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The Social Work Contract and Survivorship Services

Roger A. Lohmann
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The concept of contracting has been found by social workers to be useful for describing the normative bounds of client-worker interaction. In part, this is because of the analogy with legal contracts. The concept highlights the dimensions of an offer of help by the worker and an acceptance of the offer by the client, along with the mutual obligations which this transaction implies for each party. Equally important for a profession whose working materials are explanations of human interaction, however, is the “Gesellschaft” nature of professional social work practice. Workers and clients are not, in the final analysis, engaging one another for reasons of friendship, or brotherhood, or community, but for specific, instrumental reasons of seeking help on the one hand and offering to help on the other. However much goodwill, empathy and such feelings enter into the exchange, this basic orientation is fundamental.

In addition to its general descriptive and expressive usefulness, the concept of contract is also useful for pointing out what can only be interpreted as major inadequacies in present social work theory and practice with respect to service for terminally ill clients in institutional settings. It is to the outlining of these inadequacies and suggestions for a way to remedy these deficiencies that this paper is addressed. We shall limit the discussion to these instances in which a worker has entered a contractual relationship with a client who is already terminally ill or becomes so during the term of the contract, and is not residing in an institutional setting, such as a hospital, long-term care facility or nursing home.

A growing literature on death and dying in recent years suggests first that such institutions are increasingly the locales for dying in our society and secondly that social workers and other professionals working in such locales have frequently dealt inadequately or not at all with the social and emotional dimensions of death and dying (Glaser and Strauss, 1967; Kubler-Ross, 1969). The ideas expressed in this paper are a continuation and extension of that critique. Social workers may also be accused of having failed in any instances to properly deal with the post-mortem reactions of family members.

The particular facet of this problem in which we are most interested involves the failure of social workers in institutional settings to routinely extend the service contract from the deceased client to surviving members of the family or close friends despite the overwhelming body of practice experience and research evidence

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suggesting that this is a time of great trauma and stress for all of those who can be termed survivors.

It is a simple economic fact that in most treatment and care institutions today the service contract between worker and client is not a free and clear expression of mutual obligation on the part of two autonomous beings, or independent contractors. Whether the patient or a third party funder is paying the bill, limits exist for the expenditure of all institutional resources including staff time. Thus, even though a worker may be free to work with the family of a client-resident prior to the time of death, the institutionally based worker does not normally contract with those family members except through the resident for whom the bill is being paid. Thus, quite naturally when the resident dies, termination of this and other service contracts between surviving family members and institutional staff including social workers must begin at once. The economics of institutional care today would appear to demand it.

Unfortunately, sometimes even tragically, the cessation of services at the point of the primary client's death comes precisely at the point when the social worker might be most valuable to surviving family members and/or close friends of the deceased. Rather than termination of the social work contract at the point of death, a far more appropriate institutional posture would be for a re-negotiation of the terms of this contract to incorporate a period of crisis-oriented survivorship services to facilitate grieving, perhaps aid with arrangements, and most importantly to aid family members in recognizing and dealing with temporary symptoms and problems likely to emerge in the immediate post mortem period. Because most of the death-related problems faced by these survivors are typically resolved within six months to a year of the time of the initial death such services would usually be of limited duration. Therefore, the issue of institutional economics mentioned above could be resolved to make this type of service feasible.

Research on Survivors

In general, the effects of bereavement upon survivors appear to have been of interest to researchers in Great Britain and the United States. These findings would all appear to be relevant to the United States, given the great similarities between the aged populations of the two countries found by Shanas, et. al (1968). Existing research indicates four principal conclusions which are of direct interest to social work practice with survivors:

1. Increased mortality rates during the period of bereavement have been found among all bereaved survivors, whether spouses, siblings or children.
2. No evidence has been found to support the conclusion that significant increases in major illnesses occur among the bereaved.
3. Evidence is plentiful that deterioration in general heath levels and marked increases in psychosomatic complaints are common.
4. There is also evidence to suggest marked increases in what might be termed psychiatric morbidity or the existence of psychiatrically significant behavior.
Increased Mortality Among Survivors

C. Murray Parkes found that mortality rates among widowers over age 55 increased by over one third in the six months following spouses' deaths (Parkes, 1964). It was also determined that this is a temporary phenomenon since mortality rates for the same population return to normal within a year of bereavement (Parkes and Benjamin, 1969). Rees and Lutkins (1967) found similar, statistically significant differences in mortality rates among surviving parents, children and siblings and determined further that such differences in mortality rates were more pronounced among males (in all categories) than among females.

Rees and Lutkins also determined a relationship between the place of the initial death and the later mortality of survivors which is of critical importance to this paper. They found that the increased risk of dying within one year of bereavement was nearly twice as high if the initial death occurred in an institution compared to those that occurred at home. Although they did not probe the implications of this, several possible explanations come to mine: First, at least some institutional deaths are due to infectious and contagious diseases which might also be spread to these defendants-cum-survivors. Second, deaths in institutions might occur over extended periods of time and thus inflict greater mental and physical trauma on individual survivors. Finally, an explanation in line with the dominant thesis of this article is that deaths in institutions may be more disruptive of traditional communal and familial patterns and thus more debilitating for the handling of bereavement. In this way, grief inadequately dealt with may be, in itself, a precipitant of increased mortality.

Decreases in Health Levels; No Increases in Major Illnesses

In a study of widows who were married to men aged 45 to 60 at the time of their death, Madison and Viola (1968) found significant decreases in self-reported health levels, but no significant increases in the prevalence or severity of major diagnosed illness categories. What they found were significantly higher reported incidence of headaches, dizziness, fainting, dermatological problems, mild gastro-intestinal disturbances (varying from indigestion to vomiting and anorexia) menorrhagia, chest pains, and frequent infections, as well as increased smoking and alcohol and drug use (particularly sedatives).

Marked health deterioration was indicated by 21.2 percent of the sample studied, while a similar control group of women who spouses had not died showed only 7.2 percent with any marked health deterioration during the same period.

Deterioration of Emotional Health

Recent research shows that death of a significant other affects the emotional health of the bereaved most seriously when the person bereaves is a spouse. Parkes (1964, 1965) found a six times greater probability of being admitted to a psychiatric clinic in the period immediately following the death of a spouse, but no increased
probability following the death of other relatives (e.g., parents, child, siblings). This would appear to suggest strongly that widows may be the group of survivors most in need of the types of survivorship services proposed here. Among the study and control group populations of Madison and Viola cited above, similarly significant increases in general nervousness, depression, fears of “nervous breakdown,” feelings of panic, other persistent fears, nightmares, insomnia and trembling were reported. Bock (1972) concluded after a study of Florida widows that “the widowed, especially males, are more likely to commit suicide than the married.”

Social Integration

Bock (1972), Silverman (1972), Philblad (1972) and Berardo (1968, 1970) all found the widowed to be less involved in social life, to demonstrate greater role ambiguity and to have fewer social interactions and fewer social outlets along with the higher incidence of mental disorders noted above. In general, all of these sources would appear to support Silverman’s conclusion that:

In the United States a person’s mourning is supposed to be of short duration and to end before the new widow or widower understands what the new role means or how it will affect his (sic) life. This pressure to not express one’s bereavement can in fact only intensify the grief.

Interpretations

In general, we can conclude that four categories of negative consequences have been observed by research among the recently bereaved: increased mortality (including suicide); deteriorating physical conditions; increased reported incidence of symptoms of mental illness, particularly those associated with neurotic disturbances; and pronounced declines in social participation and involvement. There is a high likelihood that these four groups of symptoms are interrelated, since they are observed in similar populations under similar conditions. However, the exact nature of the connections between these four categories has not been examined, or even conjectured. In the existing literature. Also still open to further investigation is the question of causal patterns: Do deteriorating physical conditions lead to increased mental illness, social withdrawal, and heightened mortality, or are any of these pairs casually reversed?

Is there some not-yet understood phenomenon associated with bereavement which in fact is the cause of all of these personal problems? We simply do not know the answer to this and similar questions at present, and more research is needed. However, a problem clearly exists and social intervention directed at these problems seems called for even in the face of these unanswered questions.
Survivorship Services

We began this discussion with the suggestion that the present nature of the social work contract is inadequate to allow for appropriate worker response to and institutional support for the needs of grieving survivors. A review of research on survivors – particularly widows – indicates strongly the existence of several types of problems for many survivors. Further, many of these problems are well within the range of problems to which social work services have commonly been directed. Thus, it is reasonable to suggest that the delivery of services to survivors would be an appropriate task for institutionally-based social workers.

We wish now to present some suggestions on how such survivorship services might be organized and what they might include. This question of organization can be said to consist of two parts: First, there is the question of organization of the delivery of service by workers, and secondly, there is the issue of administrative and institutional support for this type of service.

As a way of facilitating discussion of these issues, let us assume that a full cycle of grieving normally takes approximately one year.4 This year can be arbitrarily divided into three periods, corresponding with significant events common to survivors. We may speak first of the pre-funeral period, in which survivors are faced with the immediate but awesome emotional tasks of accepting the reality of the death that has occurred, while simultaneously dealing with the multitude of demands and obligations which death in modern society imposes on survivors: Disposition of the body, completion of funeral arrangements, gathering of personal effects, signing various releases and documents, fining insurance claims, and much more. Institutions can be heartless in varying degrees with respect to such matters, but few, if any survivors are able to completely escape the details in the initial period after death has occurred.5 The second phase which typically occurs only a few days later involves the ceremonial rituals of the dead. Depending upon geographic location, ethnic identity, religious preferences and a host of other factors, this may involve visitations, wakes, funeral processions or meals, all of which require the ceremonial participation of survivors. Finally, the longest phase with which we are concerned is the long post-funeral period in which survivors often become disengaged from society (Cumming and Henry, 1961). Sometimes, the mutual withdrawal Cumming and Henry term disengagement is mutual and voluntary. Sometimes it is partial, and sometimes totally. It may be either temporary or permanent. In any event, the disengaged survivor is typically left alone in this

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4 Later research suggested that the one year timeline of grief was far too short, and the timeline for many widows is often more on the order of ten years, and in some cases, the rest of their lives. See, for example, the landmark study of widows by Helena Lopata [Lopata, H. Z. (1979). Women As Widows. Cambridge MA: Schenkman. ]

5 One of us, for example, was once forced to deal with the emotional consequences of a child who died at birth and his wife who learned of the death immediately upon awaking from the anesthetic by a physician whose first words were “You’ll have to deal with the body of that baby.”
condition to work through their grief. In those cases where death occurs over an extended period of time we may also speak of a fourth stage, previous to the others. This is the anticipatory, or terminal illness phase, during which many of the social and emotional dynamics of bereavement may be set in motion prior to any actual death.

What should be the nature of the social work contract extended to survivors during each of these phases? Perhaps the starting point for the answer to this question should begin with the terminal illness phase. In this circumstance, the worker would appear to be faced with ample opportunity to begin the process of transfer of affiliations which we spoke of above as renegotiation of the contract. Two facets of this renegotiation which seem critical are the building of trust in the worker among surviving family members and the dynamics of dying patient-survivor relations during this time. In particular, family members may need aid in understanding the dynamics of the patient’s own bereavement where this is present. The worker should also be sensitive to the rather common incongruence between the bereavement of the dying client and the survivors, who may or may not, in the case of extended illness, work through much of their grief prior to the actual death (C.f., Kubler-Ross, 1969, 157-180).

During the other three periods the nature of social work services to survivors are likely to be three-fold: general helping services; advocacy and socio-emotional support (and more intensive therapy where indicated.). During the pre-funeral period, for example, the worker may perform general helping and advocacy tasks allegedly once reserved for extended family members. Most notably there may be a major advocacy for workers in dealing with morticians – whose practices have recently been called into question by a Congressional committee. Aid may also be required in preparing obituary notices, notifying distant relatives and friends, and other such tasks.

The role of the worker during the ceremonial phase is considerably less clear. Certainly, attending funeral or memorial services could be important factor in maintaining the relationship with the family in some localities. Possibly the most cogent social work role in this period could be social planning one – directed at evaluating conventional American death rituals from a mental health standpoint.

The principal role for social work survivorship services, however, is likely to come in the final and longest stage of bereavement. During this time the workers may become involved in a host of familiar problems, incliving such matters as whom to consult regarding tax matters, disposition of belongings, housing relocation, arrangements for home help (or in the case of younger widows, employment and child care).

More important during this period, will be the socio-emotional support needed. Depression, frustration, rage, anger and guilt and a host of additional emotions all play some part in the personal adjustment to death. However, survivors faced with these emotion may have great difficulties in dealing with them , or in even
accepting their legitimacy. Given the comments in the research section above the worker should not only be attuned to the professional role in venting these feelings, but also to the long term stabilizing influence of survivors developing new or modified intimate relations with friends or confidants.

The administrative and policy implications of survivorship services need more detailed attention than we can offer in this context. In general, however, the problems most in need of attention involves the following:

1. Can patterns of institutional support be altered to allow for the channeling of resources to survivorship services?

2. Will institutions and other professions, especially morticians, tolerate the kind of meddling implied by the above discussions of advocacy in such an emotionally charged area as death?

3. How do we train social workers to overcome the range of concerns and “hang-ups” about death sufficiently to enable them to effectively provide survivorship services?

These are difficult questions, and the creation of survivorship services as outlined in this paper will depend ultimately on their successful resolution. Perhaps the most feasible avenue for financing survivorship services at present would be through demonstration grants. If their utility can be demonstrated the inclusion of post-mortem service delivery in Medicaid or Medicare might be a future possibility along with fee-for-service payments by survivors in some cases. The question of institutional and professional tolerance of advocacy is equally complex, although it does appear likely that the law in most states stops short of prohibiting social work assistance to clients in arranging for funeral services and the like. Likewise, the question of training on death-related matters may well benefit from parallels with training efforts in other topics which have been in the past similarly taboo (sex, for instance). These and other related issues must be dealt with in more detail, however, before it will be feasible to develop effective survivorship services in institutions.

**Summary**

We have attempted in this paper to outline the limitations implicit in conventional social work notions regarding the nature of the client worker contract as these affect the survivors of persons dying in institutional settings. Research on survivorship was revived and found to suggest the need for such services. Extension of the social work contract into this area would, it was found, involve with three distinct phases of grieving. The terminal illness phase, the pre-funeral, the ceremonial and the post-funeral. Of these, the post-funeral was said to involve the greatest attention by the worker and could be the most critical area for the bereaved family members. Social work services for survivors were said to consist of three types: general helping, socio-emotional support and therapy and client advocacy. As a whole, this paper represents a challenge to the profession of social work and to the
management of institutions. The need exists and the profession has the skill to meet this need. Whether the two will get together remains to be seen.
References


