.
- Criteria - the criteria used to determine group membership were discovered to be unrealistic in the health setting. The use of these criteria meant that no group was initiated (due to inadequate membership) before the group was even attempted.

This resistance indicated that the issues around group work in hospitals were associated with other structural and inter-professional dynamics that had not been anticipated. While the process of negotiating entry may well have been part of the problem, the researcher developed the sense that more needed to be known first about the current situation of group work in hospitals. Since the objectives had changed, this changed the research that was being done. The focus of the investigation had shifted, and therefore the approach had to be altered. The project that was designed as a result, seeks to understand how social workers in hospitals experience and utilise group work, with many of the reasons behind the failure of the first study being used in planning this investigation. It was decided that social workers already present in the hospitals would be better able to provide this data, since they are actively involved in the hospital routines; are already known and respected by hospital staff; and are accorded trust by the patients.

The complete sample (n=195) was selected (see section 3.4) from health settings around the

country. A questionnaire was then drawn up (see section 3.5), this having been chosen as the most suitable method of data collection for this research - due to practical reasons such as time constraints and lack of experience, as well as the fact that questionnaires are standardised, and that they allow the subject to decide when and where to answer them.

A pre-test was performed on the questionnaire. This involved selecting one hospital from each province (pre-test n=9) in an effort to make the sample representative. Five of the pre-test questionnaires were returned, and on the basis of these, adjustments were made. The final questionnaire was then sent to the selected sample (n=186) (see Table 3.1 for the provincial distribution of the final selected sample). The final questionnaire can be found in Appendix A.

3.4. SAMPLING PROCEDURE

Each year, a Hospital and Nursing Yearbook of Southern Africa is published by H. Engelbrecht Company. This book contains a listing of all registered health settings in the country, their geographical location, details regarding the number of beds and services provided, and administrative posts (including the presence of a social worker on staff).

According to the South African Survey 1996/1997, health care personnel (i.e. doctors, nurses, specialists, etc.) are distributed in the following manner across the provinces:

Gauteng:	47 785
Kwazulu-Natal:	39 882
Eastern Cape:	24 689
Western Cape:	24 026
Northern Province:	14 294
Free State:	11 565
North West Province:	11 530
Mpumalanga:	6 460
Northern Cape:	2 911

(1997: 477)

For this study, questionnaires were sent out according to a similar ratio (see Table 3.1).

Table 3.1 Provincial distribution of health settings in the initial sample

Provinces	Public	Private	Mining	Total
Western Cape	10	13	0	23
Eastern Cape	23	6	0	29
Northern Cape	3	1	1	5
Kwazulu-Natal	24	9	0	33
Free State	10	7	1	18
Gauteng	19	22	2	43
Mpumalanga	5	2	0	7
Northern Province	14	4	0	18
North West Province	10	0	0	10
	118	64	4	**186**

Purposive sampling techniques were chosen because they allow for the inclusion of elements of particular importance to the researcher (Marlow 1993: 113; Royse 1991: 114). This means that the researcher has some control over which subjects make up the sample. This is of course an advantage, as it ensures that the information collected is directly relevant to the subject under investigation. Non-random sampling is, in addition, very convenient to the researcher. It is however, accompanied by many disadvantages, the most important of which is that sampling methods that are not random result in data that is impossible to generalise to a wider population (necessitating a larger sample) (Marlow 1993: 114). Due to the fact that a random sample was not taken, it was also possible to miss out on important opposing viewpoints or suggestions that may have been revealed. In addition, purposive sampling reflects the bias of the researcher, which may influence the data collected. However, in the case of this study, the use of purposive sampling was justified because data directly relevant to the subject matter was needed, and the time constraints of the study would not allow for extraneous data.

By using the information contained in the Hospital and Nursing Yearbook 1995/1996 (which is supported by the South African Survey 1996/1997), hospitals were selected, using non-randomised

sampling techniques, based on the following criteria (in order of priority):

- the known presence of a social worker
- the number of beds (the larger the hospital, the more likely there would be a social worker present e.g. provincial hospitals)
- the services provided (hospitals offering psychiatric services, haemodialysis, drug and alcohol dependence treatment, etc. were more likely to have social workers present)
- the geographical location of hospitals (to ensure good provincial spread - unless below 250 beds).

Therefore, using purposive sampling, the following sample was chosen: both public and private hospitals (having discovered the stigma towards social work present in private hospitals); hospitals that listed social workers and those that did not (but which the researcher was able to ascertain did employ social workers); hospitals that offered services frequently involving input from social workers; and hospitals that would ensure a good geographical spread throughout the country, and were large enough to possibly include a social worker.

According to this process, 195 hospitals throughout South Africa were selected, which included the 9 hospitals (1 per province) used as a pre-test sample. The final test sample thus consisted of 186 medical facilities across South Africa (see Table 3.1 for the provincial distribution of the sample).

Of the 186 questionnaires sent to the hospitals, 3 were returned due to incorrect addressing; 22 were returned marked 'no social worker'; and 4 were returned marked 'no social worker' (but without any identifying information e.g. name of hospital). A returned questionnaire marked 'no social worker' was possible if the setting was included in the sample because of services offered or geographical location (and not because of the known presence of a social worker on staff). A total of 64 fully completed questionnaires were returned to the researcher for use in this project (see Table 3.2 for the provincial breakdown of the completed and returned questionnaires). A total response rate of 49% was thus achieved. Since, "[a] response rate of at least 50% is usually considered adequate" (Grinnell 1988: 308; Rubin & Babbie 1997: 352), this survey achieved a fair to adequate response level.

Table 3.2 Provincial distribution of health settings in the final sample

Provinces	Public	Private	Mining	Total
Western Cape	3	4	0	7
Eastern Cape	6	2	0	8
Northern Cape	1	0	0	1
Kwazulu-Natal	7	2	0	9
Free State	5	4	0	9
Gauteng	11	2	1	14
Mpumalanga	4	0	0	4
Northern Province	3	3	0	6
North West Province	6	0	0	6
	46	17	1	**64**

Table 3.3 Percentage return of completed questionnaires

Provinces	No. Sent	No. Completed	% Completed
Western Cape	23	7	30
Eastern Cape	29	8	28
Northern Cape	5	1	20
Kwazulu-Natal	33	9	27
Free State	18	9	50
Gauteng	43	14	33
Mpumalanga	7	4	57
Northern Province	18	6	33
North West Province	10	6	60
	186	**64**	**34**

The initial sample of the study is thus adequately reflective of the South African situation, but given the response rate from each province, it is clear that for some provinces, the sample is not reflective. For instance, there was a 60% response rate from the North West province, but only a 20% response from the Northern Cape. Thus, although the original sample was reflective, the return sample was not equivalently so (see Table 3.3).

3.5. INSTRUMENTS OF DATA COLLECTION

Questionnaires were chosen as the most suitable method of data collection for this study since:

- they would allow the respondents to find the best time, individually, to complete them;
- completing them at their own leisure would result in less pressure on the respondents;
- a standardised set of pre-tested questions should have decreased the chances of respondents supplying inaccurate or incomplete information, or of misunderstanding the question asked (Royse 1991: 129);
- it was not considered practical to conduct 195 in-depth interviews given the time constraints;
- it was more cost-effective to use questionnaires rather than travelling around the country or using telephonic surveys.

The use of questionnaires however, incurs certain disadvantages. These include: a generally low response rate to mailed questionnaires; the inability to discuss answers with subjects if clarification should be needed; the respondents are much more able to ignore a mailed questionnaire rather than an interviewer standing on their doorstep; subjects may not all be literate in the language used; and respondents may be put off by some of the questions, resulting in incomplete answers or an unwillingness to be completely honest (Royse 1991: 130).

Both open- and closed-ended questions were used, so that information would be available in both qualitative and quantitative forms. It was also hoped that the advantages of using both open and

closed questions would balance the disadvantages.

Closed-ended questions allow the researcher to be specific in the information required and thus more reliable data is elicited. In addition, individual answers are more easily compared which facilitates the analysis of the data (Grinnell 1988: 317). Since these questions supply all the respondents with the same response options, "... their greater specificity communicates the same frame of reference to all respondents" (Converse and Presser cited in Royse 1991: 132), and as a result there are fewer "I don't know" responses (i.e. fewer gaps in the data). Sensitive data is also more easily gathered using a technique where respondents are not forced to express themselves in words. However, the use of closed-ended questions also means that the alternatives provided by the researcher may not actually apply to the respondent (which could result in gaps) or that respondents may be tempted to choose one of the available options rather than find a way of expressing their own opinion in the 'other' category (Grinnell 1988: 318).

Open-ended questions do not offer the respondents any response options. This advantage can be used in two ways. Open questions can be used when the researcher does not have an exhaustive list of alternatives to offer the respondent, and they also offer the respondent the opportunity to give answers in greater detail and in greater depth (there are no constraints on the respondent's expression of feeling or opinion). The answers of open-ended questions can also be used in the later construction of closed-ended questions. The difficulties of using open-ended questions include: the fact that these questions take a long time for the respondent to complete; respondents may be discouraged if they feel they are not good at expressing themselves in written words; and, because the researcher often has to decide into which category the responses to open-ended questions fall, the answers may be incorrectly coded by the researcher (Grinnell 1988: 315-316).

3.6. ANALYSIS OF DATA

The data produced by this study is both quantitative and qualitative in nature. This was done in an effort to discover as much information regarding the topic under investigation as possible; which will in turn serve to create a more detailed and accurate understanding.

Graphs and tables are used to illustrate the findings more clearly. To analyse the findings most comprehensibly, use was made of frequency distributions, and measures of central tendency, to enable the calculation of the average value for variables (Marlow 1993: 190-194).

For statistical analysis, the findings were summarised into contingency tables, which were used to test whether there is an association (or relationship) between any two variables (e.g. the type of hospital and the use of therapeutic groups). As with every statistical test, both a null hypothesis (H0) and an alternate hypothesis (H1) are required. In this case, the null hypothesis would read:

H0: type of hospital and the use of therapeutic groups are statistically independent.

The alternate hypothesis, which the researcher is trying to establish, would read:

H1: type of hospital and the use of therapeutic groups are associated.

This test of association uses the Chi-squared distribution of sample.

Under the assumption of independence made in the null hypothesis, theoretical frequencies can be calculated. If these theoretical frequencies (which assume independence) and the observed frequencies of the test are 'too different', the null hypothesis of independence will be rejected. This would lead to a conclusion that there is some dependence or relationship or association between the two variables tested. The nature of the association can be determined by examining the contingency tables.

The above test was performed on a number of factors (see Appendix D). A 'p-value' is calculated for each test, representing the probability of rejecting the null hypothesis, when it is in fact true. Smaller p-values are thus desirable for a given test, and p-values of less than 5% are regarded as 'statistically significant', and the two variables are considered to have a 'statistically significant' relationship. Smaller p-values indicate a 'highly significant' or 'very highly significant' association. If the p-value is above 5%, any degree of association between the two variables is regarded as 'not statistically significant' (Underhill & Bradfield 1996: 241-247).

As this study focuses on whether group work is used in health settings, it is necessary to explore the area. To do this, it was important to ask social workers to give us their opinion on the use of group work. The qualitative data received will enable the understanding of what is involved in running groups, how it feels to negotiate their existence, what type of groups are considered possible in medical settings, and possible ways in which the problems surrounding successful group work can be resolved.

3.7. LIMITATIONS OF THE STUDY

The criteria of the first project were established to facilitate smoothness in the researcher's running of groups. These criteria were not meant to be typical of all groups in hospitals, or to imply that only groups that complied with these criteria would be possible in health settings. Rather, they were to serve as a guideline for the researcher, which it was felt was needed due to lack of experience. Unfortunately, these criteria proved unrealistic e.g. number of members considered adequate for group work to take place.

It would have been impossible for the researcher to obtain first hand information concerning group work alone. Much assistance from other members of staff would have been needed since, without understanding the symptoms, or being able to envisage the practical consequences of cancer to a mother of three young children, for example, effective group work would have been a difficult goal to attain. This made it necessary to obtain information from social workers already working in the setting, who were more familiar with the physical illnesses and the emotional adjustments necessary to optimal recovery than the researcher. This was most easily done through the use of questionnaires, but involved a distancing from the direct use of the group method.

As mentioned previously, one of the major limitations of this study was the lack of personal medical social work experience on the part of the researcher. This made progress slow, and meant that some inappropriate questions were asked or suggestions made, e.g. respondents were asked whether the relationship with staff members demonstrated understanding, but the question was biassed towards the understanding of discharge planning, and not other activities - results would have been clearer if specific questions had been asked.

Unfamiliarity with the routines of hospital social work and the environment of the hospital itself, also impacted on the method of data collection. This led to incomplete investigation into issues such as: structure of the social work department; methods of referral; descriptions of interaction with medical professionals; methods of negotiation with medical staff concerning the running of groups; and a thorough description of the groups run in the hospital setting.

The use of questionnaires, in itself, meant that additional difficulties would be faced. By posting

questionnaires to respondents, it was necessary to take the risk that they would not be completed and returned, or that they would be incorrectly completed. There was no way to maintain control over this factor, considering the distances involved in this study. A pre-test was done in order to cut down on as many of these predicted difficulties as possible, but errors still occurred e.g. respondents answered sections concerning the running of groups when they had stated earlier that groups were not run in their hospital. The low response rate in this case, may also be due to the fact that no follow-up of the questionnaires was done by the researcher.

Experience of South African hospitals was also in many ways dissimilar to that of overseas health care (of which the greater part of the literature consists). Thus, since much of this research was based on the findings of literature from overseas, many of the issues involved are different to those revealed by these studies e.g. members of South African groups seem to encounter more frequently issues of hunger, malnutrition and inadequate housing.

In setting up the questionnaires, much reading was done in preparation, but again due to the lack of familiarity, the researcher may not have asked important direct questions such as "What groups have been run successfully in the past in your hospital?", rather than implying that it was only groups run by the social worker personally that were relevant. Because of this, the study should be viewed as exploratory, laying the groundwork for further research.

Since South Africa has eleven official languages, there may also have been difficulties with literacy, or fluency and ease of expression in a foreign language. The questionnaires were only distributed in English, which may have resulted in a low response rate due to language problems, rather than low motivation to participate, especially from health settings in the rural areas.

CHAPTER 4:

FINDINGS - PRESENTATION AND DISCUSSION

4.1. INTRODUCTION

This chapter documents the findings of the study. These findings explore the current use of group work in South African health settings, and describe some of the ways in which groups are run. Discussion of these findings will occur alongside this presentation. This was done to enhance the reading of this chapter. It is also hoped that this form of presentation will decrease the repetitiveness of reading results to the same questions in five different sections. Tables and graphs are used as graphic representation of some of the data. A complete table of statistical analysis may be found in Appendix D.

To facilitate the presentation and discussion of findings, this chapter is divided into the categories of health settings used in obtaining the data, viz. public hospitals, private hospitals, and other health settings. For the purposes of this study, these categories have been further sub-divided into:

- General public hospitals: those that offer services (usually medical or surgical) to all general hospital patients.
- Public psychiatric hospitals: open to the general public, but limit their services to the treatment of psychiatric conditions (i.e. non- medical causes).
- General private hospitals: serve patients covered by medical aid or paying all fees privately. While some patients in the private hospital categories may also use public hospitals, it is not the norm.
- Private psychiatric hospitals: serve the same group of patients, but only for psychiatric conditions.
- Mining hospitals: attached to mining groups, and serve the employees of the mines.

- Other health settings: in this study these include old age homes (public and private), drug and alcohol rehabilitation centres and facilities for the mentally retarded. These settings are included as medical settings in the Hospital and Nursing Yearbook for Southern Africa 1995/1996, and offer services with which social workers are often associated.

This sub-division was considered useful due to the special nature of psychiatric settings, i.e. their focus on psychological aspects of health and emphasis on social functioning, as opposed to medical or physical treatment only.

In the interests of providing as complete a picture as possible, all the data obtained is presented under the sub-headings described below. While this may appear repetitive, it was justified in this study, by the improved analysis and comparison that it provides. In so doing, it enables the reader to see a more detailed 'picture' of the results.

Each section will be sub-divided into: biographical data of each type of hospital; a description of the kinds of group activity occurring (if any); an exploration as to why groups are not used (if not); and also a view of social work in health care settings; and the future of medical social work, as seen by this sample of social workers. The ratio of social worker to patient in each hospital was used as an indication of the size of the hospital or health setting.

The covering letter and questionnaire that was distributed to the sample (n=186), can be found in Appendix A.

4.2. FINDINGS OF THE TOTAL SAMPLE

4.2.1. Construction of the Sample

Questionnaires were sent to both public and private hospitals in all provinces, and to mining hospitals in particular provinces, viz. Northern Cape, Free State, and Gauteng. This distribution (as explained in Chapter 3) was determined by the presence of a social worker in the health setting, the size of the setting, and the services offered by the setting.

From a sample of 186 health settings, 26 questionnaires marked 'no social worker' were returned (predominantly from private institutions - 52%). This reflects the difficulties encountered by the researcher when attempting to run groups in health settings. From this response, it appears that most private settings do not offer social work services to patients, only referring the occasional case when necessary. This supports the researcher's impression of social work services being perceived as insulting to patients in private settings. Thus, a total of 64 completed questionnaires were returned by social workers in settings which were situated across South Africa, representing all 9 provinces.

In Figure 4.1 the provincial distribution of those health settings which responded positively to the questionnaire can be seen.

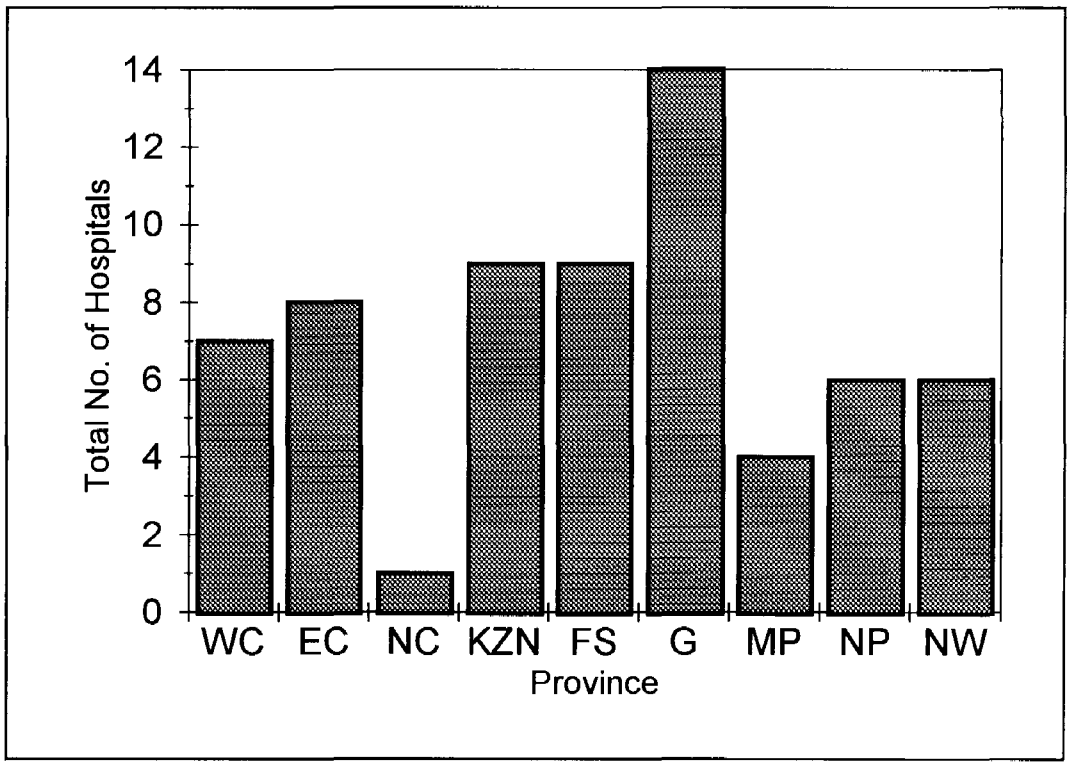

Figure 4.1 Provincial distribution of sample (n=64)

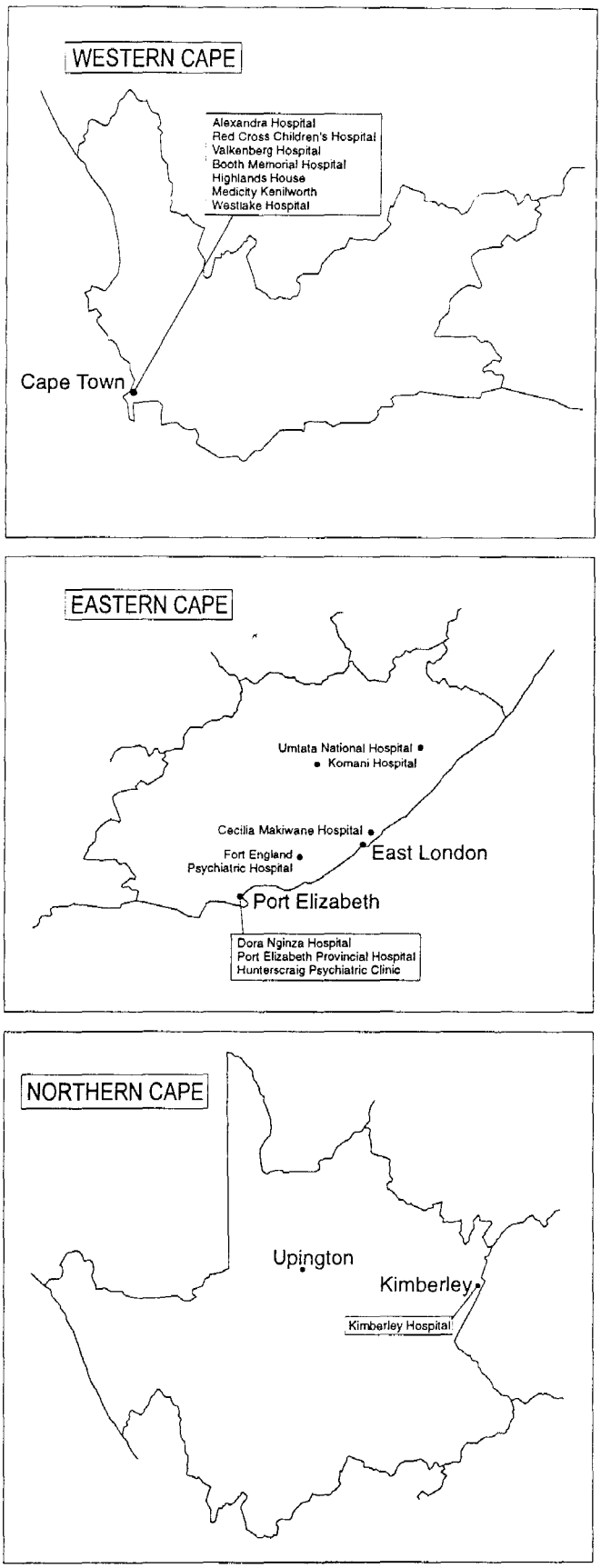

Figure 4.2.1 Distribution of study sample in Western, Eastern and Northern Cape Provinces

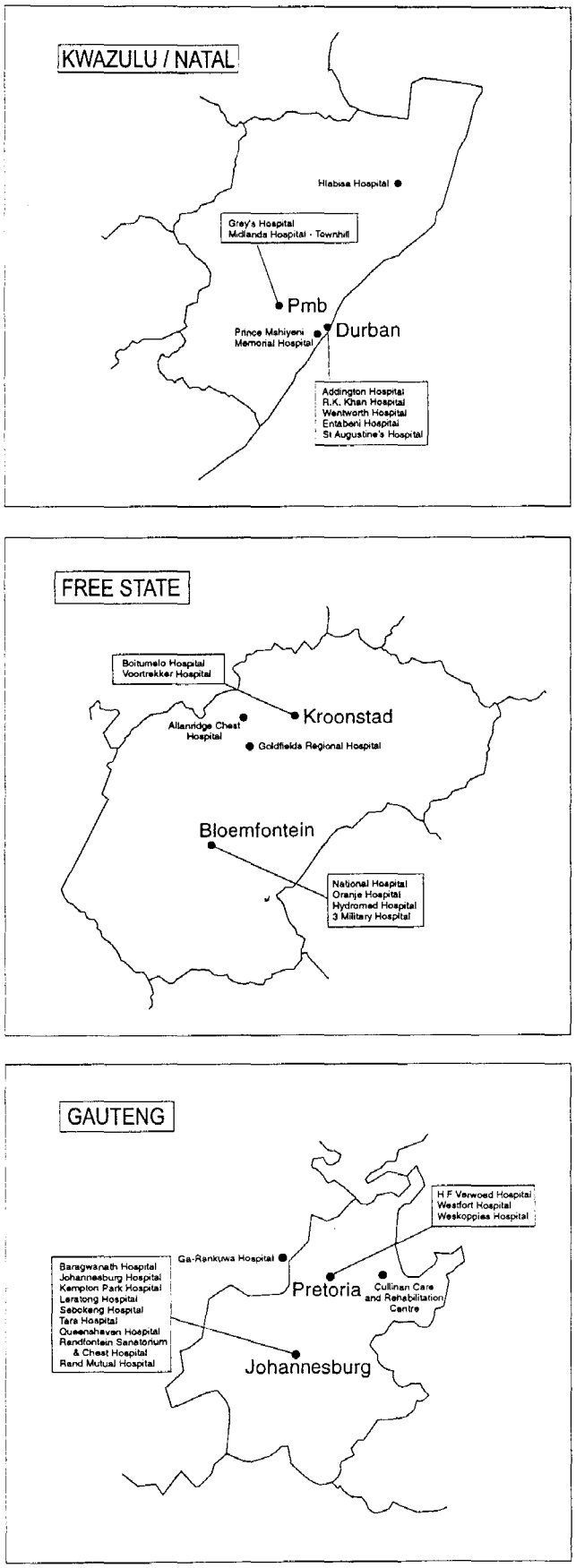

Figure 4.2.2 Distribution of study sample in Kwazulu-Natal, Free State and Gauteng Provinces

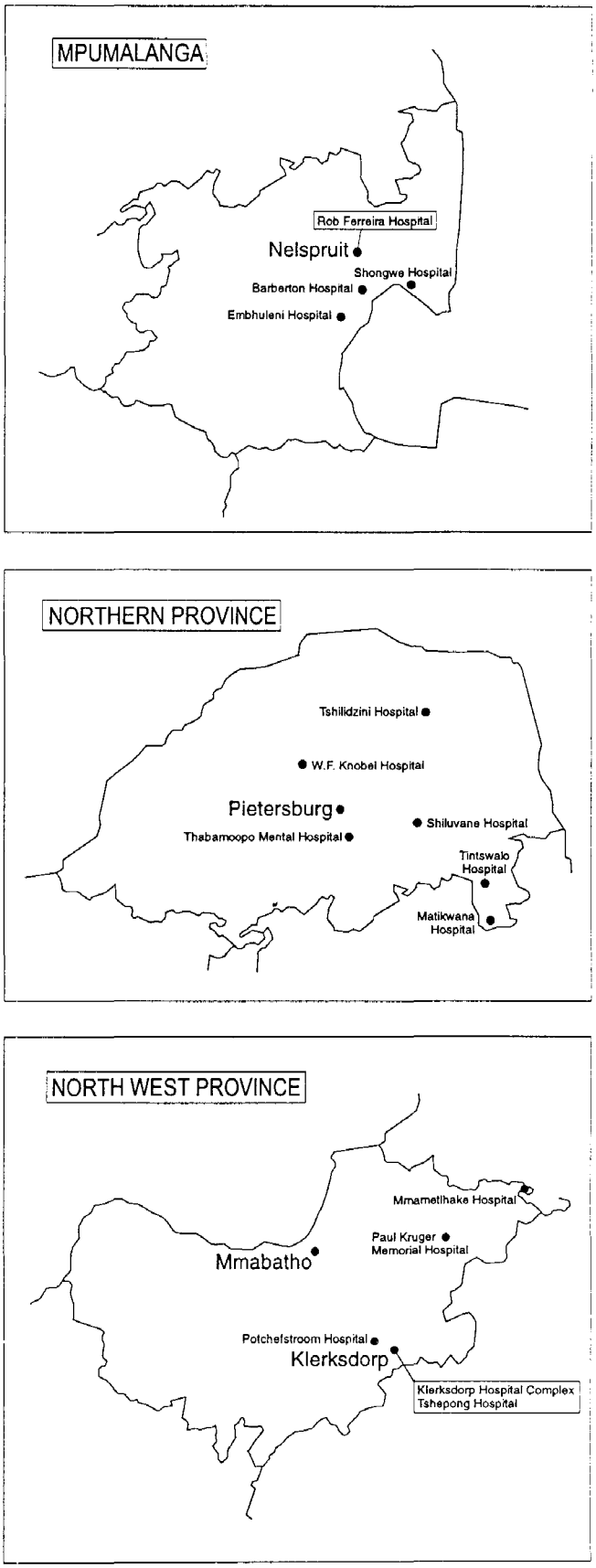

Figure 4.2.3 Distribution of study sample in Mpumalanga, Northern and North West Provinces

Most responses (22%) came from the Gauteng region, the least responses (2%) from the Northern Cape. As mentioned in Chapter 3, this response reflects the distribution of questionnaires, as well as the distribution of health personnel, health settings and therefore resources in South Africa, as recorded by the South African Survey 1996/1997.

Although an effort was made to ensure the geographical spread of the health settings in the study, many of the respondents were centred in major cities such as Cape Town, Durban, Johannesburg, Port Elizabeth and Bloemfontein. This is illustrated in the maps of the nine South African provinces (see Figure 4.2).

This concentration of respondents in the major cities may be attributed to two factors:
Firstly, major cities possess more resources (perhaps due to their size or wealth, which correlates with Iyun's view (see Chapter 1) concerning the distribution of resources along financial, political or racial lines). Thus, a greater number of questionnaires were sent to these areas, and consequently a greater number were returned.

Secondly, because the questionnaires were only distributed in English, language may have been a problem for some of the subjects. It is probable that English is spoken more commonly in urban areas due to the fact that a wider variety of languages are spoken, and it is thus necessary to find a common language of communication, viz. English. In rural areas however, where there is less interaction with other language groups, English may not necessarily be understood by all. This may be why fewer responses were received from health settings in rural areas.

Public hospitals form the majority of this sample (n=46). Only one mining hospital social worker responded, and very few private hospital social workers returned questionnaires (n=12). The response rate per category was also to some extent anticipated due to the ratio of distribution. However, the low response rate from private and other health settings means that it is impossible to generalise the findings of this study.

Figure 4.3 depicts the total number of health settings making up this study, as they were categorised.

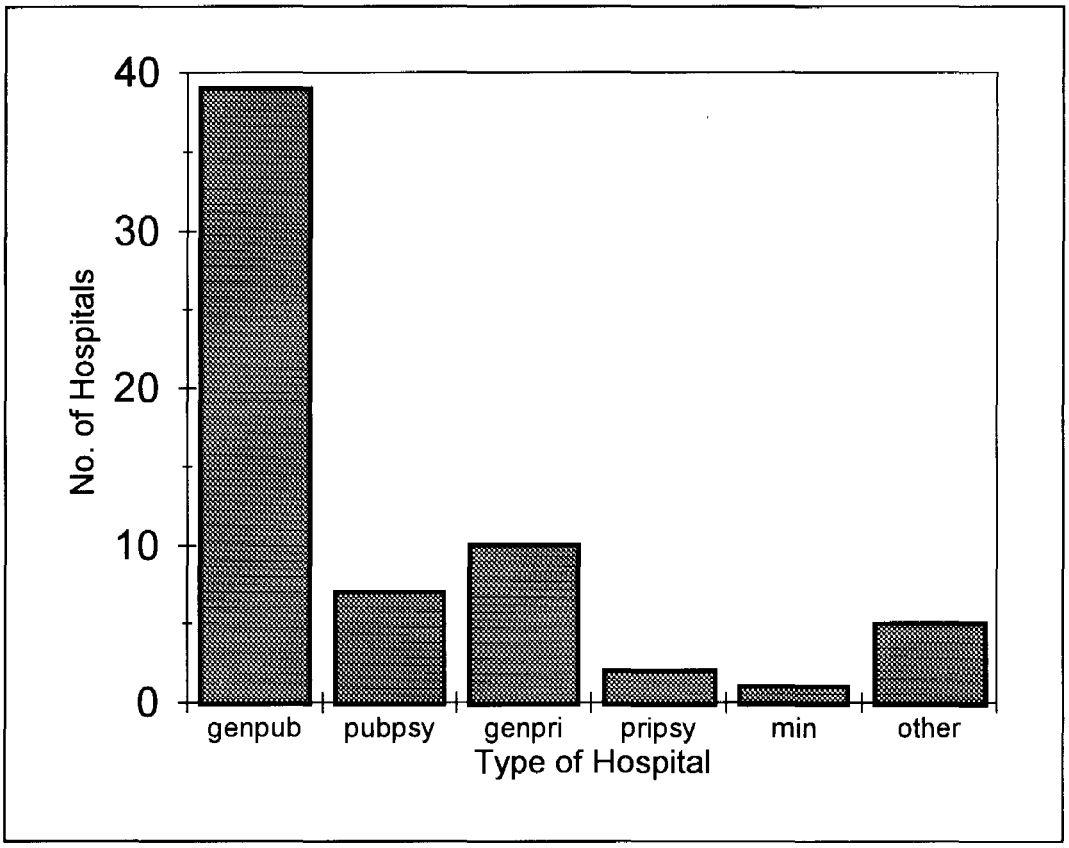

Figure 4.3 Total number of health settings according to category (n=64)

4.2.2. **Biographical Data**

Across the entire sample of social workers, the average length of employment is 5.9 years (range: 0.2 to 20 years). Most of the social workers making up this study are employed for an 8 hour day. This means that a 40 hour week is most common. Respondents were asked to indicate how many hours per week were spent on casework, group work and community work. Although half of the sample i.e. 32 out of 64 hospitals, do not spend any hours on group work, the average number of hours per week spent on group work is 2.2 hours (range: 0 to 20 hours per week). To provide a comparison, an average of 26 hours per week is spent on casework (range: 5 - 45 hours).

Using tests of association, a statistically significant relationship ($p = 0.0229$) was observed between the type of hospital and the area where the social worker was based. This could mean that there is some association (across the entire sample) between the type of hospital and whether social workers work generally in the hospital, or are based on particular wards e.g. burns or haemodialysis. Whereas 92% of the social workers in private settings report working in the hospital generally, only

39% of social workers in public settings work generally. In other settings, 50% of social workers work in the hospital generally. No social workers in private hospitals report working on particular wards.

Patient referrals are received by 97% of the sample of social workers (most commonly from doctors (n=34) and nurses (n=27), as well as para-medical staff, self-referral patients, and community referrals). There is a statistically significant association ($p = 0.0374$) between the type of hospital and the use of referrals to social workers. This association demonstrates that the relationship between patient and social worker is in many ways controlled by medical staff e.g. doctors and nurses, who are responsible for most referrals. Access to the patient is controlled by these referrals. Only one hospital (in the 'other' category) reports not working on a referral basis. This setting is the alcohol and drug rehabilitation centre, where the team works together in the care of every patient. A referral to the centre implies a referral to every team member. This social worker is thus a part of the treatment process of every patient, simultaneously carrying a lower average caseload (1 social worker to 6 patients). In this setting, teamwork might also be responsible for the lack of referrals, and instead the *inclusion* of a social worker.

This is beneficial to the patient in terms of the services a social worker offers. The patient is also not made to feel any stigma on referral to a social worker, or by expressing the need of a social worker. Patients are thus assured of a member of staff who is available to them, and who they might feel to be more approachable.

The rehabilitation setting is unique in not working on a referral basis, and this is obviously due to the nature of the setting, the caseload carried by the setting, the expectations (of the setting) of the social workers function and also of the lack of pressure to discharge patients as rapidly as is necessary in the more traditional health settings.

At this point, it is interesting to examine the types of referrals received. The context of South African health care presently, the effects of Apartheid, and the distribution of resources along racial lines, have all had a noticeable effect on the individuals that seek medical treatment. Social workers in all settings report referrals concerning poverty and destitution, malnutrition, financial problems,

housing problems, lack of employment and the need of material assistance.

The Department of Health's White Paper notes that mental illness is highest in "communities which have been ravaged by State neglect and abuse for decades" (Department of Health 1997: 135). These communities are considered 'at risk', and frequently exhibit the following manifestations: interpersonal violence, trauma, neurosis of living under continual stress, post-traumatic stress disorder, substance abuse, suicide and disturbances in children and the elderly.

This situation is confirmed by the results of the study. Problems that are commonly referred to social workers include: marital and relationship difficulties, emotional, social and psychological problems, family problems, child abuse (both physical and sexual), woman battering, drug and alcohol abuse, abandoned babies, depression, suicide, and other behaviour problems. Social workers are requested to assist in the acquisition of grants and accommodation, and aids such as wheelchairs, hearing aids, etc. Social workers are also involved in counselling and support in terms of medical conditions, adjustment to the illness and planning for the future.

Thus, patients are referred to social workers for practical and material reasons, as well as for social and emotional ones.

A relationship with staff members that is characterised by understanding of the social workers' role and function in the setting was reported by 59% of the total sample. A significant association was noted in this area ($p = 0.0285$), demonstrating a possible relationship between the type of hospital and the level of understanding of other hospital staff members. The level of understanding on the part of staff members of the social worker's role was reportedly higher amongst social workers in private hospitals (83%). No information was obtained, however, regarding what factors had any impact on this level of understanding. It was hypothesised that factors that might be relevant would be: length of employment, previous experience, the presence of staff groups in the setting, or the use of teamwork in the setting, amongst others.

Group attendance was recommended to family members by 70% of the social workers in this study. These referrals were made most commonly by the private hospitals in this study. Patients are

referred (on discharge) to groups in the community by 64% of the total sample. This also means that the majority of the social workers in this study are involved in some form of discharge planning.

Statistical analysis revealed a very highly significant association ($p = 0.0002$) in the relationship between the type of hospital and the referring of patients to groups on discharge. While patients are referred to groups by 70% of the social workers from public hospitals, and by 67% of those from private settings, only 17% of the social workers at other settings reportedly refer patients to groups on discharge. The fact that two of the other settings are homes for the mentally retarded (who are never discharged) may have some impact on this association. This might also be due to the fact that groups for patients are used in the setting, so that the patient has already received the necessary support before being discharged.

It was expected that staff groups would be used as a method of education for staff members, especially in general hospitals where the role of the social worker seems to be misunderstood (i.e. incorrect referrals received), as well as a support mechanism for staff members. No statistically significant association was revealed ($p = 0.8603$) for this relationship.

4.2.3. Group Work Used

Subjects were asked in section 3 of the questionnaire (see Appendix A) whether they used group work with patients. Affirmative responses were received from 35 hospitals (55%) of the total sample. However, only 32 hospitals (50%) completed Part A of section 4 of the questionnaire, in which respondents were asked to describe the group work they were involved in. Therefore, data is only available concerning the groups run by 50% of the health settings in this study i.e. 32 out of 64 hospitals.

This contradiction may be the result of factors such as: misunderstanding of the question; confusion over whether to answer the question personally, or for the social work department as a whole (i.e. the social worker may not personally run groups, but other social workers in the setting might); or confusion over the classification of the group work done (i.e. groups may be informal). In some cases, respondents answered both Part A (for those who do run groups) and Part B (for those who do not run groups). In these cases, the context of the questionnaire as a whole was used to decide

whether the data was classified under Part A or Part B.

Respondents were asked to indicate what types of group they used with patients (see Appendix A, section 4).

Table 4.1 Types of groups used by different categories of health settings (n=32)

	Therapeutic		**Educational**		**Task**		**Recreational**		**Other**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Public	20	83.3	18	75	2	8.3	3	12.5	2	8.3
Private	4	100	4	100	1	25	1	25	0	0
Other	4	100	3	75	0	0	3	75	2	50
Total*	28	**87.5**	25	**78.1**	3	**9.4**	7	**21.9**	4	**12.5**

*Totals greater than 32 (100%) because more than 1 possible answer

In Table 4.1, it can be seen that therapeutic and educational groups are most common, with very few hospitals running task or other forms of groups. This is confirmed in the literature consulted (Northen 1990: 7, 12-19). A very significant dependence ($p = 0.0196$) was noted for the relationship of recreational groups and the type of hospital, and a similarly significant relationship ($p = 0.0475$) for the relationship between the type of hospital and the use of other forms of group work. These statistics indicate that recreational and other forms of group work are used more commonly by certain types of hospitals viz. other health settings.

Of the hospitals in the study, 75% record the use of more than one form of group e.g. therapeutic as well as educational. This may be seen to demonstrate the use of different forms of group amongst the various populations of patients in health settings. Different forms of group may be considered more useful for different problems, and for different group members.

Respondents were asked what, if anything, was done for family members. Table 4.2 indicates that in most health settings where the use of groups is included in patient care, the family system as an environment is often not supported, although social work attends to the person-in-environment (of the patient). A statistically significant association exists between the type of hospital and the

inclusion of family members in group sessions (p = 0.0336), with the majority (75%) of the private hospitals sampled including family members. No significant relationships exist for the other options (see Appendix D).

Table 4.2 Provision made for family members by different types of hospital (n=32)

	Inc Fam		**Sep Fam**		**Ref Fam**		**Ot Fam**		**None**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Public	2	8	9	35	11	46	4	17	2	8
Private	3	75	1	25	2	50	0	0	1	25
Other	1	25	2	50	1	25	0	0	2	50
Total*	6	**19**	12	**38**	14	**44**	4	**13**	5	**16**

*Totals greater than 32 (100%) because more than 1 possible answer

Eighteen out of 32 hospitals (56%) run groups of 1 hour in length (range: 0 to 3 hours). For 22 of the hospitals (69%) that run groups, these occur once a week (range: 0 to 5 times per week). A statistically significant relationship was noted between the type of hospital and the frequency of group sessions (p = 0.0055). Groups that occur once a week are common to 79% of public hospitals and to 75% of other health settings, but to none of the private hospitals. Private hospitals seem to run groups as often as is needed (e.g. up to five times a week). Most social workers from public hospitals (79%) and from other settings (75%) report group sessions of 1 hour in length, as opposed to 0% of social workers in private hospitals. Groups are generally run on an open membership basis (38%), but frequently use closed membership (28%), and both open and closed membership (28%).

In the hospital environment, open membership is widely used due to the rapid turnover of patients. Open membership groups do not usually involve intimate exchanges that necessitate confidentiality among group members. Where confidentiality is important (e.g. in therapeutic groups), membership may often be closed, with members being able to decide when new members would be allowed to enter.

It was anticipated that the study would reveal that the use of groups would have some positive influence over the length of stay of patients. However, no statistically significant relationship was revealed (see Appendix D).

4.2.4. Group Work Not Used

This research was anticipating that most social workers in health settings would not make use of group work. This hypothesis was arrived at because of the researcher's experience (in all the hospitals approached for the initial study) of groups not been run in the setting.

However, the results of this study indicate that group work is used by 50% (n=32) of the social workers in health settings in South Africa. This percentage is in contradiction to that revealed in the literature. This could be attributed either to the fact that the value of social work in South African hospitals is well-recognised, and thus social workers are able to use services and methods not supported in other areas; or that many of the social workers who are not presently running groups did not return a completed questionnaire, which may be due to lack of motivation or language difficulties or other factors such as post office crime.

The reasons given by respondents for not running groups can be seen in Table 4.3.

Table 4.3 Reasons for not running groups (n=32)

	Turnover		**Insuf Staff**		**Insuf Time**		**Insuf Mem**		**Other**		**None**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Public	6	27.5	2	9.1	5	22.7	2	9.1	3	13.6	4	18.2
Private	1	12.5	0	0	4	50	0	0	3	37.5	0	0
Other	0	0	0	0	1	50	0	0	1	50	0	0
Total	7	**21.9**	2	**6.3**	10	**31.3**	2	**6.3**	7	**21.9**	4	**12.5**

Insufficient time was the most frequently cited reason (31%) for not running groups. Other reasons that seem relevant are the rapid turnover of patients (22%), and other factors such as new posts or bed-ridden patients (22%). It was hoped that this study might reveal one reason behind the lack of use of group work. For this reason, respondents were requested to select only one answer to this question. The results reveal that no one factor is responsible for social workers not using the group method. This of course makes it harder to offer solutions or improvements to social workers. Most of the social workers sampled used mainly casework, and worked with the problems which were

referred to them. With an average overall ratio (of social worker to patient) of 1:153.5, social workers are understandably extremely busy.

Casework with individuals is demanding and time-consuming, and social workers find themselves unable to do intensive counselling with individuals. Many social workers see their present work as filling gaps only, and not having a long-term beneficial effect for the patient (Farley 1994: 210). This feeling was evident among the social workers in the sample, who reported that although group work would be very beneficial to patients, and offered many opportunities (which they felt they were missing), present circumstances e.g. new posts and old or unmotivated patients, prevented their running groups.

Explanations received from social workers included:

- "Since it is for a first time for a social worker to be employed in the hospital I'm working in. Social work is still in a process of being established in the hospital."
- "Patients acutely ill."
- "Patients extremely frail."
- "Time, lack of motivation from residents, practical problems."
- "Post only occupied for 2 months."

It is interesting to note that many of those who do not make use of group work say that it is due to a heavy caseload and insufficient time. However, many of those social workers who do run groups, make mention of the fact that group work enables more patients to receive the same benefits as in individual counselling, and to benefit in additional ways unique to groups, such as sharing ideas, gaining in motivation and support from others, and in less time than an equal number of intensive individual interviews might take.

Only 16% of the total sample felt limited by the hospital structure and hierarchy itself. When embarking on this study, it was hypothesised by the researcher that the structure of the hospital or hospital personnel might have some influence over the use of group work by social workers. While the results indicate that personnel do have some say, for example, in cases of referral, or in a willingness to be involved or to assist, most social workers feel that their environment is supportive

of their efforts. No social workers from private psychiatric or mining hospitals are included in Table 4.3, as all social workers in these categories (n=3) do make use of group work.

Although not running groups presently, 81% of the sample claimed that they would like to use group work, if a solution to their difficulties could be found. A significant relationship ($p = 0.0312$) was observed between the type of hospital and those wanting to use group work if a solution could be found. This association is interesting since 91% of the social workers in public hospitals, and 100% of the social workers in other health settings sampled indicated an interest in using group work, but only 50% of social workers in private hospitals. This could mean that there is some relationship between public and other health settings and the use of group work, or in turn some association between private hospitals and the small number of social workers wishing to use group work, even if solutions to problems experienced were available.

Only 38% of the total sample had attempted to use group work in the past, and been unsuccessful. Since less than half of those not running groups have attempted to make use of groups at all, it is not clear why these social workers were so reluctant to use groups. Again, there seems to be some reluctance on the part of social workers in private hospitals to make use of group work. Only 13% report having tried to use groups, but unsuccessfully, as opposed to 46% of public hospital social workers, and the 50% of social workers in other health settings. The existing literature concerning the variety of patient populations that participate in groups in other countries, even in other institutions in this country, seems to indicate that with adequate planning, and the necessary time and effort on the part of the group workers, most patients could benefit from the use of groups. Once the benefits of groups have been demonstrated to patients, the success of the group almost seems to become the task of the members, with the social worker needing to be less and less directive (Corey 1990: 130). The fact that this is reportedly not happening in South African hospitals, might be due to factors other than a heavy caseload, such as inadequate planning and insufficient effort. This implies that social workers need to establish solutions that work in their own settings, and not wait until such time that they might be presented with a ready-made solution.

Group work is considered to be a useful method by 100% of those social workers that *do* run groups, and by 94% of those who *do not.* This means that 97% of the total sample believe that group work is a method that could offer benefits to patients (and yet only 50% presently make use of

groups). This discrepancy is disheartening. This study does not reveal (in sufficient detail) why the problems of rapid patient turnover and insufficient time due to a heavy caseload, should be so debilitating to the social workers ability to use group work in some health settings, and yet not in others. Although these problems are recognised and validated by most social workers in health settings, some social workers have been successful in being able to overcome these difficulties.

A total of 18 of the 32 social workers who do run groups (56%), believe that group work is beneficial, and do not believe that any other method can equal this benefit to patients. Although presently making greater use of casework, these social workers acknowledge the observed benefits of group work, and 9 of these 18 social workers, if given the choice, would prefer to make greater use of group work in their daily routine.

4.2.5. View of the Future

When asked to reflect on their experience of social work in health settings, 89% of the sample felt that their training in the three methods of social work (casework, group work, and community work) had been of use to them. No explanation as to the usefulness of all three methods was sought, in terms of specific tasks that had been undertaken by the social worker. However, it can be hypothesised that counselling could be done with patients and families; group work may be used in working with family systems, and also with inter-disciplinary team members (Abramson 1990b: 49); and community work may be used in educating patients and family members or in developing resources. In this way, the three methods of social work practice can be employed in health settings. The social workers were asked to indicate which method they would like to make most use of:

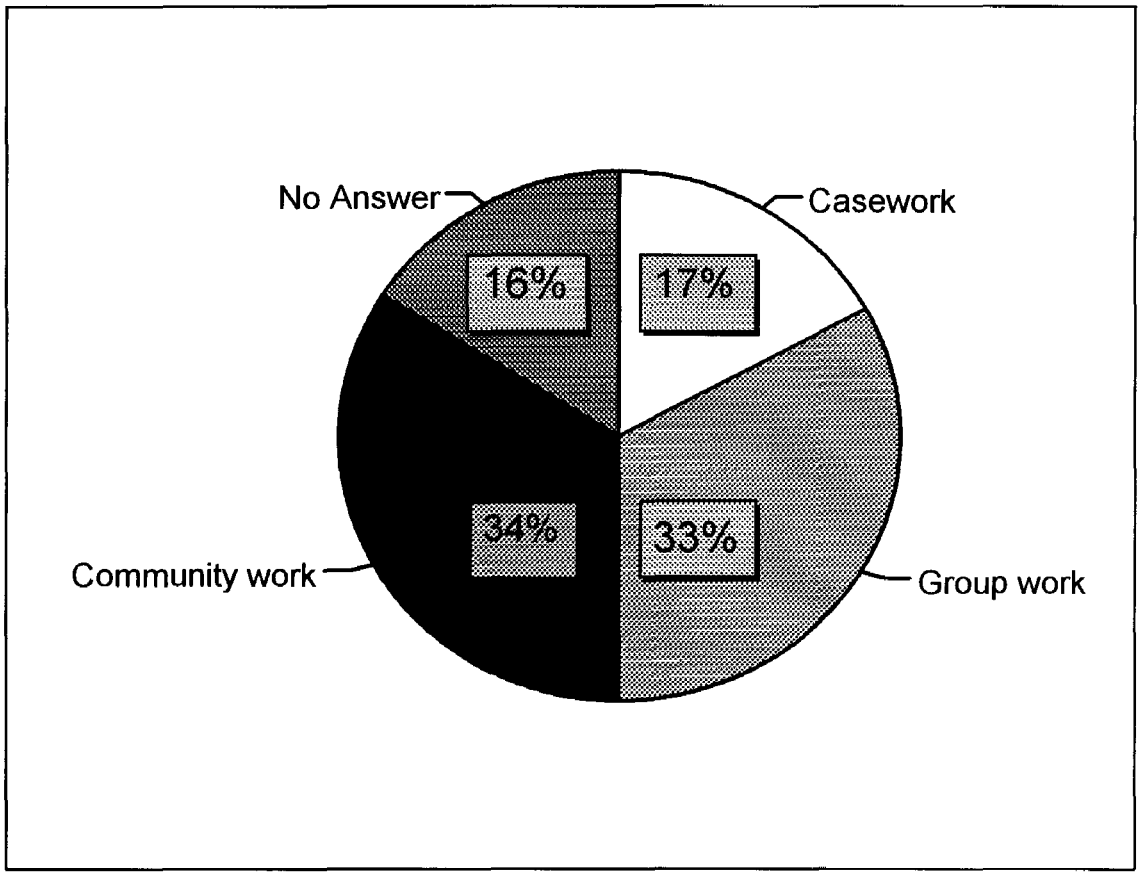

Figure 4.4 Sample's preferred method of intervention (n=64)

The high percentage of social workers wishing to increase their involvement with communities is especially interesting when considering South Africa's focus on PHC. A great number of social workers wish to be involved at this level in health care, and this is especially valuable since the Department of Health plans to include social work services at PHC level (Department of Health 1997: 37).

A fairly large percentage of social workers also expressed an interest in increasing their use of group work with patients.

Group work was considered a feasible method of hospital social work by 88% of the sample (n=56). Of these, 46% (n=26) of social workers do *not* run groups. The majority of this group claim that the main reason for their not using group work is insufficient time. It is interesting that these social workers do consider groups to be feasible in hospital settings, and yet they themselves do not have

enough time in which to use group work.

In the light of South Africa's increasing emphasis on PHC, subjects were asked whether a social worker in primary health clinics would relieve their heavy load, as planned by the Department of Health's White Paper of 1997. This was considered a good idea by 70% of the sample of social workers in health settings. A very highly significant association was found between the type of hospital and the support for the need of a social worker in PHC ($p = 0.0002$). Perhaps some social workers are reluctant to support this in case they are compelled to take on this function and do not wish to, and perhaps others are reluctant to lose their position in hospital settings.

A social worker in primary health using group work to assist patients is supported by 88% of the sample. This idea is supported by the majority of social workers in public and private settings, but only one third of the social workers in other health settings. This may be because social workers in these 'other' settings do not feel they can be useful at PHC level, since their settings are in the main residential. This percentage indicates that many social workers support the Department of Health's plans for medical social work, and also that they have considered their role in the future carefully.

On-going training in the use of group work (especially as it relates to health settings) is endorsed by 94% of the sample of social workers. By noting the need for on-going training, this sample of social workers support Farley's claims (in Chapter 3) i.e. that social workers are noting their lack of involvement in the patients' recovery, and are attempting to find ways in which they can do more for patients, both to aid in recovery and to improve the patients' level of functioning after discharge. Any perceived lack of support for on-going training could be due to the lack of an answer to this question, or a feeling of insufficient time, among other reasons.

It was felt by the researcher that these factors could, in certain circumstances, add to or improve the understanding of fellow personnel and team members. It could not be established however, whether there was any correlation between the staff members' understanding of the role and function of the social worker, and factors such as the length of employment of the social worker, the area of the setting in which the social worker is employed, the presence of specialist units (e.g. burns or haemodialysis), or the running of staff groups in the health setting. However, details regarding the relationship between staff members and the social worker were not sought in the questionnaire, and

so no conclusions can be reached in this matter.

The findings will now be presented in the categories used to obtain the data viz. public, private, and other, with each section being sub-divided thereafter.

4.3. FINDINGS OF PUBLIC HOSPITALS

SNAPSHOT

- 46 public hospitals i.e. 72% of the total sample
- recommend group attendance to family, and refer patients on discharge
- 24 run groups
- therapeutic and educational - 1 per week, 0.9 hrs, open membership
- 22 do not run groups
- main reason: patient turnover and insufficient time
- 44 public hospital social workers believe group work is beneficial

4.3.1. Biographical Data

Public hospitals (n=46) form the majority of the sample (72%). The average ratio of social worker to patient in these hospitals is 1:150.6 (range: 4 to 520), and the average length of employment of the public hospital social workers sampled is 6.7 years (range: 0.3 to 20 years). Social workers in public hospitals have the highest average length of employment. The data collected was unable to determine if any correlation exists between the length of employment and any other factors e.g. working on particular wards, running groups, or supporting the idea of a social worker in PHC. Figure 4.5 shows the provincial distribution of public hospitals.

Specialist units are present in 54% of public hospitals, and include such specialities as renal/dialysis units, burn units, oncology, as well as spinal units, neurosurgery, neonatal surgery, and transplant units. Specialist units are usually areas in the hospital where intensive care is necessary, where health and life are often at most risk, where the more dangerous and invasive medical procedures occur, or where permanent post-discharge life-style change will be necessary. It is in many of these areas that

social workers are able to make the greatest impact, with both patients and family members. Although exploration was performed regarding the types of units and services offered by hospitals, insufficient information regarding the social workers' particular contributions to these areas was obtained.

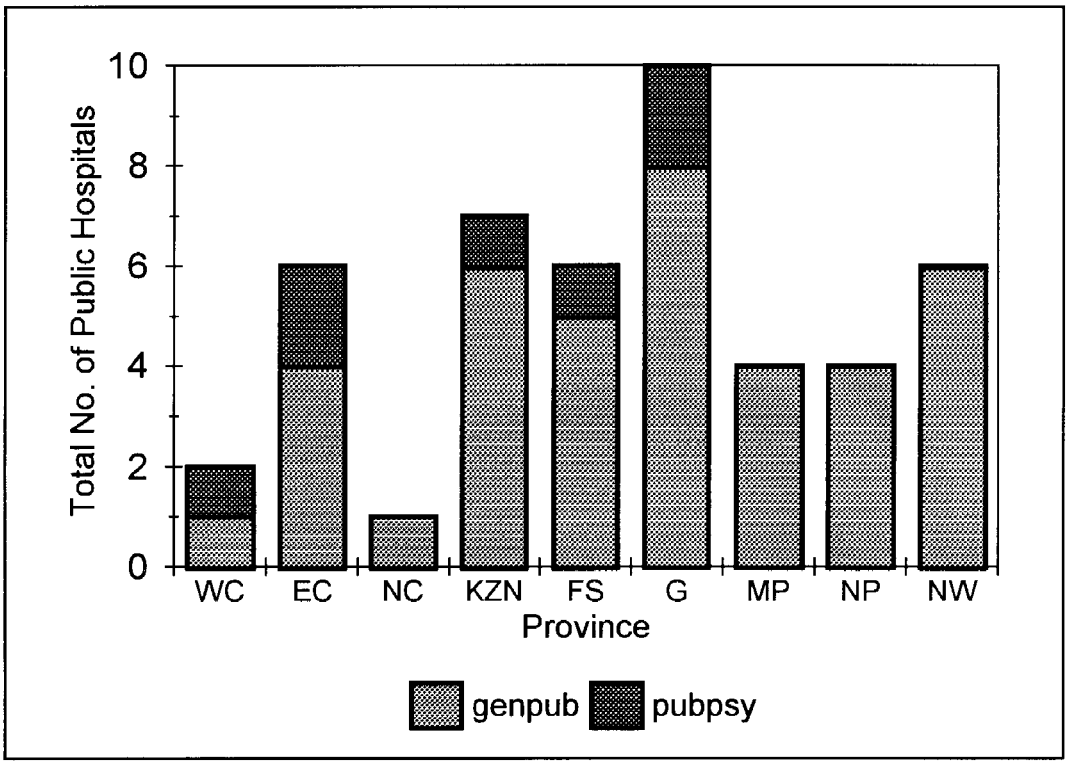

Figure 4.5 Provincial distribution of public hospitals (n=46)

According to the responses received, 98% of the social workers in public hospitals receive referrals from other members of staff. The relationship between the social worker and other staff members is considered by 54% of the social workers in public hospitals to be good, i.e. that staff have an understanding of the role of social workers, especially with regard to discharge. The fact that social workers thus see predominantly the patients referred to them by other staff members, could again mean that this relationship is 'controlled' by other staff members (as discussed in Chapter 3). Although this control is not always executed consciously, it can also occur because medical staff refer those patients they consider in need of social work services. Thus, referral centres around the staff's perception of the role of the social worker in the health setting, and of what they consider to be the patients' needs. It is interesting to note that although more than half of the social workers employed in public hospitals consider other staff members to have an understanding of their role, the percentage is only just over half, and not a large majority (54%).

Most social workers in this sample are based on particular wards (48%), with 39% working in the hospital generally. Language problems i.e. between social workers and patients, are experienced by 48% of the sample. This means that a large portion of South Africa's population experience language difficulties in the hospital environment. This has a direct impact on the delivery of social work services e.g. social workers may have to use interpreters, which may in turn, result in some loss of confidentiality; interpretation of the facts (not just translation) on the part of the interpreters; and loss of subtleties not *observed* by someone not trained in the field of social work. Language difficulties are particularly relevant in present-day South Africa, where there are eleven official languages.

Of the social workers in public hospitals, just over half (57%) reported that they ran groups with patients, and 70% said that they refer patients to groups in the community on discharge. Family members are advised to attend groups by 72% of the sample, and groups for staff members are run by 39%. Since these findings are made up of both general public and public psychiatric hospitals, a more specific reflection may be found in section 4.3.5.

Social workers from public hospitals gave some of the following definitions of group work:

- "... working with 3 or more individuals with a common problem - working with specific objectives in a structured way."
- "... more than 2 persons, with similar problems sharing ideas, coping skills, experiences in order to reach certain goals to the benefit of each person."
- "... therapeutic interaction of group of people who experience similar problems with aim to improve their coping under the guidance of a trained counsellor."
- "... managing of greater workload without compromising the needs of both patients and employer."
- "... source of support."
- "... mutual sharing groups whose people with similar problems can explore through activities / discussion facilitating growth and healing. Usually task-centred, goal-directed, structured (but flexible) maintained and inner needs met through relationships."

These definitions show that the social workers sampled have an accurate understanding of the group work method, both theoretically and in practice, according to the findings of the literature search. It

is also interesting to note that these quotes confirm the fact that groups enable members to find mutual aid, to share common problems, and also that it can be used as a method of coping with a greater workload. Thus, the findings of this study support the data obtained from literature sources, and other social workers.

Respondents were asked to offer some ideas as to the possible implementation of group work within their setting. Of the responses received, many social workers in public hospitals advocate the use of support and educational groups with patients, as well as with caregivers and parents. Groups for particular patient populations (ranging from TB and dialysis patients, to abused women and children, to cystic fibrosis, cancer and diabetic adolescents in particular) are noted by many social workers. Some social workers use recognised programmes such as STEP (for effective parenting) and 'I can Cope' (for cancer patients), while others run more spontaneous group programmes.

4.3.2. Group Work Used

Of the total public hospital sample, social workers in 24 hospitals (52%) run groups. The most common types of group which are reported are therapeutic (83%) and educational (75%). In reference to the involvement of family members, it was found that social workers in public hospitals most often refer family members to groups in the community (46%). Services to the families of patients are thus indirect (and these from less than half of the sampled hospitals using group work). Only two of these social workers (8%) include family members in the group sessions conducted in the health setting. Since it is this category of hospital that has the highest percentage of specialist units, where family members may be forced to cope with factors such as changes in life-style; changes in the patients' status or role in the family; and the effects of hospitalisation, it is perhaps these hospitals that need to pay most attention to the involvement (in some way) of the family members of patients.

Respondents report that groups in public hospitals generally take place once a week (79%), are of open membership (42%), and on average last 0.9 hours (range: 0.5 to 3 hours). Co-workers are used by 58% of the sample, and include disciplines such as occupational and physio-therapists, other social workers, nurses, psychologists, and other personnel such as AIDS counsellors and stoma therapists, depending on the groups' needs. Social workers in this category of hospital make the most use of co-workers, most commonly from among occupational therapists, other social workers,

and nurses. Co-workers do not usually include doctors or surgeons.

Group work is considered to be beneficial to patients by 100% of the social workers in public hospitals presently running groups. When asked if any other method could equal the benefits of group work, responses from some of the social workers concerned included:

- "No. While patients gain from the group for own self-development, more people have the opportunity as against individual counselling. Saves time and money."
- "... better therapeutic intervention than casework because of the avenue to share ideas and problems."

Most of the responses received from this group of social workers (54%), reflect this opinion. Thus, according to the social workers who make use of group work, this method has benefits to the patient that are only found in the use of groups.

4.3.3. Group Work Not Used

Group work is not used by 22 (48%) of the social workers in public hospitals in this study. The most common reasons cited for not running groups are the rapid turnover of patients (27%) and the lack of sufficient time (23%) due to the heavy caseload of social workers in hospitals. Of the social workers in this category, only 18% believe that the hospital itself imposes some form of limitation on their ability to make use of group work with patients.

Of the public hospitals where groups are not run, 91% of social workers believe that group work is beneficial to patients, and would use groups if a solution could be found to the problems they experience (91%). Groups have been unsuccessfully attempted by 46% of the social workers in these hospitals. With almost half of the social workers in public hospitals not using group work at all in their involvement with patients, it is interesting that so great a majority believe that it is beneficial, and would use it if they could find solutions to their problems.

The fact that less than half of this group of social workers have made any previous attempt at using group work, seems to indicate that many social workers are making very little effort to improve their effectiveness or services to patients, or to find alternative ways of managing their heavy workloads - which many other social workers in this study, and in the literature, report that group work as a

method is able to do.

4.3.4. View of the Future

Training in all three methods of social work is considered useful by 87% of the sample of social workers in public hospitals. If given the option of how to spend their time, most social workers report that they would choose to increase the time spent on community work (37%). Group work in the hospital setting is considered feasible by 91% of these social workers, with on-going training in the methods' relevance to hospital social work endorsed by 94% of the sample.

When asked if a social worker in PHC could be of assistance, 76% believe this would be very helpful, and 89% feel that this social worker could make use of group work. These figures are especially promising for the future of social work services in health settings in South Africa. It would seem that despite social workers having heavy caseloads and the rapid turnover of patients, resulting in little time to work intensely with patients, social workers in this category of the study believe that group work is feasible in health settings, and wish to be kept up-dated regarding the skills of group work. In considering the planned PHC services, social work at this level is supported, and many social workers seem to feel that group work can be used at this level too.

4.3.5. General Public and Public Psychiatric Hospitals

Of the complete sample of public hospitals (72%), public psychiatric hospitals comprise 11% (n=7), and general public hospitals 61% (n=39). The average ratio of social worker to patient in general public hospitals lies at 1:162.3 (range: 4 to 520), while that of public psychiatric hospitals is 1:100 (range: 20 to 200). The provincial distribution of both categories of public hospitals can be seen in Figure 4.5.

More than half of general public hospitals (64%) offer an extensive range of specialist units. Public psychiatric hospitals specialise in psychiatric procedures (e.g. Electro Convulsive Therapy [ECT]), but are not concerned with more complicated medical management of conditions.
Psychiatric hospitals, by their very nature and treatment modality, usually compel staff to work closely with one another. Since psychiatric hospitals often involve more developed teamwork, where

collaboration across disciplines is necessary to the patients' treatment and optimal recovery, team members have often been forced to engage in activities that have familiarised them with the roles played by other team members, i.e. input from non-medical staff is facilitated by the nature of the team. Staff in these hospitals could therefore understandably demonstrate a greater awareness of the role of the social worker. This may be indicated (in this category) by the reporting of a good relationship in public psychiatric hospitals by 71% of social workers, as opposed to 51% of social workers in general public hospitals.

Comparing the hospitals in which group work is used, it is obvious that a greater proportion of social workers in public psychiatric hospitals (86%) run groups than do those in general public hospitals (46%). Once again, this may reflect the nature of treatment in the different hospitals. Psychiatric hospitals (due to their focus on the psychological aspects of patients' health) are often better able to ensure the holistic treatment of all patients. To this end, more intensive counselling, on an individual as well as a group level, occurs.

While it has been noted previously that social workers in public hospitals (as a whole) generally refer family members to community groups, it is interesting to note the difference between general public and public psychiatric hospitals. Family members are referred by 36% of social workers in general public hospitals, and by 100% of the social workers in public psychiatric hospitals. This perhaps indicates that these social workers are aware of the value of support to patients after discharge from the health setting. This may also be related to the nature of this particular type of health setting. No social worker in a public psychiatric hospital on the other hand records the inclusion of family members in the group sessions, while 11% (n=2) of those in general public hospitals do.

Co-workers are used most often by social workers in general public hospitals (67%). It is worth noting that amongst the social workers in public psychiatric hospitals, there seems to be equal use made of open (33%), closed (33%) and both open and closed (33%) membership in their group sessions. This could mean that in public psychiatric settings an assortment of groups is held, and therefore membership could be determined by the nature of the content, the wishes of the group members, the aims of the group or the aims of the institution. Two thirds of the social workers in public psychiatric hospitals claim that groups may have some influence over the length of stay of patients, as opposed to the 28% of general public hospitals.

Of the 21 social workers in general public hospitals (54%) that do not run groups, 19 report a belief that groups are beneficial to patients. They go on to say that if a solution could be found to difficulties such as the rapid turnover of patients and the lack of time, they would make use of group work (91%).

This trend is followed by social workers in public psychiatric hospitals, where all of the social workers believe that groups are beneficial, and would use group work if they could solve the problem of insufficient time. Again, although faced with what are perceived to be insurmountable difficulties, most social workers would like to make use of group work in their dealings with patients.

With the expressed difficulties in mind, 90% of the general public hospital sample report that group work is a feasible method of social work in health settings, and 92% believe that on-going training in group work skills (relevant to the hospital environment) would be beneficial.

4.4. FINDINGS OF PRIVATE HOSPITALS

SNAPSHOT

- 12 private hospitals i.e. 19% of the total sample
- recommend group attendance to family and refer patients on discharge
- 4 run groups
- therapeutic and educational - 1-5 per week, 1.1 hr, both open and closed membership
- include family members in group sessions
- 8 do not run groups
- main reason: insufficient time
- 12 private hospital social workers believe group work beneficial

4.4.1. Biographical Data

Private hospitals (n=12) make up 19% of the total sample. The provincial spread can be seen in Figure 4.6. Among these hospitals, the average ratio of social worker to patient is 1:135.3 (range: 8 to 500), and the average length of employment amongst these social workers is 3.3 years (range: 0.2

to 10 years). Specialist units are present in 42% of these hospitals, offering services in areas such as trauma units, chemical dependence units, cardiothoracic surgery, and ICU.

Referrals are made to all of the social workers in private hospitals. This might indicate that social workers in the private settings in this sample have no access to patients unless referred by medical staff. This may perhaps be due to the stigma attached to those patients requiring social work services i.e. no patients in private settings request an appointment with the social worker voluntarily.

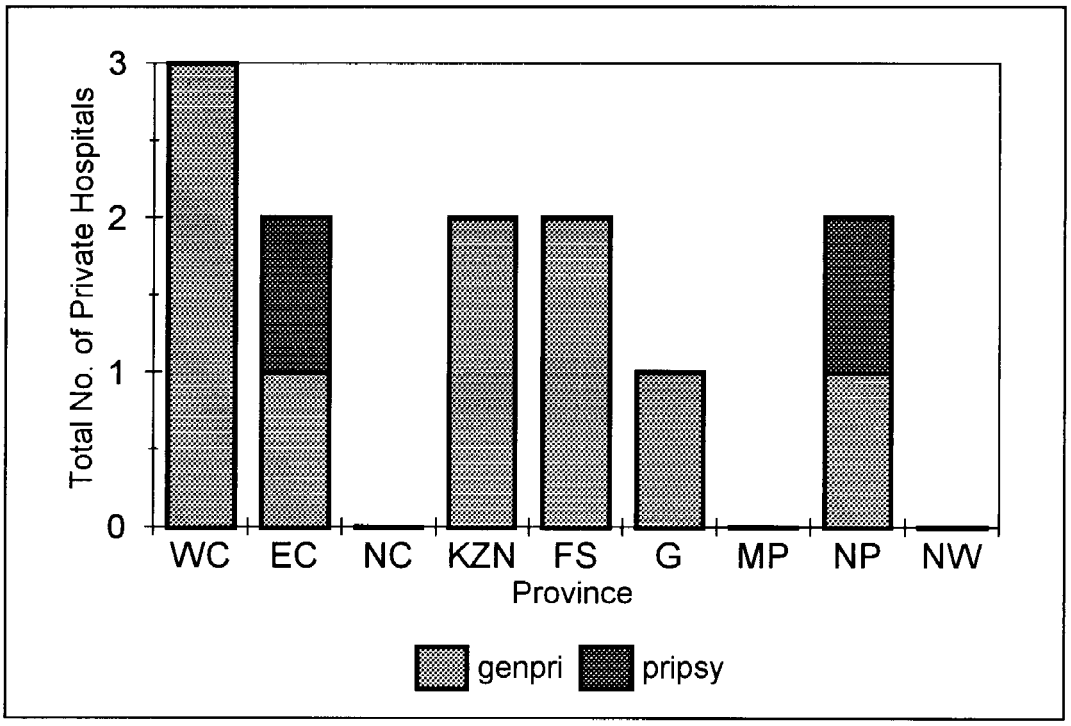

Figure 4.6 Provincial distribution of private hospitals (n=12)

It is reported by social workers in private health settings that there is a good understanding of the role of the social worker (83%). This may be having a positive impact on the referrals received, i.e. even though social workers do not have any direct access to patients, because of the staff's familiarity with the role of the social worker, a large number of referrals are received by social workers in these settings. Groups for staff members are run in a third of the private hospitals sampled. Language problems are only experienced by one quarter of the sample, and 92% of the social workers work in the hospital generally.

Social workers in private institutions are usually part of a very small social work department (e.g. 1 or 2 social workers at most), or even a single social worker that works on a consultancy basis for hospitals.

- "I am the only social worker here."

This might not allow the social worker enough time to concentrate services on particular wards. Group attendance by family members is recommended by three quarters of this sample of social workers.

Social workers in these hospitals defined group work in the following ways:

- "... assist group members therapeutically; supportively; or educationally through group dynamics - may be employed with other methods concurrently."
- "... bring together individuals with similar problems; to encourage participation and sharing of coping strategies; time and cost effective intervention strategy."

Social workers in private settings seem to run a range of groups. These include life skills training (which is therapeutic, educational and supportive); staff groups and support for patients. In private psychiatric settings, preparation for weekend leave is considered the main focus of group work.

4.4.2. Group Work Used

Reports of group work are given by four (33%) of the social workers in private hospitals. Both therapeutic and educational groups are run by all of these social workers, and family members are included in the group sessions by three of the social workers in the sample. Referrals to groups in the community are given to family members by two of the social workers in these hospitals.

According to the responses received, groups are an average of 1.1 hour in length (range: 1 to 2.5 hours), and are of both open and closed membership (50%). The frequency of group sessions ranges from twice to five times a week.

Co-workers are used by none of the hospitals in this category. The lack of co-workers in all hospitals in this category is worth noting. No information regarding the reasoning behind this was

obtained in the questionnaire, so that it is difficult to have any real insight into the effect of this on the social worker running the group sessions, on the group content or type of group used, and in the long-term, on the patients. Although co-workers are not compulsory to group work, the frequency with which co-workers are made use of, makes this total absence noteworthy.

Groups are believed to have an impact on the patients' length of stay in hospital by half of the social workers using group work in private hospitals. Group work is considered to be a beneficial method by all of these social workers.

4.4.3. Group Work Not Used

Of the social workers in private hospitals that responded, eight (67%) do not run groups. The reason given by most of them (n=4) is that of insufficient time due to a heavy caseload. Among the private hospital sample, only one social worker feels that the hospital plays a limiting role in any way, and only one had previously tried to use group work (unsuccessfully). No method apart from casework is used by any of these hospitals.

While some social workers feel limited by the nature of their hospital, and their inability to gain access to patients and to build the sort of relationships that are typical of social work, it seems that most social workers do not try to develop new ways of working with clients. Other hospital staff members can thus not be expected to see the benefits of the group method, if social workers do not engage in it sufficiently to prove its value.

Of these social workers, all believe that group work is beneficial, and half would use groups if their problems could be resolved. As with public hospitals, many social workers claim that they would use the group work method if a solution could be found to their problems, but what solutions they expect, who will find them and how they will be implemented, is never considered. If group work has such widespread support among social workers in all types of hospitals, then some constructive effort must be made to increase its use. What is interesting here, is that although all of the social workers in these hospitals believe group work to be beneficial, only half of them claim they would actually use it if their problems were solved.

4.4.4. View of the Future

Training in all three methods is considered useful by 92% of the total private hospital sample of social workers, and group work is believed to be feasible in a hospital setting by three quarters of them. On-going training in group work skills is important to 92% of this sample. From this, it can be seen that the method of group work can be useful in many ways to social workers in health settings, and not just in working with patients. And it is heartening to know that these social workers realise the importance of up-to-date training in all skills.

In thinking about PHC, two thirds of the sample believe a social worker could be valuable, and 83.3% believe this social worker could make use of groups. The plans for PHC which the Department of Health has put forward in the White Paper (1997: 37-38), seem to have the support of social workers in health settings. These social workers also seem to be attempting to find ways in which they can be part of this move to meet the needs of the South African population.

4.4.5. General Private and Private Psychiatric Hospitals

Of this category, general private hospitals (n=10) comprise 16% of the sample of private health settings (19%), and private psychiatric hospitals (n=2), a total of 3%. The provincial distribution of these categories of hospitals can be seen in Figure 4.6. The average ratios of social worker to patient in these hospitals are also vastly different. While the average ratio in general private hospitals is 1:163.6 (range: 12 to 500), the average ratio in private psychiatric hospitals is 1:22 (range: 8 to 36). Private psychiatric hospital social workers also had the lowest average length of employment i.e. 0.8 years (range: 0.5 to 1 year).

All social workers in this category, both general private and private psychiatric, work in the hospital generally, and are not attached to specific wards or units. As mentioned earlier, social work departments in private hospitals are usually much smaller, in comparison to those of public hospitals. This might offer some explanation for the fact that social workers in this category work in the health setting generally. Other factors which may be relevant at this point, are the unwillingness of social workers to specialise their skills (towards working with particular patients), or a need to be involved with a variety of people and illnesses.

Staff groups are not reported by the social workers in private psychiatric hospitals, and the relationship between social worker and staff is considered to be good by the two hospitals in this category. Many social workers, according to the literature, use staff groups as a means of educating hospital personnel regarding the role of the social worker, and social or psychological aspects of patients' treatment. Private psychiatric hospital social workers report that staff groups are not used, but that staff have a good understanding of the role of the social worker. While this may be due to the knowledge, attitudes and awareness of individuals, it might also be due to the closeness with which these staff members often work.

Only four social workers in this section make use of group work. While two failed to supply an answer, one social worker in a general private hospital reported group sessions taking place twice a week, and one social worker in a private psychiatric hospital reported a group frequency of five times per week. This frequency is understandable given the nature of the psychiatric hospital (as discussed previously).

It is interesting to note that while neither of the general private social workers believe that group work has any impact on the length of stay of patients, both of the social workers in the private psychiatric hospitals maintain that it does. Here, it must be noted, that in certain institutions (e.g. psychiatric) group work may be part of the treatment regimen prescribed to patients. However, it seems very rarely to be the case that patients are not discharged from hospital, once medically or psychologically stable, because they have not attended the prescribed number of group sessions.

Group work is usually used as a support mechanism for patients (which is why many are referred to groups in the community once discharged from the hospital setting), and as such is intended to aid the patient in adjusting to the disease, treatment, and recovery, so that discharge occurs promptly once the patient is judged to be functional. This means that group work could speed up discharge, ensuring that it occurs promptly (and that the patient is prepared for it), but not delay the patients' discharge.

Among this category are eight general private hospital social workers that do not use group work. Of these eight, all believe that group work is beneficial to patients in hospital settings. While four

claim they would use group work if a solution could be found to their problems, only one of the social workers in these general private hospitals has attempted to use group work in the past. No social worker reports using any method other than casework at this time though.

4.5. FINDINGS OF OTHER HEALTH SETTINGS

SNAPSHOT

- 6 other hospitals i.e. 9% of the total sample
- recommend group attendance to family and run staff groups
- 4 run groups
- therapeutic, educational and recreational - 1 per week, 0.9 hrs, closed membership
- 2 do not run groups
- main reason: insufficient time
- 6 social workers from other hospitals say group work beneficial

4.5.1. Biographical Data

Other health settings make up the smallest category in this study, only 9% (n=6). Health settings included here are old age homes, facilities for the mentally retarded, alcohol rehabilitation, and mining. These were included in the study due to the fact that they are registered as medical facilities in the Hospital and Nursing Yearbook for Southern Africa 1995/1996, and that they offer services that are often associated with a social worker.

The provincial location of these settings can be seen in Figure 4.7. The average ratio of social worker to patient for these settings is 1:199.2 (range: 6 to 450), with an average length of employment among the social workers of 5.3 years (range: 2 to 10 years).

Referrals are received by five of the social workers in this sample. The only social worker not receiving referrals is based in the rehabilitation centre. Patients are referred to this setting, and all team members collaborate from the time of admission concerning the treatment and recovery. The team of hospital personnel works together from the beginning with each patient, so that at all times, the patient is being treated holistically. What makes this different from some of the other settings

sampled, is that the social worker has immediate, continual and equal access to every patient in the hospital. The involvement of the social worker is expected by both medical personnel and patients, and is accepted as such. Whereas many social workers see only those patients others consider in need of their services, or patients who wish to see a social worker, the social worker in the rehabilitation setting sees every patient.

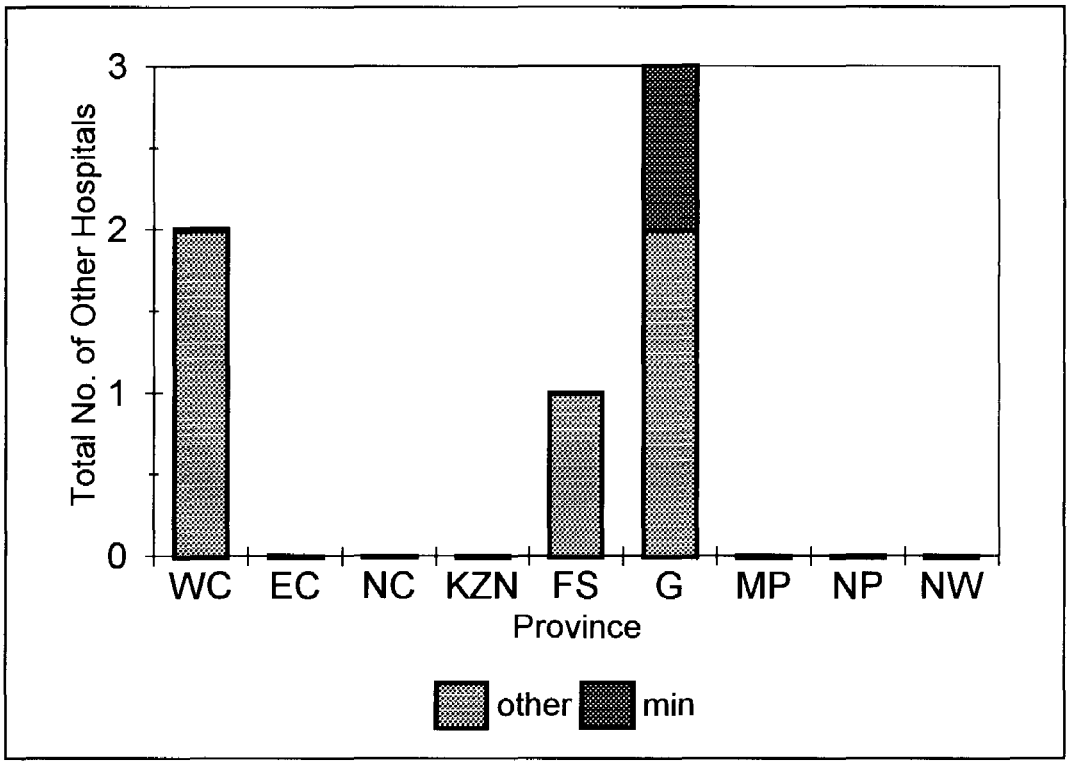

Figure 4.7 Provincial distribution of other health settings (n=6)

Three social workers report an understanding relationship with other members of staff. Groups for staff members are run by three of the social workers in these other settings.

Within these health settings, one of the hospitals has specialist units, e.g. burns and haemodialysis, while one is a specialised setting i.e. alcohol and drug rehabilitation. Language problems are experienced by two of the social workers, and three of the social workers work in the health setting generally, with two on particular wards.

Social workers in three of these hospitals recommend that family members attend groups, but only

one social worker (from the rehabilitation centre) refers patients to groups in the community on discharge. Activity in the community is performed by three of the social workers in these settings (the highest recorded percentage in this sample).

Group work was defined as follows by social workers in other health settings:

- "... purposeful intervention with a number of individuals, to achieve a special goal."
- "... method to address the needs, problems, etc. of people with similar experiences of a particular phenomenon."

Social workers from health settings in this category consider groups such as support for patients (heart, cancer, spinal injury) and family members, as well as staff orientation groups, as possible in the hospital setting.

4.5.2. Group Work Used

Social workers in four of these health settings (two thirds of the sample of other hospitals) run groups. The most common forms of group that are used are therapeutic (n=4; 100%), educational (n=3; 75%) and recreational (n=3; 75%). Groups for family members are run separately by two of the social workers, with the rehabilitation centre also including family members in some group sessions, and referring family members to groups in the community where necessary. No support of any nature is offered to family members by half of this sample. It is thus the rehabilitation centre (whose holistic treatment of the patient has been discussed previously) that is also aware of the needs of family members. The social worker in this setting works with both patients and families, in optimising recovery and functioning.

Group sessions are held most commonly once a week (n=3), last on average 0.9 hours (range: 0.8 to 1 hour), and are of closed membership (n=3). Co-workers are used by two of the social workers in this sample, and include disciplines such as: occupational therapists, social workers, and psychologists.

Group work is considered to be beneficial by all of these social workers.

4.5.3. Group Work Not Used

Groups are not run by one third of the social workers in these other settings (n=2). The reason given by one of them is insufficient time due to a heavy caseload. Neither social worker (0%) felt that the hospital imposed any limitation on their ability to use group work. From this category, only one social worker had tried to use group work (unsuccessfully), but both felt they would use groups if a solution was found to their difficulties.

Group work is considered to be beneficial by both of these social workers, but neither make use of any method other than casework. As with public and private hospitals, social workers in other health settings, although not making use of group work, seem to feel that it would be a good method to use with patients.

4.5.4. View of the Future

Training in all three methods of social work was reported to be useful by all of the social workers in these health settings. Group work is considered feasible by five of the social workers in this sample, and four would choose to use more group work in their contact with patients. It was felt by all of the sample that on-going training in group work was needed, especially specific to hospital settings.

Considering PHC, only two of the social workers felt that a social worker in a primary health clinic would be of assistance, but five believe that group work should be used at PHC level. This raises the question of who would run group sessions at PHC level, if a social worker would not be present. This has further implications for training, evaluation and supervision of the person chosen to provide the group services.

4.5.5. Mining and Other Health Settings

The only mining hospital in the study (making up 1.6% of the study sample of 9%) is located in the Gauteng Province. It has a social worker to patient ratio of 1:42, which is far below the average ratio of other health facilities viz. 1:230.6 (range: 6 to 450). Other settings (n=5) comprise a further 7.8% of the study sample, and are situated in the Western Cape and Gauteng provinces. The provincial distribution of these categories of other health settings can be seen in Figure 4.7.

Of the three social workers in other settings who do make use of group work, two offer no support to family members. Surprisingly, both of these facilities are homes for the mentally disabled. While group work is used in caring for the patients of these settings, family members are not considered a part of this.

Given the choice as to how to spend their time, three of the other hospital social workers would choose to increase the time they spend using group work, as well as would the social worker in the mining hospital in this sample. This could indicate a growing awareness of the benefits of group work, to both patients and social workers, and a developing interest in the use of this method.

CHAPTER 5:

CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter will outline the conclusions reached in this study, and recommendations will be made as to possible future research. By drawing the findings together in this way, it is possible to view the research in the context of social work in South Africa.

5.2. CONCLUSIONS

A total of 90 responses were received (49%). Of these, 26 were returned marked 'no social worker' and thus could not be used in the study. Completed questionnaires were received from 64 health settings (38% of the total initial sample). The highest number of responses were received from social workers in health settings in Gauteng (22%), and the least from the Northern Cape (2%).

Since it is not possible to look at the method of group work without having some understanding of the practice of social work in health settings, it was necessary to gain some insight into the profession of social work as a whole. Most social workers in this sample work an 8-hour day (i.e. 40 hour week). Of this time, an average 2.2 hours is spent on group work per week, but only by 50% of the sample. Social workers in hospitals in South Africa receive referrals regarding the following needs: child abuse, relationship difficulties, depression, substance abuse, as well as financial grants, lack of accommodation, and poverty.

It is suggested by the literature that hospitalisation can be a time of crisis in the lives of many people

(Keen 1990: 293; Longeran 1980: 53). Due to the unfamiliarity, discomfort, anxiety and loneliness created by most hospital environments, many patients demonstrate the need for social work services, even those not hospitalised with what are commonly considered the illnesses/diseases/circumstances usually referred to social workers. Halpern & Dlugacz (in Lurie *et al* 1982: 117) especially, mention the use of groups to orientate patients to the environment and to the routines of health settings, to provide patients with education, companionship, amusement and support, and to offer therapeutic benefit to those in need. The variety and flexibility provided by groups mean that many of the patients' uncertainties can be handled using this method.

Accepting the ratio of social worker to patient as an indicator of the size of the setting and thus the number of patients that are potential consumers of social work services, one becomes aware of how difficult it is for social workers to deliver effective services in health settings in the way they do elsewhere. And yet, the crisis of hospitalisation as a whole demonstrates a great need of social work services.

Many referrals are reported which result from the inequalities of health resource distribution (relating to apartheid) e.g. causes of mental illness, lack of adequate housing, malnutrition, etc. Easy access to social work services may play a role in meeting some of the needs of patients. To this end, social work at PHC level would bring social work closer to the communities.

The findings reveal that more social workers in public hospitals (92%) work in the hospital generally rather than those in private hospitals (39%). It was previously mentioned that social workers in private hospitals are usually part of a very small social work department, and often are the only social worker in the setting. Thus, it is interesting to note that with less staff than public hospitals, a lesser percentage of the social workers in private health settings reported working generally. It was anticipated that since public hospitals commonly have larger social work departments, there would be more social workers in public hospitals working on specialist units or on particular wards, as opposed to those social workers in private hospitals. The results obtained indicate that in this sample, this is not the case.

The findings of the study reveal that groups are run by social workers in 50% of the health settings of this sample. It is reported by the sample that therapeutic and educational groups are most

common. Although only 50% of the social workers sampled are using group work, 97% of the total sample believe that groups are beneficial to patients. Some of the social workers not running groups have previously tried to use group work, and been unsuccessful. Many reasons are given for this, mostly that there is insufficient time (due to the heavy caseloads carried by most social workers). Many of the social workers indicate that if their difficulties could be solved they would make use of group work, but what solutions they expect, who will find them and how they will be implemented, is never considered. If group work has such widespread support among social workers in all types of hospitals, then some constructive effort must be made to increase its use. What is interesting here is that although 97% of the social workers in these hospitals believe group work to be beneficial, not all of these claim they would actually use it if their problems were solved.

Many benefits are recorded by social workers using group work with patients in health settings. These range from support through the process of hospitalisation, and the adjustment to the effects of the disease and any lifestyle changes, to therapeutic support for life circumstances (such as teenage pregnancy) and education regarding disease and treatment. These benefits are also reported by social workers in South African health settings. Patients benefit from feelings of support from others experiencing similar events and circumstances, from the opportunity to share their own feelings and experiences, and from the chance to develop new behaviour and to practice these in an environment where they feel accepted and supported.

From the findings of this study, it appears that groups are used mostly in private psychiatric settings. This could be due to the fact that psychiatric settings use groups more willingly than their general hospital counterparts, which might relate to the nature of psychiatric hospitals. More social workers from private psychiatric hospitals also report a good relationship with other staff members. Considered together, it seems that social workers in private psychiatric settings have a good relationship with other staff members, are able to work together in receiving the appropriate referrals and are aware of each other's roles, allowing for social workers' access to patients. This acceptance by other staff members may be partly why the social workers feel able to use methods other than the more well-known and thus more widely accepted casework.

Group work also carries limitations however. It has been mentioned that group work allows individuals to see themselves in relation to others in the same situation as themselves, and to learn

from these others. However, in comparing oneself to others, individuals may become inhibited by the need for approval from the other group members. This may lead to a denial of their own experiences, thoughts and feelings. In addition, it is more difficult to keep a group moving through a process together, allowing the time and space for each individual to learn and grow together. Thus, group problem-solving can take longer than individual problem-solving would.

In the hospital environment, group work can be limited by the rapid turnover of patients. It is difficult to run long-term groups, of a therapeutic nature, if patients are constantly being discharged. This can be very distracting to other patients, and may negatively affect the group members. Group work is also limited by the fact that many patients (who may be in need of group services) are unable to participate in these groups due to their physical condition, for example ICU patients, bed-ridden geriatric patients and patients receiving chemotherapy. Thus, although the support of others in similar circumstances may be very valuable to them, it is not practical in the health setting.

The rapid turnover of patients (which is a reality in health settings that cannot be avoided) impacts on the use of social work and also, where group work is used, on the type of structure of the group. Patients entering and leaving groups as their physical treatment comes to an end make closed membership very difficult. This results in some social workers having five group sessions a week (as opposed to the average one session), or using open membership even when sharing intimately, and others use groups, but do most of the therapeutic work on an individual basis (which does not use groups to their full potential), and means that most of the social workers' time is still spent individually. Other social workers resign themselves to group work not being possible in health settings.

All the categories of health settings in this study indicate some pressure to discharge patients rapidly at the end of their physical treatment. Very little time is allotted to social / emotional treatment. This pressure to discharge patients does not allow social workers time to engage in the therapeutic relationships which they prefer. In addition to the heavy caseloads carried by most social workers, rapid discharge of patients forces hospital social workers to work with patients on a shallow level and without achieving any lasting therapeutic benefit with most patients.

The fact that less than half of those social workers not currently using group work have made any

attempt to initiate groups, seems to indicate that many social workers are making very little effort to improve their effectiveness or services to patients, or to find alternative ways of managing their heavy workloads - which many other social workers in this study (and in the literature) report that group work as method is able to do.

Because of the flexibility of group work, groups can be adapted to ensure usefulness to many different patient populations. Groups can be used for the support of patients, for the purposes of educating and orientating new patients (or re-educating 'old' patients), for recreation and also with the aim of learning and performing certain required tasks.

Social work in medical settings is a first step. In order to be effective, it must be followed up in the community. This is the reason for the focus on discharge planning and on referral to groups (if needed) on discharge. The high percentage of social workers (70%) who expressed an interest in social work at PHC level, are simultaneously indicating their interest in community involvement (which is supported by the choice of the social workers in the study regarding which method they would prefer to spend more of their time using).

With the new emphasis in South Africa on PHC, many opportunities are arising for the use of social work at this level. PHC enables patients to avail themselves of health care at a lower cost, with less travelling and at a much speedier rate. As a relatively new aspect of health care, PHC is still in the process of being developed. Plans include the provision of social work services to patients at primary health clinics. This would allow social work to be active in the community, while still being involved with medical social work.

If given the choice as to how to spend most of their time, 34% of the sample indicated that they would spend a greater portion on community work. When considering the future plans for health care in South Africa, it seems that offering social work services at primary health level would not only be supported by many of the social workers currently delivering medical social work services, but might also be just what they wish to become involved in. Thus social work at primary health clinics would decrease many of the referrals for basic needs of relationship difficulties, financial grants and housing. This would in turn set social workers in larger hospitals free to be involved in closer teamwork with other staff members, developing their role, and educating others as to their

abilities. Groups could also be used very effectively at primary health level, for example educational groups can teach basic nutrition, parenting skills and health education.

5.3. RECOMMENDATIONS

This study has been predominantly exploratory in nature, concerning the use (or lack thereof) of group work in health settings. It lays the groundwork for further research, and reveals questions that have been raised as a result of this study.

Issues which deserve further attention, and which warrant research in greater detail, are the following:

- In many of the studies conducted in health settings, concerning the use of social work (Brandon 1970; Keen 1990), findings reveal that there is limited understanding of the role of the social worker. Thus, it would seem that social workers need to engage in education of staff members in their settings. Not only may this have some impact on the sorts of referrals received by social workers, it may also affect the relations and thus the functioning of inter-disciplinary teams. If other medical professionals possess an accurate understanding of the function of the social worker, and are aware of the difficulties encountered, patients holistic treatment is likely to be more completely so.

- Further investigation of the impact of this education on the social worker, in terms of the referrals received and the understanding of the staff members, is necessary.

- Discharge planning (which is presently experienced as problematic due to a shortage of resources and the rapid turnover of patients) also requires further study. If this could be examined in a more in-depth manner, studies may produce significant data.

- As South Africa moves towards PHC, further information will be necessary. Social workers need to assess the manner in which they will be able to offer social work services to patients at this level. In addition, it may be possible to use methods which

they considered impossible in larger health settings. More information must be acquired as to the practicality and feasibility of using group work at PHC level.

- As this study investigated the implementation of the group work method only to a limited extent (i.e. small sample), it is necessary that a greater investigation is made. Information regarding what groups have been previously used successfully; what groups were unsuccessful; which patients obtained the most benefit from the group work experience; and the reactions of other staff members is necessary to make a more accurate assessment of the use of group work.

- Social workers need to be encouraged, and assisted in making use of groups. For those experiencing difficulties in initiating the use of groups, some understanding is essential, so that these problems can either be solved, or the social workers be empowered to make alternate plans.

CHAPTER 6:

BIBLIOGRAPHY

Abramson J S. 1990a. Enhancing patient participation: clinical strategies in the discharge planning process. Social work in health care. 14(4).

Abramson J S. 1990b. Making teams work. Social work with groups. 12(4).

Alberts A S. 1993. Knowledge beats cancer. Pretoria: HAUM Tertiary.

Anstey M. 1983. Working with groups. Cape Town: Juta & Co, Ltd.

Arnowitz E; Brunswick L & Kaplan B H. 1983. Group therapy with patients in the waiting room of an oncology clinic. Social work. 28.

Babbie E. 1992 (6th edition). The practice of social research. USA: Wadsworth Publishing Co.

Balgopal P R & Vassil T V. 1983. Groups in social work: an ecological perspective. New York: Macmillan Publishing Co.

Ball S. 1994. A group model for gay and lesbian clients with chronic mental illness. Social work. 39(1).

Bauman J A & James G L. 1990. A support group for burn victims and their families. Social work with groups. 12(4).

Bond J & Bond S. 1986. Sociology and health care: an introduction for nurses and other health care professionals. Edinburgh: Churchill Livingstone.

Bowling A. 1991. Measuring health: a review of quality of life measurement scales. Milton Keynes: Open University Press.

Boyd I & Skittrall J. 1995. Educating, in Social working, edited by P Carter; T Jeffs & M K Smith. London: Macmillan Press Ltd.

Brandon J. 1970. The functions of the hospital based social worker - a study of doctors' expectations. Social work today. 1(3).

Butrym Z. 1967. Social work in medical care. London: Routledge and Kegan Paul.

Butrym Z & Horder J. 1983. Health, doctors and social workers. London: Routledge and Kegan Paul.

Caires J. 1994. A study of some of the multi-disciplinary teams at Addington Hospital - with special emphasis on the role of the social worker in these teams. Unpublished B.Soc.Sc (SW) 4th year Dissertation, Rhodes University.

Carlton T O. 1984. Clinical social work in health settings. New York: Springer Publishing.

Carter P; Jeffs T & Smith M K (eds). 1995. Social working. London: Macmillan Press Ltd.

Chesney B K; Rounds K A & Chesler M A. 1990. Support for parents of children with cancer: the value of self-help groups. Social work with groups. 12(4).

Compton B R & Galaway B. 1994 (5th edition). Social work processes. California: Brooks/Cole Publishing Co.

Corey G. 1990 (3rd edition). Theory and practice of group counseling. California: Brooks/Cole Publishing Co.

Corey G & Corey F. 1982 (2nd edition). Groups: process and practice. California: Brooks/Cole Publishing Co.

Coughlan F J & Suluman A. 1995. Student group work as an extension of the scope of social work services. Social work practice. 1.95.

Daste B M. 1990. Important considerations in groupwork with cancer patients. Social work with groups. 13(1).

Davies B. 1975. The use of groups in social work practice. London: Routledge and Kegan Paul.

de Bocanegra H T. 1992. Cancer patients' interest in group support programs. Cancer nursing. 15(5).

de Kiewiet C W. 1941. A history of South Africa: social and economic. London: Oxford University Press.

Department of Health. 1997. Annual Report 1996. S A Government.

Department of Health. 1997. White paper for the transformation of the health system in South Africa. S A Government Gazette. Vol. 382. No. 17910.

Douglas T. 1991. A handbook of common groupwork problems. London: Routledge.

Douglas T. 1979. Group processes in social work: a theoretical synthesis. Chichester: John Wiley & Sons.

Douglas T. 1976. Group work practice. London: Tavistock Publlications Ltd.

Drum D J & Knott J F. 1977. Structured groups for facilitating development: acquiring life skills, resolving life themes, and making life transitions. New York: Human Sciences Press.

du Preez M S E. 1972. Maatskaplike groepwerk: 'n teoretiese uiteenstelling. Pretoria: McGraw-Hill.

Farley J E. 1994. Transitions in psychiatric in-patient clinical social work. Social work with groups. 39(2).

Frankental S & Stevens M. 1995. The importance of effective discharge planning for the elderly. Social work practice. 1.95.

Friedman W H. 1994 (2nd edition). How to do groups. New Jersey: Jason Aronson, Inc.

Galinsky M J & Schopler J H. 1972. Warning: groups may be dangerous. Social work. 22(2).

Garvin C D. 1981. Contemporary group work. New Jersey: Prentice-Hall, Inc.

Germain C B. 1984. Social work practice in health care: an ecological perspective. New York: The Free Press.

Gilbert M C. 1990. Developing a group program in a health setting. Social work with groups. 12(4).

Gitterman A. 1982. The use of groups in health settings, in Social work with groups in health settings, edited by A Lurie; G Rosenberg & S Pinsky. New York: Prodist.

Gonyea J G. 1989. Alzheimer's disease support groups: an analysis of their structure, format and perceived benefits. Social work in health care. 14(1).

Gottlieb B H (ed). 1988. Marshalling social support: formats, processes and effects. California: Sage Publications.

Gray M. 1996. The role of social workers in developmental social welfare: is there a place for them? Social work practice. 2.96.

Grinnell R M. 1988 (3rd edition). Social work research and evaluation. Illinois: F.E. Peacock Publishers, Inc.

Grinnell R M & Williams M. 1990. Research in social work: a primer. USA: FE Peacock Publishers, Inc.

Halpern & Dlugacz. 1982. Working with groups on an in-patient psychiatric setting, in Social work with groups in health settings, edited by A Lurie; G Rosenberg & S Pinsky. New York: Prodist.

Harding G; Nettleton S & Taylor K. 1990. Sociology for pharmacists: an introduction. Hampshire: Macmillan Academic and Professional, Ltd.

Heinrich R L & Schag C C. 1985. Stress and activity management: group treatment for cancer patients and spouses. Journal of consulting and clinical psychology. 53(4).

Helm B. 1962. Social work in a South African City. Board of Sociological Research, UCT: Cape Town.

Henry S. 1992 (2nd edition). Group skills in social work: a four-dimensional approach. California: Brooks/Cole Publishing Co.

Hepworth D H & Larson J A. 1990 (3rd edition). Direct social work practice: theory and skills. California: Wadsworth Publishing Co.

Holland J C & Rowland J H (eds). 1990. Handbook of psycho-oncology: psychological care of the patient with cancer. New York: Oxford University Press, Inc.

Holmes-Garrett C. 1990. The crisis of the forgotten family: a single session group in the ICU waiting room. Social work with groups. 12(4).

Hospital and nursing yearbook for Southern Africa 1995/1996. 1995. Cape Town: H Engelbrecht & Co.

Iyun B. 1990. Health care in the third world: Africa, in Health and development, edited by D R Phillips & Y Verhasselt. London: Routledge.

Johnson D W & Johnson F P. 1982 (2nd edition). Joining together: group theory and group skills. USA: Prentice-Hall

Johnson E M & Stark D E. 1980. A group program for cancer patients and their family members in an acute care teaching hospital. Social work in health care. 5(1).

Jones K. 1991. Sociology of health and illness. Kenwyn: Juta & Co, Ltd.

Keen A W. 1990. Patients' emotional reactions to hospitalization. Social work/Maatskaplike werk. 26(4).

Keen A W. 1988a. Introduction to hospital-based social work: a literature review. Social work practice. 3.

Keen A W. 1988b. Problems experienced by medical social workers in respect of role performance. Welfare focus. 23(2).

Kitto P. 1989. Running a cancer support group. Turning point. 18.

Kloos H. 1990. The poorer third world: health and health care in areas that have yet to experience substantial development, in Health and Development, edited by D R Phillips & Y Verhasselt. London: Routledge.

Konopka G. 1983 (3rd edition). Social group work: a helping process. New Jersey: Prentice-Hall, Inc.

Leratong Hospitaal. 1988. Groepwerk by Leratong Hospitaal in Krugersdorp. Social work practice. 3.

Levine B. 1990. Part I. Social work with groups. 13(1).

Longeran E C. 1982. Discussion of use of groups in the health field, in Social work with groups in health settings, edited by A Lurie; G Rosenberg & S Pinnsky. New York: Prodist.

Longeran E C. 1980. Humanizing the hospital experience: report of a group program for medical patients. Health and social work. 5(4).

Lund F J. 1987. The community based approach to development: a description and analysis of three rural community health projects. Unpublished MSocSc, Centre for Social and Development Studies, University of Natal, Durban.

Lurie A; Rosenberg G & Pinsky S (eds). 1982. Social work with groups in health settings. New York: Prodist.

Macaluso E & Berkman A H. 1984. Sex counselling with groups in a general hospital. Social casework. 65.

Marlow C. 1993. Research methods for generalist social work. California: Brooks/Cole Publishing Co.

Massie M J; Holland J C & Straker N. 1990. Psychotherapeutic interventions, in Handbook of psycho-oncology: psychological care of the patient with cancer, edited by J C Holland & J H Rowland. New York: Oxford University Press, Inc.

Matthew B S. 1986. The changing face of South Africa: socially, politically and economically. National Convention of the Society for Social Workers of South Africa.

Mbandazayo N P. 1988. Interpersonal relations within a general hospital: social work intervention. Social work practice. 2.

McKendrick B W (ed). 1987. Introduction to social work in South Africa. Pretoria: Owen Burgess Publishers.

Middleman R R & Wood G G. 1990. From social groupwork to social work with groups. Social work with groups. 13(3).

Mizrahi T & Abramson J. 1985. Sources of strain between physicians and social workers:

implications for social workers in health care settings. Social work in health care. 10(3).

Morales A & Sheafor B W. 1989 (5th edition). Social work: a profession of many faces. Boston: Allyn & Bacon.

Nightengale J. 1990. Discharge planning: promoting patient involvement through group process. Social work with groups. 13(2).

Northen H. 1990. Social work practice with groups in health care. Social work with groups. 12(4).

Orten J D; Allen M & Cook J. 1989. Reminiscence groups with confused nursing centre residents: an experimental study. Social work in health care. 14(1).

Parsonnet L & O'Hare J. 1990. A group orientation program for families of newly admitted cancer patients. Social work. 35.

Patel L. 1992. Restructuring social welfare: options for South Africa. Ravan Press (Pty) Ltd: Johannesburg.

Phillips D R & Verhasselt Y (eds). 1994. Health and development. London: Routledge.

Radley A. 1994. Making sense out of illness: the social psychology of health and disease. London: Sage Publications, Ltd.

Reid K E. 1981. From character building to social treatment: the history of groups in social work. Connecticut: Greenwood Press.

Richman J M. 1990. Groupwork in a hospice setting. Social work with groups. 12(4).

Robinovitch A E & Ransohoff M E. 1982. Groupwork in general hospitals: crisis intervention and politics. Social work with groups. 4(3/4).

Rotholz T. 1985. The single session group: an innovative approach to the waiting room. Social work with groups. 8(2).

Royse D. 1991. Research methods in social work. Chicago: Nelson Hall Publishers.

Rubin A & Babbie E. 1997 (3rd edition). Research methods for social work. California: Brooks/Cole Publishing Co.

SA Institute of Race Relations. 1997. South African Survey 1996/1997. Johannesburg: S A Institute of Race Relations.

Schlebusch L (ed). 1990. Clinical health psychology: a behavioural medicine perspective. Johannesburg: Southern.

Schlebusch L & Lasich A J. 1990. Clinical health psychology, behavioural medicine and consultation-liaison psychiatry, in Clinical health psychology: a behavioural medicine perspective, edited by L Schlebusch. Johannesburg: Southern.

Schlesinger E G. 1985. Health care and social work practice: concepts and strategies. Missouri: Times Mirror / Mosby College Publishing.

Schopler J H & Galinsky M J. 1990. Introduction - Social groupwork: promoting a more holistic approach to health care. Social work with groups. 12(4).

Shulman L. 1992 (3rd edition). The skills of helping: individuals, families and groups. Illinois: FE Peacock Publishers.

Skidmore R A; Thackeray M G & Farley O F. 1991. Introduction to social work. New Jersey: Prentice-Hall.

Smoczyk C M; Zhu W & Whatley M H. 1992. An instrument for measuring cancer patients' preferences for support groups. Journal for cancer education. 17(3).

Subramanian K & Ell K O. 1990. Coping with a first heart attack: a group treatment model for low-income Anglo, Black and Hispanic patients. Social work with groups. 12(4).

Taylor S E; Falke R L; Shoptaw S J & Lichtman R R. 1986. Social support, support groups, and the cancer patient. Journal of consulting and clinical psychology. 54(50).

Telch C F & Telch M J. 1986. Group coping skills instruction and supportive group therapy for cancer patients: a comparison of strategies. Journal of consulting and clinical psychology. 54(6).

Toseland R W & Hacker L. 1995. Social worker's use of self-help groups as a resource for clients. Social work. 30(3).

Turshen M. 1989. The policies of public health. London: Zed Books Ltd.

Underhill L & Bradfield D. 1996 (2nd edition). Introstat. Cape Town: Juta & Co., Ltd.

Vugia H D. 1991. Support groups in oncology: building hope through the human bond. Journal of psychosocial oncology. 9(3).

Walmsley J; Reynolds J; Shakespeare P & Woolfe R (eds). 1993. Health, welfare and practice: reflecting on roles and relationships. London: Sage Publications in association with Milton Keynes: The Open University Press.

Weiner H J. 1959. The hospital, the ward and the patient as clients: use of the group method. Social work. 4(4).

Wilson F & Ramphele M. 1989. Uprooting poverty: the South African challenge. Cape Town: David Philip.

Yalom I D. 1983. Inpatient group psychotherapy. New York: Basic Books, Inc.

Zastrow C. 1990. Introduction to social welfare: social problems, services, and current issues. California: Wadsworth Publishing Co.

APPENDIX A

Department of Social Work
Rhodes University
P.O. Box 94
Grahamstown
6140
13 September 1996

Dear Sir/Madam

re: Assistance with Research Questionnaire

As a Masters student at Rhodes University, Grahamstown, I am conducting research in the area of "Social Groupwork in the hospital setting". In attempting to set up a group and start determining group membership, I approached a burn unit, a renal unit, an orthopaedic ward, a radiotherapy ward, a ward catering for geriatrics, and a private hospital. Unfortunately, for a variety of reasons explored in the accompanying questionnaire, it proved impossible to locate a medical setting that fulfilled the necessary criteria.

It was thus decided that for an independent researcher to enter this environment would be inadvisable. Since hospital staff are already familiar with the routines surrounding team collaboration, and since the hospital Social Worker carries more credibility with both staff and patients, it was felt that any data collected would be more accurate and complete if solicited by the Social Worker already present in the hospital (Should there be no full-time Social Worker employed at the hospital, please pass this to a para-medical staff member willing to complete it, or return it marked "No Social Worker").

I am thus approaching you to request your assistance in collecting the relevant data. Enclosed, you will find a questionnaire concerning the implementation of groupwork as a method of Social Work practice in your hospital. It would be most appreciated if you could complete the questionnaire and return it to me in the envelope provided before:

11 October 1996.

Many thanks for your assistance in this matter.

Yours sincerely

J. M. Caires (Ms)

QUESTIONNAIRE:

Please answer as fully as possible. In questions involving a choice, please circle the appropriate answer.

SECTION 1: BIOGRAPHICAL DETAILS

1. Name: _____
2. Age: _____
3. Degree / Qualification: _____
4. Hospital of employment: _____
5. Current position held: _____
6. Length of employment in this institution: _____
7. Experience in other medical institutions: _____
8. Other experience in the field of Social Work - please explain: _____

_____

_____

_____

SECTION 2: DETAILS OF MEDICAL INSTITUTION

1. Type of hospital

Public	
Private	
Mining	
Other	

2. Does your hospital operate specialist units (eg burns, haemodialysis, radiotherapy, etc) **Yes / No**

   If so, which ones? _____

3. As a Social Worker, do you work on a particular ward or in the institution generally? **Yes / No**

   If you work on particular wards, what are they? _____

   _____

4. What is the relationship between medical and para-medical personnel in your hospital? _____

   _____

5. Are hospital patients referred to a Social Worker? **Yes / No**

   If so, who are the most typical referees? _____

6. What are the most typical problems that patients are referred for?

_____

_____

7. Are you experiencing any particular problems as regards language or communication with patients? **Yes / No**

SECTION 3: ROLE OF SOCIAL WORKER

1. Length of day (no. of hours at work): _____
2. No. of hours per week spent on: casework _____
   groupwork _____
   community work _____
3. Do other staff members show an understanding of the difficulties experienced by Social Workers, especially as regards the preparation of patients for discharge? **Yes / No**
4. What is the ratio of Social Worker to patient: _____
5. Do you run groups with patients in the hospital setting? **Yes / No**
6. Do you refer patients to outside groups on discharge? **Yes / No**
7. Do you recommend group attendance to family members? **Yes / No**
8. Do you perform any work in the community under the auspices of the hospital (eg education; health)? **Yes / No**
9. Do you run any groups with hospital staff other than Social Workers? **Yes / No**
10. Having been trained in all 3 Social Work methods, what would be your description of Groupwork? _____

    _____

    _____
11. Give one example of how groupwork could be implemented in your particular hospital: _____

    _____

    _____

SECTION 4: GROUPWORK

If you do run groups, please answer A & C only

If you do not run groups, please answer B & C only

A -

1. What kind of groups do you offer patients:

Therapeutic	
Educational	
Task	
Recreational	
Other	

2. Do you use a co-worker? **Yes / No**
   If so, from what discipline/field? _____
3. Length of group session: _____
4. Frequency of sessions (per week): _____
5. Are groups open or closed? _____
   Please explain motivation behind this: _____
   _____
   _____
6. Do you:

Include famiy members in group sessions	
Run separate groups for family members	
Refer families to groups outside the hospital	
Other	
None	

7. What would be your primary aim in running a group? _____
   _____
8. Do you see participation in groups as beneficial to the patients in a hospital setting? **Yes / No**
   If so, in what way? _____
   _____
   Could this benefit be equalled through the use of any other method of Social Work? _____
   _____
9. Does participation in a group seem to influence the length of the patient's stay in the hospital? **Yes / No**

B -

1. Please mark the main reason (1 only) why you do not use groupwork:

Patient turnover too fast	
Insufficient staff	
Insufficient time due to caseload	
Insufficient membership - problems with mobility, language, venue size, etc	
Other	

2. Are you hindered by hospital limitations in any way eg not obtaining permission for group activities, interfering with other hospital routines, etc? **Yes / No**
3. Have you tried to run a group, but been unsuccessful? **Yes / No**
   If so, what was the main reason for the failure? _____
   _____
   _____
4. Do you feel that groupwork could be beneficial to the patients in hospital settings or not? **Yes / No**
5. If a solution could be found to your difficulty (in 3 above), would you use groupwork? **Yes / No**
6. Do you make use of any method other than casework with patients? **Yes / No**

C -

1. From your experience, has your training in the 3 methods of Social Work been of benefit to you? **Yes / No**
2. Would you like to spend more time practising casework, groupwork, or community work (choose one)? _____
3. From you experience, is groupwork feasable in the hospital as a secondary setting? **Yes / No**
4. Could a Social Worker situated in a primary health clinic relieve you of some tasks? **Yes / No**
5. Do you think such a Social Worker could use groupwork as a method of assisting clients? **Yes / No**
6. Do you think there is a need for on-going training in groupwork skills specific to the hospital setting? **Yes / No**

APPENDIX B

Primary Health Care (PHC) services

(Department of Health White Paper 1997: 37 - 38)

Services	Relevant Health Personnel
Personal promotive and preventive services: Health education Nutrition / Dietetic services Family planning Immunisation Screening for common diseases	 PHC nurses; health educators Nutritionists; dieticians PHC nurses PHC nurses PHC nurses - Referral to generalist doctors as appropriate
Personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases	PHC nurses - Referral to generalist doctors as appropriate
Maternal and child health services: Antenatal care Deliveries Post-natal and neonatal care	Midwives - Referral to generalist doctors as appropriate
Provision of essential drugs	Pharmacists and assistants; PHC nurses
PHC level investigative services: Radiology Pathology	 Radiographers; X-ray technicians Laboratory technicians - Referral to generalist doctors as appropriate
Basic rehabilitative and physical therapy services	Physiotherapists and assistants; occupational therapists and assistants
Basic oral health services	Dental therapists; oral hygienists - Referral to generalist doctors as appropriate
Basic optometry services	PHC nurses - Referral to optometrists as appropriate
Mental health services	Psychiatric nurses; social workers
Medical social work services	Social workers
Services organised and provided at the district level	
Health education	Health educators
Health-related nutritional support	Nutritionists; dieticians

Services	Relevant Health Personnel
Communicable, non-communicable and endemic disease prevention and control	Epidemiologists; public health specialists, Epidemiology assistants Public health officers; generalist doctors
School and institutional health services for children: Oral health Audiology Optometry	 PHC nurses Dental therapists Audiology technicians Optometrists
Health-related water and sanitation services and other environmental health services	Environmental health officers
Community mental health and substance abuse services	Generalist doctors; PHC nurses; social workers
Occupational health and safety services (*)	Health inspectors Epidemiologists; public health specialists Generalist doctors
Community nursing and home care services, including care of the terminally ill	Generalist doctors; PHC nurses
Essential accident and emergency services	Emergency trained personnel; drivers
Community geriatric services and care of the elderly	Generalist doctors; PHC nurses
Health services support: Epidemiology and health information system Health monitoring Planning and Administration	 Epidemiologists; health information system specialists Health Planners; administrators
Basic medico-legal services (*)	Pathologists; generalist doctors

* These services are likely to be provided at the district level, but may be in part or completely funded from sources other than the health vote.

APPENDIX C

List of Possible Groups

This list is by no means exhaustive, but it offers a broad range of common groups run for a variety of populations.

Chesney *et al* (1990: 127):

information and education
sharing and emotional support
social and friendship
fund-raising
making changes in the system of care

Gonyea (1989: 62):

divorce
single parenthood
child abuse
mental illness
substance abuse
families caring for frail / dependent elderly members
dementia

Gottlieb (1988: 28):

widows
victims of domestic violence
family members caring for elderly relatives
separated couples (and children)
new parents
people who have recently experienced difficult life changes

Halpern & Dlugacz (cited in Lurie *et al* 1982: 117):

basic groups: preadmission
new patient orientation
sponsor group
patient government and executive committee
group pass
leisure time use
roommate meetings
programme planning committee
unit night
predischarge

all-hospital groups: inter-unit council
activities therapies - socialization and vocational exploration
newspaper
library

special groups: group therapy
grooming and identification
patient community
patient staff and community group
role playing group
field trips

similarities group: peer group - mothers, adolescents, aged, etc.
problem group - alcoholics; drug abusers; Holocaust survivor child group

natural/informal group: the clique
koffie klatsch
lounge programme

family groups: parent groups - educational; socialization; therapeutic
multi-family groups

Heinrich & Schag (1985: 445):

stress activity management: education about cancer
spouses
relaxation and problem-solving
activity management techniques

Johnson & Stark (1980: 339):

information group: medical aspects / nursing perspectives
living with cancer / perspectives on faith / nutrition and the cancer patient / activity and relaxation

discussion group

Longeran (1980: 54):

patients on general medical floors
seriously ill and deteriorating
candidates for nursing homes
children
stroke victims
post-myocardial infarctions
open-heart surgery
relatives of seriously ill
out-patients: diabetes / hypertension
prenatal
stroke victims
asthmatic children
cystic fibrosis
parents of chronically ill / disabled children
combined patients and out-patients: dialysis
hemiplegics
gastrointestinal problems

Macaluso & Berkman (1984: 20):

diabetics
moderate / severe hypertension
alcohol abuse
haemodialysis
physical disability
stroke
cancer

all with sexual dysfunction

Richman (1990: 173-174):

staff meeting
inter-disciplinary team meeting
bereavement group
volunteer training and support
staff support

Taylor *et al* (1986: 610):

elderly
obese
widowed
alcoholics
mentally / physically handicapped
single parent
cancer

Telch & Telch (1986: 807):

coping skills training: relaxation and skills management
assertive communication
cognitive restructuring and problem-solving
feelings management
pleasant activity planning

Vugia (1991: 97):

parents with children with cancer

women with breast cancer

parents / families with heterogenous cancer diagnoses

patients facing terminal-stage cancer

adolescent survivors

out-patient chemotherapy recipients

in-patient chemotherapy / radiotherapy / surgery patients

crisis of first diagnosis

APPENDIX D

Statistical Analysis

Table of Statistical Analysis (Tests of Association) - Type of Hospital vs .....

VARIABLE	P-VALUE	χ^2	D.F.
Province	0.3548	17.487	16
Specialist units	0.6134	2.676	4
Area (general or ward)	**0.0229**	**11.350**	**4**
Referrals	**0.0374**	**10.188**	**4**
Language problems	0.3253	2.246	2
Understanding relationship	**0.0285**	**10.837**	**4**
Groups with patients	0.5404	1.231	2
Refer patients on discharge	**0.0002**	**22.288**	**4**
Recommend family attendance	0.6411	2.520	4
Community involvement	0.1299	7.116	4
Staff groups	0.8603	1.307	4
Therapeutic groups	0.4668	1.524	2
Educational groups	0.5273	1.280	2
Task groups	0.4507	1.594	2
Recreational groups	**0.0196**	**7.863**	**2**
Other groups	**0.0475**	**6.095**	**2**
Co-worker	0.0970	4.667	2
Group frequency	**0.0055**	**21.685**	**8**
Membership (open, closed, both)	0.1595	9.259	6
Include family in groups	**0.0336**	**10.444**	**4**
Separate family groups	0.8620	1.296	4
Refer family to groups	0.8032	1.631	4
Other family support	0.6515	2.462	4
No family support	0.2648	5.227	4
Other methods equally beneficial	0.8390	1.430	4

VARIABLE	P-VALUE	χ^2	D.F.
Influence stay	0.9723	1.289	6
Reason no group work	0.5682	8.623	10
Hospital limitations	0.7639	0.539	2
Unsuccessful group	0.2392	2.861	2
Groups beneficial	0.9144	0.970	4
Solution	**0.0312**	**6.937**	**2**
Use other methods	0.0722	8.589	4
3 methods	0.4884	3.431	4
Choice	0.2735	7.543	6
Feasable	0.3524	4.418	4
Social worker in PHC	**0.0002**	**22.431**	**4**
Groups in PHC	0.1691	9.081	6
In-service training	0.9013	1.055	4