1960

Family attitudes toward schizophrenics on trial visit

BOSTON UNIVERSITY
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FAMILY ATTITUDES TOWARD SCHIZOPHRENICS ON TRIAL VISIT

A thesis

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CHAPTER I

INTRODUCTION

Background

This study will explore and describe the attitudes of twenty-two families of veterans who left on trial visit during the year 1958 from the Veterans Administration Hospital at Bedford, Massachusetts. The specific areas to be investigated will be the families' attitude toward the patients' social worker; toward his attempts, and theirs to help him, socialize and find employment and finally toward the taking of medication.

There have been few changes in society's treatment of the mentally ill over the ages. From "Bedlam"[1] and "Abandon hope all ye who enter here" to some of the institutions of today the interest has been all too often on custodial care without hope and more or less emphasis on the humanity of the keeper.

As the knowledge of medical science and psychology has developed, attention has slowly centered on this troubled area and there is evidence that today, society is thinking of mental patients with hope and treatment in mind.

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[1]The first mental hospital in London, England established 1547 as the Hospital of St. Mary of Bethlem but popularly known as "Bedlam".

One writer has expressed it rather well in the following way:

> One can say, therefore, that Pinel taught us that the mentally ill have human and civic rights, that Kraepelin taught us that they suffer from clinical diseases, and that Freud taught us that they are understandable.[2]

Great effort must still be made to improve the treatment to understand the patient and his family and to help them understand each other.

There are indications that the hopeful, treatment oriented approach is realistically reversing a two century trend. Writing in Mental Hygiene, Dr. Saul Fisher says:

> Following the wide spread use of these new drugs in 1956 for the first time in approximately two hundred years in the history of the public mental hospitals in the United States, instead of the expected increase of ten thousand patients there was a reduction of over seven thousand patients.[3]

The mental hospital is no longer a hopeless place of custody. We approach the mentally ill with hope in heart and confidence in our treatment; there are many individual set backs, we do not truly know many answers yet but "Hope springs eternal from the human heart" and contrary to the days of "Bedlam" we can apply it now to our mentally ill.

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[2]Frederic Wertham in the "Introduction" to The World Within, editor Mary Louise Aswell.

[3]Saul H. Fisher, "The Recovered Patient Returns to the Community", Mental Hygiene, vol. 42, no. 4 (October 1958), p. 466.

The Veterans Administration

The Veterans Administration is an independent government agency charged with administering benefits provided by laws for veterans, their dependents and beneficiaries. The agency was created in July 1930 by combining the Bureau of Pension, Veterans Bureau and the National Home for Disabled Volunteer Soldiers.

Part of the responsibility of the Veterans Administration has been the operation of hospitals for veterans who are physically and/or mentally ill.

It was as a result of this that the installation at Bedford was constructed and opened to care for the mentally ill veterans of Eastern Massachusetts, Maine, New Hampshire and Vermont, in 1928.[4]

The institution opened as a neuropsychiatric hospital with a capacity of 354 beds, to-day the capacity is 1640. The administration, policy and program of the hospital has altered over the years to conform to the needs of the mentally ill veterans as the Veterans Administration has outlined that need, until now there are many specialties involved in the total treatment program.

There is the Medical-Surgical Service with its supporting services of laboratories, pharmacy, radiology, dental

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[4]Veterans Administration, Handbook of Information, p.3.

and complete consultation services. Then the psychiatric and neurological service with clinical psychology and vocational counseling.

The Physical Medicine and Rehabilitation Service grew out of the valuable lessons in rehabilitative techniques learned during World War II and now includes occupational therapists, physio-therapists, manual art, education and corrective therapies.

The other services involved in treatment and service to patients include nursing service, dietetic service, the chaplains and special services and to be treated separately because of the writer's special interest, the social service.[5]

Social Service

The Veterans Administration has employed social workers for many years and when the hospital at Bedford opened in 1928 there was a staff of one. As the stature and capacity of the profession grew the need for an enlarged staff became increasingly evident. Between 1944 and 1948 the staff was enlarged to eleven and is now thirteen.

The social worker has been called the link between the patient and the community and only the constantly

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[5] The above concerning the services available at the Bedford Veterans Administration was summarized from The Silver Anniversary edition of the Oval Mirror, June 1953.

growing professionalism of the staff and its leadership has made it possible for them successfully to cope with the increased responsibilities that the modern concept of mental treatment has added to their role.

The staff is augmented nine months of the year by six graduate students from three schools of social work who also use the facilities and problem areas of the hospital for research at the master's level.

The Setting

The writer a student, was placed on Building Seven for his supervised work experience. Here were 180 patients in four wards of forty-five patients each, experiencing a "total push" program started in January of 1958 that was designed to rehabilitate as many patients as possible.

The writer was informed that it was impossible to identify the patients as to age, years of hospitalization, etc., who were on the building when the program started, because the hospital does not maintain the type of records that would give such information.

Interviews with staff members elicted the following information. The patients were mostly young, chronic schizophrenics with a few older men but all had spent considerable time in the hospital. The wards were all locked and the building was considered a custodial building euphemistically called part of the continued treatment service.

There was one patient on trial visit, and five patients had privilege cards which allowed them to leave the building. Practically none of the patients were able to use the many therapies and activities available to them and little if any activity took place on the building.

As the "total push" program developed the changes came fast. In only a few months the first ward was unlocked, by the eighth month the second ward was open, by the end of the first year over one hundred patients were privileged,, many of them going home on week-end visits, and thirty-nine men had left on trial visit to be replaced by chronic patients from other buildings.

All services were participating, some sections vieing with others to aid the program that was salvaging so many chronic, mental patients, from a life of stagnation in an institutional setting to an adjustment in society. The writer was interested in the nature of the families' part in the patients' adjustment.

Previous Studies

In reviewing the literature it became apparent that there is need for a major study of the mental patients return to society. Some of the present knowledge seems to be contradictory, possibly the present orientation of using the family needs to be re-evaluated. One wonders if there are better methods of handling this problem than exist today?

There is evidence at many points, however, that considerable attention is being given to the problem of the mental patient's rehabilitation and answers are slowly accumulating.

A number of studies have been done at Bedford by students concerning parents' attitudes toward the mental patients.[6]

Ongoing studies in this area are being made by Veterans Administration Hospitals through out the country. Some are published, some are not as in the case of one recently done at the Veterans Administration Hospital in Pittsburgh, Pennsylvania.

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[6]Samples of theses concerning parent's attitudes toward patients:

Mildred H. Bauer, "The Social Worker's Preparation of the Psychiatric Patient for Leaving the Hospital".

Francis Durkin, Paul Hand and Joyce Hutchins, "Attitudes of Mothers and Fathers of Schizophrenic Patients".

Geraldine G. Lerner, "Fathers of Hospitalized Schizophrenic Patients".

S. Modell, "Family Relationships and Relatives' Attitudes Affecting Improvement or Lack of Improvement of Hospitalized Schizophrenic Patients".

Mary R. San Martino, "Attitudes of Relatives of Improved and Unimproved Schizophrenic Patients Hospitalized at the Bedford Veterans Administration Hospital".

Sybil M. Shapiro, "Relatives' Attitudes Toward Hospitalized Mental Patients, Part 5".

One study done a few years ago found that having an interested family was one of the three most important factors in leaving the hospital and being able to remain out.[7]

More recently Freeman and Simmons have made a wider study of the problem and have this to say:

> The additional analysis supports the basic proposition underlying the survey, namely that differences in family structure and attitudes, personality, and behavior of family members are associated with the level of performance of mental patients who succeed in remaining in the community.[8]

An English study has shown that the odds on a patient leaving the hospital go up in direct relationship to the number of years he has been hospitalized. The survey also evaluated the "success" and "failure" of patients in various types of settings such as parental home, foster home, marital home, sibling's home, hostels and lodgings. This study seemed to indicate that perhaps a home with a relative was not the best place for a mental patient to attempt to make his adjustment to society. The following indicated the thinking on this problem.

> The differential "failure" rates imply that it may not always be beneficial for such schizophrenic patients to

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[7]William F. Orr, Ruth B. Anderson, Margaret P. Martin, Des F. Philpot, "Factors Influencing Discharge of Female Patients from a State Mental Hospital", American Journal of Psychiatry, (February 1955), p. 576.

[8]H. E. Freeman and O. G. Simmons, "Mental Patients in the Community; Family Settings and Performance Levels", American Sociological Review, (April 1958), p. 154.

> return to the close emotional ties of parental and marital groups. A definite tendency towards seclusion and lack of close personal ties was noted in many patients living with siblings, and more especially in patients living in lodgings. However, it must remain at present speculative whether in high "failure" rate living groups actual deterioration in behavior could be attributed to post-hospital experiences.
>
> The following pieces of evidence were suggestive of this. Reported outbursts of temper and violence occurred relatively more frequently with wives and parents but the incidences of other psychotic symptoms, such as delusions was comparable in all living groups. Continued interpersonal contact of the patient all day with the mother was related to higher "failure" rates.[9]

Saul H. Fisher writes: "The existence of a family which is willing to accept the patient home is a very important factor. The absence of a family strongly militates against the eventual recovery of the patient".[10]

Many other studies of considerable scope dealing with various aspects of mental illness are shedding light on the problem of the patients' return to society.

Hollingshead and Redlich in their recent study state:

> The attitudes of the family toward its psychotic member are responsible to a significant degree, for the determination of who goes to a hospital, who stays home, who improves in hospital, who "deteriorates" and eventually stagnates in a chronic ward. This generalization is

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[9]"Experience of Discharged Chronic Schizophrenic Patients in Various Types of Living Groups", Medical Research Council, Social Psychiatry Research Unit, Institute of Psychiatry, Maudsley Hospital, London, England, Millbank Quarterly, July 1959, p. 127.

[10]Fisher, op. cit,, p. 467.

> applicable particularly in a disease like schizophrenia where there is a marked though variable, tendency toward "deterioration".[11]

In dealing with the specific problem of their survey they point out:

> Social inequalities in treatment are seen most clearly among schizophrenic patients. The Class IV or V schizophrenic once cast off by his family and community may receive one or two series of organic treatment in a public hospital. If these treatments do not succeed, the patient drifts to the back wards where in stultifying isolation he regresses even more into a world of his own.[12]

In a companion study to the above Myers and Roberts show that, "Like lower class patients in general, schizophrenics in both Classes IV and V were isolated from warm intrafamilial experiences and neglected by their parents whom they feared".[13]

An ever increasing number of projects are resulting in more knowledge in specific problem areas such as employment for patients outside of the hospital. An example of this is a paper by Linder and Landy entitled, "Post-discharge Experience and Vocational Rehabilitation Needs of Psychiatric

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[11] Hollingshead and Redlich, Social Class and Mental Illness, p. 342.

[12] Ibid., p. 350. Class IV and V refer to the two lowest classes on the socio-economic scale developed by these authors.

[13] Myers and Roberts, Family and Class Dynamics in Mental Illness, p. 90.

Patients",[14] which is an excellent study of the work experience of forty patients and which points up some of the needs in this area.

There is a growing need for someone to pull together the information available concerning this problem area in a compendium. Pertinent material is showing up in psychiatric studies, psychological research, from hospital research and from individual research. It is being published in social work journals, psychological, psychiatric, medical and sociological publications which make it almost impossible to keep in touch with all developments.

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[14] Marjorie P. Linder and David Landy, "Post-Discharge Experience and Vocational Rehabilitation Needs of Psychiatric Patients", Mental Hygiene, vol. 42, no. 1, (January 1958)

CHAPTER II

CHARACTERISTICS OF THE STUDY

Purpose and Justification

The purpose of this study is to explore and describe certain attitudes of the parent, parental figure or relative with whom the patient lived while on trial visit attempting to adjust to society.

The writer is interested in the attitude of family members toward social workers with whom they may have come in contact. He is also interested in attitudes toward the patient's socialization, his efforts to find and maintain himself in employment and toward medication that at this point seems to make it possible for the patient to remain outside the hospital.

It is further hoped that a comparison between the families and patients who made a successful adjustment and those who did not will contribute to greater understanding of patient and family.

A number of studies have been done at Bedford Veterans Administration Hospital dealing with the attitudes of relatives. To date there have been none dealing with the family's attitude toward the patient's adjustment while on trial visit or after discharge.

Freud indicated that the problems of adult psychotics are laid down during their childhood.[1] Arieti says that: "Although it is the mother who contributes mostly in producing the conditions which we are going to describe, we usually find in the history of schizophrenia that both parents have failed the child, often for different reasons".[2]

Other investigations have pointed out that one of the most important factors in making an adjustment outside of the hospital is to have an interested family.[3]

There is, however, the qualification to this found in several surveys, that patients tend to have less success in their adjustment in the parental family than in other settings. Freeman and Simmons say:

> Return of the patient to the parental family, where there is less likely to be an expectation of instrumental performance, may well occasion regression from, rather than movement toward, better functioning, and eliminate any gains of a theraputic hospital experience.[4]

In a similar vein an English study reports:

> The results and interviews suggested that continous close contact between a patient and relative was sometimes a

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[1] Silvano Arieti, Interpretation of Schizophrenia, pp. 22-27.

[2] Ibid., p. 52.

[3] Orr, et al, op. cit., p. 576.

Fisher, op. cit., p. 467.

[4] Freeman and Simmons, op. cit., p. 154.

strain to both and might contribute to the different percentage of "failures" of the working and non-working patients.[5]

In practice a great many patients do return to the parental home where there is reason to believe the problems of the psychotic originated. As yet there is no adequate substitute for the home placement and as a result much greater attention is being given to the situation existing in the home.

As the direction of treatment, under modern psychiatric philosophy changes to a consideration of a greater portion of the patients environment, it became imperative that we learn how to effect that environment. It would seem proper therefore, to investigate the environmental milieu in which the patients find themselves when attempting to make this very difficult adjustment.

The increased use of social workers in an effort to smooth the path for the patient leaving the hospital for trial visit increases the social worker's responsibility to understand the situation with which we are dealing.

Selection of the Sample

As the writer's attention focused on the idea of investigating the family relationships and particularly on

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[5] "Experience of Discharged Chronic Schizophrenic Patients in Various Types of Living Groups", Millbank Quarterly, p. 123.

the selection of a sample several problems came to the fore. One was that both successful and unsuccessful patients should be studied. Therefore some criteria were needed to help determine which patients had been successful in maintaining themselves outside of the hospital and which had not been successful.

Most mental patients of Veterans Hospitals when leaving are placed on trial visit.[6] If at the end of the period they are still out of the hospital and, in the opinion of their social worker, have made a reasonable adjustment they are discharged by the ward physician. It was thought that a sample that would include patients who had successfully completed a year as well as patients who had returned to the hospital before the year was out would be useful.

Therefore the sample became all schizophrenic patients who had left for trial visit from Building Seven between January 1, 1958 and December 30, 1958. Their total number was thirty-nine.

Limitations of time and travel imposed on a master's dissertation would make it impractical to attempt to contact all of the patients. An arbitrary limit of fifty miles was set within which the writer felt he could operate. This,

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[6] There are state laws establishing legal periods of trial visit of various lengths. Massachusetts requires one year, Rhode Island six months.

however removed seven patients from the sample. It was found that two patients had been placed in foster homes and one had been a member-employee and there had been no relative involved in their care which reduced the sample three more. There were two deceased patients and two patients who were by reason of chronic brain syndrome not truly psychotic.

This reduced the number to twenty-five patients. All families were informed of the study by letter and advised that the writer would arrange an interview by phone at their convenience. All interviews were conducted by the writer in the home of the relative. A few days after the letters went out the writer was contacted by an attorney representing the family of one patient. The mother had very recently died and in the words of the attorney the patient was "barricaded" in the home refusing to see anyone. The attorney requested in the name of the client that the writer not attempt to visit the patient. In as much as the patient had completed a year of being absent without leave three days prior and had been discharged from the rolls of the hospital the day prior to the phone call, and with the mother's death went the only person to have been with the patient during his trial visit, the writer could find little justification for not complying with the attorney's request. Two other families were uncooperative by not being home for either of two visits.

The final sample then consisted of twenty-two cases.

Composition of the Sample

This study will be primarily concerned with the family of the patient. However since the patient is an integral part of his family and was living in the home during the period of interest some information concerning him should be of value.

There was a thirty year span in age between the youngest patient aged twenty-three years and the oldest aged fifty-three, the median being thirty-five years. Thirteen of the group fell in the decade from thirty to forty years.

One patient was married and returned to live with his wife and two children, one was married and separated, one was divorced and the rest of the sample, nineteen, were not and had never been married.

There were twenty mothers and twelve fathers living. In nine instances both parents were in the home and in seven more the mother was present, making a total of sixteen homes where at least one parent was present.

In regards to education there were three patients who left school between the sixth and eighth grades, nineteen patients entered high school and thirteen finished. Of this group three patients entered college and one received a degree.

At the time the study was made six patients had returned to the hospital unable to complete the year of trial visit. There were six patients working and the other ten

were at home in poor to fair adjustment, several of them very tenuous.

Methods of Data Collection

This is an exploratory, descriptive study based primarily on data collected during a single interview with a member of the patient's family who was in the home during the trial visit period. An attempt was made to see the parent and the sibling or other relative who was designated the responsible person on the hospital records. The informant was encouraged to talk freely concerning the period of trial visit and the interviewer directed her attention to areas not adequately covered by questions from the schedule. (see Appendix A)

In analyzing the material the information obtained during the interview was treated as the primary data. However, supplementary and identifying material were collected from the patients clinical and social service records on a separate schedule. (see Appendix B)

Limitations

This study has the usual time and travel limitation with which student research efforts are restricted. The writer found some difficulty for both himself and the relative in maintaining the interview as an investigative rather than a casework relationship.

The writer found that all the material produced by

those interviewed did not fit the facts as they appeared in the record and is well aware that the emotionally charged material covered in the interview has probably affected his objectivity as well as that of the relatives.

Hypotheses

In speaking of what we expect to find, it might be well to see what previous studies have found.

In a five part study mentioned earlier, which was done in 1955, Charles L. Rose made the following summary:

> ... relatives felt dissociated from the hospital and its treatment program; they regarded the hospital as a custodial institution rather than as a psychiatric treatment setting; they had difficulty in seeing the illness as a psychiatric disorder; they felt hopeless about the illness and resisted the possibility of improvement, and finally they 'closed ranks' in the home against the patient.[7]

In 1959 Durkin, Hand and Hutchins said:

> Contrary to expectations, mothers and fathers exhibited a marked lack of knowledge with regard to mental illness and did not indicate that any attitudes which they expressed came as a result of any educational process through literature, films, radio or television.[8]

They also say:

> Attitudes were expressed in terms of patient improvement rather than knowledge of therapy, expectations of recovery were hopeful but somewhat unrealistic in terms of prognosis.[9]

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[7]This writer's italics. Charles L. Rose, "Relatives' Attitudes and Mental Hospitalization", Bedford Research, Vol. 5, (September 1958), p. 12.

[8]Durkin, et al., op. cit., p. 45.

[9]Ibid., p. 48.

It would seem from the efforts of previous investigators such as Hollingshead and Redlich, Roberts and Myers, Freeman and Simmons, as well as student research that we may find relatives in the homes of our veteran-patients who have many unresolved fears, doubts, and emotional problems and who may be ill-equiped to aid in the adjustment of the patient.

From our knowledge of treatment of mental patients we would expect that those homes that provided a warm friendly, accepting atmosphere for the veteran should be where he would still be living. While in the homes where there were rejecting, nagging, hostile attitudes the patient would be returned to the hospital.

We might find that where the patient has returned to the parental home a "child-like" dependent adjustment has been made by many.[10] We may find that if the only parent left is the mother that a tenuous adjustment has been effected to maintain the patient in the home with her but with no outside interests.

We expected that many families would not have clear cut ideas of just what should be done for, by or with the patient.

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[10]"Experience of Discharged Chronic Schizophrenic Patients in Various Types of Living Groups", Millbank Quarterly, p. 125.

We anticipated that families who had social work contact would have done a better job of providing a social milieu that aided the veteran in maintaining himself outside of the hospital.

CHAPTER III

PRE-TRIAL VISIT PERIOD

Introduction

Many services are provided the veteran in the hospital. However, we are primarily concerned with his socialization and work experience, and especially with what is done in the hospital to rehabilitate him in these areas. The responsibility for his work experience lies with preventive medicine and rehabilitative services and his social and recreational activities are organized by the recreational department of special services.

Social Service provides case work to a rather large number of patients and group therapy is provided to a relatively large number by social workers, psychologists, psychiatrists and vocational counsellors. The vocational counseling service, provides testing, counselling, referal service and actual job placement.

Therapies

The therapy program which occupy the major portion of the patients' work day include a wide variety of activities from the simplest physical exercise to employment in the community while still residing in the hospital. This facilitates the transition back to society in a realistic manner.

The first is corrective therapy which consists of a wide variety of physical activity inside the gym and outside,

all under a trained therapist.

In educational therapy many kinds of courses are available including commercial, vocational, high school and college preparatory subjects. There is also a chance for patients to participate in current events, travel study and similar groups.

Occupational therapy starts at the lowest possible level which might be an assignment to empty ash trays in the patient's day room through such activities as helping to make beds, participating in general cleaning in the building in which the patient resides, cleaning the tunnel that connects all buildings, ground maintenance, building maintenance, work in the laundry, work in the carpenter shop, paint shop, furniture repair, machine shop, any one of various kitchens or dining rooms, or perhaps a work detail on truck farms in the area during the summer, or in the modified community project where work is done by patients for various companies who will sub-contract jobs that can be performed in the existing facilities. In both of the latter cases the patients are paid for their efforts. Some patients work in industry near the hospital and live in and a few patients who seem to need special help in making the transition work on member-employee status. This arrangement allows the patient to work for the hospital as a regular employee at the going rate of pay but he resides in a special dormitory for the member-employees for a year

during which time he may use all the facilities as a patient. Then he is discharged from the hospital and although he may remain an employee he lives off the grounds.

The work activity for patients starts at the simplest possible level of helping the aides to care for their own living quarters. As the patient progresses and develops interest he is assigned to a group detail where there will be a considerable amount of supervision. From here he may move on to an individual assignment which requires the responsibility to get himself to work and back to his ward and also to perform a reasonable amount of work without close direct supervision. A patient who shows considerable movement might go from a group detail to an outside job or to other types of work requiring a fair amount of self discipline.

Music therapy for those patients interested may be on a basis of lessons, playing in a small orchestra or, as occasionally happens, the patient may leave the hospital several times a week for private lessons.[1]

In addition to the above well defined therapies there are hundreds of grey ladies working with patients. There are movies, dances, parties and church activities. The patients live in ward arrangements with a day room provided each

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[1]The material explaining the therapy program of the hospital was obtained during an interview with a most cooperative supervisor, Miss Dorothy Fahey.

forty-five patients. This is equipped with a large number of easy chairs, television, tables for games, current periodicals and a regularly changed assortment of books. There is a beautiful chapel and various chaplains available. There is a canteen with a wide assortment of clothing, sundries, personal items and excellent cafeteria where patients may buy extra food, cigarettes and ice cream.

Patient Participation

For some months prior to going on trial visit each patient will have been going home on week ends, traveling by himself on public transportation. He will have been assigned to a work detail or educational therapy for both morning and afternoon where he will have been rated periodically by trained therapists for socialization and effort. Regular conferences and reports have enabled the treatment team of physician, social worker, nurse and therapists to adjust the patient's activities to his capacities and attempt to keep him trying to accomplish more without discouraging him.

Every patient in the sample participated in both corrective and occupational therapy. Half of the group, eleven, also participated in educational therapy and seven were given vocational counseling, five of these were part of those seen in educational therapy. Surprisingly two of these five failed to make an adjustment and returned to the hospital rather quickly. It is interesting to note that

one of these patients holds a degree in engineering and the other, younger, was attending college while on trial visit.

The records are not complete enough to indicate whether the patient or the staff instituted the contact with educational therapy and vocational counseling. Did the staff feel that the educated patients needed more help or did the educated patients themselves feel they needed more help? It is interesting to note in conjunction with this that three patients of the sample had some higher education and they are three of the six returnees. Speculation leads one to wonder if society, the family and the patient himself expects more of the better educated patient thus creating greater pressures that make adjustment difficult?

The Family's Preparation

It is now necessary to turn our attention to the family. In an earlier reference it was pointed out that Freud had indicated that the problem of the psychotic is laid down in his childhood. Considerable research relative to the families of schizophrenics has been done by Lidz who had this to say:

> The early family environment is commonly accepted as a critical force in personality development both normal and abnormal. Numerous other factors, some of which may be of shattering intensity, may disturb the process of personality development, but few can be as long lasting and as pervasive as the intra-familial relationships. Here the basic attitudes toward interpersonal relationships are established; the formation of the projective systems

by which the individual perceives the world is begun.[2]

Previous student studies done at Bedford indicate that the emotional ties in the family of the psychotic have considerable impact on the behavior pattern of the family.

One such study, a five part project was compiled into one report by Charles L. Rose who states:

> While this study is not concerned with etiological questions, it is based upon the assumption that the development and maintenance of psychiatric illness is influenced, in part, by emotional ties among family members, that is, the extent to which they have strong emotional involvements with each other. The psychiatrically ill member through hospitalization brings about further attitude changes, distinct from those which were apparent when the ill member resided in the home.[3]

A recent study by Hollingshead and Redlich gives further indications of the family's feelings and attitudes.

> In general, members of the families of psychotic patients regard their mentally ill relatives with mixed feelings of fear, shame, guilt, pity and resentment. These sentiments, however, are differently distributed in the class structure. As a rule, the lower the class, the greater the feelings of fear and resentment, the higher the class, the more pronounced the feelings of shame and guilt. During the course of treatment, resentment in the families of patients in the two lower classes are replaced by feelings of helplessness, apathy and lack of co-operation.[4]

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[2]Ruth W. Lidz, et al., "The Family Environment of Schizophrenic Patients", American Journal of Psychiatry, vol. 106, (November 1949), p. 332.

[3]Rose, op. cit., p. 1.

[4]Hollingshead and Redlich, op. cit., p. 342.

How long a patient is gone from the family may also be a deciding factor in how well he is accepted when he returns. One writer states that: "Studies indicated that the longer the stay in the hospital, the less chance there is for the patient to recover both medically and socially".[5]

A look at our sample indicates that it is a chronic group of schizophrenics. The range in years of hospitalization is from one year, three months to a high of fourteen years, eight months. The median length of hospitalization is seven years and seven months.

In an effort to explore this area the writer inquired of the families if they had thought the patient would get well enough to come home. Ten replied in the negative, indicating that they had given up hope, one said they did not know and eleven replied positively.

An attempt to correlate these answers with the length of hospitalization was inconclusive. The families of the two longest hospitalized answered in the negative, the two with the shortest period of hospitalization answered positively. From there on some other factors seemed to be operative. Of six patients who each had less than five years hospitalization four families answered positively and two negatively, among

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[5]Fisher, op. cit., p. 466.

the eight families where the patient was hospitalized for ten years or longer there were five positive answers, one did not know, and only two were negative. There seems to be little correlation between the length of hospitalization and the family's hope for patients recovery. This would appear to be a different result than several studies have found.

An interesting breakdown reveals that in the readmitted group there were three positive answers, one don't know and two negative. However, in the six patients working there was one positive answer and five negative. The balance of the sample broke up into seven positive and three negative. One might speculate that the families of the working group were more realistic in their evaluation of the patient's illness and were possibly more objective when the patient returned home.

There is considerable material available that indicates the general public is not particularly well informed as to the problems of mental health. Several studies[6] done at Bedford Administration Hospital indicate that the families of patients are not knowledgeable in regard to mental health,

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[6]Durkin, et al., op. cit., p. 21 and 48.

John H. Coleman, et al., "Fathers of Hospitalized Schizophrenic Patients", p. 35.

Marjorie Fearing, "Relative's Attitudes Toward Hospitalized Mental Patients", p. 44.

and are particularly uninformed in the area of therapy.

In view of the material previously presented the writer thought it would be interesting to explore how much preparation may have been done with the families before the patients went on trial visit.

To explore this point the families were asked during the interview whether they had had any contact with a social worker to discuss the patient's return home.

TABLE 1

FAMILIES' SOCIAL WORKER CONTACT

	Yes	No
Before Trial Visit		
According to family member interviewed	11	11
According to Social Service Record	15	7
During Trial Visit		
According to family member[a]	20	2
Think it Helped		
According to family member	16	6

[a]It is not possible to verify this with the Social Service record because trial visit reports from the Regional Offices are made quarterly and do not specify who was seen by the social worker.

Table 1 shows that eleven had discussed patients return

with a social worker prior to his return and eleven denied that there had been such discussions. However, the social service records of four patients in the eleven denying prior contact, clearly indicated that there had been such contact with the family interviewed. With this correction then we had fifteen families who had actually had social work contact prior to the trial visit and seven families who had not.

Speculation leads one to wonder what type of defense is operating here? Is this denial? Does the social worker's visit to a not well adjusted mother cause her to feel that she too is being treated? Does it create guilt feelings? Is this why she denies such contact? In one instance considerable casework was done with an aunt as a mother substitute who was never able to accept her responsibility and the patient soon returned to the hospital.

During the trial visit period twenty families were seen by social workers. This does not imply, however, that the same family member was seen by the same social worker, each month. Two families claimed to have had no social work contact.

Previous studies have indicated that family members of hospitalized patients do not feel free to criticize the hospital and the staff.[7] Despite this previous finding the

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[7]Rose, op. cit., p. 12.

writer who was clearly identified as a social worker found that six of the twenty-two families interrogated were able to state that they did not feel the social work contact helped in the patient's adjustments. There was no common factor easily discernable. One family was unhappy because they had been unsuccessful in having their patient-son declared service-connected. In another the aunt who served as mother denied previous social work contact and then denied that it had any value. Still another was the patient who returned in thirty days because the mother stopped his medication. The other three indicated no specific reason for feeling that social work contact did not help in the patient's adjustment and no reason was discernable to the writer.

Sixteen families did feel that this contact was of a very positive nature and helped materially in both the family's acceptance of the patient and in his adjustment to society. Although the writer did not explore the preceeding question to any considerable depth due to the limitation of time a number of reasons were given for the families' appreciation of the social work contact. They felt the social worker had explained the patient's behavior to them to make it easier to accept him, that she had explained his needs so they could do a better job of meeting them, removed some pressure by being understanding, and by allowing them to express openly their fears and doubts.

The six families who were critical of the efforts of the social workers were equally divided between three families whose veteran-member did not make a successful adjustment and three families whose member did make an excellent adjustment. There were also three families of veterans who were readmissions but who felt the role of the social worker was a positive contribution in spite of their member's failure. The remaining thirteen families of discharged veterans also thought the social work contact had been a positive contribution. Sixteen of twenty-two families felt the social work contact was a positive contribution to the patient's adjustment.

Related to the topic of the family and the social worker but not part of it is how the family was informed or decided that the patient was well enough to go on trial visit. In eleven instances the decision was reached through a discussion with the doctor during visiting hours or during a special trip to inquire of the doctor concerning the patient's condition. In five cases a social worker discussed it with the family and helped them with the decision, four trial visits were arranged by telephone and two by letter.

It is of interest to note that of sixteen mothers participating in the interview fifteen of them all answered either glad, good or happy, in spite of the fact that many of the patients had in previous years been assualtive, many times

toward their mother, with considerable acting-out behavior. The one mother who did not answer as the rest, was being interviewed with an older sibling due to her difficulty with English.

TABLE 2

FEELINGS OF FAMILY MEMBERS CONCERNING TRIAL VISIT

Response	Family Member Interviewed			
	Mother	Siblings	Wife	Aunt
Glad	8	1		
Good or happy	7	1		1
Interested or willing		1	1	1
Want him out of hospital		1		
Totals	15	4	1	2

A number of other studies have indicated that the families of patients felt less joyous than did our sample toward the patient.[8] The writer has in his caseload several mothers of patients who have been able in a casework relationship to express feelings of doubt, fear and hesitation in relation to their son as they prepare to bring him home on trial visit from extended hospitalization.

It is evident that even after a period of many months has elapsed the families were unable to admit to any feelings

[8]See p. 10 quote from Myers and Roberts and p. 27 quote from Hollingshead and Redlich.

other than joyous ones in bringing the patient home. From the result of this and other studies it is possible that some form of defense is operating to help the families handle their feelings.

We have previously seen Arieti's[9] remarks in regard to mothers and schizophrenic children and it may well be that the mothers' answers were in large part determined by their feelings of guilt. They may well feel that their sons' hospitalization is public recognition of their failure, but they can only say they are glad to have him home to, in some degree, erase this mark as well as to atone for their failure.

Who composed the rest of the group? An older sister, a wife, an aunt and three brothers, all of whom could describe their feelings as being interested or willing. These include two of the patients who have made excellent adjustments and one who has returned; it is difficult to find any significant differences.

Another investigator who interviewed fathers found that of a sample of sixteen, three were ambivalent about having the patient home for trial visit, six were definitely unaccepting and only seven of the sixteen were acceptive of the patient coming home for trial visit.[10]

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[9]Silvano Arieti, op. cit.

[10]Lerner, op. cit., p. 34.

CHAPTER IV

TRIAL VISIT PERIOD

Introduction

The re-introduction of this long missing member of the family to the routines, habits and accomodations of the family was certain to cause pressures, emotional problems and adjustments on the part of the family members and patients.

The writer was particularly concerned with the efforts of the family to aid the patient in re-establishing himself socially both within the family and beyond its confines, and has looked at the family's attitude toward the patient being employed and the taking of medication.

Social Adjustment Activities

To investigate the trial visit period the writer first attempted to discover how many patients had some special problem when they arrived home for trial visit and as a corollary to this whether anyone else in the family had any problems at this time.

Only two families were able to state that both patient and a family member had some adjustment difficulties. Significantly enough, both of these were patients in the home of an aunt. In one instance the problem was discussed and recognized and the patient has made an excellent adjustment, probably the best of anyone in the group. The other situation was not handled and in a few months the patient returned to

the hospital. Two other families indicated that the patient had a problem. In one case the patient walked a great deal and returned to the hospital at the end of his first month - this was from his mother's home. The other was sleepy, ate too much, drank alcholic beverages to excess but settled down and made an excellent adjustment living with his sister and aged mother.

We find that we have four patients with problems, eighteen with none, two family members with problems and twenty with none. The social service record containing trial visit reports prepared quarterly by the social worker assigned to the patient indicates that at least ten of the patients and their families were involved in problems that were of some concern to patient, family and social worker during the trial visit. Most of the problems recorded seem to be those of the patient; it is impossible to know if this is because of the social worker's orientation toward the patient, or the family's inability to raise a problem concerning any member other that the patient or a result of the family feeling that the patient is the ill member and they should confine themselves to his problems. Concern is expressed because the patient smokes too much, sleeps too much, does not go out, drinks too much, does not want to take his medication or is messy in his eating habits and, very rarely, some one will say "uncle does not get along with him".

The family is the primary social unit where all learn to socialize through the normal growth-maturation process. It is of special interest to note therefore, concerning our patient's activity within the family that only five families felt that they had any regular social activity of which the patient had been a part (such as a weekly card game or dinner out) while seventeen answered in the negative. This possibly reflects the modern trend noted by many sociologists of less family activity, although in a few instances it might be attributed to the small size of the family. Possibly this also reflects the problems that exist in a family which has a mentally ill member.

The above figures were reversed in relation to the patient visiting relatives and friends outside of the home. Here eighteen families said they encouraged the patient to visit out of the home and four said they did not. However, when it was asked whether the families took patients to visit anyone the affirmatives dropped to eleven and the negatives rose to eleven so the group was equally divided. This point has increased significance when we remember that none of these patients has a driver's license and recall the long years of hospitalization that would tend to disrupt relationships with friends and relatives beyond the immediate group.

The time was not available in the study to explore why there should be such a spread between the number of families

thinking the patient should visit and the number actually implementing his socializing outside of the home by taking him visiting. Were family member's feelings so involved in relation to a mental patient that they could not take the patient out to visit? Did they not see the importance of such visiting? Eighteen families of twenty-two could say they had encouraged the patient to visit but only eleven could say they had made this possible by taking patient.

One of the major problems of the schizophrenic patient in remission is attempting to re-establish relationships with others. As another indication of what was taking place during the trial visit the writer established that only four of the twenty-two patients had a close enough relationship with a family member to be able to call it a friendship. Seven of the sample had a personal friend outside of the family. This was not duplicated in even one instance which means that eleven of the sample had a personal friend. It is interesting to note that these eleven include all six patients who were employed and further that only one of this eleven was readmitted while of the other eleven none of whom had a close personal relationship five have returned and none are employed. The ability to establish a relationship with at least one person would seem to be an important part of making a more or less successful adjustment to life in the community. It evidently increases the possibility of the patients finding

and maintaining employment.

In a more direct attempt to discover the family's contribution to the patient's socialization they were asked if they had aided the patient in establishing social contacts or relationships outside of the family. There were fourteen positive responses to this and eight negative answers.

Twelve families said they actually encouraged the patient to go out to movies, sports activities, sport participation, dances, and general entertainment but ten families did nothing to encourage such activity.

There were four families where efforts were made to engage the patient in specialized activity, such as fly tying, fishing and counselling at a boy's club. Several of these were activities in which the patient had previously been interested. The other eighteen families made no such efforts.

Are the families really this unknowledgeable about healthy social relationships? Perhaps they felt so threatened that they could not allow this person out. Many of them do think of this patient as having been ill for a long period and may equate this in their own minds with the lack of physical strength that so often is one of the marks of prolonged physical illness. Is this the only reason for the over-protectiveness of many parents or parental figures? There has been a history of over-protectiveness on the part of many of these mothers; are they unaware of this? Why do they perpetuate

this same atmosphere in the home when the patient is there on trial visit? The majority of the patients in this sample were probably prevented by their families during trial visit from socializing as much as they were capable when they left the hospital.

An interesting comparison may be made between the group of six readmitted patients and the six patients who were working at time of discharge. In the questions asked covering the area of socialization the working group received thirty-three positive responses and fifteen negative while in almost exact reversal of this the readmitted patients received thirteen positive responses and thirty-five negative. This would seem to correlate with other findings that the family's attitude will determine what happens to the patient.

The writer cannot refrain from making an observation here that some of the family members seemed to think him a little mad for even asking if they had helped the patient to socialize outside of the home. The families who did the most were those were the patient was living with an aunt, a brother or sister. In only one instance where the patient was living with a parent was there attention paid to this area of the patient's rehabilitation.

The Work Area

An area of human endeavor and experience that gives one the opportunity to meet many emotional needs, allows one

the feeling of mastery that is so important to maturation and allows sublimation of aggression and drives for the health and welfare of the individual and society, is the work area.

Work experience is a very difficult area for mental patients, possibly because the worker cannot control the demands made on him, because he may at any moment be confronted with a new situation and he may be called upon to establish new relationships with strange persons. As the writer has shown, a great deal of attention went into the effort to help these patients adjust to a work experience before leaving the hospital so they might be, to some degree, prepared to undertake gainful employment.

There are other factors involved just as in the patient's socialization, that neither he nor the hospital can control. One of these seems to be the family's idea about whether the patient is well enough to work. A great many of the veterans who are mental patients are receiving compensation. If their illness is considered service-connected they receive compensation in the amount of two-hundred twenty-five a month while on trial visit and others may receive on the basis of need up to eighty-five dollars per month as pension. Even the smaller amount may effectively remove the incentive of need from the work area for the patient. This income represents security in a very tangible form which may be curtailed if the patient can adjust well enough to work steadily.

Patients and families are well aware that employment for ex-patients is not usually of a permanent, well-paid or stable nature. This is therefore an area that has much feeling connected with it.

When the families were asked if they had wanted the patient to be employed upon leaving the hospital nine replied positively and thirteen replied negatively. In five instances where the family answered positively the patient did have employment upon leaving the hospital. Interestingly the other four families were of readmitted patients. Three of this group live so distant from the hospital that vocational counseling could not be effective, employment would be scarce and transportation difficult. The fourth patient has a degree in chemical engineering. Special factors may be operating here. Thus one might speculate that where the patient could meet the families expectation in the work area, adjustment was easier to establish but that where, for perhaps physical reasons the patient could not meet the families' expectation, it was much more difficult for the family to accept him.

The thirteen negative answers are divided between ten patients who are discharged, one who is also discharged but found employment and two returnees one of whom was attending school.

The families of the ten discharged patients did not expect them to work when they came home, they are not working

but they have made an adjustment, in some cases very tenuous, that permits them to stay out of the hospital. If we continued the previous line of thought we could say this group is meeting the families' expectations and the family can therefore accept them.

A major study found a similar situation existing and says:

> If those with whom the patient resides place little emphasis upon his being gainfully employed and, moreover, made few demands upon him to be socially active, he can exist as if in a one person chronic ward, insulated from all but those in the highly tolerant household.[1]

Five families wanted the patient employed before leaving the hospital and these five patients were employed. One went to school and sixteen had no commitment of any nature.

In regards to working during trial visit period we find the positive answers have increased. Fourteen families said they wanted the patient to work during his trial visit and eight replied negatively. It was with one of the four families who changed and decided they wanted the patient to work that the only patient to find employment resided. An interesting point relative to the patient's need to meet the families' expectations shows up. Three other families who felt prior to trial visit that the patient need not work, changed their position during trial visit and wanted patient to find employ-

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[1]Freeman and Simmons, op. cit., p. 148.

ment, in one instance the patient has recently returned to the hospital and the other two in the writer's estimation probably have the most tenuous adjustment of the entire sample. One wonders if the families' changing demands had a deleterious effect on the patients' adjustment.

The reason for deciding the patient should work during trial visit were two, of about equal weight: the patient was better than they thought he would be, and the social worker thought he should work.

The same fourteen families stated that they encouraged the patient to work during his trial visit by supporting him in his effort and aiding him to seek employment by furnishing transportation. The same eight who had replied in the negative to employment during trial visit again stated they did not encourage patient to work.

Throughout the period of trial visit the same five patients continued to be employed. One patient did obtain employment at the end of his trial visit and as this study is being completed the six patients are still employed. The other discharged patients, ten in number, are all unemployed.

Seven of the families still felt after the patient had been discharged that he should not work and would not encourage the patient to seek employment. Three families of unemployed patients said they were still encouraging patient to seek employment.

It would appear to be difficult for patients on trial visit who have not been employed upon leaving the hospital to find employment. One patient out of a total of sixteen succeeded.

Medication

As has been indicated all of these patients were being treated with tranquilizer drugs. More than a few times the hospital staff has had considerable trouble getting the patient's co-operation in accepting and taking his medication. There seems to be at times with a few patients a complete denial of the illness which then precluded any need for medication. We have seen a tendency on the part of some families to handle the mental illness of its members in the same manner and the writer wondered what might be the attitude toward the medication when the patient was home.

When the writer asked who took care of the medication sixteen families replied that the patient did and six families indicated that another member of the family assumed responsibility for medication. Speculation can lead us to wonder about the responsibility involved here. Is the family interested in the patient continuing or discontinuing his medication? Do they want him to assume the responsibility so he will make a good adjustment or so he will not adjust? Are the feelings that various investigators have ascribed to the families' functioning at the unconscious level to keep the 'closed

ranks' that may have formed? Are they confused and not sure what should be done in the situation?

There was only one family that admitted that medication was stopped. In this instance the mother said the patient objected to taking it and she did not insist, although she was one who had answered the previous question to the effect that she had assumed responsibility for the medication. This patient remained on trial visit one month.

There were medical indications that some of the other readmitted patients had not been taking their medication prior to their return but only the above family could say that it had been discontinued.

The writer then asked who had supervised the taking of medication and the answers changed slightly. Now thirteen families answered that the patient took care of it himself and in nine instances a family member made sure that patient took his medicine. The three who now agreed that some one had policed it but had not accepted responsibility for the medication included two readmitted patients and the patient from the family who "had wanted him home" and who in the writer's opinion was the least well adjusted. There are some indications in the changing answers by several families that there might be considerable confusion and lack of understanding, but this could also mask their unconscious rejection of the patient. Perhaps they do not really want the patient

home. They may have trouble accepting the fact that he has been ill and would therefore have trouble accepting the need for medication.

The majority of families felt that the medication had made it possible to bring their member home and during the interview expressed this in rather positive ways. Those few families who failed to indicate their attitude on this were asked if they thought the medication helped. There were nineteen families who were positive in their feeling toward the drug, two families felt it did not help and one family did not know. The two families answering negatively were divided equally, the patient member of one had been readmitted, the other was working and had made an excellent adjustment. The family who did not know was the family of a readmitted patient.

A comparison of the readmitted patients and the six working shows nothing conclusive. Four patients and two relatives took care of the medication in the first instance. There were no changes in the working group on the "policed" question but two readmission families changed - which might, as indicated above show confusion. There were five families in the working group that thought it helped and one negative answer, while among the returnees there were four positive answers, one negative and one family that did not know.

The only possible conclusion the writer can draw is

that the issues seemed more clearly drawn among the six employed patients; perhaps it was easier for them to know what was expected of them in this area too.

The majority of families expressed wonder and in more than a few instances a feeling of some magical quality being present in the medication to restore their loved one after they had given hope for his return.

The writer is of the opinion that the area of medication has so much feeling connected with it for both patient and family members that a very careful, detailed study would need to be done to reach a true understanding of the values involved.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The purpose of this study was to explore and describe the attitudes of the families of a group of schizophrenic patients toward those patients when they came home for trial visit from the Veterans Administration Hospital, Bedford, Massachusetts. A sample of twenty-two patients who left on trial visit from Building Seven during the year 1958 as a result of a "total push" program was chosen. Consultation with a considerable number of staff members and reviews of clinical and social service records were utilized in an effort to collect as much information as possible about the patients' families. Interviews were conducted with family members in their homes.

A single interview is a very limiting factor; therefore the material to be covered was focused in four main areas: (1) attitudes of the family prior to trial visit with some exploration of the role of social work during this period; (2) attitudes toward the patient's socialization, with attention to the contribution of the family; (3) attitudes toward the patient being employed, with evaluation of the role of the family; and (4) attitudes toward the patient's medication with attention to responsibility for the medication.

There was considerable indication of emotional bias

in the material presented by the family members and the writer, of course, has his own biases; however, the answers given were accepted. In those cases where hospital records give a counter indication attention was drawn and the correction made.

The area of inquiry alternated between general and specific topics with a movement toward becoming more specific. In general there was a tendency for there to be more positive answers to the broader questions and more negative answers to the specific ones.

The positive aspects of the social work relationship far outweigh the negative. The readmitted patients divided evenly, three had and three had not seen a social worker prior to trial visit. However, the discharged group of sixteen patients had twelve of their number who had seen a social worker and four who had not. Similarly there were sixteen of the sample of twenty-two who felt that social work contact had helped in the adjustment.

None of the families investigated could admit to any feelings except joyous ones concerning the patients return home despite the opposite findings of other studies and the writer's own experience.

The families seemed to have handled the question of the patient's recovery in the same unrealistic manner. There was only the slightest correlation between length of illness

and attitude of family toward recovery. The family of the two longest hospitalized did not think their patient would recover, the families of the two with the shortest period did think so, but no further pattern could be discerned.

An effort was made to explore the family's attitude toward the patient's socialization and their degree of participation in helping the patient. Typical of the families' response was that eighteen families said they encouraged patient to visit relatives and/or friends and four replied negatively. However, when it came to taking the patient to visit friend or relative only eleven responded positively and a like number negatively. Seven families would encourage but not make any particular contribution to helping the patients socialization. It appears that there is considerable relationship between the patient's socialization and the families' attitudes toward his socialization.

In the area of work the facts became somewhat more material. Five families of nine wanting the patient to work on trial visit had their wishes met; the other four patients were not able to complete the trial visit period and returned to the hospital.

Seven families insisted they did not want the patient to work at any time, these patients are at home unemployed.

The five patients employed at start of trial visit continued to work after discharge and were joined by one more

at the end of trial visit, who was the only patient to find employment during trial visit.

Another area of investigation was to explore who assumed responsibility for the taking of medication - the patient or a family member. It would appear that this is an emotionally loaded subject, and is a problem area for many of the families.

There is no opportunity for the patient to develop any self discipline in this regard while hospitalized as the nurse is responsible for giving all medication. This may contribute in some degree to the problems involved.

The families overwhelming feel that the drug has made it possible for the patient to reach the point where he was able to go home on trial visit. Nineteen families were positive in this, two were negative and one did not know.

The families tend to express much ambivalence in regard to all areas with two major types of defenses used when the interview moves into especially sensitive areas. They seem to rely primarily on denial and reaction formation.

Conclusions

Some general impressions have an insistent priority. The relatives interviewed were sincere, interested, willing, devoted, but confused; poorly and in some instances ill informed persons coping with serious problems of emotional adjustment in their own way. Many of them indicated that the

limited amount of social work contact had been of value to them and there were indications they could have used more.

The social worker has traditionally and practically been the link between the hospital and the family. There are indications in this study that perhaps a stronger link needs to be forged. A few families have shown what might be done. With deeper understanding of the patient's need to learn to socialize, with an awareness of the importance of employment to the patient's rehabilitation many more families could make the contribution necessary to aid the patient in his adjustment to society.

The emotional problems of individual relatives intrude and it would seem to be only practical wisdom to aid the relative to handle their problems in such fashion as to remove the need to establish "one man chronic wards". When the parent dies the patient goes back to the hospital and nothing has been solved.

There would seem to be a need for more social workers to do more work earlier with relatives in order to rehabilitate an increasing number of patients.

One of the major problems in the area of socialization of patients was what they could do and where they could do it? A special problem exists for social workers to facilitate the meeting of patients and social-recreational agencies where continuing social needs might be met with professional guidance.

As production conscious as is our modern culture it would seem that these families should want the patient to be employed if they understood that he was physically capable, that he was well enough, that this would aid his adjustment, and if their own emotional needs and problems did not intrude into their relationship. But this can only be achieved by raising the level of understanding of the relatives; this is a social worker's responsibility. The social worker can also interpret to both family and patient the attitudes of employers and the community and help them to a more realistic perception of those attitudes. The pressures exerted by the community may contribute a considerable amount to the families' problems in handling this difficulty.

In regards to medication - the writer feels that little of a conclusive nature was discernable in this study. There were indications that the families did not appreciate or understand the emotional values inherent in the medication. The writer wonders if patients could be helped to accept their medication more realistically and exercise more control of it while still hospitalized to remove some of the responsibility from the family when the patient returns home. Could not the magical quality of the medication be dealt with during the families' pre-trial visit preparation. The writer wonders what the medication means to the patient and feels that considerable research could be done around the psychological

problems and values involved in drug therapy.

Man creates many of man's problems and it would seem that what man creates he can correct, this man feels the need to help - not only sorrow for man's fate.

To ————————

I heed not that my earthly lot
   Hath little of earth in it —
That years of love have been forgot
   In the hatred of a minute: —
I mourn not that the desolate
   Are Happier, sweet, than I,
But that, you sorrow for my fate
   Who am a passerby.

Edgar Allen Poe

Accepted
David Landy
Research Advisor

APPENDICES

APPENDIX A: INTERVIEW SCHEDULE

I. FAMILY MAKE-UP

A. Name of patient:

B. Name of interviewee:

C. Relationship to patient:

D. Who else was living in home during trial visit?

II. SOCIAL WORK CONTACT

A. Did a family member see a social worker prior to patient coming home on trial visit?

B. Did a family member see a social worker during trial visit?

C. Do you think the social worker contact helped with patient and family's adjustment?

III. DISCHARGE FROM HOSPITAL

A. How did you find out patient was to be discharged?

B. How did you feel when you found out patient was to be discharged?

C. Did patient have any adjustment problems when he first came home?

D. Did anyone in the family have any problems when patient came home?

E. Did you think patient would ever get well enough to come home?

IV. SOCIALIZATION

A. Has there been any regular social activity in the family of which patient became a part?

B. Did the family encourage patient to visit relatives and friends?

C. Did they take him to visit?

D. Did the patient have any special friend among family members with whom he went places?

E. Did the patient have a friend from outside the family who he went out with?

F. Did the family aid patient in establishing social relationships outside the family?

G. Was there any specialized activity that the family attempted to get patient to participate in while on trial visit?

H. Did the family encourage patient to go out to movies, sports activity, sports participation or dancing?

V. EMPLOYMENT

A. Did the family want patient to have a job before leaving the hospital?

B. Did he have employment before leaving?

C. Did the family encourage patient to work?

D. Did the family want patient to work during the trial visit period?

E. Did he work during the trial visit?

F. Did the family want patient to work after he was discharged?

G. Is he working now?

VI. MEDICATION

A. Who took care of medication?

B. Did patient continue taking medication or was it stopped?

C. Did any member of the family have to police the patients taking his medication to make sure that he did?

D. Does the family think the drug helped the patient?

APPENDIX B: IDENTIFYING INFORMATION

Name of patient:

When was he on trial visit?

Date of birth:

Marital status:

Periods of hospitalization:

Present status:

Service connected?

Social work contact:

Before trial visit:

During trial visit:

Parents:	Living	Deceased
Mother		
Father		

Patients Preparation:

Corrective Therapy

Music Therapy

Occupational Therapy

Vocational Counseling

Educational Therapy

Group Therapy

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