Clinical social work in mental health – aspects with depressive inpatients
Zagadnienia kliniczne socjoterapii w grupie pacjentów z zaburzeniami psychicznymi – aspekty pracy z pacientami hospitalizowanymi z powodu zaburzeń depresyjnych

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Summary
In 2007, 92 new patients belonging to the (F31–F34 ICD 10) group were admitted to the department for affective clinical pictures – also known as the depression unit – at the Psychiatric University Clinic of Basel. 101 patients were discharged in the same year. Of these 92 patients, 55 were women and 37 men. The average duration of their stay in hospital was 61.3 days.

The in-house social service was involved in the treatment of around 80% of these patients.

This publication describes the social problems of the above-mentioned group of patients as surveyed in 2007. In addition, it outlines the content of social work with depressive patients under the case management approach. Furthermore, some information will be given regarding the clinical picture.

Streszczenie
Obserwacji poddanych zostało 92 nowoprzyjętych pacjentów z po raz pierwszy rozpoznanymi zaburzeniami z kategorii F31 – F34 według ICD – 10, hospitalizowanych na oddziale zaburzeń afektywnych – zwany też „oddziałem zaburzeń depresyjnych” – w 2007 r. w Szpitalu Klinicznym Uniwersytetu w Bazylei. W tym samym czasie 101 pacjentów zostało wypisanych z tego oddziału.

W grupie pierwszej znajdowało się 55 kobiet i 37 mężczyzn. Średni czas pobytu na oddziale wynosił 61.3 dnia. 80% z tych pacjentów korzystało z pomocy społecznej w warunkach ambulatoryjnych.

Artykuł opisuje problematykę społeczną dominującą w opisywanej grupie. Dodatkowo, zarysowana została specyfika pracy socjoterapeutycznej z pacjentami z rozpoznaniem zaburzeń depresyjnych oraz zagadnienia kliniczne.

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Introduction: clinical social work

Social problems constitute the key object of social work (cf. Ortmann, Röh 2008), and social work is always concerned with health (Mühlum 2005).

‘Matters social’ form the truly essential part of clinical social work (cf. Schaub 2008). In the field of psychiatry, social work has developed from the traditional care and the non-medical concerns handled by the Lady Almoners in 1890 into a discipline that increasingly perceives itself as a service to assist in coping with complex psycho-social problems and disturbances (cf. Dällenbach 1993; Bährer 1994). Methodologically, clinical social work (CSW) is rooted in the case work approach. The term was used for the first time in the late 1960s (cf. Pauls 2004).

Case management differs from the traditional method of individualised social assistance. The concept is an attempt to meet the stringent requirements applying to professional and institutional social support. Regarding processes and methods as part of a system, it employs networking and concentrates on solutions (cf. Wendt 1991).

This method of support management especially addresses the design of networks (design of networks; original term used by Wendt: shape).

One of its key elements is a network involving institutions which is frequently needed by ‘multi-problem clients’. Another is the interaction between network participants (cf. Wendt 1991). The methods and strategies of case management concentrate on providing a ‘mix of services’ and on the interactions between them instead of focussing on individual services.

Clinical professionality must prove itself in concrete situations. Social-work specialists working in clinics are expected to employ their knowhow and skills directly and competently in practice (cf. Allen-Meares & Garvin 2000) to the benefit of those who use their services (Hüttemann et al. 2007).

The aim is to humanise the living conditions of mental patients and counteract their marginalisation. Better opportunities, better integration, and a better quality of life are indispensable parts of the process (cf. Dällenbach 1993).

The objectives of social work include focussing the self-help capabilities and competences of those seeking assistance, providing access to available resources, analysing and, if required, changing the environmental situation, and supporting patients in developing their coping and prevention strategies (cf. Schaub 2008).

According to Braig, psycho-social counselling is a reflected form of relational work that is context-specific, individualised, and process-oriented in character. Consequently, he emphasises the importance of motivating patients and developing targets together with them, a skill that takes some learning (cf. Bachmair et al. 1996). The counselling process extends to the social environment of a patient, including his family members, his employer, government authorities, organisations, colleagues, etc. (cf. Hanimann-Malicki 1987).

The statements made above coincide exactly with what the International Federation of Social Workers has to say: „social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. Social work utilises a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments.“ (IFSW – International Federation of Social Workers 2008).
Sabine Bährer-Kohler: Clinical social work in mental health

The National Association of Social Workers (NASW) has this to say about clinical social work: Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders (after Barker 2003).

The assumption that forms of professional support, networking, and case management promote health has not so far been supported by any substantial body of evidence from the practice of social work (cf. Schaub 2008, 21; Wendt 1997). Nevertheless, the results obtained by Hedtke-Becker (2001) and Hedtke-Becker et al. (2000) in a cooperation project on social work and family medicine document that qualified social support and/or social work may help patients to cope better with the consequences of their disorders.

**Introduction: social work with inpatients in Basel**

Social work with inpatients at the unit of depression treatment at the Psychiatric University Clinic in Basel includes

- analysing the individual situation,
- analysing problems and social stressors,
- general and resource-oriented counselling,
- internal and external actions/interventions, and
- supporting primary and secondary networks (cf. Starace & Gritti 1987); which, for example, protect the rights and interests of the patients (cf. Priller 1999, Angermeyer & Klusmann 1988)

in order to

- solve problems,
- find solutions,
- promote re-integration,
- promote rehabilitation (cf. Sticher-Gil 1993),
- encourage self- competences,
- develop individual resources (cf. Stimmer 1994),
- develop coping strategies, and
- promote preventive aspects

for a better quality of life.

The term 'resources' refers to all those mental and interactive actions and/or means of assistance and support that may be employed to cope with stress, overwork, and crises (cf. Petzold 1998).

Next to content-related competence, expert social work with depressive inpatients in Basel is specifically characterised by empathy, meaning a sympathetic understanding for the client’s view of the world and his own problems, as well as by the ability to communicate this empathy to the client. Further characteristics include competence in social counselling (cf. Kreft, Mielenz 1996) as well as technical knowledge about the disease itself and about how to deal with depressive people. This implies

To begin with, meeting and picking up the patient at the spot where his health places him. This presupposes, of course, that making contact with the patient is feasible in the first place (cf. Sachse 1999). Whenever a patient’s ability to make contact is impaired by his health, ‘other interventions and/or means’ must be employed (Pauls 2004).

To pick up a patient at this spot, which may be marked by anxiety, resignation, sadness, aggression, fidgetiness, distant behaviour, and desperation, a social worker needs certain skills, including:

- accepting the patient,
- serenity,
**Clinical social work in mental health**

- receptiveness,
- signalling his ability and willingness to enter into a process shared by both,
- a personal structure and the ability to impart it,
- introspection and self-reflection (cf. Jakobs & Röh 2005),
- self-regulation (cf. Schiepek & Reicherts 1992),
- knowledge about demarcation techniques during cooperation and the competence to apply them, and
- reflecting on his own motivation.

(Cf. Schiepek et al. 1993; Kähler et al. 1991; Rogers 1972; Bandura et al. 1963; Bandura 1976; Ortmann & Schaub 2002; Schaub 2008.)

Reaching a patient calls for congruent sympathy and transparency in the course of a conversation, mutual motivation, mutual comprehensibility, a unifying language, and mutual tolerance, respect, and esteem (cf. Lazarus 1971; Rogers 1972; Pauls 2004). In the course of the first interview, it is important to win the patient’s trust and dissipate any distrust he may harbour. As a general rule, the initiative in conversation should be left to the depressive patient. At the end of the first conversation, any ‘working alliance’ (Müller 1991) concluded should be clearly put into words, core contents should be summarised, and the next moves formulated by both sides (social worker and patient). Putting all this into writing is helpful as well. During an initial interview, it is essential for the social worker to take stock of his patient’s resources, his own as well as those of his network, always under the heading of self-help (cf. Wendt 1992).

Inpatient treatment in Basel aims to empower the patient by enabling him to acquire useful tools in the course of shared work. Their use is supposed to enable the client to explore and retain, within his own control and competence, the resources that he needs to support him in what is called living success, so that he may exercise action competence, self-determination, and a sense of individuality in difficult situations of life (cf. Herriger 1995).

The social service offered by the affective disorders unit at the Psychiatric Clinic of Basel is entirely optional. Patients may withdraw from it at any time, as may the social service itself in the presence of good and sufficient reasons. First contacts are always made at the request of the patient, mostly in consultation with the medical service.

The structure of the unit’s social work reflects Staub-Bernasconi’s general action theories (2007) applied to the technical competences of social workers, such as description, explanation, prognosis, practical problem analysis, action plan, realisation, and evaluation, as well as specific action theories relating to the development of resources, the formation of awareness, the modification of models, training in action competence, social networking, and dealing with power sources.

In Basel as well as elsewhere, action still needs to be taken with regard to the standards of clinical social work. The fact itself was documented, for example, by Crefeld in 2002, whereas disciplinary details, such as modularisation and accreditation of curricula as well as professional details such as registration, certification, and licensing were explained by von Mühlum in 2005.

**Introduction: the clinical picture of depression**

‘Depression occurs in persons of all genders, ages, and backgrounds. Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual’s ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850 000 thousand lives every year.’ (WHO-www.who.int/mental_health/management/depression/definition/en/2009)
Depression is the leading cause of disability and the 4th leading contributor to the global burden of disease in 2000. By 2020, depression is expected to reach 2nd place in the ranking for all ages and both sexes (Lopez & Murray 1998).

‘Mental health therapists try to distinguish between “situational” and “clinical” depression. Situational depression is generally understood to be reactive to some unusually stressful event such as grief related to death, loss of employment, or being trapped in a situation or relationship over which one perceives a lack of control or power to extricate one’s self. Clinical depression is understood to have a biological basis which may be triggered by some relational or environmental cue, or may be so much a part of a personality that it is different to comprehend life as a joyful experience. As with most mental illness, the distinction between “situational” and “clinical” is not always clearly delineated.’ (http://www.naswdc.org/research/naswResearch/substanceAbuse/Depression.asp/2009)

In the following, the stressful events described by the National Association of Social Workers (NASW) will be outlined as found in the patients of the Basel depression unit who were advised by social workers in 2007.

**Fig. 1.** Areas of social work

### Question

What were the main social stressors for inpatients with depressions at the Psychiatric University Clinic of Basel in 2007?

### Results

In 2007, 79 patients or 80.06% were supported by the female social worker of this hospital unit. This percentage is higher than that quoted in the above-mentioned study by Hedtke-Becker, which is 66.2% of the cases examined. However, psycho-social stress was diagnosed in 88.6% of the patients admitted into KISMED (N = 183).

### Finance-related stressors

Most of the main social stressors were found in the area of financial problems with 76 or 96.20% of the 79 patients analysed (with social work).
This area included livelihood, salary, pension, income, wealth, and extra-income problems as well as debts and receivables.

As described above, the first step of the social worker always was to understand each case and the financial problems involved.

This was not easy because of missing documents, a poor health status, or the lack of a common language.

The next step in social work was to support the patients in validating their claims, to manage them together with the patients, and to inform them in general about the requirements laid down in the social law of Switzerland.

Moreover, patients were informed about limitations in their individual cases and about the rules that a citizen has to accept.

More than half of the 79 patients had debts outstanding. Some of them had difficulties with social welfare and other social institutions.

Another subject which very often involved social stressors was negotiating a disablement pension. The patients’ views often deviated from the opinion of the institutions in charge.

Accepting that a patient had lost all his legal entitlements and thinking together about solutions was always a process that called for a great deal of experience as well as competence in dealing with the aggressions and the helplessness of the individuals and their families.

Counselling patients and their families who found themselves in financial trouble on top of the difficulties occasioned by the disease called for a broad range of personal capabilities.

In all cases, it was necessary to find an institution to provide voluntary counselling after the end of the inpatient treatment.

Some previous studies on the subject of material factors and depression

Certain social factors such as income and training have been surveyed with regard to their preventive role and their impact on psychiatric clinical pictures in several studies, such as those by Schepank (1987), Klusmann (1988), Haberfellner et al. (1995), Brandenburg et al. (1995), Burgos et al. (1995), Hambrecht et al. (1996), Stuck (1995a, 1995b), and Kaplan et al. (1987).

As far as low incomes are concerned, Kaplan et al. distinguish between the presence and absence of monetary problems experienced either subjectively or objectively. Whereas no relation was found between depression and low income as such, the presence of monetary problems was closely associated with depression.

Another study conducted by Laessle et al. on 2,873 first-time inpatients at the psychiatric clinic of the Max Planck Institute in Munich found that socio-economic status is significantly associated with psychotic but not with neurotic clinical pictures (cf. Laessle 1988).

Steiner et al. (1992) reported that low income was frequently named as an objective stressor in a structured survey of a total of 187 depressive patients. Consequently, they emphatically suggest either to ameliorate objective stressors (such as low income) or to enable the patient to cope with such stressors better on an individual basis.

A direct link between material factors and depression was discovered in more recent studies on depression and poverty, such as that by Bread et al. (2007) and that by Keita (2007) which addressed
depression and mid-life women and that by Adams et al. (2009) which addressed depression and socio-economic status.

**Work-related stressors**

Further social stressors were found in the area of work and work ability: 66 or 83.54% of all patients investigated asked for the support of a social worker in this field.

In most cases, patients had difficulties with their job; many were dismissed or informed that they would be dismissed soon.

Others had difficulties in obtaining sick pay or a daily allowance.

In each case, a great deal of competence, experience, and sensitivity was needed to find a solution without losing sight of the patient and his interests or infringing the employer’s rights.

The point was to insist on the patient’s rights as an employee of the company while respecting the company’s interests at the same time. It was very important to talk with the patient and his employer and to consider the responsibility of the company to find a solution, such as a gradual return to work. This part of social work is comparable with mediation.

Some other inpatients had lost their job for good. Occasionally, it proved necessary to review the dismissal notice and inform the patient about legal advice. Some dismissals had to be contested.

Fig. 2

In those cases where a patient had lost his job for good but still wanted to work, the task of the social worker was to find new job interests together with the patient, develop realistic views of his future job or daily structure, and inform the patient about institutions that either had jurisdiction or could support him in the matter.

For most of the patients, it was difficult to manage their application for a new job, so that extensive support by the social worker and other staff members was needed.

Patients who had lost their job for good and were unable to work at the moment had to be informed about their financial claims and the responsibilities of the various institutions in charge.
Some previous studies on the subject of work and depression

Bode’s study (2008) examined the relationship between psychosocial factors at work and the risk of depression. His review provides findings that the perception of adverse psychosocial factors in the workplace is related to an elevated risk of subsequent depressive symptoms or major depressive episode.

The studies conducted by Kaplan et al. in 1987 investigated the connection between social factors and the onset of depression. To gather data, questionnaires were mailed to 8,023 non-institutionalized adults living in 4,452 households. They contained 18 questions about depressive symptoms and 16 about age, education/training, income, family status, and human resources. It was found that, independently of each other, a low education level and unemployment were highly correlated with the incidence of depressive disorders.

Another study conducted by Böllner (1987) similarly emphasises the eminent part played by work. A total of 371 patients of different nosology were questioned about a multitude of social factors using rating scales (problem list; life event list; questionnaires on self-communication; social history [familial situation, housing, formal education, vocational training, income], the effects of inpatient treatment, treatment methods, and the atmosphere in their ward).

Among the inpatients, unemployment was found to be significantly higher at the time of admission than among the 375 ‘healthy’ persons in the control group.

Whereas another study by Steiner et al. (1992) reports a negative impact of unemployment on the incidence of psychiatric disorders, the study conducted by Costello (1982) found no connection between employment status and morbidity. One possible reason for this negative result might be the composition of the population studied by Costello which, unlike the population investigated by Steiner et al., consisted entirely of women of whom only one third were gainfully employed.

Hautzinger’s study (1984) examined the relationship between critical events in life and the onset of depression. Within one year, 354 persons were interviewed using a variety of methods. Critical events in life were studied in a structured interview using a version of the social readjustment rating scale by Holmes et al. that was reduced to 23 items. A significant correlation was formed between the ‘out of work’ item and an enhanced risk of illness (Hautzinger 1984).

In a study conducted on a population of 1,365 elderly depressives in Finland, Pahkala et al. (1993) successfully established that hobbies and leisure activities are important because of their prophylactic effect on depressive disorders.

Similarly, De Lisio et al. (1986) were able to establish in a study involving 176 patients at the Psychiatric University Clinic of Pisa that the presence or absence of social leisure activities significantly influences the incidence of depression.

Family-related stressors

Social networks were involved in all cases. Whereas the general function of social networks for mental well-being is seen as their main effect, the function of reducing the strain of stressful life events is described as their buffer effect (Manz, Schepank 1988).

56 or 70.88% of the patients analysed had problems with their networks and related effects.

Patients who called for the support of a social worker in handling their networks named the following stressors:

- Difficulties with children and/or parents (primary networks)
- Divorces and difficulties with child visiting rights
- Difficulties with the family and friends (secondary networks) for various reasons
In both individual and family talks, social workers supported the patient and attempted to defend his wishes and rights. While such matters could be settled in most cases, lawyers specialising in family and/or inheritance law had to be called in for counselling in c. one out of five cases. In matters of child custody, it proved indispensable in several cases to call in the local youth welfare office.

In many cases, separation and divorce had been issues even before the admission, and patients continued to discuss them during their stay in hospital. Without exception, these issues were connected to questions regarding financial arrangements.

As separation and divorce normally constitute protracted legal affairs, the time spent in hospital was used to offer consultation, establish contacts with lawyers and government authorities, and recommend follow-up support and/or a support institution in all cases investigated.

Some previous studies on the subject of networks and depression

The relationship between social factors and the incidence of depression was investigated by Costello. Structured interviews were used to survey 449 women aged 18 to 65 in Calgary. Lack of intimacy with a friend, confidant, or partner was found to be directly related to the onset of the disease (cf. Costello 1982, 329).

Hautzinger (1984), Isele et al. (1982), Blazer (1983), and Pahkala et al. (1993) discovered close links between the factors ‘unmarried, dissatisfied with the marriage and/or its status’ and the incidence of depression.


Conversely, Kaplan et al. (1987) found no correlation between separation and/or divorce and the incidence of depressive disorders. Frequencies were evenly distributed among groups labelled as married, single, and divorced.

In a study published in 1984, Hautzinger was able to show that relations with spouses and married status are variables which are of relevance to the pathogenesis of depression. At the same time, he found no significant correlation between the frequency of social contacts or the number of friends and the risk of developing a depressive disorder.

In 2007, Keita found that the loss of a close friend contributes to the occurrence of depression. Similarly, Beard et al. found in 2007 that low levels of social support appear to increase the risk of later episodes of depression.
Housing-related stressors

43 or 54.43% of the patients examined needed support with their housing situation or the admission to another form of housing.

The following stressors were documented:

- changing their residence, apartment, house, or home
- obtaining admission to sheltered forms of living
- difficulties with landlords
- difficulties with family members
- difficulties with neighbours
- difficulties with cohabitants
- general or specific difficulties with the apartment or residence
- lack of support for independent living (e.g. nurses, cleaning staff)

Next to dissatisfaction with their housing situation which might be caused by the furnishings, the location, the neighbours, etc., patients concentrated on issues like finding a flat, moving house, cleaning, etc.

Whenever social-welfare support was sought the information given normally covered financial matters and housing regulations.

Advice on all issues, including those involving cohabitants, always concentrated on help towards self-help.

In a wide variety of processes, social workers engaged in intervening, counselling, settling, mediating, fact-finding, supporting, preventing, and organising activities.

Some previous studies on the subject of housing situation and depression

The housing situation is an issue which numerous studies emphasise as relevant, including those by Schepank (1987), Wilken (1973), Brandenburg/Zimprich (1995), and Stuck (1995b). The subject is addressed explicitly in the studies conducted by Böllner (1987) and Steiner et al. (1992). Both papers closely associated bad housing and/or living conditions with illness. More recently, Keita documented in 2007 that lack of adequate housing and housing problems are related to depression and mid-life crises in women.

Conclusions

The fact that 80% of the patients investigated asked to be advised by social workers is proof positive that most inpatients suffering from depression have social problems and, moreover, that neither the patients nor the patients’ families investigated in this study were able to cope with these problems independently and to their own satisfaction.

The very large number of patients in the depression ward who had problems with their finances and their job indicates that the clinical picture may result in impaired performance, earning capacity, and work ability. This is entirely congruent with the findings of the WHO and the Federal Institute for Occupational Safety & Health (WHO 2004; Federal Institute for Occupational Safety & Health 2003).

The consequences of this may be many and varied. The persons concerned, their families and other networks may have to bear many additional burdens besides the disease itself, and after the entitlement to sickness benefit runs out, people may become dependent on income support.

As they hold a very important position, family doctors and outpatient psychiatrists should therefore ask questions about these matters and indicate competent consultancy agencies before the patient is
admitted to the clinic. Furthermore, members of these professions should have access to the institutions in charge to ask for more detailed information and/or to connect their patients with them. Although desirable, these considerations are nothing new, as Salomon’s publication of 1927 documents.

During the compilation of some case histories in 2007, questions arose about why debt traps and job problems had not been addressed more early and effectively, or why the patient and his spouse equivalent failed to organise help at an earlier date.

Ideally, employers and institutions should be adequately informed about the clinical picture of depression and the possible consequences of dismissals and other major job-related decisions occasioned by the illness of employees and the subsequent deterioration of their performance. Thus, burn-out training courses might be held for executives to instruct them in recognising any early signs of depression in their employees, which could then be offered support options and scientific knowhow in good time.

Next to counselling individual patients, social workers at the depression unit of the Psychiatric University Clinic of Basel also advised family doctors, institutional staff, outpatient therapists, and employers in order to search for customised solutions and share with them their expertise in work integration, debt relief, budget planning, social-insurance issues, and legal entitlements.

This offering should be evaluated in the future. In addition, medical associations or other agencies might establish the general demand for this option among family doctors and psychiatrists.

The purpose of the conclusions and proposals mentioned above is to improve the way in which we deal with depression, especially because in Switzerland alone, 5% of the population aged 15 and over had depressions in 2002 (Swiss Health Interrogation, BFS), and 121 million people are affected worldwide (WHO 2009).

References

Sabine Bährer-Kohler: Clinical social work in mental health


109

Sabine Bährer-Kohler: Clinical social work in mental health


Sabine Bährer-Kohler: Clinical social work in mental health


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