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The role of the social worker in the rehabilitation of patients from mental hospitals who have been treated with chlorpromazine.

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Boston University

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THE ROLE OF THE SOCIAL WORKER IN THE REHABILITATION OF PATIENTS FROM MENTAL HOSPITALS WHO HAVE BEEN TREATED WITH CHLORPROMAZINE

Submitted by

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In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service

1956
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CHAPTER I
INTRODUCTION

In its annual report of 1952 - 1953 the National Association for Mental Health cited estimates on the basis of population studies that 9,000,000 people were suffering from mental disorders, and at least 1,500,000 of these were severe enough to require hospitalization. The admission of more than 250,000 patients was anticipated each year. The care and treatment of these patients fall largely upon the state institutions. Included in the treatment are virtually every known method that has proved to be of any value. The evaluation of the methods of treatment has become a necessity for those involved in the treatment process. As social workers we have a professional responsibility to take part in this evaluation process as the methods of treatment used by the social worker are now an integral part of almost every state mental institution in the country.

1. Purpose of the Study

This brings under consideration the part of the evaluation process that is carried out in this study. Before an evaluation can take place it is essential that there be exploratory concepts which can be evaluated. It
is in this area of exploration that this study has its basis. In particular it is concerned with the role that the social worker will be playing in the treatment situation where the drug, chlorpromazine or thorazine is being used. The drug has been used extensively at the Metropolitan State Hospital, and improvement has been noted clinically following its administration. It becomes the concern of the staff to sustain these improvements wherever possible, and to help patients reestablish as advantageous an adjustment to society as is possible. Thus, the authors' specific area of exploration is the problems in the psychosocial adjustment of mental patients who have made a significant improvement in their clinical condition. It is concerned exclusively with problems that can be handled by psychiatric social workers. However, it must be kept in mind that it is the use of the drug that stimulated this research, and thus the clinical effects have been considered both in the body of the thesis and in a description of the clinical effects.

2. Justification for the Study

As students placed at the Metropolitan State Hospital the writers, presented with the remarkable effect that the use of this drug had on some patients, were given the opportunity to work with some of them. In addition, it was found that the hospital social service department needed
some exploratory study into the social work problems presented by the group of patients that had improved. The way was open to utilize a clinical study already concluded.

In consideration of the contribution that this type of effort makes to the professional field of social work the writers were not unmindful of the function of the social worker in the psychiatric hospital. In this instance the fact that patients were improving and in some cases leaving the hospital is something that social workers in mental hospitals have been concerned with for a long time. In the opinion of authorities in the field, the concentration of the social workers' efforts had been in the early years of the profession on the patient who was either entering or leaving the hospital. However, a much broader and more acceptable concept of the function of a social worker has come from the writings of Hester Crutcher.

"Many hospitals take the stand that the social worker's first responsibility is to the patient on parole and that services to hospital patients are not as essential as parole services if a choice is to be made as to emphasis in social service. My own feeling is that the best treatment can be given to the parole patient when social service has been an integral part of the treatment plan throughout entire hospitalization." 1/


This thought has been followed more recently by two reports on the practice of psychiatric social work in mental hospitals. From the first report edited by Tessie Berkman it was felt by the group studying the practices of social workers in hospitals that the social worker was concerned with the feelings, attitudes, or conflicts which in the seriously ill person they find in acute form and also that the social worker is responsible for the tangible services that might be administered to the patients.  

Some of the thoughts in the latest report on psychiatric social work will be included in the concluding chapter, but basically they are elaborations of the previous report. Basic to this idea is the fact that it is now becoming more important to the social worker in defining his job to consider services given to patients between admission and discharge.

3. Scope and Method of Study

This is an exploratory study of the adjustment that patients have made following the use of the drug thorazine. The paper is concerned with changes in his clinical condition and changes in his social functioning as related to the

1/ Tessie D. Berkman, Practice of Social Workers in Psychiatric Hospitals and Clinics, American Association of Psychiatric Social Workers, 1953, p. 8

2/ Ruth Knee, Better Services for Mentally Ill Patients, Proceedings of the Institute on Social Work in Psychiatric Hospitals, 1955, p. 43
problems of psychosocial adjustment that would normally become the concern of the psychiatric social worker. Thus, in the final chapter the question is asked: "Are the problems that were seen treatable by social work methods?" A description of what is meant by social work methods is also included in the last chapter.

To effect this study it was decided to conduct interviews with the patient, a relative, and some member of the hospital personnel, in most cases the ward attendant. This pattern was varied when it was discovered that a patient that was selected had a social worker who was active on the case. The caseworker was then interviewed along with the hospital personnel but the patient was not interviewed. The rationale behind this move was that the research interview itself would mean something to the patients, and if a relationship was being built up by a caseworker, there was a possibility that such an interview might prove damaging to that relationship.

The sample of 20 patients was selected from a larger population defined by the clinical study conducted by the Clinical Director of the hospital. From this larger population of 251 patients there were eliminated all those that, according to the clinical evaluation made in the study, 1/Meyer Askeff, Chlorpromazine in the Treatment of Psychotic Reactions, Metropolitan State Hospital, 1955.
failed to show significant improvement. This left 115 patients of which 30 had left the hospital at the time this study took place. The distribution of men to women and those in and those out of the hospital are seen in Table 1.

Table 1. Population and Distribution from which the Sample Was Selected

<table>
<thead>
<tr>
<th>Population</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
<tr>
<td>Patients in Hospital</td>
<td>20</td>
<td>65</td>
<td>85</td>
</tr>
<tr>
<td>Patients out of Hospital</td>
<td>12</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>83</td>
<td>115</td>
</tr>
</tbody>
</table>

\* Figures are from one given day. Population is mobile.

The decision was made to choose an equal number from each of the four groups above. Each of the groups was randomized, according to a table of random numbers, and the first five patients that were available from each group were taken. For an analysis of the cases according to age, length of stay, and diagnosis, see Chart A, Appendix I.

The interviews with the patients and the relatives were not structured in the strict sense of the word, but a general outline was made of the areas that were to be covered, and the interviewers were to keep the conversation within those limits. The writers were greatly aided in this
process by an outline of interviews and suggested leading questions used by the research project at the Harvard University School of Public Health. In addition a standard introduction was used explaining that this was a follow up study on the effects of thorazine so that the Social Service Department might be in a position to give better services to people. Included was the thought that it was felt that the respondent would help. (For interview plan, see Appendix II.) The interviews were under an hour apiece, and as part of the interview, the interviewers, if they thought it appropriate, suggested further interviews with either themselves acting as social workers or with other members of the social work staff.

The data have been used to bring out the problems under study, and, where appropriate, comparisons are made of reactions of the group that had left the hospital and those of the group that are still in the hospital. It was felt that it was necessary to make this comparison because in terms of the patients' functioning it would seem from what was already known that a patient who leaves the hospital must have something (not necessarily better mental health) that the ones in the hospital are lacking.

1/ Interview with Katherine Spencer, member of the research team of the Harvard School of Public Health.
4. Limitations

It is recognized that in one hour interviews a limited amount of real information can be uncovered. The research problem was being carried on during the researchers' learning process as students and reflects the fact that much of what might have been used in the interview regarding skill and self-awareness has only recently been assimilated in course work and has not been utilized as much as might be desired.

The records that were used in some cases where information was wanted were not complete, in the sense that they did not give a dynamic picture of what had been going on in the case.

5. Chlorpromazine

To acquaint the reader with some technical clinical material that is somewhat descriptive of the drug, the writers have included this section. The writers learned about the drug in several ways. One of the more dramatic was the film sponsored by the Smith, Kline, and French Company, makers of thorazine, the trade name for chlorpromazine. Before, during, and after, shots were shown of the selected patients being interviewed by the doctor. The tranquilizing effects and the restoration of clear contact with the doctor was obvious. These cases were chronic for the main part and excited or agitated and depressed.

A more detailed description of the drug is needed and
is found in abundance in the clinical and professional journals. As a treatment tool it was just recently introduced into this country in 1953 and 1954. The drug can be administered either orally or through intra-muscular injections. Both of these were used in the clinical study at the Metropolitan State Hospital. The drug is used primarily for its tranquilizing effects, and therefore the criteria for treatment were disturbed behavior, regardless of the diagnosis, characterized by such symptoms as excitement, overactivity, restlessness, aggressiveness, destructiveness, self-mutilation, or increased tension and anxiety.

The amount given varies. The maximum dosage recommended is 800 mg. per day. This amount has been increased upon occasion, but some patients require only 100 mg. daily. The length of a course of treatment varies, but one authority recommends a variation from three days to three or four weeks. The drug has become widely used and the length of treatment has extended into months. In such cases the dose is usually 25 to 50 mg. two to four times a day. In this

1/ Meyer Asekkoff, op. cit.

study of the group that has left the hospital, three patients are receiving thorazine in the approximate dosages just mentioned.

There are physiological changes in the body that necessitate certain precautions. Primarily, changes occur in the composition of the blood and the patients receive a weekly blood count.

A description of the use of the drug and the typical reaction to it has been given by Dr. Kinross-Wright. He calls the first of three periods in the treatment program the period of initiation when the improvement in the patient's condition can be attributed to the sedation through the use of the drug, but as is noted in all the articles there is not the usual effect of sedation produced by barbituates. There appears to be no tendency to have a withdrawal reaction such as is seen in addiction. The second stage of treatment is called the therapeutic stage which lasts from five to ten days when the patient shows increased ability to communicate, social responsiveness, and increased depth of affect. Improvement in this stage can be seen from day to day. In the third stage the improvement begins to lag, and some evidence of the psychosis may still be present. It is during this time that the dosage is decreased. The author saw the advantages of this drug four ways. It produces sedation without confusion, reduces drive without
coma, stimulates appetite and is effective where rapid sedation is needed. The disadvantages seen were that sensitivity reactions were unavoidable but never severe, Parkinsonianism, convulsions, and confusional states need careful management, and the drug is not helpful in depressed cases.

In considering the connection between the drug and a study such as this one the writers had an informal interview with Dr. Robert Hyde of the Boston Psychopathic Hospital. He was most helpful in contributing ideas about thorazine and further helped to focus the study on the fact that it was not the major concern to discuss the drug. However, there were some questions which he brought out that would be well to enumerate here as they seem to have some application to our findings.

Dr. Hyde described what he felt the implications to be for the social worker working with the thorazine patient. The drug clearly diminishes tension in the patient, but it does not replace it with a feeling of euphoria or even a feeling of well being. It produced more inertia, but as a depressant it does not make the patient sleepy. Under the influence of the drug one shows disinterest in things in which one would normally show interest. Thus, it is possible

that persons who have thorazine may not be aggressive and may not appear motivated to get out of the hospital as there would be no exhibition of the normal amount of separation anxiety seen on the average patient leaving the mental hospital after a period of time. Therefore, the social worker or whoever was working with the patient would have to reach out to him in order to stimulate motivation that would be needed.

Continuing further with the implications that the use of this drug has for the care of the mentally ill in state hospitals, it was pointed out by Dr. Hyde that now for the first time some patients are accessible to further treatment. As he put it, the attendants, personnel, and perhaps the relatives are no longer as afraid of the patients as when they were in the acute phase of their illness. By the very fact that he no longer "makes trouble" on the hospital ward, the patient is considered a better adjusted person. Others like him better, and he notices this change. This means that the drug in itself does not create the increased socialization.

The basis for the success of the drug is not then in itself alone but in the things that are done for the patient after it has created an initial superficial change in the patient's behavior. From personal experience Dr. Hyde pointed out that the end of social rehabilitation can be
carried on in some settings such as the Boston Psychopathic Hospital as well without the drug as with it, in some cases. Therapists reported that it was harder to work with the acutely-ill patients who became "apathetic" after the use of thorazine, and they preferred them in their "raw state" in order to see and work with the dynamics. Thus, the writers were left with the conclusion that the use of the drug was best suited to the larger state institutions where there were a number of severely ill chronic patients that had not improved with the use of the existing forms of treatment. Also, it provided a way of reaching these patients that was impossible with the low personnel - patient ratio in which little if any psychotherapy was attempted with persons who exhibited excited and agitated behavior.
CHAPTER II
HOSPITAL ADJUSTMENT

Though the sample used has included only those patients considered improved by Dr. Askooff's study, the writers have been mindful that social workers do not rely exclusively on the clinical appraisal of a patient's condition in working with him. It seemed proper, therefore, to get a dynamic appraisal of the patients' present condition and their attitudes by interviewing and observing the patient, interviewing a relative and a hospital employee who have been close to the patient, and by reading their hospital records. The assumption has been that the manner in which the patient has adjusted to the hospital since he was treated with thorazine and his attitudes toward that adjustment would provide some clues to the social work problems or opportunities for social workers to be helpful which center in this area.

1. Attitude toward Improvement

The term improvement has been used to refer to whether a patient feels and acts as if he is better able to function adequately in society since the administration of thorazine. The concern has not been with the actual degree of improve-
ment, but with the patient's attitude toward his improvement, whether positive, indifferent, or negative. The following table will show the response of patients both in and out of the hospital to their improvement.

Table 2. Attitudes of Patients toward Improvement

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Patients in Hospital</th>
<th>Patients Released from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Positive</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Indifferent</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

All these patients had shown considerable improvement in the unanimous opinion of the other persons interviewed. Of the three patients in the hospital who did not think they had improved, one is quite dependent on the hospital and admits frankly that he thinks it is better for him to stay there. Another thinks that she has not improved because she has not been ill. She feels she should be released from the hospital.

The first case above is a man who is, in many respects, capable of functioning outside the hospital, but who does not have the motivation to leave. His attitude toward
himself plays an important part in that lack of motivation. In the second case cited the familiar defense mechanism of denial can be seen. The patient denies that she is or has been ill. Both these problems, dependency and denial, reflected in the patient's attitude toward himself or in this case toward his improvement, are familiar ones which social workers are equipped to handle. The two patients released from the hospital who felt they had not improved have since both returned. This is no tribute to the soundness of their judgment because another patient who felt he had improved sufficiently to leave the hospital has also returned. None of these were receiving continuous casework help although the latter did receive some help on leaving.

Of the seven patients in the hospital who felt they had improved, four have sufficiently improved that they have been referred for casework help in preparation for release from the hospital. Of the three who have not been referred, two are not in sufficient contact with reality and one does not seem to have motivation to leave the hospital. The significance of motivation will be discussed in a later chapter on specific problems. Of the eight patients released from the hospital who felt they had improved, two are receiving continuous casework help, five are managing without special help, and one has returned to the hospital. The patient's attitude toward himself can often provide clues
which are helpful in his rehabilitation.

2. Attitude toward Treatment

All the patients still in the hospital and nine of those released received some form of treatment after their response to thorazine. The most common forms of treatment have been group therapy - consisting of unstructured group discussions led by an attendant, social worker, or physician; occupational therapy - consisting of arts, crafts, or recreation; and industrial therapy - consisting of a half or full time job in some aspect of hospital maintenance. Table 3 shows the amount of participation in these various programs.

Table 3. Treatment Received by Patients after Being Treated with Thorazine

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Patients in Hospital</th>
<th>Patients Released from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Industrial Therapy</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>None Reported</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

Of the patients still hospitalized six had a positive
response to treatment. This means that they participated in the treatment plan with cooperation, satisfaction, and in some cases enthusiasm. There were eight positive responses among the ten patients released. Though prescription of treatment is the responsibility of the medical staff, the patient's response to treatment is of special relevance to the social worker. In working with patients toward adjustment to the community outside the hospital, valuable clues can be gained from the manner in which they respond to situations in the hospital including particularly their attitude toward receiving help. Table 4 shows the total range of responses.

Table 4. Attitudes of Patients toward Treatment

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Patients in Hospital</th>
<th>Patients Released from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Positive</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Indifferent</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>None Reported</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>
Of the five hospitalized patients who have been referred for casework help in leaving the hospital, four were among those with positive reactions to their treatment. Of the eight persons released from the hospital with positive attitudes toward their treatment, seven have continued to stay out of the hospital even though only two are receiving casework help. This seems to indicate a high degree of correlation between the patient's actual capacity for adjustment outside the hospital and his attitude toward the above treatment programs. The significance of this attitude in rehabilitation is also supported even in the case of the one patient being prepared for release from the hospital who feels indifferent toward these programs. He is the same man who also expressed indifference about his improvement. Both these attitudes seem to be symbolic of other problems for him which will be discussed later.

3. Attitude toward Activities

It can be seen also that activities not directly described as treatment can both have therapeutic value for the patient and provide certain indications of the patient's capacity for adjustment outside the hospital. The fact that all the patients in the hospital have ground privileges provides a certain amount of freedom and opportunities for experiential functioning. The common activities in which these patients have participated are reading, television,
movies, dances, bowling, and going to church. Table 5 shows their attitudes toward this participation.

Table 5. Attitudes of Patients toward Participation in Non-Treatment Activities

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Patients in Hospital</th>
<th>Patients Released from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Indifferent</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>None Reported</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

The patients in the hospital seem to respond more favorably to these activities than those who were released. A similar, though slighter discrepancy, can be seen in their attitudes toward the treatment programs in the previous section. This could be accounted for in several ways. The patients released from the hospital were responding in retrospect. They might have inadvertently judged their response toward activities in the hospital in terms of being out. Another way of stating this is that the patients who remained in the hospital might have invested more of themselves into these activities than those who were released reasonably.
soon after taking thorazine. In any case the significance for each individual of his attitude toward these activities has to be determined individually, part of the process of individualizing the client which will be discussed in the last chapter.

4. Attitude toward Personnel and Care

In interviews with the patients and others it was difficult to get representative expressions of the patient's attitude toward hospital personnel. It was not as difficult to get them to talk about the patient's attitude toward his care, so these two categories have been combined in this report. Any expression or actions which indicated that the patient felt negative - including dislike, mistrust, or fear - toward any of the hospital personnel have been scored as hostile. All general submissiveness and helplessness have been included under dependent. Any attitudes that seemed neutral or not pronounced enough for description have been called indifferent. Cooperating and pronounced positive attitudes have been included as cooperative. Table 6 shows the attitudes of the two groups of patients to their ward care and the hospital personnel. It will not show their attitude toward all personnel, but the writers have tried to judge which category seemed to be more representative of the patients' general attitude and have listed it accordingly.
Table 6. Attitudes of Patients toward Hospital Personnel and Care

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Patients in Hospital</th>
<th>Patients Released from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Hostile</td>
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<tr>
<td>Dependent</td>
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</tr>
<tr>
<td>Indifferent</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cooperative</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

The slight preponderance of dependency among hospitalized patients would seem normal since hospitalization breeds dependency and the group released has had some opportunity to emphasize their own independence. The other differences do not seem significant in comparing the two groups. Yet dependency, hostility, indifference, and cooperation all provide certain problems or opportunities for social workers to be helpful to the client in his efforts to readjust to life outside the hospital.
CHAPTER III

ADJUSTMENT TO LEAVING THE HOSPITAL

With the group of patients still in the hospital, this study sought to determine their attitudes toward the prospect of leaving. All of them showed obvious anxiety about the prospect. Patients referred to leaving the hospital variously as "like starting all over again", or "like looking for your first job". It was found that the patients who had had continued contact with close relatives and particularly those who had been able to spend weekends and holidays at home were much less anxious about the prospect of leaving the hospital than others. They were not frightened as much about what it would be like outside the hospital. They seemed better prepared emotionally to make the transition.

1. Attitude toward Leaving

Seven of the patients showed definite feelings of ambivalence toward leaving the hospital. They wanted at the same time to leave and to stay. Of these seven, the desire to stay in the hospital seemed stronger than the desire to leave in two cases. The other five showed the opposite picture. One patient was completely resistant to the idea of leaving the hospital. There seemed to be
consistent relationship between their resistance to leaving and their state of improvement. The one patient who was most resistant has been referred for casework help around leaving. Nor was there any consistent relationship between their resistance and the length of hospitalization. One patient who was less resistant to leaving has been hospitalized for 12 years. Another who was most resistant has been hospitalized for less than two years. The former, however, has had continual contact with close relatives. The latter has had no contact. This would seem to emphasize the importance of family visitation, although other factors may have also been operating.

Of the three patients who wanted to leave without serious reservation, one has been hospitalized for 10 years, another for one year, and the third for seven years. Only the last of these three has been referred for casework help in preparation for release from the hospital. The attitude of the patient is not itself sufficient to measure his treatability by social workers, but attitude is one of the important determinants with which social workers are concerned.

2. Problems Anticipated

After an appraisal of the patients' general, overall attitudes toward leaving the hospital, some of their specific feelings were examined in terms of the problems which could
be anticipated for them or their relatives after leaving the hospital. Table 7 shows the areas in which problems can be anticipated and the number of patients around whom problems are anticipated.

Table 7. Areas in which Patients Anticipate Problems on Leaving Hospital

<table>
<thead>
<tr>
<th>Areas</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>7</td>
</tr>
<tr>
<td>Family Problems</td>
<td>6</td>
</tr>
<tr>
<td>Vocational Problems</td>
<td>9</td>
</tr>
<tr>
<td>Social Relations</td>
<td>10</td>
</tr>
</tbody>
</table>

Personal problems.-- Some situations centering around the patient himself - his attitudes and feelings - can be seen as presenting problems with which social workers might help. These are called intrapsychic, or personal problems. Of the seven persons placed in this category, two are not in sufficient contact with reality to make an adequate adjustment to the community without special help. Two others seem to be excessively passive and dependent. They need to rely on others unduly and beyond their own satisfaction for support which in these cases is both emotional and economic. Their lack of initiative in their own behalf has
been supported by hospitalization which takes away much of the necessity for personal initiative. Three others evidenced pronounced feelings of rejection. They felt that they would experience repulsion in their efforts to readjust to family and community.

The anxiety of relatives about the possible return of a mental hospital patient should perhaps be considered in this category. Relatives express this in various ways. Some wanted to make sure that the patient was "well" before he came home, but could not point to any problems in the patient who had been visiting home for several week-ends. Several were afraid the patient might do something irresponsible to himself or someone else. Often this anxiety seemed to stem not so much from reality considerations as from feelings of guilt on the part of relatives as having been responsible for the patient's hospitalization.

Family relations.-- Some patients would be subjected to problems which seem to center in the family situation. Though this categorization is somewhat arbitrary, for the sake of clarity, the writers have considered in this category any noticeable problems in the relationships among family members or between any member of the family and the patient. This includes also any personal problems of family members which would seem to affect the patient. Since one patient left home, for instance, his sister has come to this
hospital, his father committed suicide, and his mother has moved in with his other married sister. Though this man has other problems, too, as the illustration infers, the family breakdown here has been considered a problem in family relations. In another case the patient would be subjected to a family situation including a strict father and an aggressive-controlling mother who do not seem able or willing to view their son as an adult. In another case the mother of the patient with whom she would live is a widow and recently underwent hospitalization which will leave her incapacitated for several months. Broken homes constitute the other major aspect of this category.

Vocational problems.-- Still other problems were situated in an area which might be called economic. Of the patients evidencing problems in this area, nine needed vocational counseling and help, two expressed the desire for more education, and two would need special placement in home or semi-institutional settings. One might need public assistance.

Social relations.-- All the patients or relatives expressed in some way their concern for "what people will think". The stigma attached to mental hospitalization - the feeling that such illness is a disgrace - seems to be an ever present factor. Patients will find it difficult to adjust to socializing activities in their communities. They
will need special help in order to venture out into the activities which bring them into intimate relationships with others.
CHAPTER IV
ADJUSTMENT AFTER LEAVING THE HOSPITAL

The adjustment to leaving the hospital has been discussed in terms of the patients who at the time of the study had not yet left. As the same thing is considered for the patients who have left the hospital, it becomes apparent that there is not the same type of response from them, as theirs was a question that had to be answered in retrospect. Therefore, it is considered that the responses in this area pertain not only to the attitude that they had toward leaving but more toward their present attitude. Two areas in dealing with this question of adjustment to the idea of leaving are covered.

1. Attitude Toward Leaving

The first of these attitudes was the patient's over-all attitude about leaving the hospital, and the second was specifically their anticipation and the anticipation of the relatives. There was elicited in all but one case the general attitude of co-operation about leaving the hospital. The ambivalence noted in the one exception was in a case that had been returned to the hospital, and it was an attitude expressing what the writers felt was more accurate of the general feeling about leaving. (This is substantiated by the attitude shown or inferred in the majority of the
patients who had not left the hospital).

The second or more specific expectation of the relatives and patients to the change from hospital to community is illustrated by the picture given by Table 8.

Table 8. Problem Expectations of Patients and Relatives at the Time of Discharge

<table>
<thead>
<tr>
<th>Problem Expectations (1)</th>
<th>Patients (2)</th>
<th>Relatives (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases seeing no problems........ 5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>&quot; &quot; &quot; anticipating some problems............. 1</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>&quot; &quot; &quot; planning for problems a/... 3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cases in which there was no data............. 1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total ........................................ 10</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

a/These cases were seen by workers at the time of discharge.

The writers felt that it was important to distinguish from the group at this point those who were receiving help prior to leaving. By help is meant that aid obtained through a relationship with a caseworker. In examining the group's expectations it seemed significant that in retrospect five patients denied the existence of any problems while the relatives were on the contrary more prone to anticipate problems. The anxiety aroused in the relatives and the connection between the anxiety and the anticipation of
problems will be considered. There seems to be some connection between this anxiety on the part of the patients and their tendency to deny existing problems. This denial which will be seen recurring in these cases is a mechanism of defence whereby the individual unconsciously shuts out reality which for a person who is severely ill emotionally is too painful to face. (Again, a truer picture may be seen of the expectations of the patients in the group not yet released.)

2. Personal Problems

As can be judged, there are many intrapsychic problems that have not come into clear focus in the hour long interview held with these people. However, the more obvious problems should be mentioned. They appear later in an overall chart (Table 11) of problems seen by the worker. These intrapsychic problems were most noticeable in the form of classical personality disturbances in the patients. The three cases that returned to the hospital can be included in this as well as three more that remained out of the hospital. It does not seem to be necessary to diagnose these illnesses here, nor would there be any reason to evaluate all the intrapsychic problems that arise in the consideration of a case such as will be presented in the following chapter. It is possible to observe the crippling effects of such disturbances and evaluate in psychosocial terms what the
difficulties seem to be. In addition, the anxiety observed in the relatives is classified as an intrapsychic problem.

The incidence of anxiety found in the relatives as plans are being made for the patient to leave merits further attention. This phenomenon is not new to social workers so it is not felt that this indicates a great deal of pathology on the part of the relative except in cases where the relatives are completely rejecting. The anxiety is not often allayed after the initial adjustment to leaving unless there has been some preparation. This anxiety is best defined as a generalized feeling seen in the relatives hinging on the fear that there is something wrong with the patient. Relatives are influenced by their recollections of the patient as he was, fear of mental illness in general and personal intrapsychic conflicts that are activated by the thought of the patient's return.

Again the matter of measuring this anxiety in retrospect becomes a difficult problem. There were indications that the anxiety was caused by the present situation, that is, the interview about the patient's present condition. The anxiety that was noted in eight out of the ten cases was felt to have been present also at the time of release.

In connection with this anxiety it was found in looking at the actual leaving that this feeling was not unconnected with the manner in which most of the patients left the
hospital. In seven of the ten cases the impression given to us was that the impetus for getting them out of the hospital came either from the relative or the patient. It was difficult to distinguish at this time which of the two had more influence, but it can be defined as a situation in which there was pressure on the relative by the patient and a concurrent feeling of obligation or guilt on the part of the relative. The writers do not pretend to define this any more finely at this time but mention it as it seems to be associated with the feelings of anxiety.

3. Family Relationships

In examining the patients' adjustment out of the hospital the authors wanted to find out what it was that the patient had to return to in the way of a home and family and his feelings toward it as well as the relatives' feelings about him. There was no one in the group that was without a family, but that did not insure that the patient could go to the family or if he did that he would be accepted there. It was found that there was a continuum of acceptance, with no relatives completely accepting their patients. Moderate acceptance was found, but the problem area as seen was not that part of the relatives' reaction that accepted the patient but the part which rejected him.

To get at the relationships in the family the terms rejecting, dependency and acceptance are used to classify
what was seen in the sample. The use of the terms does not indicate that the relatives were seen in either a rejecting or an accepting light per se but that these elements of feelings which indicated problems in adjustment between the relative and the patient were recognized. Basic to this relationship between the patient and his family are the dependency needs of the patient and whether or not they are being met by the family.

To define the terms, there had been a lot said about the dependence relationship between the patient and the hospital. The authors think that the dependency that a hospitalized person develops toward the hospital, particularly if he has been hospitalized over a long period of time, has similar elements to the dependency that one has upon the life group with whom he lives, be it family or friends. It shall also be seen how this applies to receiving help when the type of help that might be given by the social worker is considered. A dependant situation is one in which a person relies on others for support which can be emotional, economic and even physical. By rejection is meant the implied or direct repulsion of one person by another, by acceptance a feeling of harmony between individuals that has not been disturbed beyond normal limits.

The harmony can be thrown out of balance by two factors in the case of a mental patient. His own fears, insecurity
about being rejected even though it may not be realistic and
the realistic fact that some relatives do find it difficult
to accept a relative who has become mentally ill.

In considering the reaction of the patients to the
family situation nine of the ten cases expressed this fear
of being rejected in one form or another so that the
interviewers felt that they could record this as such.
There were varying expressions of this fear and the study
relied upon the writer's knowledge of dynamics and powers
of observation to determine the feeling of fear of rejection
and consequently dependency needs. In one case for instance
the patient met his fear of rejection by over-compensation
and reacted in a very controlling manner toward his family.
He resented his daughter's plans to get married, he resented
the undisciplined appearance of his grandchildren, and he
used these as points upon which to disagree with his wife.
There were other examples which presented less open
aggressiveness on the part of the patient as he tried to
overcome the fear of rejection. In one case a woman had
completely attached herself to the employer for whom she
worked as a companion. This elderly woman was giving her
the approval that she had not found in her now divorced
husband nor in her well meaning but busy brother, who
could not quite accept his sister.

As is suggested in the preceding paragraph the very
noticeable fear of rejection on the patient's part was
accompanied by the feeling of rejection of the part of the
relative. The rejection, as has been said, varied in
intensity. In one of the cases it was felt that the
rejection by the relative was complete. In this case the
social worker was active and found it necessary to rely on
a more distant relative than the patient's immediate family.

In eight of the cases there was evidence of feelings
of rejection that took on the magnitude of a considerable
conflict. In four of these cases the rejection took place
in the form of attempted control of the patients' behavior
actively denying the patient certain rights and underestimat­
ing his abilities. There are two sides to every story,
but one of the things that went into the accepting situation
was the expression of confidence in the patient. So when
the relative, as was the case in one instance, thought that
perhaps the patient should never stay away from the hospital
too long as she then became sick, she does not express much
confidence in the situation. Another instance of controlling
behavior was seen in the husband of a patient who intended
to limit his wife's activities to those that he chose and
rather than allow her to get a job insisted that she return
to school. More of these cases will be seen as this chapter
progresses.

The one accepting situation, the case in which there
was found a more accepting than rejecting reaction was the one in which the wife of the patient was attempting to create a comfortable arrangement for him.

4. Vocational Problems

Continuing the descriptive part of the analysis it is felt that the use of the individual's time with regard to employment and economic support was particularly important. As might be expected, the men are the breadwinners. Table 9 gives a clearer picture of the comparative employment for men and women.

Table 9. Employment and Training of Patients After Leaving the Hospital a/

<table>
<thead>
<tr>
<th>Employment and Training</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Employed</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Skilled</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Unskilled</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

a/ Included in this table are the three patients who were returned to the hospital. For this purpose they were considered while they were out.

Since the number is so small it is not valid to draw too many conclusions, but it is interesting to point out that
only the woman who was not skilled became employed. Along with this it seemed significant to go back and evaluate the relatives' attitude toward the patient's work and where it was expressed it was found that the four women that were unemployed had relatives that did not want them to work, not because they were not able to, but because they did not feel that their relative was well enough to do so. It seemed that this was a good point to make the observation that as two of these women were returned to the hospital the relatives in those cases seemed to have some basis for their decision. Or perhaps it was that the relatives who were also rejecting influenced the patient's return to the hospital by preventing the thing that they felt would precipitate the patient's return. This is not a justifiable conclusion here but the implication still remains that this is a possible form of unconscious rejection.

From the point of view of controlling relatives it does seem justifiable to make the observation that it is easier for the men to assume a breadwinning role than for a woman.

5. Social and Community Relations

One more area of adjustment in the patient's life was considered. This was his use of leisure time and recreation habits. A very crude measure of the use of time was employed, and it is offered here as being far from exacting. The activities were divided into two groups. There were those
activities that could be considered socializing activities and those considered isolating. In the socializing group were included such things as church attendance, going to meetings, lodge activities and participating in group recreational events. In the isolating activities were included watching TV, going to a movie, occasionally shopping, reading and other isolating activities. (See Table 10)

Table 10. Use of Leisure Time

<table>
<thead>
<tr>
<th>Activities</th>
<th>men</th>
<th>women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socializing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Isolating</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

It should be understood by the reader that one could not hope to gain an accurate evaluation of the type of activities in this study. It was noted again that the use of time posed certain problems to some of the relatives, and it was found that these are similar to those involved in the matter of employment. The relative was anxious that the patient use his time in the manner that he thought best. In the use of time it was clear that both the patient and the relative...
were fearful of contacts with the community. The fear stemmed partly from within themselves and also from obvious reality factors pertaining to the social stigma of mental illness that is held by many people in the community.

To come to a conclusion it was felt necessary to give the reader a more definite picture of the problems that are seen. The writers have attempted to describe what they felt was the attitude toward the four major areas of personal problems, family relations, vocational problems and social and community relations by the patients and their relatives. The shading between areas makes it difficult to describe them accurately as they occur in the various situations, and it is doubly difficult to make judgments about them when it comes to an objective quantification of problems. This quantification of problems was made not by case but by problem and area into which the problem seems most logically to fit. Problems as they were described before include those elements in the psychosocial adjustment of the patient that appear distorted, lacking or needing support.

It is felt that a more accurate report of the problems would be had if those who had returned from the visit were separated. As the score was tabulated it would indicate that problems in all areas for those people were more ubiquitous than in the others' cases.
Table 11. Problems by Area as seen by the Social Worker in Patient and Relative (Multiple Coded)

<table>
<thead>
<tr>
<th>Number of Patients</th>
<th>Problem</th>
<th>Family</th>
<th>Personal</th>
<th>Economic</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
<tr>
<td>7 Patients still out of the hospital</td>
<td>Problems which were seen to exist in the patient</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Problems that pertained to the patient found in the relative</td>
<td>b/</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3 Patients that had returned to the hospital</td>
<td>Problems which were seen to exist in the patient</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Problems that pertained to the patient in the relative</td>
<td>b/</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

a/ Under family were included conflicts, rejection, unmet dependency needs.
   Personal included intrapsychic conflicts and relatives' anxiety.
   Economic included employment status.
   Social included use of leisure time, social stigma.

b/ We felt that family and patient problems in this category were synonymous.
The purpose of this chapter is to answer the question referred to in the introduction; are the problems noted in this study treatable by social casework methods? In order to answer this question, the various problems discussed in previous chapters will be summarized in specific case material. For the sake of clarity, these problems have been somewhat arbitrarily delineated and discussed in terms of problem areas. In these brief case summaries they will be pulled together again in terms of people. Then the role of the social worker in helping to meet these problems will be discussed.

Case Number One.--

This 17 year old single male has a clinical diagnosis of schizophrenic reaction, schizo-affective type. He has been hospitalized for three years. At present he is in contact with reality. He is able to think rationally and participate intelligently and co-operatively in conversation and hospital activities, and in his relationships with hospital patients and personnel. Since he has been ill his father has committee suicide, his sister has become hospitalized for mental illness, and his mother has gone to live with the other married sister. He has expressed a desire to continue his education when released from the hospital.

The problems here can be seen to cut across the areas previously referred to as personal, family, vocational, and
social. What is it, then, that a social worker may do to help this man?

Swithun Bowers has indicated the general approach which would be used.

"It would seem that the large area of social work practice in relation to the mentally ill will lie in what has been designated supportive and environmental treatment .... environmental adaptation will usually be the key that opens the door to successful rehabilitation."

Social workers know that in order for this individual to adequately handle the situations which await him outside the hospital, he will need a certain positive attitude toward himself and confidence in his capacity for adjustment. In order to meet this need social workers give support, that is, they provide sympathetic understanding of the problems the individual faces and his feelings about them, and encourage the utilization of strengths the individual has to deal with these problems. Florence Hollis has said that the aim of support is "to enforce the ego strengths through reassurance, guidance, and release of emotional tension."

The young man in this case will face problems beyond

1/ Swithun Bowers, "Social Services for Mentally Ill - Their Place in the Field of Social Work", Better Social Services for Mentally Ill Patients Ruth I. Knee, Editor, American Association for Psychiatric Social Workers, New York, 1955, p. 5

his capacity to solve alone even with a healthy attitude toward himself and his abilities. What will be his relationship with his family? What kind of education does he really want? What are the educational facilities available to him? How will he be supported financially? How will he handle the process of resocialization after hospitalization? These are situations in which he will need the kind of help social workers call environmental modification. His environment including possibly the attitudes of individuals toward him will need to be modified in order to facilitate his adequate adjustment outside the hospital. This is one of the important functions of social workers. Gordon Hamilton has defined environmental modification as "activity on the part of the social worker, both in and out of the interview situation, designed to help the client plan his emotional, professional, recreational, and other activities." 1/

Case Number Two.--

This 42 year-old single man also has a diagnosis of schizophrenia. He entered the hospital 25 years ago when he was 17 years old and a student at a public trade school. At present his thinking is clear and he is able to converse and participate cooperatively in hospital activities. He is able to work and care for himself. He speaks of wanting help with finding a job, but with not much conviction. He is, in fact, quite dependent on the hospital and feels that it is better for him "to stay right here." All his known relatives

are dead. He has friends whom he hears from at Christmas time when they send him packages. He has been released from the hospital once during these years, but returned after one day with a severe depression.

Social workers know that in order for a patient to make adequate adjustment to the community after hospitalization, he needs sufficient motivation, capacity, and opportunity. Helen Harris Perlman has pointed out that in helping individuals adjust to life situations social workers are often called upon to help the individual develop or stimulate motivation and capacity, and help him find the opportunities necessary for his adequate adjustment.

The man in this case seems to have sufficient capacity for adjustment outside the hospital but the motivation is lacking and the opportunities for adjustment are not indicated in this material. In helping this man with the problem of opportunities for adjustment outside the hospital, the social worker would again utilize the special skills in dealing with the environment which were referred to in discussing case number one. His lack of motivation as exemplified in his dependency on the hospital may be a greater problem for him. The social worker may be able to help him find ways to meet his dependency needs other than

1/ Helen Harris Perlman, "Treatability in Social Casework", An Address Delivered to the Boston University School of Social Work Alumni Association, Boston, March 8, 1956
hospitalization.

Helping him make such necessary decisions will involve the use of very limited goals. It may be, for instance, that his movement from the hospital to a similar institution such as a boarding home would be the most realistic first step for him. Such a setting would allow more freedom and opportunity for independent functioning and yet would not place greater demands on him than the hospital does. If accompanied by continual casework relationship, such experience might help encourage him to take on a progressively more complicated role in society.

Case Number Sixteen.--

This 39 year-old divorced woman has been diagnosed as schizophrenic reaction, paranoid type. She has been hospitalized for six years. At present she has been released from the hospital for about six months but has continued on thorazine. She has secured a job companion to an 86 year-old woman and lives with her. Her present functioning, though greatly improved since thorazine, is considered only fair. She would like to have her present thorazine dosage strengthened, but resents coming back to the hospital once a month to see the doctor. She thinks her employer will discover that she has been hospitalized and is anxious and uncomfortable about the prospect. This follows a pattern she established in the hospital by becoming closely attached to an elderly woman and doing favors for her. Her brother who feels responsible is particularly anxious about her condition. He does not want her to make friends outside because it might damage the family's reputation and he wonders how he will manage her in another six months when she is officially discharged from the hospital.

This case material shows something of the tenuous nature of this woman's emotional stability. Her dependency,
reflected in her relations with elderly women and her desire for stronger doses of thorazine, is a particular problem for her. Her dependency needs are not being adequately and satisfactorily met. The dependency needs of such a patient who has been hospitalized for a long time are well stated in a paraphrase of Frieda Fromm-Reichmann by Dr. Walter E. Barton. \(^1\) In this view the schizophrenic patient, whose dependency needs probably stem from maternal deprivation, has a deep seated fear of being rejected or abandoned but is unable to ask for what he wants.

What this woman seems to want is continued support. She has found it only partially in thorazine and in her relationship with her employer. A relationship with a social worker might help fill this need by providing a parent substitute of which the patient need not be afraid and who would use professional skill aimed at inducing self reliance. The effects of such treatment can not be readily anticipated. It seems certain, however, that it would need to be prolonged and continuous.

The anxiety of the relative, in this case, is also a problem for the patient. The brother seems to be acting out of feelings of guilt and obligation imposed by his

\(^1\) Walter E. Barton, "The Hospital as a Therapeutic Community"; Ruth I. Knee, *op. cit.*, p. 13
mother. He is markedly uncomfortable in his role as responsible relative. A social work relationship with him should involve both support and clarification. Dr. Grete Bibring has defined the latter concept as follows:

"Clarification consists of attempts to bring to the patient's attention feelings and attitudes which are vague and obscure but which still are on a conscious or preconscious level. Clarification helps the patient to gain an adequate perspective of his problems — a step in the direction of understanding himself, and consequently of handling his problems differently."

Thus the brother may be helped to understand himself better and to change some of his attitudes which have had an adverse effect on the patient's readjustment to life outside the hospital.

**Case Number Eighteen.**

This 52 year-old, divorced woman has been diagnosed as schizophrenic reaction, chronic undifferentiated type. She has been hospitalized 11 years. Her present functioning is poor. She is, in fact, recently returned to the hospital from a trial visit of two months, showing tendencies to expose herself and psychotic forms of thought such as sensory hallucinations and depression. She has one married daughter and another daughter who is 11. The younger daughter does not know her mother because the relatives have felt the patient was "incurable" and there would be no need for the daughter to know her real mother. The relatives describe the patient's recovery as a "miracle" and admit that it has complicated family problems.

The patient's older sister has assumed the role of responsible relative. The patient's married daughter, who also came for a research interview, seemed to be interested in her mother but is kept in the background by the patient's older sister. The sister,

herself a former mental patient, is a very anxious and aggressive woman. She and the patient engaged in continual disputes while the patient was on trial visit. The patient saw herself, in relation to the family, as "an old shoe that didn't fit."

It would be asking too much to assume that this patient could adjust to such a family situation without help no matter how miraculous was her response to thorazine. The problems here of personal disorganization and breakdown in family relations are complicated indeed and they seem to play on each other. It has not been the purpose of the writers to produce an operating diagnosis of this case, and therefore, it would not be possible to specify a detailed treatment plan. But in working with this patient and her family the social worker would be guided by certain broad considerations which have been well stated by Doctors Herbert C. Modlin and Bernard H. Hall of the Menninger Foundation:

"At times the relationship between patient and family may be so deteriorated that the relative in his discomfort seizes upon hospitalization as a way of deserting the patient. ....... In addition the relative may suffer feelings of guilt about himself as an accessory to the patient's illness."

Social workers would admit this as a possibility in any work with the relatives and particularly with the older sister. This family situation calls for clarification.

1/ Herbert C. Modlin, and Bernard H. Hall, "The Psychiatric Patient Bridges the Gap between the Hospital and the Community," Ruth I. Knee, op. cit., p. 32
Before trying to go back into the family, the patient needs to have a clear and realistic picture of the situation. What are the bonds of love and mutual concern on which she can depend? How strong are they? In what individuals and in which home may they be found? Some selected relative or relatives would need to be helped to consider their own attitudes, anxieties, and the complicated pattern of family relationships as they affect the patient's readjustment. Then the patient and family may be helped to make sounder decisions regarding the most helpful arrangements for the patient during trial visit.

Proceeding with such plans as might be formulated would involve the use of a social work method called manipulation. As Dr. Arthur F. Valenstein defines it, one aspect of manipulation is the kind of environmental modification referred to in discussing case number one above. Would it be more helpful for the patient to live some other place than with relatives? Would someone other than the older sister - the married daughter, for instance - be a more helpful responsible relative?

Another aspect of manipulation would involve activity on the part of the social worker designed to reduce anxiety.

\[1/\] Arthur F. Valenstein, Class Lecture at Boston University School of Social Work, March 12, 1956
of a specific type in order to bring about a certain result. This would suggest a step by step approach to the many free floating anxieties in this family situation.

Still another aspect of manipulation would require the social worker to provide a "corrective emotional experience" for the patient or a selected relative or both. In such a role the social worker would encourage the development of a close relationship with the client through interviews and would consciously present himself as an accepting and understanding authority figure with certain specific competence to deal with life situations. The client, then, through attachment and identification with the social worker, may come to feel like giving up certain attitudes and actions which have produced or aggravated problems for her and her family and adopting more constructive ones. The confidence with which such treatment can be undertaken will depend greatly on the relative emotional stability of the client and, therefore, depends on careful diagnosis and selectivity.

These, then are ways in which a social worker might be helpful to this patient in her efforts to adjust to the community outside the hospital. Meanwhile, during the period of her hospitalization, there are specific ways in which a social worker might be helpful. The recent workshop on Social Services to Mental Patients has defined this responsibility as follows:

"The job of the social worker is to help the patient with social and interpersonal problems during hospitalization in order that he may adjust as a patient, and then to help him leave the hospital."

In carrying out this responsibility the social worker may, 1) help the patient make use of hospital facilities, 2) help the patient make satisfactory social relationships in the hospital, and 3) assess the patient's ability to relate to the hospital community and to move out of it.
CHAPTER VI
SUMMARY AND INTERPRETATIONS

This study has been concerned with the role of the social worker in the rehabilitation of mental hospital patients who have been treated with the drug chlorpromazine, or thorazine. The approach has been to find out what problems were anticipated and experienced by patients and their families, then to point out appropriate social work methods of meeting these problems. The sample of twenty patients studied was drawn from a larger population of patients at Metropolitan State Hospital, Waltham, Mass., who had improved after the administration of thorazine. Ten of these patients were still hospitalized and ten had been released.

The study involved interviewing the patients, a close relative, and an attendant on the hospital ward. Further information was secured by reading the case records and by an informal interview with Dr. Robert Hyde of the Boston Psychopathic Hospital.

The study has examined three areas of the patients' adjustment to the hospital. The writers looked for opportunities for social workers to be helpful at each of these stages of the patients' transition from the hospital.
to the community.

In the first area it was discovered that the patients' attitudes toward their improvement, their treatment, and their activities in the hospital provided valuable clues to their willingness and ability to adjust outside the hospital.

Most of the patients both in and out of the hospital felt that they had improved since taking thorazine. Some were willing to admit that they had been ill. A few both in and out of the hospital were unwilling or unable to admit that they had been ill.

All the patients studied were able to participate in some of the "activities or therapies" after thorazine. The most common of these were occupational therapy, industrial therapy, and group therapy. Most of the patients exhibited a positive attitude toward these prescribed treatment programs. All the five persons still in the hospital who had been referred for help with leaving exhibited positive responses to these programs.

Most of these patients also participated in such other activities as reading, watching television, attending movies, dancing and church services. The patients still in the hospital seemed to have more positive attitudes toward these activities than the out group. To appreciate the significance of this each patient has to be studied individually.

Most of the patients exhibited some degree of dependency
toward the hospital personnel and their care. The nature of hospitalization seems to account for a great portion of this.

With the group still in the hospital the writers tried to ascertain their adjustment to leaving in relation to their attitudes toward leaving and the problems they anticipated in adjusting to the community. Most of these patients were ambivalent toward leaving. In some of these the desire to leave seemed most prominent and in others the desire to stay seemed most prominent. There seemed to be no consistent relationship between their condition and their attitudes toward leaving. It was found that consistent relationship with their families was an important factor in their willingness to leave the hospital.

All of the patients anticipated problems in the area of social relations. Stigma and fear of rejection played important roles in this. More than half of the patients or their relatives anticipated problems of personal adjustment, family relations, or vocational adjustment.

The patients released from the hospital expressed favorable and cooperative attitudes about leaving. The relatives of this group seemed to have anticipated more problems than the patients did. The relatives were almost universally anxious about the patients' adjustment into the family and community. The patients seemed to reflect
similar anxiety in their denial or problems.

The initiative for the patients leaving the hospital came primarily from the patient or the relatives rather than from hospital personnel. One motivating force for the relatives' action seemed to be guilt. Full acceptance of the patients by relatives was difficult, and a number of patients were not having their dependency needs adequately met.

The men in this group seemed to have less difficulty finding employment than the women. All the patients tended to isolate themselves from community activity, reflecting the kind of fear of stigma anticipated by the group still hospitalized. This was also a major problem for relatives.

The chapter on the role of the social worker seeks to answer the question: are the problems noted in this study treatable by social casework methods? One casework method which seemed applicable in a number of cases is support.

Using this method the social worker provides sympathetic understanding of the problems the patient or the relative face and his feelings about them plus encouragement for the individual to use his own strengths to deal with the problems.

Another method which seemed appropriate in several cases is environmental modification, by which the social worker helps to change some of the aspects of the patient's
environment including possibly the attitudes of other individuals toward him in order to facilitate his adjustment outside the hospital.

Clarification is another method which seemed appropriate in several cases. Using this method the social worker would be able to help relatives gain perspective of the patient's problems and their own attitudes which have adverse effect on the patient's rehabilitation. The social worker also helps them to make sound decisions and plans for the patient's adjustment.

A number of problems pointed out in this study call for the use of manipulation. This is a broad casework method which includes environmental modification, increasing or decreasing the individual's anxiety in order to further a desired goal, and/or providing a corrective emotional experience for the patient or relative.

It has not been possible to answer conclusively in this study whether casework with these patients would be different than with patients who had not received thorazine. The study does seem to indicate, however, that casework with these patients would be different than if they had not been treated with thorazine. Dr. Hyde has noted a feeling of inertia this drug creates in some patients. The question is raised whether this feeling extends to their feelings about leaving the hospital making it more
necessary for the social worker to reach out to these patients than to other psychotics. Again, this study does not answer the question. It does seem conclusive, however, that a number of these patients are now amenable to casework help who would not have been able to use it before they were treated with thorazine. The drug appears to be a particular aid in caring for large numbers of mentally ill patients where the personnel-to-patient ratio is small and where individual treatment for severely ill patients is limited.

The general surface attitude expressed by the patients toward their improvement and toward their leaving was a positive expression. However, along with this expression of confidence there was also seen an expression of ambivalence. This ambivalence was manifest in the patients who were in the hospital by anxiety as they considered the possibility of leaving and was manifest in the patients out of the hospital by denial of the problems that they clearly had. In the case of the "ins" the ambivalence can be more openly expressed, while in the "outs" the insecurity was repressed through this denial mechanism. The social work problem that can be pin-pointed here is that the patients now in the hospital should be supported so that the fears about leaving can be expressed and worked with. In the case of the "outs" the support is aimed at reducing the
need to be defensive and denying through the acceptance of the patients by the worker and supporting the strengths.

In one way it was determined that there was a high degree of association between the patients' actual capacity for adjustment outside the hospital and his positive feelings about treatment, which for the most part meant thorazine. The in-group was least positive about treatment. This seems to tie in with the dependency needs of all of the individuals involved. The "ins" were more positive about the activities than the "outs". The two groups seemed to cling to different things. The expression on the part of the patients also followed a pattern. The "ins" expressed more dependency on the hospital than the "outs". The conclusion can be drawn that the "outs" were more dependent on the treatment. (thorazine)

The dependency needs of these individuals is further spelled out in their family relationships. The indication was that where the patient had come to rely on the family the dependency needs were not being met. What amounted to attitudes of rejection on the part of the relatives resulted in the fear of rejection on the part of the patients. The relatives' guilt over their reactions toward their patients was particularly pointed in the face of an unexpected change for the better.

In addition there can be seen the need for tangible services to supplement the efforts described above. This is
seen mainly in the vocational and social areas. The "ins" need help in finding jobs. This problem was only partially solved by the out-group and then largely by the men. In considering the question of stigma that almost everybody feared or felt, the worker has to use his skill in knowing resources that will ease the patient over this very real problem or support the patient so the realistic elements will not be clouded by the patient's imagination.

In all of this the patient's motivation for help is of prime importance. In the process of the study some patients and some relatives asked for help, but this was not the majority. Some of those who were in need of help were receiving it through casework services. However, this was limited to three in the out-group and five in the in-group. In the matter of motivation for someone to be helped, there has always been the feeling that with psychotic individuals one must reach out more than with the neurotic. The question is raised here whether or not the reaching out process must go farther in the case of those who are currently taking thorazine. This includes only a small group of the patients in the study, but it does present a problem for the social worker.
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Chart A (Concluded)

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The years of hospitalization represent only the latest admission, not any previous ones.

The first ten cases comprise the group remaining in the hospital, while the last ten cases are in the group out of the hospital.

The abbreviations under Marital Status are listed below.

s .... single  w .... widowed
m .... married  d .... divorced
sep.... separated
APPENDIX II

Chart A. Schedule of Questions to be Answered by Interviews

1. Adjustment to Work and Daily Routine
   a. Employed
      satisfied, dissatisfied, indifferent
   b. Unemployed
      unable to work, seeking work, skilled, unskilled
   c. Leisure-time Activities
      what activities
      adequate, inadequate
   d. Special problems around the use of time for the relatives

2. Adjustment to Leaving the Hospital
   a. Attitude toward leaving
      ambivalent, resistant, cooperative
   b. Problems anticipated
      family, personal, work and daily routine,
      community and social relations
   c. Help received on leaving the hospital
      family, personal, work and daily routine,
      community and social relations
   d. Where did they receive the help?
   e. Relatives' Attitude
      Initiated idea that the patient should leave,
      guilt, pressure from the patient
      Cooperative to the idea when faced with it by
      the staff, uncooperative
Appendix II, Chart A (concluded)

3. Adjustment in Family Group
   a. Personal relationships and family roles
certainty, rejection, acceptance
   b. Transition from hospital to home
       separation anxiety, regression, anxiety of relatives
   c. External factors having direct bearing on the
       patient and his family.
       crowded living conditions, need for medical care
       no family, broken family, economic hardship

4. Hospital Adjustment
   a. Attitude toward self
       indifferent, improved, worse
       description
   b. Attitude toward hospital
       Treatment
       positive, negative, indifferent
       Activities
       positive, negative, indifferent
       Care
       positive, negative, indifferent
   c. Attitude toward hospital personnel
       dependant, hostile, indifferent
   d. Maintaining contact with the hospital
       What contact?
       Attitude toward contact--helpful, not helpful
   e. Suggestions for change
APPENDIX III

BIBLIOGRAPHY


BIBLIOGRAPHY (continued)


