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A study of twenty mental patients who completed trial visit.

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CHAPTER I

INTRODUCTION

Trial visit planning, preparation and supervision for patients from a mental hospital will be presented and discussed in this thesis.

Public awareness and concern about the problem of mental health have shown a great increase as evidenced by growing demand for more information regarding the causes and treatment of mental illness. This interest is reflected in the increasing number of articles and books which are being published. President Eisenhower keynoted the growing national concern, in general terms in his State of the Union message on January 6, 1955 when he proposed, "vigorous steps to combat the misery and national loss involved in mental illness". Over fifty bills, both in Congress and in State Legislatures, reflect nationwide determination to tackle these problems on a scale suitable to their magnitude.[1] There would appear to be a need for continued and increased public cognizance so that further funds for research into this disturbing problem may be available.

Trial visit is a process whereby the recovered or im-

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1 Editorial, "Nation Tackles Mental Health Problems", Mental Hospitals, 6: pp. 10-13, March 1955

proved patient is returned to the community. New methods of treatment have enabled more patients to be returned to the community with varying degrees of successful adjustment.

Purpose of the Study

The objective of the study is to examine a group of twenty patients who left the Northampton Veterans Administration Hospital on trial visit during the years 1952 and 1953. These patients were all able to remain out of the hospital during the trial visit period of one year and all were subsequently discharged. The writer wished to examine two general questions: 1. Are there common problems that patients encounter in remaining out of the hospital with respect to attitudes of relatives, socialization and employment? 2. What is the role of the social worker in supervising patients who remain out of the hospital after a period of hospitalization?

Scope and Method of the Study

One hundred and three patients, who left the hospital on trial visit during 1952 and 1953, were discharged at the end of a one year period. Of this number, only thirty-five were supervised directly by social workers from the hospital. The remainder were supervised by various Regional Offices or, in several cases, no follow-up supervision was indicated. The reason for deciding to focus the study on cases supervised by social workers from the hospital was to increase

the possibility of having more case material available. Also, it was felt that the examination of the role of the social worker would be more meaningful if only one setting was included.

Of the thirty-five eligible cases, twenty were finally selected on the basis of age. The thirty-five cases were first arranged by age and the youngest twenty patients were selected. This was done to increase the availability of living relatives which might be expected with younger patients. It was also felt that a homogeneous age group would present more common problems as regards social interests, employment and family attitudes.

The information for this study was gathered by means of a schedule, which may be found in the Appendix. Several casework records were examined before a schedule was designed and after its terms were clarified, the schedules were completed.

The compiled information was obtained chiefly from the social service records. In addition, finance records and clinical records were consulted. In several instances, interviews with hospital social workers were obtained when the records were unclear. The social service records provided most of the information concerning the patient while on trial visit.

Review of The Literature

There have been many articles in social work literature which concern themselves with trial visit planning and supervision. Martin E. Grobman[2] emphasizes the importance of planned trial visits when he states, "It is important to determine the problems which have created difficulties for the patient so that preventive measures can be outlined either to avoid conflicting situations in the future or to prepare the patient in meeting problems which cannot be avoided." Dr. Grobman also advises that trial visit planning is the responsibility of the entire hospital "team".

Irving Greenberg[3] points out that the social worker has a twofold contribution to make; First, to the patient directly; second, to the patient's family. He emphasizes the importance of continuing contacts with relatives from admission until discharge. Mr. Greenberg feels trial visit planning and supervision call for the closest kind of collaboration between doctor and social worker. He points out that the social worker, planning under medical direction, is the one staff person who will go over in detail with the patient the kinds of alternative plans which would best

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2 Martin E. Grobman, "The Planned Trial Visit", Veterans Administration, Information Bulletin, 1B 10-17, November, 1951.

3 Irving Greenberg, "Role of the Social Worker in a Psychiatric Hospital", Veterans Administration, Information Bulletin, 1B 10-29, October, 1952.

suit his needs in going back to community living. Mr. Greenberg, in discussing the family care program, states that all factors which contribute to the patient's adjustment must be considered with the patient and affirmed by medical authority. Edward J. Sanders[4] enlarges further on family care trial visits and briefly summarizes background information about early foster care efforts. Robert T. Dacy[5], in a highly summarized article, discusses trial visit in three divisions; 1. The philosophy of trial visit, 2. Preparation for trial visit, 3. Trial visit supervision. He emphasizes that "careful preparation for trial visit is our most effective means of safeguarding the progress made by the patient while in the hospital and of preventing return to the same situation and environment which contributed to the illness".

Edith M. Stern[6] in her book, Mental Illness, A Guide for the Family, shows clearly how the attitudes of relatives toward hospitalization may affect the patient. She discusses the different reactions of families such as fear, guilt, over-protection and shame and attempts to show a relationship

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4 Edward J. Sanders, "Foster Home Trial Visit Program", Veterans Administration, Information Bulletin, 1B 10-29, October, 1952.

5 Robert T. Dacy, "Some Aspects of Trial Visit in the Veterans Administration", Veterans Administration, Information Bulletin, 1B 10-53, February, 1954.

6 Edith M. Stern, Mental Illness, A Guide for the Family.

existing between these attitudes and a patient's adjustment.

In general, there has been a quantity of articles and books written about the meaning of hospitalization to the family and the patient. There are innumerable articles prepared by the Veterans Administration which are concerned with trial visit. The large volume of such articles serves to emphasize the importance of the subject.

Limitations

The Social Service records from which most of the material for the study was gathered are designed for treatment purposes rather than for research. In addition, much of the recording is in a highly summarized form and sufficient information about specific topics was not always present in all records. Further, the small sample of cases studied places an additional limitation upon generalizations which can be drawn from the study. The fact that the group studied were all relatively young males limits the conclusions which may be drawn to that group.

CHAPTER II

THE NORTHAMPTON VETERANS ADMINISTRATION HOSPITAL

The Northampton Veterans Administration Hospital was opened for service in May 1924 in order to provide for the care and treatment of male veterans suffering from psychiatric disorders.

The hospital has been increased gradually from its original 462 beds to a present capacity of 1105 beds. The total of 1105 authorized beds is comprised of 1031 standard beds and 74 emergency beds distributed throughout 12 wards.

Since activation, approximately 6800 patients have been served by the hospital. The total number of Psychiatric admissions for the preceding year (1954) was 196 patients. During February of 1954, tuberculous-neuropsychiatric service was discontinued and 55 patients were transferred to the Brockton Veterans Administration Hospital.[1]

The organizational structure of the Northampton Veterans Administration Hospital is divided into two principle units: Administrative Services and Professional Services.

Administrative Services Division is the unit which carries out the total operation and functioning of the hospital. These services consist of the Manager, who, with the Assistant Manager and his Staff, is responsible for the

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1 Northampton Veterans Administration Hospital, Book of Historical Data, January, 1955.

total operation of the hospital (including the Professional Services). Included in the Administrative Services are the following departments: Communications and Records; Finance; Personnel; Special Services; Supply; Engineering and Contact.

Professional Services Division has as its function the care and treatment (both medical and psychiatric) of patients admitted to the hospital. It is composed of Medical and Psychiatric Services, Nursing Services, Physical Medicine and Rehabilitation Services, Clinical Psychology Department and the Social Service Department.[2]

The Social Service Department is concerned chiefly with the social and personal difficulties of the patient as they affect him during hospitalization and after release. Irving Greenberg states that a social worker in a neuro-psychiatric setting has, "five major responsibilities".[3] These are: 1. Orientation of new patients, 2. Interviewing for a social history, 3. Continued service in relation to the patient's hospital adjustment, 4. Planning with the patient for his discharge, 5. Interpretation to relatives of patient's progress and need of treatment. Finally, a

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2 Timothy J. Clifford, The History of Family Care for the Mentally Ill, Unpublished Masters Project, University of Connecticut, Connecticut School of Social Work, 1954, pp. 6-7.

3 Irving Greenberg, "Neuropsychiatric Hospital", Adventure in Mental Health, pp. 65-67.

major concern of the Social Service Department is that of offering trial visit supervision to the patient when he leaves the hospital. This study is concerned with this particular aspect of Social Service responsibilities.

At the Northampton Veterans Administration Hospital, the trial visit program is medically directed and supervised. When a patient is to be considered for this type of leave, he is presented at staff by the physician who has responsibility for his case. The full medical staff, headed by the Clinical Director, discuss the patient's suitability for trial visit and also have a personal interview with him. Also present, and encouraged to participate are representatives of Finance, Nursing Services, Chaplain Service and Social Service. Following this, trial visit is either approved or disapproved and the reasons for the action are recorded. If approved, the medical staff often requests Social Service to assume direct supervision of the patient. If the patient's home is located more than 50 miles from the hospital, a Regional Office is usually asked to assume responsibility. Occasionally, no trial visit supervision is requested because of a patient's plan to travel, because it is not considered necessary, or because it is felt supervision itself might be a harmful thing for a particular patient. The medical staff requests reports on the patient's adjustment at regular intervals and these reports form the

basis for a decision to extend or limit further trial visit status.

Trial visit is a period usually of twelve months duration following hospitalization. A patient is granted ninety day leave periods which are renewable until a year has passed if he maintains his ability to adjust in the community. Home visits are made during this period and casework services are extended to the patient and to his family. The purpose of this assistance is to help the patient with problems that may arise in his efforts to re-establish himself in the community and to maintain and extend the gains made by the patient as a result of hospital treatment.

Another type of leave, which is similar to trial visit, is the Family Care Program. Family Care is the act of placing patients in homes other than their own. Patients selected for this type of care usually have no families or their families are unwilling to accept them. The entire hospital staff has a part in the selection of the patient for family care, for all who come in contact with the patient in his daily job and who, therefore, observe his adjustment to the hospital, can suggest to the ward doctor a patient for this kind of placement. The manner of selecting patients is described in TB 10A-334 which states that this selection

is a "highly individualized matter".[4] This bulletin further emphasizes the importance of careful selection of family care homes and the need for close and intensive supervision. It is required by the Chief of Professional Services, that the patient be visited at least once a month. However, visits are usually more frequent with the patient often being seen on a weekly basis during the initial few months of placement.

Both of these programs, Trial Visit and Family Care, also make beds available to other veterans in addition to their theraputic value. This is an important consideration because of the long waiting lists at most mental hospitals and because of the financial savings realized by providing care outside the hospital.

To carry out these various programs, the Social Service Department is organized with a Chief of Social Service, a case supervisor and four psychiatric case workers. In addition, there are four second year social work students from the School of Social Work of Boston University and the University of Connecticut.

These workers are assigned as follows:

a. Admissions--Acute and Intensive Treatment--two workers

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4 Veterans Administration, Trial Visit Procedure in the Case of Patients with Psychosis, Improved, Who Are Going To Homes Other Than Their Own, TB 10A-334, May 29, 1953, p. 2.

b. Trial Visit and Post Discharge Continued Treatment--two workers. (One of these case workers carries, as well as his other duties, the Family Care Program.)

Each caseworker, through the Chief of Social Service, coordinates patient planning with the various Veterans Administration Regional Offices. Finally, there is active participation by the department in medical and psychiatric conferences and in the various orientation programs of other hospital services.

CHAPTER III

WHO WERE THE PATIENTS STUDIED

There were one hundred and three patients discharged from trial visit status at the Northampton Veterans Administration Hospital during the years 1953 and 1954. Of this number, sixty-one patients were offered trial visit supervision by Regional Offices. In seven cases, no follow-up supervision was requested by the medical staff. The remaining thirty-five patients were supervised directly by the social service workers at this hospital. This study is concerned with twenty patients in the last category.

In order to assure as homogeneous a group as possible, these twenty patients were selected on the basis of age. It was felt that any findings might be more pertinent and valid in such a group because they would perhaps present more common problems and would be faced with similar life situations. This chapter will present a description of the personal and social characteristics of these patients.

All of the twenty patients studied were white, male veterans of World War II and the Korean War.

The patients ranged in age from twenty-one to thirty-five. As shown by the following table, the patients were quite evenly distributed into three groups.

TABLE I

AGE AT TIME OF TRIAL VISIT

Age	No. of Patients
21-25 years	6
26-30 years	6
31-35 years	8
Total	20

All of the patients studied claimed affiliation with some religion. Thirteen were Roman Catholic and the remaining seven were Protestant. In two cases, patients had changed their religion after marriage. One had been converted to Catholicism and one to the Methodist faith. The much larger percentage of Catholic patients is in line with total hospital figures for religious affiliation. This is partially explained by the location of the hospital in an area where there is a large proportion of people who are Roman Catholic.

Eleven of the patients studied were single and eight were married. One patient separated from his wife prior to this present trial visit after a number of previous trial visit reconciliations had proven unsuccessful. The slightly larger number of single patients is partially explained by

the youth of the age group studied. It can also be inferred that the patient's symtomatology may have been a deterrent to marriage. Of the eight married patients, seven had children. One patient had three children, two patients had two children and three patients had one child. One married patient had no children. The last married patient had adopted a child after his wife had six miscarriages.

There was a wide difference noted in the educational level for this group. Three patients completed the eighth grade level of education only. Nine patients attended high school with five graduating. Three patients attended trade school with only one graduating. Three patients had some college training but again only one patient received a degree. The remaining two patients had specialized training--one completed two years of aeronautical engineering and the other attended art school. It is interesting to note that nine patients (45 per cent) failed to complete the requirements of the schools they attended. It may be inferred that these patients were already experiencing some difficulty in adjustment due to their illnesses.

TABLE II

EDUCATION

Level of Education	No. of Patients
Grammar School	3
High School	9
Trade School	3
College	3
Other	2
Total	20

The occupations of the group, as shown by Table III, varied greatly as would be expected. Only one patient was self-employed. Two patients were students and had never been employed except on a part-time basis. Several were laborers, factory workers and construction hands. Those who are classified as skilled and semi-skilled included a welder, carpenter, printer and machine inspector, among others. Data regarding regularity of work, attitude toward employers and work habits were insufficient for any meaningful comments to be made. Frequently, relatives of the patients were unable or unwilling to give information in any detail.

TABLE III

OCCUPATIONS PRIOR TO TRIAL VISIT

Occupation	No. of Patients
Professional	1
Skilled and semi-skilled	10
Unskilled	7
Student	2
Total	20

The fact that many veterans receive compensation or pensions as a result of military service is considered of importance for several reasons. Often Family Care plans depend upon the amount of compensation being received. Family attitudes toward a patient may change when compensation increases or decreases. The patient's attitude towards employment, family responsibilities and his own illness can also be affected by his feelings regarding compensation.

Compensation is granted by the Veterans Administration Adjudication Boards in several ways. Service connection is established when it can be proven that the condition developed in service, or was aggravated by service, or that the condition became a disabling one within two years after discharge. Non-service connected pension is granted to those whose condition is adjudged to be permanently and totally

disabling without reference to service.

Table IV shows that thirteen patients received service connected compensation varying from 10 per cent to 100 per cent. Ten per cent compensation amounts to $17.00 monthly and 100 per cent compensation amounts to $181.00 monthly at the present time. This amount changes from time to time. Additional allowances are made for dependents. Of the thirteen, eleven receive compensation for their mental illness and two patients were compensated for physical conditions. Four patients received no compensation from any source. Three patients were receiving non-service connected pensions of sixty-eight dollars a month. It is important to note that sixteen, or three-fourths of the patients studied, were receiving varying amounts of compensation or pension.

TABLE IV

INCOME AT TIME OF TRIAL VISIT

Income	No. of Patients
Service connected compensation	13
Non-service connected pension	3
No Income	4
Total	20

The total length of hospitalizations varied greatly for the group. However, two-thirds of the patients, fourteen, were first hospitalized eighteen months or less prior to this trial visit. For the remaining six patients, their first hospitalizations had occurred from three years and three months to ten years and three months prior to the time of trial visit. It must be recognized that this does not necessarily indicate that the patient was hospitalized continuously during this period, because many patients had several discharges and admissions and it was not possible to determine the actual time spent in institutions. Thirteen of the patients were first admissions to a mental hospital. Four patients had been hospitalized here previously--one had three admissions and three patients had two previous admissions. The remaining four patients had been admitted to other mental hospitals prior to their admission to Northampton Veterans Administration Hospital.

The lengths of hospitalization for the current admissions were similar to the foregoing distribution. Seven patients were admitted less than six months before their trial visit, and thirteen had longer stays. The shortest period of hospitalization was three months. This was the first and only trial visit experience for fourteen of the patients. The remaining six had had varying numbers of unsuccessful trial visit experiences. However, two patients had been discharged

from trial visit at the time of a previous hospitalization and had subsequently been readmitted.

TABLE V

HISTORY OF HOSPITALIZATIONS

No. of Years	Length of Time Since First Admissions	Length of Time This Admissions
Under 6 mo.	6	7
6-12 mo.	5	4
13-18 mo.	3	3
19 mo. and over	6	6
Total	20	20

The final psychiatric diagnoses of these patients is noted in Table VI. The diagnosis of schizophrenia appears in over three-fourths, sixteen, of the patients. This can be partially explained by the age group studied and the tendency of this illness to begin during this period of life. It should also be noted that "the most common of all psychosis is schizophrenia...and one-fifth of all first admissions to mental hospitals are schizophrenics".[1] The type of schizophrenia, catatonic, which is predominant in this sample is again partially explained by the age group studied.

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1 Louis I. Dublin, The Facts of Life: From Birth to Death, p. 313.

TABLE VI

PSYCHIATRIC DIAGNOSIS AT TIME OF TRIAL VISIT

Psychiatric Diagnosis	No. of Patients
Schizophrenic reaction--catatonic type	13
Schizophrenic reaction--undifferentiated	1
Schizophrenic reaction--unclassified type	1
Schizophrenic reaction--paranoid type	1
Manic depressive reaction	1
Psychotic depressive reaction	1
Anxiety reaction	1
Encephalopathy, paranoid type	1
Total	20

Summary

The foregoing data reveal that the patients studied were all between the ages of twenty-one and thirty-five. Thirteen patients were Catholic and seven were Protestant. Eleven patients were single and nine were married. These patients completed different levels of education and held many different jobs prior to their latest hospitalization. Over three-fourths received compensation of some sort at the time of trial visit. There was a wide difference in the length of time since first hospitalization which varied from three months to ten years and three months. Seventy per cent (fourteen) of the patients were attempting trial visit for the first time. There were many different psychiatric

diagnoses with Schizophrenia appearing in the largest number, sixteen, or eighty per cent of the patients studied.

The following chapter will deal with the patient's adjustment during the trial visit period.

CHAPTER IV

WHAT HAPPENED TO THE PATIENTS

One important factor considered in determining whether a patient will be granted trial visit is the availability of a suitable place of residence. In the selection of such a placement, many factors are studied including: family and patient attitudes toward one another, community attitude, employment opportunities and previous failure in the same environment. Unfortunately, it frequently becomes necessary to return patients to unfavorable environments in which chances of successful trial visit are lessened due to pressure exerted by relatives. Many times it is felt that such a trial visit experience is still better for some patients than continued hospitalization. The Family Care and Job Placement Programs will hopefully lessen the need for patients to return to homes where experience has shown their needs will not be met.

The patients studied in this group returned to several different residences which included parental homes, own homes, Y.M.C.A., and a Family Care Home. Eight of the nine married patients returned to their own homes to live with their wives and children. The remaining married patient obtained a room at a Y.M.C.A. and remained separated from his wife during the entire trial visit period. Nine of the single patients returned to homes which included a parental figure. One

single patient first returned to his parental home and left almost immediately to live at a Y.M.C.A. The final single patient was placed from the hospital in a Family Care Home.

TABLE VII

RESIDENCE

Residence	No. of Patients
Parental home	9
Own home	8
Y.M.C.A.	2
Family Care Home	1
Total	20

Occupational Adjustment

The occupational adjustment of the group was studied with respect to their employment records and attitudes toward work. In Table VIII, the category "regular" employment is used to describe the status of patients who were gainfully employed during at least three-fourths of the trial visit period. The category "irregular" employment was used to describe those patients who worked for short periods of time not amounting to more than one-half of the entire trial visit period. The category "unemployed" was used to describe those patients who worked not at all or no more than a few weeks.

TABLE VIII

EMPLOYMENT RECORD

Employment	No. of Patients
Regular	10
Irregular	5
Unemployed	5
Total	20

Occupations of the ten patients classified as regularly employed included six factory workers, a printer, furniture mover, stock clerk and one self-employed businessman. Those in the irregularly employed category held jobs as construction workers and carpenters. One patient, who was classified as unemployed, had a workshop where he made a great deal of furniture which he was unable to sell.

Thirteen of the employed patients were apparently satisfied with their employment. One patient who was dissatisfied, changed jobs very frequently without apparent reason. The other patient was employed by his father and was unable to get along well with him. He was undecided about finding other employment but verbalized considerable resentment about his work.

Four of the five patients who were classified as unemployed made no attempt to look for work. They all received

compensation and it appeared that they were content to live on this income. The remaining patient's symtomatology seemed to be interfering in his attempts to obtain work since he was suspicious, preoccupied and unable to concentrate on his work. There was only one married patient classified as unemployed. He received compensation amounting to $253 per month due to a statuatory award for a specific injury, and for this reason was not interested in looking for work.

The fact that five patients (twenty-five per cent of the group studied) were unemployed during the entire trial visit period is interesting but of no great importance until other factors in the patient's adjustments are considered. The important area of family and marital attitudes and relationships must be examined before too many inferences are drawn from the above findings.

Family and Marital Relationships

Patients become accustomed to the care and protection which the hospital offers and the process of readaption to home and social life is at best a rather difficult one. Parents, wives, siblings and the community are able, by their attitudes towards the patient, to help or hinder this adaptation. The writer will first examine the attitudes of the wives and families (if recorded) of those patients in this group who were married. A highly summarized statement about each of the nine married patients follows.

1. Relationship not indicated too clearly--wife and family appear to be overprotective of the patient and accepting of his limitations.

2. Masculinity was threatened by a domineering aggressive wife who was rejecting of the patient's increasing dependency upon her. She could not accept his limitations and often provoked his hostility by pointing these out to him. Social worker was able to help minimize and modify her attitude as the trial visit progressed.

3. Wife was hostile, distrustful and irrational regarding the patient's illness and fearful of what hospitalization would do to their marriage. Patient's father was a domineering, insecure and fearful parent who was put out of the home by the wife during the trial visit period. Her attitude was modified as the trial visit continued.

4. Wife was a hostile and controlling woman with large unmet dependency needs. She was in competition with the patient for the masculine role and appeared to be more concerned about herself than about the patient. She gradually became more helpful and accepting of the patient.

5. Patient's wife had also been recently hospitalized for a mental illness. She was a very withdrawn, fearful and excessively passive woman who had periods of high excitement and vulgarity. Patient's parents were tolerant, understanding and made many allowances for his behavior.

6. Wife was considered to be somewhat hostile towards and demanding of the patient. She was helped by the social worker to become more accepting and understanding of the patient's limitations. Patient remained away from his parents during the trial visit period as both parents were considered to have been rejecting of him.

7. Wife was accepting and understanding of the patient's hospitalization and was felt to be most helpful in affecting an excellent adjustment for the patient. Patient's oldest brother was also helpful and worked with the patient and family attitudes and feelings around hospitalization.

8. Wife was an extremely compulsive, suspicious and

negativistic person who, nevertheless, was able to accept some guidance and became quite helpful to the patient. Father was an extremely domineering man who denied any acceptance of the patient's illness. Mother was a socially retiring self-sacrificing woman who showed little active interest in the patient.

9. Patient was separated from his wife who was a very demanding and rather domineering woman. Patient had rebelled against this domination during a previous trial visit. It was felt that wife's attitudes towards the patient could not be modified and patient was, therefore, helped to arrange a separation.

The above case illustrations indicate that, frequently, married patients on trial visit are faced with marital and family situations which increase the tensions and fears they probably already have as a result of their hospitalizations. In five cases, patients were probably helped to remain on trial visit because of the social workers success in modifying unfavorable attitudes on the part of wives and family. Two patients had wives who appeared to be warm, accepting and understanding of the patient's needs. In one case, the patient's family was tolerant of him and helpful in his adjustment. The remaining patient was helped to separate from his wife and to adjust in an new environment away from a domineering wife.

There were eleven patients who were single and the following case descriptions indicate briefly what the attitudes of parents and siblings were regarding the patient's return to the home.

10. Patient's mother was an extremely over-protective woman who was resistant to supervision and who had a close relationship with the patient. Father was a cold, distant and domineering man who could not accept the patient. An older brother was a "father-figure" in the family and was helpful in assisting the patient with his adjustment.

11. Mother was a very over-protective woman who was strongwilled and moralistic. She did little to stimulate the patient to any activity and encouraged passivity. Father was a weak, quiet and passive person who found an outlet in drinking.

12. Father and mother were both warm and over-protective of the patient. They had no understanding of the patient's illness and were content with the slightest of gains in behavior. They were able and willing to play an extremely supportive role in trial visit adjustment.

13. Father was a highly aggressive person who was a threatening figure to the patient. Mother was a warm, accepting, over-protective parent who attempted to shield the patient from the father as much as possible. Patient's siblings were accepting of him and tried to help him to socialize.

14. Father deserted family when patient was a child. Mother was distant in relationship to the patient and had two previous mental hospitalizations. The siblings were all quite successful people and regarded the patient as a "sore thumb".

15. Mother was considered to have been a rigid controlling woman who had no understanding of the patient's illness and who became over-protective of him. Father was deceased--he was an alcoholic who left home early in the patient's life.

16. Mother and father were both aggressive, domineering, controlling people. They sought to place patient's illness on a physical basis and were hostile toward the hospital as regards supervision. They both tended to over-protect the patient.

17. Mother was an alert interested woman who could accept guidance and supervision. Siblings were inclined to be protective of the patient and were

trying to be helpful in his adjustment.

18. Father was a very difficult, self-centered man who was very rejecting of the patient. Mother was a suicide and had been found by the patient. The step-mother was an insecure, quick-tempered woman who had no real affection for the patient.

19. Parents were divorced and both remarried. Mother was a very anxious, guilty woman who lacked understanding of the patient and was rejecting of him. Patient went to her home for about a week and then received permission from the hospital to move to a Y.M.C.A.

20. Both parents were deceased. Patient was placed in a Family Care Home with a woman who was able to provide him with a protective atmosphere. She had a great deal of warmth and affection for the patient.

The word "over-protective" is used to describe the attitudes of families in eight of eleven cases of single patients on trial visit. This may be explained when one considers that families are, perhaps, extremely fearful of angering or disturbing a patient on leave from a mental hospital. They, therefore, try very hard to shield him from the outside world and from the hospital authorities--in this case the social worker. The writer considers an "over-protective" attitude to be a positive one inasmuch as it is this "over-protection" on the part of wives and families which many times enables a patient to remain on trial visit. However, this attitude may have a negative aspect also. "Over-protection" may be considered to be negative when it increases the feeling of dependency on the part of the patient so that he is blocked in his efforts to establish himself in the

community.

A comparison of employment record and family attitudes shows that in all five cases of those patients listed as "unemployed", the family attitude was a negative form of "overprotection". It may be inferred from this that these patients were under no family pressure to obtain employment and reacted by avoiding seeking work. This may be shown more clearly when the patient's total adjustment is considered.

Total Adjustment

In order to measure the degree of adjustment which a patient makes on trial visit, four classifications were decided upon and each case was placed in one of these categories. The patient's ability to socialize, his employment record, interpersonal relationships and general stability were factors which were considered in determining the degree of adjustment. In addition, the social worker's opinion was usually stated in each record.

The category "excellent" adjustment was used for patients who showed no evidence of symtomatology and who were able to function with greater ease in all of the above mentioned areas. The category "good" adjustment was used for those patients who showed improvement in most of the determining factors with little regression noted. The category "fair" included those patients whose adjustment was considered to be tenuous and who had considerable difficulty in finding

steady employment, forming relationships or in socializing. The fourth category "poor" adjustment included patients who were markedly regressed and who failed to show any improvement in any of the determining factors. The following case illustrations will present one patient in each of the four categories.

The following case is an example of an "excellent" adjustment.

1. This patient was a twenty-five year old, married man who carried the diagnosis of Schizophrenic Reaction--Catatonic Type. He had been hospitalized for the first time four months prior to trial visit.

   While on trial visit, the patient was gainfully employed on a regular basis as a maintenance man in a factory. His marital situation improved and patient's wife was helpful and understanding of the entire situation. Patient was also accepted by his family and given increased responsibility for the operation of a family business. He showed himself able to handle this responsibility and expressed confidence in himself. He showed much more tolerance in stress situations. Patient was able to socialize very well. His wife was pregnant and he was very pleased with this news.

The next case indicates what was considered to be a "good" adjustment.

2. This patient was a twenty-one year old single man who carried the diagnosis of Schizophrenic Reaction--Catatonic Type.

   The patient was a basically inadequate man who had difficulty in controlling his impulsivity. During the trial visit, it was noted that he had an increased capacity for friendship and was much more outgoing. He appeared to be getting some satisfaction from meeting new people and it was felt he had gained some degree of self-awareness.

   Patient had begun to socialize quite well and had a

"steady" girl friend who had a good influence upon him. He was steadily employed in a paper mill. Patient continued to have some difficulty in handling money and was not stable in some of his actions.

The following is a case where adjustment was felt to be "fair".

3. This patient was a twenty-six year old single man who carried a diagnosis of Schizophrenic Reaction, Undifferentiated Type.

   The patient was working steadily as a stock clerk for a large concern and seemed satisfied to keep this position. The patient had completed three years of college and was at first unwilling to accept any limitations. He appeared to be making an attempt to socialize a little but was not successful in his efforts. Patient's entertainment consisted chiefly of movies, shopping tours--activities he could do by himself. The patient was having a difficult time in seeking acceptance by his family and this was a serious source of conflict.

The last case illustrates a "poor" adjustment.

4. This patient was a twenty-five year old single man who carried a diagnosis of Schizophrenic Reaction--Catatonic Type.

   This patient was a weak, immature man who had regressed from a rebellious adolescent stage in which he was preoccupied with his sexual adjustment to a submission before a strong, maternal, over-protective mother. Due to the over-protection of the mother, the patient made no effort to obtain work or to socialize. He appeared content to remain home.

The following table shows how the total number of patients were classified.

TABLE IX

TOTAL ADJUSTMENT

Degree of Adjustment	No. of Patients
Excellent	1
Good	6
Fair	10
Poor	3
Total	20

Sixty-five per cent (thirteen) of the patients studied made only a "fair" or "poor" adjustment. In many of these cases, patients appeared to be remaining out of the hospital due to those attitudes and feelings on the part of parents and wives which resulted in "over-protection" of the patient. The writer is convinced also that the social worker as the bridge between home and hospital was able to help these patients to remain in the home.

The following chapter will concern itself with the role of the social worker in an effort to learn if the above conjecture is correct.

CHAPTER V

WHAT DID THE SOCIAL WORKER DO

There has been a gradual expansion of the Social Service Department at the hospital which has been carried out as a result of the introduction of the "team" approach to mental and physical illness. The "team" usually includes a psychiatrist, psychologist, nurse, aide and social worker. The writer is interested in the position of the social worker on this "team". One way of determining what this position is, would be to look at some of the activities of social workers with regard to patients on trial visit.

When a patient is admitted to the hospital a social anamnesis is usually requested by the Chief, Professional Services, to aid in diagnosis and treatment of the patient. This information is obtained from relatives by the social worker in a personal interview. A psychiatrist interviews the patient and uses both sources of information in forming a psychiatric diagnosis.

There was a social anamnesis completed in eighteen of the cases studied. In the remaining two cases, one patient had been hospitalized prior to the establishment of an active Social Service Department and the other patient had been admitted while still in the Army and an abstract from the Walter Reed Hospital was included in his record. With single patients, the mother was the most frequent informant, being

interviewed in eight of the eleven cases. In six cases siblings were interviewed. Only three fathers were listed as informants. This may be explained due to the fact that the male parent was usually working during hospital hours. It also may be inferred that there was less effort made by social workers to contact fathers.

Wives were the only informants listed for eight of the nine married patients. In the remaining case, the wife had been hospitalized for a mental condition just prior to the patient and could not give the necessary information. The writer feels that parental figures should also be contacted when a patient is married. There was a lack of early family history and background material noted in those records where only wives were interviewed.

In thirteen of the cases studied, Social Service activity was continuous from the time of admission to discharge. During this period, there were regular contacts with patients and relatives with primary emphasis on trial visit planning. In the remaining seven cases, there was a period when there was no Social Service activity. These cases were closed after the anamnesis was obtained and reopened when trial visit planning was requested. In four cases, there was no further activity in a case until the patient was already on trial visit.

The frequency of Social Service contacts with patients

and relatives was studied. "Very Frequent" contacts were those made at least twice a month. "Infrequent" was used to describe contacts of less than once a month. "None" is used to describe those cases where no contacts were recorded or where relatives were contacted only for anamnesis information. The following table shows the Social Service activity in these classifications prior to trial visit.

TABLE X

FREQUENCY OF TRIAL VISIT PREPARATION CONTACTS

Contacts	Patients	Relatives
Very Frequent	8	3
Frequent	4	9
Infrequent	4	3
None	4	5
Total	20	20

In sixty per cent (twelve) of the cases studied, contacts with patients and relatives were found to be "very frequent" or "frequent". The remaining cases showed much less activity and in four cases, no contacts at all were recorded with patients. The reasons for lack of contacts were not clearly indicated. In one case, a patient refused to see a social worker. In the other three cases, activity ceased due to unfavorable progress and the case was unexpectedly

reopened at a time after trial visit was already granted.

The patients and relatives were seen by the social worker during this period in order to plan for the patient's return home. After a patient was released, the social worker continued contacts to assist the patient with any problems that might arise in his efforts to re-establish himself in the community. The following table indicates the frequency of Social Service contacts after the patient left the hospital.

TABLE XI

FREQUENCY OF TRIAL VISIT SUPERVISION CONTACTS

Contacts	Patients	Relatives
Very Frequent	6	3
Frequent	8	9
Infrequent	6	7
None	—	1
Total	20	20

Seventy per cent (fourteen) of the patients and sixty per cent (twelve) of the relatives were seen at "very frequent" or "frequent" intervals. Relatives were contacted during the supervision period except in one case. This patient had been helped to separate from his wife and was adjusting satisfactorily at a Y.M.C.A.

Table X and Table XI indicate that Social Service was very active in trial visit preparation and supervision for over one half of the patients in this group. In order to show what form this activity took, the role of the social worker is illustrated by the following summarized examples of services rendered. The cases which follow have the same identifying numbers as those already listed beginning on page 27, chapter IV.

1. Relationship was considered to be rather superficial. Supportive help was offered and attempts were made to increase patient's incentive to work (without apparent success).

2. Social worker was helpful in patient's acceptance of need of hospitalization. Support and reassurance were given regarding his need to feel adequate. He was helped to recognize physical limitations and encouraged in choice of work. Patient's wife was helped with their financial problems, allowed to ventilate her feelings regarding her husband's limitations, and it was attempted to help her in her understanding and acceptance of the role she would need to play to meet her husband's needs.

3. Worker helped with problems regarding marriage, financial situation and environmental situation due to attitudes of the community as a result of suicide attempt of the patient. Worker used community resources (S.P.C.C. and A.R.C.) in helping patient's wife due to her hostility towards the hospital. Patient was helped to gain considerable insight into his difficulties.

4. After psychiatric consultation, a male worker was assigned to help patient with his problem of identification. Patient was helped to strengthen masculine identification because worker was able to arouse anxiety. Sharing the worker helped the patient's wife to work through some of her sibling rivalry. Worker offered a great deal of support.

5. Worker performed in a listening role during hospitalization. Patient's relatives were helped by worker who clarified some of behavior patterns of the patient and his wife who was also hospitalized. Worker attempted to alleviate much of the home friction and referred the wife to clinics for continued help.

6. Worker offered casework services to the wife who was able to accept guidance and was able to stabilize the situation. Patient seemed to progress much better at home than while in the hospital. Worker gave a great deal of support and reassurance to the patient as changes in living patterns were brought about.

7. Worker had a superficial relationship with the patient who was able to make an excellent adjustment at home. Worker made frequent contacts with the patient's wife to give support regarding the patients progress.

8. Relationships were chiefly with the wife who was helped with decisions involving further referral for the patient. There was environmental manipulation in planning for a part time job for the wife and for nursery school for the child.

9. Worker was able to help with problems involved in separation, employment and living arrangements. Supportive help seemed to be an important factor in helping patient to remain on trial visit.

10. Worker's role consisted of helping the patient with practical problems involving employment opportunities and financial management. Patient kept the relationship on a surface level as much as possible.

11. Worker attempted to encourage the patient's mother to withdraw from the situation as it was evident she was over-solicitous and encouraged dependence. Worker felt little success was achieved.

12. Superficial relationship existed with the family unable to accept patient's illness. Patient was helped with anxiety feelings about area of employment.

13. Worker was actively working with the parents due to their hostile attitude towards the hospital as a result of difficulty in claiming compensation.

Worker felt the relationship established with parents and patient was important in maintaining an even balance until trial visit ended.

14. Worker encountered extreme resistance in trying to get patient and relatives to accept hospitalization and trial visit supervision. Worker attempted to work with this resistance but without apparent success.

15. Worker's role was to provide support for the patient and to help him clarify his thinking about personal difficulties. Worker had difficulty in forming a good relationship although contacts were on an intensive basis.

16. Worker was regarded with extreme suspicion and hostility by patient. Work was with family to help them accept the patient's illness. Worker felt patient was able to adjust due to the protective atmosphere of the home--and felt the patient's hostility was a result of his rebellion against this protective environment.

17. Worker offered support and reassurance to the patient and family. Some clarification and interpretation was attempted to help the family accept the patient's illness.

18. Worker was helpful in the areas of employment, financial management and family attitudes. Patient's family and employer were helped to understand his behavior. Some attempt was made to help the parents with their feelings about the patient's lobotomy.

19. Worker helped the patient to become more independent and masculine by encouraging him in his plan to move from the family home. He was offered supportive help to alleviate some of his fears and doubts in these areas. Worker became involved in a relationship with patient's mother which was threatening to the patient and made progress more difficult.

20. Worker was concerned with rehabilitation of patient who was a chronic alcoholic. Worker's role was supportive in helping the patient achieve recognition for his artistic work. Several months were spent in getting acquainted and in making placement plans. Relationship was considered to be superficial.

The above illustrations describe briefly the role which the social worker indicated was most important in the trial visit experience of the patients in the group. In eight of the cases, the relationship between worker and patient was evaluated as being superficial. This meant that in these cases the worker was not accepted by the patient or his family, nor were these patients able to accept casework services which were offered. These patients remained on trial visit due to the protective atmosphere of the family. This may be further understood when it is recognized that the nature of the patient's illness, many times, makes forming a casework relationship a long and difficult process. It is also difficult to determine how much a relationship may mean to a patient even when the worker regards it as being superficial. The fact that the majority of these patients were seen quite often, indicates that the workers recognized the need these patients have for supervision.

Patients were helped during trial visit in many ways. The worker offered supportive help and reassurance in ten cases, indicating that this treatment technique is the most frequently used with these patients. In seven cases, patients were helped with practical problems involving employment and financial management. In six cases, the worker indicated that there was an effort made to help the patient with his feelings about his need for, and acceptance of hospitalization.

In nine cases, workers were helpful in interpreting and clarifying problems with relatives. In only one case, is there evidence of a worker using community resources to help with patient and family adjustment. There would appear to be an opportunity for further activity in this area. It is possible that patients could be helped in the area of socialization and employment with an increased use of community resources and by further efforts by all workers to support community organization projects. The social worker should be the person who is acquainted with these resources for referral and should be less hesitant in recommending increased use of them. There is the added factor that, when the one year trial visit period is over, these referral resources might continue to offer the patient and his family guidance and supervision where needed.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The first question set forth in the introductory chapter, asked whether there were common problems that patients encounter in remaining out of the hospital involving employment, socialization and family attitudes. The results of the study indicate that these patients had a variety of trial visit experiences and handled their common problems in several different ways.

Chapter III concerned itself with the characteristics of the patients studied. It is important to note that the majority of these patients had been hospitalized for a period of less than eighteen months prior to trial visit, and this may indicate that early preparation and release is important in successful trial visit adjustment. However, it may be that the ones who get well faster are not so sick and find it easier to adjust outside the hospital. It is also significant that three-fourths of the patients received compensation and this, perhaps, influences families to accept dependent patients.

In all but three cases, patients returned to the same environmental situation which existed prior to their hospitalization. One patient, who had failed on several placements with his wife, was helped in deciding to separate from her, and this time made a good adjustment. Most patients

were able to find employment with which they were apparently satisfied. In those cases where patients remained unemployed, it was felt that the family was negatively "over-protective" of the patient. It must also be remembered that these patients received compensation and were, therefore, under less pressure to seek employment.

An examination of marital and family relationships revealed that patients were faced with situations which, in most cases, made their adjustments more difficult. Most relationships tended to be "over-protective" of the patient, which helped him to remain on trial visit but hindered his assuming his full social role in the family and community. In general, patients were able to make "fair" or "good" adjustments, with eighty per cent being classified in these categories. Only three patients made "poor" adjustments, which is an indication that not many patients are able to remain out of the hospital during the entire period while making a "poor" adjustment.

The second question which the study examined was the role of the social worker in trial visit preparation and supervision. In order to do this, social service activity was studied in relation to services rendered. It was found that in almost all cases a social anamnesis had been obtained and that, with sixty-five per cent of the patients, services had been continuous from admission to discharge. In addition,

contacts with relatives and patients were found to be on a "very frequent" or "frequent" basis in over one-half of the cases studied. These contacts continued throughout trial visit preparation and supervision.

An attempt was also made to show the casework relationship and the way in which a patient and family were helped to accept each others limitations and needs. The social worker performed various functions in achieving these goals. The most frequently used techniques were support and reassurance. Workers also helped patients with problems involving employment, financial management and feelings about hospitalization. Another area in which workers were helping was with the relatives in interpreting and clarifying the patient's situation. It was also apparent that, in many cases, the social worker was unable, in spite of intensive effort, to establish more than a superficial relationship due to the nature of the patient's illness. Even in these cases, there may well be value in continuing supervision, as it may not always be apparent how much such contacts mean to the patient and relatives.

Some of the findings in the study suggest that greater use might be made of community resources as it would appear that most of the patients made little, if any, use of facilities in the community. Another weakness would appear to be the ignoring of parental figures in those cases involving

married patients. It might be important to establish such contacts in helping to determine early childhood patterns leading to marital difficulties. In certain cases, more consideration might be given to the use of family care homes where previous experience indicates trial visit will be unsuccessful. Patients might be helped by casework services to gain partial insight into the reasons for previous failures and recognize the need for another placement plan.

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APPENDIX

Schedule--Trial Visit Study

I. Identifying Data

1. Name ____________________ No. __________
2. Age at time of trial visit ______
3. Religion: Catholic ____, Protestant ____, Jewish ____, Other ____
4. Marital status at time of trial visit: Married ____, Single ____, Divorced ____, Widower ____, Separated ____
5. Number of children at time of trial visit ____
6. Education (circle highest grade completed)
   - Grade School--1,2,3,4,5,6,7,8
   - High School--1,2,3,4
   - College--1,2,3,4
7. Occupation prior to trial visit: (check and list job)
   - Professional ____ ______________
   - Skilled ____ ______________
   - Unskilled ____ ______________
   - Student ____ ______________
   - No occupation ____ ______________
8. Monthly income--(designate amount)
   - Service Connected ______
   - Non-service Connected ______
   - Other ______
   - None ______
   - Total ______
9. Diagnosis at time of trial visit: ______________
10. Years since first hospitalization: year ____ month ____
11. Total number of admissions: ____
12. Total number of trial visits: ____
    Successful ____ Unsuccessful ____ Other status ____

II. Patient and Trial Visit

1. Environmental Adjustment:
   a. Own Home ______
   b. Patental Home ______
   c. Home of Sibling ______
   d. Family Care Home ______
   e. Boarding Home ______
   f. Other ______

Describe: ______________________________

2. Occupational Adjustment (check and describe)
   a. Regular____ ______________________________
   ____
   b. Irregular____ ______________________________
   ____
   c. Unemployed____ ______________________________
   ____
   d. School____ ______________________________
   ____
   e. Other____ ______________________________
   ____

3. Attitudes of Patients re Employment:
   a. Employed
      1. Apparently satisfied__________
      2. Dissatisfied__________
      3. No Information__________

   Describe:______________________________
   ____
   ____
   ____
   ____

   b. Unemployed
      1. Looking for work__________
      2. No attempt__________
      3. Symptoms interfering__________
      4. Other__________

   Describe:______________________________
   ____
   ____
   ____
   ____

4. Family and Sibling Relationships
   a. Marital: (Describe)______________________________
   ____
   ____

   b. Parental: (Describe)______________________________
   ____
   ____
   ____

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c. Siblings: (Describe) ____________________

____

____

d. Others: (describe) ____________________

____

____

____

5. Total Adjustment:
   Excellent ________
   Good ________
   Fair ________
   Poor ________
   Describe: ____________________

____

____

____

III Role of Social Worker and Trial Visit:

1. Prior to trial visit
   a. Anamnesis ________ yes
   ________ no
      1. Informants (list) ____________________

____

   b. Social Service Activity: (check and describe)
      1. No follow up ________
      2. Follow up and closed ________
      3. Continuous ________
      4. Closed and reopened ________
   Describe: ____________________

____

____

____

   c. Frequency of contact with patient:
      1. Very frequent ________
      2. Frequent ________
      3. Infrequent ________
      4. None ________
   Describe: ____________________

____

____

____

   d. Trial visit preparation with patient:
   Describe: ____________________

____

e. Frequency of contact with Relations:
   1. Very Frequent________
   2. Frequent________
   3. Infrequent________
   4. None________

Describe:____

f. Trial visit preparation with Relations:

Describe:____

2. During the trial visit period:

a. Frequency of contacts with patient:
   1. Very Frequent_____
   2. Frequent_____
   3. Infrequent_____

Describe:____

b. Frequency of contacts with Relatives:
   1. Very Frequent_____
   2. Frequent_____
   3. Infrequent_____
   4. None_____

Describe:____

c. Total number of figures worked with________

d. Nature of the relationship between social worker and patient:

Describe:____