1958

# Fathers of hospitalized schizophrenic patients

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

# FATHERS OF HOSPITALIZED SCHIZOPHRENIC PATIENTS

A thesis

Submitted by

Geraldine Grand Lerner

(A.B., Vanderbilt University, 1954)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1958

TABLE OF CONTENTS

# LIST OF TABLES

# CHAPTER I

# INTRODUCTION

## Background

### The Changing Function of the Psychiatric Hospital

Throughout the ages, the understanding and the treatment of the mentally ill have been neglected. The distinction between mental and physical illness dates back to antiquity but was most marked during the Middle Ages. In this period, hospitals were built for the physically diseased but the mentally ill were excluded. If the latter state manifested itself in religious enthusiasm, these individuals were sometimes regarded as religious figures. But if it took abusive or depressive form, the unfortunates were chained in madhouses until they died of neglect and exposure.

In 1547, the first mental hospital, Bethlehem, was established in England and was popularly known as "Bedlam." The conditions therein fully justified the popular connotations this word has acquired. A medical book of that era summarized the accepted treatment of mental illness in these words:

> I do advertyze every man which is madde or lunatycke or frantycke or demonyack to be kept in safegarde in some close house or chamber where there is lytell light; and that he have a keeper which the madde man do fear.[1]

---

[1] H.W.Haggard, Devils, Drugs and Doctors, p. 232.

As a result of this early method of treatment combined with the guilt and stigma felt by the patient's family and the ignorance of the general public, the mental hospital became the refuse heap of human despair.

Recently, however, the treatment of mental illness has progressed to a more enlightened view. The contributions of Freud greatly advanced the understanding of the individual's internal conflicts, and more and more, dynamic personality theories are being combined with the concept of the importance of interpersonal relationships for the better understanding of emotional health and illness. In brief, mental hospitals are becoming centers for short term treatment rather than for endless custodial care.

Setting

The Bedford Veterans' Administration Hospital is a neuropsychiatric hospital located approximately fifteen miles from Boston. Established in 1928, the Bedford Hospital originally had a capacity of 354 beds. Today, the total bed capacity numbers 1800 including a complete self-contained women's unit of eighty-five beds that was built in 1947. Patients are accepted from Eastern Massachusetts, Maine, New Hampshire and Vermont.[2]

The primary function of the hospital is the care and treatment of patients with mental or nervous disorders. Treatment is provided on an individual and group basis in the form of group therapy, individual psychotherapy, and narcosynthesis. Insulin shock treatments and electric

---

[2] Handbook of Information, Veterans' Administration, p. 3.

shock treatments have been largely replaced by the use of tranquilizing drugs. Facilities are also provided for the diagnosis and treatment of all types of illness. In accordance with the widely accepted experience that teaching hospitals are generally the most progressive, facilities are offered at Bedford for the formal training of doctors, nurses, social workers and psychologists.[3]

The auxiliary services that are offered by the hospital are Social Service, Vocational Rehabilitation, and Physical Medicine and Rehabilitation, the last of which includes various therapy programs.

Other than specific treatment facilities, the patients are offered recreational entertainment such as a well equipped library, dancing, bowling, and other sports.

Social Service

The Social Service Department plays an integral part in the treatment and discharge plans for the patients. Social Service may be regarded as a "link" between the patient and the community. This involves both the patient's family and the community in which he and the family live. At the time of admission, or as soon thereafter as possible, a social worker talks with the closest relative or guardian of the patient in order to obtain social history information and to help with any problems that the family may have as a result of the patient's hospitalization. The social worker who is assigned to a particular patient will continue working with this patient from his admission to the hospital, throughout his

---

[3] Oval Mirror, Silver Anniversary, 1928-1953, p. 8.

hospitalization and until his discharge from Trial Visit. The social worker provides the one continuous contact that the patient has with the hospital.

Importance of the Family Setting

Although the patient remains the primary focus of hospital concern, more attention is being given to the part that relatives play in his rehabilitation. It is now an accepted premise that "... the patient does not exist by himself, but as a member of the family unit."[4] "In accepting responsibility for the treatment of the mentally ill patient, we have, in effect, accepted responsibility for education of the family members."[5] The full meaning of these statements is a far cry from the philosophy advanced 100 years ago when it was considered good therapeutic care to isolate the mentally ill from all contact with society.

The personality of every individual is primarily the result of his early relationships with his parents. As Freud pointed out, "Analysis has revealed that the child lives on almost unchanged in the sick patient."[6] Therefore, we must recognize that the adult patient is affected by his family's attitudes of over-protection, indifference, or hostility. Hence, these familial attitudes must play an important part in his ability or inability to recover and readjust to the world outside of the hospital. It has been found that the participation and attitudes of the relatives play an important part in the long range effects of treatment.

---

[4] H. B. Richardson, Patient's Have Families, p. xv.

[5] M. Greenblatt, et al, From Custodial to Therapeutic Care in Mental Hospitals, p. 237.

[6] S. Freud, in the Foreward to Wayward Youth by A. Aichorn.

The primary aim of treatment of the mentally ill is to return them to society sufficiently recovered to take up their place in community life. In this area, it has been found that the attitudes of relatives are extremely important. Therefore, knowledge of their attitudes toward the patient and his illness is important both for the purpose of dealing with the illness per se and in order to help the family to understand the condition and eventually accept the patient back into the home.

The Father

Social Work studies made at the Bedford Veterans' Administration Hospital during the past few years have dealt almost exclusively with the relationships between patients and their families. These studies have shown repeatedly that although the intent was to work with the entire family, the father of the patient was consistently left out of the picture. A 1955 study dealing with casework with relatives found that relatives' understanding of the patient and his illness was hindered by their own problems and thus retarded the patient's chances of recovery. Although this thesis comprised only five case studies, it is interesting to note that the mother was the only relative "worked with" by the social worker.[7] The results of another study indicated, "... the need for much further investigation and examination of the whole area of the father in the development and course of the schizophrenic disease process."[8]

---

[7] J. F. Lyons, "A Study of Casework with Relatives of Mental Patients," p. 84.

[8] S. Modell, "Family Relationships and Relatives' Attitudes Affecting Improvement or Lack of Improvement of Hospitalized Schizophrenic Patients," p. 60.

This thesis is based upon a five part study done in 1955 on "Relatives' Attitudes and Mental Hospitalization" which delineated the same areas of research covered herein. The analysis of the findings on relatives' attitudes showed that the relatives regarded the hospital primarily as a custodial institution, that they felt dissociated from the hospital and its treatment plans; they had trouble thinking of the illness as a mental disorder, they felt hopeless about the patient's recovery, and they "closed ranks" against the patient's return home. This study concerned itself with the principal visitor of 100 patients and only ten per cent of these were fathers.[9]

If we accept the importance of familial attitudes in the treatment and recovery of the mentally ill patient, then it is impossible to exclude the attitudes of the father of the patient for he has played a very vital part in the creation of the patient's personality. O. Spurgeon English thoughtfully points out that the personality can only develop in a healthy way when the father is truly a member of the family, taking an active interest in the growth and development of his child.[10] Thus, the interest and attitudes of the father are equally important if the mentally ill patient is to recover.

## Plan of the Study

### Purpose

It is the objective of this study to identify and describe the father's

---

[9] C. L. Rose, "Relatives' Attitudes and Mental Hospitalization," p. 16.

[10] O. S. English, "The Psychological Role of the Father in the Family," Social Casework, vol. 25 (October, 1954), pp. 323-329.

attitudes toward hospital personnel, toward his son's physical and therapeutic treatment, toward mental illness in general and his son's specific disturbance, and toward visiting the hospital. It is hoped that the study will contribute, in some measure, to the creation of a program of social service which will include the father in the treatment and rehabilitation of the mentally ill patient.

Selection of Sample

Initially, the cases of all male patients[11] were selected from the existing hospital records who met the following criteria:

1. A diagnosis of schizophrenia had been established by the psychiatric staff of the hospital.

2. The patient had been hospitalized at Bedford for a period of not less than one year.

3. The patient was forty years of age or younger.

There were 450 cases that met the above criteria. A search of clinical and visiting records indicated that 207 of the initial cases selected had living fathers. On the basis of a geographical limitation of a twenty-five mile radius from the hospital, seventy-seven of these cases were excluded, resulting in the final study sample of 130 cases.

Of the 130 cases thus selected, seventy-three were eliminated for the following reasons:

Patient released from the hospital since the beginning of the study---7

---

[11] Female patients were included in the original sample selection. However, only two female patients met the criteria and since it was thought that there would be a substantial difference in the attitudes of fathers of female patients, only male patients were finally considered.

Father's whereabouts unknown---8

Father too ill to be interviewed---10

Father uncooperative---48

These eliminations resulted in a total of fifty-seven cases in which it was possible to interview the father.

Methods of Data Collection

This is an exploratory study based primarily upon data obtained from a single interview with the father in each case (see Schedule, Appendix D). In addition to the interviews, supplementary information was obtained from clinical, hospital, and visiting records (see Schedules, Appendix B and C), and the social service records when they contained information related to the study. In analysis, the information obtained from the interview was considered the primary data, and the secondary data obtained from the above mentioned sources were used principally for factual data on the personal and social characteristics of the study group.

This study was undertaken by a team composed of three students from Simmons College School of Social Work and one student from Boston University School of Social Work. Each student conducted as many interviews as possible from the initial sample of 130 cases, selected according to the sampling procedure described above. Each student recorded his own interviews, but all were discussed by the entire group participating in the study. The total fifty-seven cases were pooled among the group for the purpose of analysis. The final study group was analyzed in two units, the Boston University student analyzing those fifteen cases from the group in which the mother was absent from the home setting. This appeared to be

the most feasible and useful basis for dividing the total study group for the purposes of analysis. The complete data have been made available for use of the hospital research staff.

In the developmental stages of the study, the four students met regularly with the research advisor from the agency to formulate general research plans, methods of study, interviewing techniques, and other problems that arose. Joint meetings were held with the two school research advisors, agency advisor, and the students for the purpose of working out the final decisions on the research procedure including the schedules and topics for analysis.

A letter (see Appendix A) was sent to both the visiting and non-visiting fathers requesting them to come to the hospital and suggesting alternate dates for the interview. Those from whom there was no response were contacted a second time by telephone, and in those cases where it was impossible for the father to come to the hospital or more convenient for the interviewer, a home interview was arranged.

Because of the nature of the material to be covered, and the likelihood of strong emotions connected with it, the order and phrasing of the questions asked were left to the discretion of the interviewer; that is, this was a focused interview with the schedule (see Schedule, Appendix D) used as an interview guide. The informant was allowed to talk freely while the interviewer's direction took the form of raising questions in areas not spontaneously covered. The interviews were usually begun with the more neutral material such as attitudes toward the hospital and treatment program. Later in the interview, the father tended to discuss his

feelings more freely and seemed less threatened than if this personal material had been brought up earlier by the interviewer. This approach proved fruitful in a previous study on relatives' attitudes.[12]

This study of fifteen cases and the larger study of forty-two cases used the same categories for analysis so that they could be put together as a total study.

Limitations of the Study

In gathering data for this study, a number of difficulties were encountered in trying to contact fathers and arrange appointments for interviews. As a result, the sample is biased in favor of fathers who visit regularly and frequently, as it was those fathers who responded most readily. Another limitation is that this thesis explores the attitudes of only fifteen fathers from a population of over 200. However, the study as a whole, comprising fifty-seven cases, should prove useful to the hospital in planning a program of social service work which would include fathers.

There are certain advantages and disadvantages in the use of the interview as a research tool. While it is possible for a skilled interviewer to create a permissive atmosphere conducive to the attainment of frank answers, this has its limitations. When four interviewers are involved, variety in technique will, of necessity, affect the results of the interview. In a treatment situation, it takes several interviews to establish a relationship in which the client feels secure in disclosing his true feelings. However, due to the limitations of time, only one research

---

[12]Rose, op. cit., p. 5.

interview was held and the results are based on such information as was learned at that time.

In several instances, it was impossible to interview the father alone, especially in the home interviews. Having another member of the family present often resulted in a more complete picture of the father's role in the family and occasionally helped to clarify his attitudes toward the patient.

## CHAPTER II

## CHARACTERISTICS OF THE STUDY GROUP

This chapter will consider the age, marital status, ordinal position, number of days out of the hospital, and length of hospitalization of the patients, as well as age, and nationality of the fathers, and their visiting frequency.

The fifteen cases in this sub-group were those in which the mother was no longer a member of the family group. In eleven instances the fathers were widowers (one of these had remarried and divorced his second wife). In two cases, the mother was living but was in a mental institution, and in two cases, the couples were divorced.

Home interviews were held in ten cases, and in four of them, at least one female member of the family was present. The other five interviews were held in the social service office with no other member of the family attending.

### The Patients

#### Age and Marital Status

A criterion for selection was that the patient be forty years old or younger. The distribution of ages may be seen in Table 1.[1] The population of the Bedford Veterans' Administration Hospital, as is true in any large mental hospital, contains a great many older patients with a long

---

[1] In one case, the father had two sons in the hospital. Therefore, while there are only fifteen fathers, the patients number sixteen.

period of hospitalization. However, in this study, the maximum age limit of forty years was used so as to offer that group which would be most likely to have living fathers. Therefore, the median age of thirty-three for this sub-group is not representative of the total hospital population, nor is the age range which extends from twenty-three to forty.

TABLE 1

PATIENT'S AGE

| Age (in years) | Number of Patients |
|---|---|
| 21 - 25 | 2 |
| 26 - 30 | 4 |
| 31 - 35 | 4 |
| 36 - 40 | 6 |
| Total | 16 |

All of the patients in this sub-group were single - a coincidental characteristic and not due to any selection factor.

Length of Time Since First and Last Hospital Admissions

Table 2 presents the length of time since the patient's first and last hospital admissions. The length of the patient's illness was considered to be dated from his first hospitalization.

TABLE 2

LENGTH OF TIME SINCE FIRST AND LAST ADMISSIONS

| Admission | Number of Years | | | | Total |
|---|---|---|---|---|---|
| | 3-5 | 6-8 | 9-11 | 12-14 | |
| First | 4 | 4 | 2 | 6 | 16 |
| Last | 8 | 3 | 2 | 3 | 16 |

All of the patients in this group had had at least one admission prior to their last admission at Bedford. The median number of years since the patient's last admission was five and one-half years and the median number of years since the first admission was eight and one-half years. The total range of hospitalization was from three to fourteen years.

Sibling Position of the Patient

It can be seen from Table 3 that nine patients came from families of four or more siblings. Five of these held a position other than oldest or youngest. Eight patients were either the oldest or the only child in the family, and only two were youngest children.

TABLE 3

SIBLING POSITION OF PATIENT

| Position of Patient in Family | Number of Children in Family | | | | Total |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 or more | |
| Only child | 3 | | | | 3 |
| Oldest child | | 2 | 1 | 2 | 5 |
| Youngest child | | | | 2 | 2 |
| Other | | | 1 | 5 | 6 |
| Total | 3 | 2 | 2 | 9 | 16 |

## The Fathers

### Age

The distribution of ages among the fathers in this sub-group may be seen in Table 4. The median age of sixty is fairly low, a fact which is related to the age limitation of the patients although the age range extended from fifty to seventy-four.

TABLE 4

FATHER'S AGE

| Age (in years) | Number of Fathers |
|---|---|
| 50 - 54 | 5 |
| 55 - 59 | 2 |
| 60 - 64 | 1 |
| 65 - 69 | 3 |
| 70 - 74 | 4 |
| Total | 15 |

Nationality

Table 5 shows that just over half of the fathers were born in this country and the rest were foreign born.

TABLE 5

FATHER'S COUNTRY OF ORIGIN

| Country | Number |
|---|---|
| U.S.A. | 8 |
| Ireland | 2 |
| Italy | 2 |
| Poland | 2 |
| Lithuania | 1 |
| Total | 15 |

No general statements can be made regarding the effect of ethnic patterns upon the fathers' attitudes toward the patients' illness in this sub-group, although in the larger study group in which the mother was present in the home, there were individual instances of strong cultural influences.

Visiting Frequency

It was anticipated that some reasons for the frequency of visits would be apparent from the factual data gathered from the hospital and visiting records (see Schedule, Appendix C) and that certain significant trends might be noted. It was thought that the age of the father might be related to his visiting pattern, and that the visiting rate would reach its peak after the retirement age due to the father's increased free time (barring the infirmities of age). However, as Table 6 indicates, the age of the father did not seem to be related to his visiting pattern.

Fathers were considered to have visited "very frequently" if the record showed the number of visits to be fifty or more in the study year,[2] "frequently" from thirteen to forty-nine visits, "seldom" from one to twelve visits, and the father was considered as a non-visitor if the record indicated no visits to the patient during the study year. Only one father in the group was a non-visitor.

TABLE 6

FATHER'S AGE AND VISITING PATTERN

| Visiting Pattern | Father's Age | | | | | Total |
|---|---|---|---|---|---|---|
| | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | |
| Very frequent | 1 | 2 | | 1 | 3 | 7 |
| Frequent | 2 | | | | | 2 |
| Seldom | 1 | | 1 | 2 | 1 | 5 |
| None | 1 | | | | | 1 |
| Total | 5 | 2 | 1 | 3 | 4 | 15 |

The number of days spent out of the hospital on passes or leaves of absence might be expected to affect the number of visits received, since these days are almost invariably spent with the family who might otherwise visit. The relationship between the number of days out and the number of visits received during the study year is shown in Table 7. Of the sixteen patients in the study group, nine were found to have had a total of 214 days out of the hospital. The mean number of visits received for patients who had no days out of the hospital was 28.6 and for those

[2] November 1, 1956 - October 31, 1957.

patients with between two and eighty-three days out of the hospital 32.4, a difference of only 3.8 visits.

TABLE 7

DAYS OUT OF HOSPITAL AND VISITS RECEIVED

| Case | Number of Days Out of the Hospital | Number of Visits Received in Study Year |
|---|---|---|
| A | 0 | 52 |
| (G) ? | 0 | 6 |
| D | 0 | 52 |
| F | 0 | 12 |
| I | 0 | 2 |
| K | 0 | 52 |
| M | 0 | 24 |
| Total | 0 | 200 |
| B | 74 | 24 |
| (C) ? | 2 | 6 |
| E | 16 | 52 |
| G | 83 | 52 |
| H | 10 | 52 |
| J | 18 | 52 |
| L | 6 | 2 |
| N | 12 | 0 |
| O | 58 | 52 |
| Total | 279 | 292 |

It was also thought that the duration of the patient's illness might have an effect on the father's frequency of visits. It was expected that the frequency of visits would decline in direct proportion to the duration of the illness. However, inspection of Table 8 indicates that no such

relationship exists.

TABLE 8

LENGTH OF MENTAL ILLNESS AND VISITING FREQUENCY

| Visiting Frequency | Duration of Illness (in years) | | | | Total |
|---|---|---|---|---|---|
| | 3-5 | 6-8 | 9-11 | 12-14 | |
| Very frequent | 1 | 1 | 1 | 4 | 7 |
| Frequent | 1 | | 1 | | 2 |
| Seldom | 1 | 3 | | 2 | 6 |
| None | 1 | | | | 1 |
| Total | 4 | 4 | 2 | 6 | 16 |

## CHAPTER III

## ATTITUDES TOWARD HOSPITAL PERSONNEL AND TREATMENT

It was found that a brief description of the purpose of the study encouraged the fathers to express themselves spontaneously. The informants often were stimulated by the statement that the interviewer was interested in their attitudes toward the hospital, and either launched into praise of the hospital services or said they knew nothing about it. Specific questions were asked as to their contact with personnel, their reaction to these contacts, physical and therapeutic treatment given to the patient, and their feelings regarding the signing of authorizing papers, only when these had not already been discussed without direct questioning.

### Contacts with Hospital Personnel

As shown in Table 9, all but three of the fathers mentioned some type of contact with the doctor, two-thirds of these being personal contacts. Two of these fathers had dual contacts. One had also been in touch with the physician by telephone and the other by mail. There was one father whose only contact had been by mail, and one who had never met the doctor but had spoken to him on the telephone. Only five fathers mentioned contact with a nurse, seven with a ward aide, and eight with a social worker. All of these contacts fell in the category of personal.

TABLE 9

CONTACTS WITH PERSONNEL

| Personnel | Name of Personnel Known | | Type of Contact | | |
|---|---|---|---|---|---|
| | Yes | No | Personal | Phone | Letter |
| Doctors | 11 | 1 | 10 | 2 | 3 |
| Nurses | 2 | 3 | 5 | | |
| Aides | 2 | 5 | 7 | | |
| Social Worker | 4 | 4 | 8 | | |

The number of contacts with each staff member varies from the number of fathers interviewed because some fathers had dual contacts while other fathers only mentioned contacts with one particular member of the staff.

It can be seen from the table that a majority of the fathers did not know the names of all of the personnel responsible for the care of their sons and had little contact with the staff. When a father did have contact with a member of the staff, it was, for the most part, a personal contact.

The reasons given for the father's contacts with personnel were divided into the following categories:

1. Father spoke to personnel in greeting but about nothing having to do with the patient.

2. Father spoke to personnel for the purpose of discussing the patient's condition and treatment program.

3. Father spoke to personnel for the purpose of discussing plans to take the patient out of the hospital, including trial visits, passes, or rides off the hospital grounds.

4. Father spoke to personnel for the purpose of making complaints.

5. Father spoke to personnel in relation to some administrative procedure.

6. Father spoke to social worker in connection with casework services.

7. Father spoke to social worker in connection with social history.

Table 10 shows the reasons for contact with personnel.

TABLE 10

REASON FOR CONTACTS WITH PERSONNEL

| Reason for Contact | Personnel | | | |
|---|---|---|---|---|
| | Doctors | Nurses | Aides | Social Workers |
| Casual greeting | | 3 | 4 | |
| Discuss patient's condition | 7 | 1 | 3 | |
| Discuss plans for taking patient out | 1 | | | |
| Make complaints | 2 | 1 | | |
| Administrative procedure | 2 | | | |
| Casework service | | | | 3 |
| Social History | | | | 4 |
| No information | | | | 1 |

None of the fathers described their contacts with physicians as being casual. The reason given for contacts with the medical staff by seven fathers was to discuss the patient's condition, and two fathers stated that their contacts with physicians were because of complaints that they wanted to make. One father spoke to the doctor with regard to taking the patient out of the hospital, and two fathers spoke to the physician with

regard to some administrative procedure. The patient's condition was discussed with only one nurse and three ward aides, and one father who had made complaints to the physician about the patient's care had made the same complaints to a nurse. The rest of the contacts with ward aides and nurses were described as being of the casual type. No father had casual contacts with a social worker. Three had obtained casework services, four had given social history information, and one father could not remember the reason for his contact with a social worker.

The fathers were asked to discuss their reactions to contacts with the staff. In order to evaluate these feelings a three point scale was used. A response was called "positive" if the father spoke well about the staff member. A response was termed "negative" if the father spoke in a derogatory way about a staff member and indicated that the contact was unsatisfactory. A response was termed "indifferent" if the father spoke about the staff member but did not indicate strong feelings about the contact either way. Inspection of Table 11 shows that three-quarters of the contacts with physicians were positive; four-fifths of the contacts with nurses were positive, as were over half of the contacts with ward aides. However, only about one-third of the contacts with social workers were considered to have been positive.

TABLE 11

ATTITUDES TOWARD CONTACTS WITH PERSONNEL

| Father's Attitudes | Personnel | | | |
|---|---|---|---|---|
| | Doctors | Nurses | Aides | Social Workers |
| Positive | 9 | 4 | 4 | 3 |
| Negative | 1 | | 1 | 2 |
| Indifferent | 2 | 1 | 2 | 3 |

A positive feeling was indicated by such statements as, "He's nice (the doctor) and doesn't put himself on a pedestal and takes an interest in my son" (B), "They (nurses and aides) were friendly and concerned" (F), or a simple statement describing the contact as satisfactory or favorable. In only one instance did a father indicate a negative reaction to a contact with a physician. In this case, the father (M) was very hostile toward the hospital because he was not allowed to become the patient's guardian. Two fathers were indifferent to their contacts with physicians although both of these were personal contacts. As one said, "I guess he's all right. He does what he can" (H).

Negative reactions were also indicated in two of the eight contacts with social workers and one contact with a ward aide. In one case, the father felt that the aide "... gives me as little information as possible" (A). Concerning the two negative reactions to social workers, one father thought that the social worker was "nosy and suspicious" (M) and the other was hostile because his requests were not acted upon (L). All eight con-

tacts with social workers had occurred several years ago and none of these cases were active with the department at the time of this study. One father could not remember the reason he had seen a social worker, and four had given social history information as a matter of routine procedure. Of the three who had received casework service, one (E) had seen a social worker about his son's type of employment, the second (L) had brief contacts with a worker with regard to his son's discharge, and the last (M) had hoped that the social worker could help him become the patient's guardian. The latter, who expressed hostile feelings about the social worker, was also the only father who had a negative reaction to his contact with a physician.

Only one father (N) had had no contacts with the hospital staff, and he had not visited the hospital in over two years. This father said that he would like to have the chance to discuss his son's condition with the physicians but he never had the opportunity to come to the hospital.

Attitudes Toward Treatment

Types of treatment that the patient received were divided into two broad categories: physical care, which involved the custodial aspects of the patient's care, and therapy. The latter category was further divided into somatic therapy, which includes drugs, electric shock, insulin shock, and lobotomy, and psychological therapy which includes psychotherapy, group therapy, and various rehabilitation programs offered by the hospital.

The attitudes expressed by the fathers about the patients' physical care were categorized as "positive" if the father felt that his son was well taken care of and in a satisfactory environment and "negative" if

the father verbalized complaints or showed dissatisfaction with the hospital. The responses varied from such brief comments as, "I know he gets good care," to detailed criticisms of the treatment that the patient received. The attitudes of eleven fathers were considered as positive, three as negative, and in one case no information was available. The fathers mentioned that the ward aides handled the patients very roughly but felt that this was probably necessary in order to control the patient. B said that he realized that the patient was a behavior problem. His son had once told him that he had been beaten up by an attendant, but the father added that, if this were so, he thought the attendant probably had a good reason. And C said that he knew nothing about the patient's physical care but "if anything went wrong, it would be R's fault because he's so stubborn." G felt that great progress had been made "since the days of chains and straight jackets." Three of the negative feelings expressed took the form of complaints about the patient's food and clothing being in poor condition.

The fathers' attitudes toward the patient's therapy is indicated in Table 12.

TABLE 12

ATTITUDES TOWARD THERAPY

| Type of Therapy | Father's Attitudes | | |
|---|---|---|---|
| | Positive | Negative | Indifferent |
| Somatic | 5 | 8 | 2 |
| Psychological | 3 | | 2 |

Father's attitudes toward the patient's therapy ranged from a complete knowledge of types of specific somatic treatments to no knowledge at all. Thirteen fathers described somatic treatments, such as drugs, electric or insulin shock and three fathers discussed psychological treatments. However, the fathers' evaluations of the various therapies indicated poor understanding of the value of these techniques. Six informants expressed negative attitudes toward insulin shock and electric shock. As B stated with regard to electric shock treatments, "It damages the brain." One father expressed strong feelings against lobotomy and one held a negative opinion of the new drugs because "they only make him quiet and he's too quiet already" (F). There were two fathers who seemed indifferent to the type of therapy that the patient received, and both of these were instances in which the patient had been hospitalized for a considerable amount of time, and the father had given up all hope of recovery (I and A).

Four fathers recommended what they felt would be good therapeutic steps. These recommendations included outdoor activities, keeping the patients on one ward rather than moving them about, and more attention from personnel.

The attitudes toward signing papers authorizing treatment were categorized in the following manner:

1. Willing---this included those fathers who signed willingly, and those who had never been asked to authorize treatment but said that they would be willing to do so. Six fathers fell into this category.

2. Reluctant---those fathers who had given permission for treatment but with reluctance. Seven fathers fell into this category.

3. Unwilling---those fathers who stated that they definitely

would not sign any authorizing papers. Two fathers fell into this category.

Of the six fathers who had willing attitudes toward signing for some type of treatment, H signed willingly because, "The doctors asked and I saw nothing wrong with it." J signed because he thought the treatments might help the patient, and C stated that he had never been asked to sign anything but would be glad to do so because he thought it was his responsibility.

Of the seven fathers who expressed reluctant attitudes, B stated that he "wasn't sold on it" but signed because there was a possibility that insulin shock might help the patient, and another felt he had to sign because of pressure put on him by the hospital. Only two fathers were unwilling to authorize any type of treatment, and interestingly enough, their reasons for this attitude were diametrically opposed. D stated that he would not sign anything because he felt that his son was beyond help and, therefore, there was no point in signing. On the other hand, M refused to sign permission for electric shock treatments because he did not feel that his son was sick enough to require this type of treatment.

## CHAPTER IV

## ATTITUDES TOWARD MENTAL ILLNESS IN GENERAL AND THE ILLNESS OF THE PATIENT

### Attitudes Toward Mental Illness

In an attempt to determine their understanding of mental illness in general, the fathers were asked to express their thoughts about mental illness and from what sources they derived their information. Further, to evaluate the father's specific attitudes toward the illness of the patient, they were questioned as to what they considered the factors contributing to the patient's illness, their expectations for the patient's recovery, and how they felt about taking the patient home both for short term visits and for possible discharge.

There is a continuing search for the causes of mental illness, and even within the field of psychiatry there are many different theories of causation. None the less, there are some fundamentals which are generally accepted. For example, it is almost axiomatic that unusual stress and strain on the adaptive powers of the individuals may cause breakdown.[1]

There are hundreds of stresses which may stand in the way of effective living. Among these are ill health, bereavements, accidents, war, and strained relationships with a family. Because of the multiple known and unknown factors, attempts to evaluate the father's feelings about mental illness are difficult and can only be subjectively determined through

---

[1] A. P. Noyes, Modern Clinical Psychiatry, p. 48.

what is felt to be reasonable in the light of present day theories.

The father's degree of understanding was categorized as "good" if he showed insight into the causes of mental illness, explaining it as precipitated by stresses and strains which the patient could not handle. Understanding was considered to be "fair" if the father said that he did not know anything about mental illness but went on to give some partially formulated ideas about it, "poor" if the father explained mental illness as being caused by factors which are no longer considered to be plausible and "none" if the father was unable to offer any explanation of mental illness.

Five fathers were considered to show "good" understanding of mental illness. Of these, B appeared to be rather exceptional in that his concept of his son's mental illness appeared to show a great deal of insight. He had also done a great deal of investigation of the subject. The causes that he advanced were threefold: (1) He did not provide a good atmosphere for the patient after the mother became mentally ill. (2) His wife's mental illness when the patient was a teenager might have had an effect on him as the father was not a good mother substitute. (3) The patient was a middle child and according to the middle child theory, these were the members of a family most likely to become mentally ill because they received less attention and affection than the other children. J felt that mental illness was caused by a person being exposed to "strain" and L thought that a person became mentally ill when he was faced with conditions in the environment that he could not meet.

The degree of understanding of seven fathers was considered to be "fair." These fathers had only vague ideas of the cause of mental illness

as exemplified by a father who thought that his son's illness was caused by something in military service but was not sure what this was specifically.

Only one father was considered to have a "poor" understanding of mental illness. D thought that the illness was inherited and stated that since his wife became mentally ill at childbirth, his son ". . . must have been born that way. It's all in the genes and there's nothing you can do about it as it's all predetermined."

Finally, two fathers had no understanding of mental illness. They both said that they had no idea what had made their sons become ill.

There were five fathers who credited their understanding of the illness to having watched television or having read about it in the newspapers. The other explanations offered, no matter with what degree of validity, were based upon the informant's own ideas.

Table 13 shows the relationship between the father's degree of understanding and what they felt to be the cause of the illness.

TABLE 13

DEGREE OF UNDERSTANDING AND CAUSE OF PATIENT'S ILLNESS

| Cause of the Illness | Degree of Understanding | | |
|---|---|---|---|
| | Good | Fair | Poor |
| Specific incidents in service | 1 | 4 | |
| Service (general) | | 2 | |
| Heredity | | | 1 |
| Death of mother | 2 | 1 | |
| Parent-child relationship | 2 | | |

Seven fathers blamed military service for the patient's condition and five of these tended to describe specific incidents rather than the entire service experience. One said that the patient "got scared walking over dead bodies" (H), and a second felt that the patient had "battle fatigue as a result of parachuting into the jungles of New Guinea" (G). The two fathers who named no specific experience only had vague ideas, but offered some partially formulated thought as, "His illness started while he was in the service. I don't know what happened" (F).

Of the three fathers who attributed the patient's illness to the death of the mother, one father said that he thought this might have had something to do with the patient's illness but could offer no further explanation and therefore his degree of understanding was categorized as only "fair." The other two fathers who attributed the illness to the death of the mother carried their explanation further and said how they thought the death may have affected the patient.

There was an attempt to evaluate the fathers' sense of stigma resulting from the patients' illness based upon the general components of the interview. However, the information obtained was fragmentary. The fathers indicated whether or not they discussed the illness with relatives and friends, and their attitudes toward having relatives and friends in personal contact with the patient, but it was not felt that this information was enough to substantiate a definite sense of stigma.

Attitudes Toward Recovery and Return Home of the Patient

The informants seemed to consider the interview as part of a plan to return the patient home. Therefore, they generally mentioned this before the question was brought up and expressed the desire to have the patient

at home. However, when the interviewer explained that the interview had nothing to do specifically with the patient's return home, the fathers seemed to feel freer in expressing their true feelings.

The fathers' expectations of the patients' recovery were categorized in the following manner:

1. Positive---the father definitely felt that the patient would recover. Two fathers fell into this category.

2. Positive ambivalent---the major orientation was positive but with some uncertainty expressed. Six fathers fell into this category.

3. Negative ambivalent---the father did not feel that the patient would recover but expressed some feeling that it was not entirely impossible. Two fathers fell into this category.

4. Negative---the father had no hope of the patient's recovery. Six fathers fell into this category.

Only two fathers had positive expectations of the patients' recovery, and one of these wanted the interviewer to make immediate plans for the patient's return home (C). There were six fathers whose responses were considered to be "positive ambivalent." An example of this type of response was the one given by E who felt that the patient would get well because of the new "wonder drugs." However, he thought that the patient had gotten used to being idle and therefore might not get well because he would not want to leave the hospital. H was one of the two fathers who held "negative ambivalent" attitudes toward their sons' recovery. He held little expectation of the patient's recovery and stated, "I wish he would, but I don't know; it's tough." Five fathers expressed no hope of the patient's recovery. As one said, "There's no hope. He's neither alive nor dead. I never saw a patient get well and this is the worst disease of all" (K).

Attitudes Toward Having the Patient Home

The fathers were asked how they would feel about having the patient home for short term visits and after discharge. Table 14 shows their attitudes to this question.

TABLE 14

ATTITUDES TOWARD HAVING PATIENT HOME

| Attitude | Short Term Visit | After Discharge |
|---|---|---|
| Positive | 5 | 7 |
| Negative | 6 | 6 |
| Ambivalent | 3 | 3 |
| No information | 2 | |
| Total | 16 | 16 |

Three fathers held ambivalent attitudes toward having the patient home for a short visit and three were ambivalent about the patient's return home after discharge. The others expressed a definite opinion either positively or negatively. There were five fathers who stated that they wanted to have or had had the patient home for short visits, and seven expressed the desire to have the patient live at home as soon as he was discharged. However, six refused to have the patient return home for short term visits, and six refused to have the patient home after discharge. They gave such reasons as, "I've remarried and my wife doesn't like J so I couldn't have him live with me" (B), or, "He'll never be able to leave the hospital anyway so it's silly to talk about it" (K).

Economic Changes

None of the fathers were economically dependent upon their mentally ill sons, and although there had been economic changes in some of the families, in no instance was this the result of the patient's hospitalization.

## CHAPTER V

## ATTITUDES TOWARD VISITING

Relatives who visit at the hospital follow a prescribed administrative procedure. At each visit, the relative gives his name and the name of the patient to an attendant at the Information Desk. This information is entered into the hospital visiting record. The relative is then given a slip of paper authorizing his visit which he in turn gives to the ward personnel. However, oftentimes, if a relative is a frequent visitor and the patient has been hospitalized for several years, the relative will by-pass the Information Desk and go directly to the ward. Therefore, the visiting records are not an accurate indication of visiting frequency.

It was thought that a comparison of the father's idea of visiting frequency with the actual number of visits as shown by the visiting record might show a relationship to his feelings about the visiting experience. The inaccuracies of the visiting records were overcome by checking the number of visits with ward personnel as well as the visiting records.

As Table 15 indicates, the record of visits and the father's subjective opinion of visiting frequency[1] differed in six instances: three fathers who visited more than was indicated by the records and three fathers who visited less than was indicated.

---

[1] cf, p. 17.

TABLE 15

VISITING FREQUENCY

| Record of Visits | Father's Subjective Opinion | | | |
|---|---|---|---|---|
| | Very Frequent | Frequent | Seldom | None |
| Very frequent | 4 | | 3 | |
| Frequent | 1 | | | |
| Seldom | 1 | 1 | 4 | |
| None | | | | 1 |

Each father expressed some degree of guilt about his visiting frequency. Three of those who were frequent visitors indicated that they felt they were being criticized by the hospital for visiting too much, and those fathers who visited seldom invariably stated that they wished that they could visit more often but were unable to do so due to transportation problems, poor health, or demands of their work.

The fathers' attitudes toward the visiting experience were categorized as:

1. Satisfactory---father enjoyed the visits. Six fathers fell into this category.

2. Unsatisfactory---father found the visiting experience disturbing in terms of his own feelings. Eight fathers fell into this category.

3. No visits---father did not visit and therefore could not comment upon the visiting experience. One father fell into this category.

The fathers were encouraged to discuss their visiting experiences fully. Table 16 indicates the relationship between the visiting experience and the frequency of the father's visits.

TABLE 16

RELATIONSHIP BETWEEN VISITING EXPERIENCE AND FREQUENCY OF VISITS

| Type of Experience | Frequency of Visits | | |
|---|---|---|---|
| | Very Frequent | Frequent | Seldom |
| Satisfactory | 3 | 3 | |
| Unsatisfactory | 4 | | 4 |

It can be seen from Table 16 that there is some degree of relationship between the frequency of the father's visits and the satisfaction he received. The fathers who received satisfaction from the experience were all either very frequent or frequent visitors. However, it is paradoxical to note that four fathers who found the visiting experience unsatisfactory were also very frequent visitors.

The fathers expressed their satisfaction or dissatisfaction in terms of the patient's behavior during the visits. In those cases where the patient was well oriented and in good contact with reality, the father invariably enjoyed the visits. G who was a very frequent visitor, enjoyed seeing the patient, liked to be with him, and felt that the patient enjoyed his visits. E, also a very frequent visitor, considered the visiting experience to be "positively satisfying" to himself and the patient. C, who had visited seldom during the past year because of his own hospitalization in a T.B. Sanitorium, enjoyed the visiting experience with one of his sons because "we go to the canteen and have coffee or else go for a walk" but did not spend much time with his other son, also

hospitalized at Bedford, because "R always acts strange and is jealous of his brother."

D, a very frequent visitor, felt that "the visits were very disappointing. My son doesn't talk to me, just sits and stares." Another very frequent visitor considered his visits as "a strain because my son's quietness upsets me" (J), and a third who found the visiting experience unsatisfactory ("I get no pleasure from visiting") visited frequently because "I'm haunted by the vision of how bad he looks" (K).

N, the non-visitor, wished that he could visit because "I would like to see him (the patient) more often, but it's impossible because of my work."

Seven of the eight fathers who found the visiting experience unsatisfactory visited only, it seemed, because the patient had no mother who could visit him. These fathers often stated that since there were no close female relatives, they felt "forced" to visit themselves. "When his (the patient's) mother was alive, she used to come down every Sunday, even when it was difficult. But now that she's no longer here, I have to see that someone does something for him" (F). "He (the patient) was my wife's favorite and now that she's gone, I don't want him to feel that he's been forgotten" (J). This feeling may be peculiar to this particular sub-group as the patients had neither wives nor mothers.

# CHAPTER VI

## SUMMARY AND CONCLUSIONS

The purpose of this study was to explore attitudes of the fathers of schizophrenic patients in a mental hospital through the primary source of interviews. There was no attempt to make broad generalizations from this study, but it was hoped that the resulting information might be useful to the hospital in providing an indication of the value that may be gained by making a special effort to include fathers in treatment plans for the patient.

Interviews covered three major areas. These were: (1) attitudes toward hospital personnel and treatment, (2) attitudes toward mental illness in general and the illness of the patient specifically and, (3) attitudes toward visiting. Utilizing clinical, hospital, and visiting records, relationships were sought between visiting frequency and the attitudes mentioned above.

The study was one part of a group project undertaken by a team of four students, one from Boston University School of Social Work and three from the Simmons College School of Social Work. This thesis encompasses fifteen cases in which the mother was no longer a member of the family constellation. These cases were taken from a total group of fifty-seven interviews that were conducted by the group members. Due to the limitations of time, it was not possible to compare the findings of the two groups although it is realized that a comparison of this sort would be valuable. However, both studies will be made available to the hospital

for their future planning of social service work with fathers.

Factors under consideration were: (1) age and marital status of the patient, (2) length of hospitalization and duration of mental illness, (3) number of days spent out of the hospital on leaves of absence, passes or trial visit during the study year and, (4) sibling position of the patient; as well as (5) age, (6) nationality, and (7) visiting frequency of the father.

Fourteen of the fifteen fathers had some type of contact with hospital personnel, most often with a physician albeit for various reasons. Over sixty per cent of all contacts were positive. Only one father did not find his contact with a physician satisfactory. Contacts with social workers were found to be the least satisfactory of all contacts with personnel. However, it would seem that all contacts, whether satisfactory or not, did little or nothing to increase the fathers' understanding of the patients' illness.

Social service was known to eight fathers and only three of these had received casework services. Since social service is a department of the hospital equipped to offer service to relatives along with greater understanding of mental illness and hospital procedure, it is evident that there is a great unmet need in this area.

Although the reactions to contacts with personnel were predominantly positive, it is speculated that this may well be the result of fear on the part of the informants to express negative opinions about the hospital. The limitations of one research interview prevent the determination of the extent to which fear hindered the informants from expressing themselves freely.

The informants, for the most part, knew the types of somatic treatment that their son had received but only three knew of any psychological treatment. None of the fathers showed much understanding of the reasons for or the value of these treatments. Electric shock treatments and insulin shock treatments are now rarely given at Bedford. These have largely been replaced by tranquilizing drugs. Therefore, the fathers' attitudes toward these treatments were based upon an experience that had occurred some time ago. Approximately one-fourth of the fathers offered their own ideas for therapeutic treatment but did this in a most hesitant manner as though afraid of offending the interviewer and thus the hospital. In order to help the father feel more a part of the patient's care, a method of including the father in treatment plans might be helpful.

Three-fifths of the fathers expressed negative opinions toward signing papers authorizing treatment. None had signed any papers recently but despite this expressed their feelings in a very emotional manner.

Attempts to evaluate the fathers' understanding of mental illness in general and the illness of the patient specifically were extremely difficult as, of necessity, they were based upon the subjective ratings of the interviewer. One-third of the fathers were considered to have a good understanding of mental illness, while almost half showed a fair understanding. One-fifth of the fathers showed either poor or no understanding of the illness. The fathers indicated their understanding of mental illness in terms of their son's illness specifically. Only one-third of the informants claimed to have read or heard about mental illness. Almost one-half of the informants blamed the patients' illness on military service. The other reasons given were: (1) heredity, (2) death

of the mother or, (3) parent-child relationship. It would seem that the fathers had difficulty in relating the patient's illness to intra-familial relationships. It is speculated that military service provided the informants with an "acceptable" and easily understood reason for the patient's illness. Even with the advanced knowledge of medical science, mental illness is still feared and shrouded in mystery to the layman. Enlightenment in this area would affect the father's attitudes toward his total relationship to the patient, his illness, and the hospital. The hospital, at one time, did offer group therapy meetings to the relatives. However, due to the shortage of funds and personnel, this is no longer true. Reinstatement of this service might result in positive effects.

Only two fathers expressed positive attitudes with regard to their expectations of their son's recovery. The rest of the fathers were, for the most part, doubtful that the patients would ever recover completely.

The informants were asked their feelings about taking the patient home for short term visits and after discharge. One-third of the fathers expressed positive attitudes toward having the patient home for short term visits, and almost half of the fathers expressed positive feelings toward having the patient return home after discharge. It is speculated that the higher percentage in the latter category is attributable to the fact that discharge is a possible future occurrence while short term visits are more likely to occur in the present.

A comparison of the visiting records and the father's subjective opinion of visiting frequency resulted in six discrepancies, three fathers who visited more than was indicated by the records and three fathers

who visited less than was indicated. It is speculated that these discrepancies are due primarily to guilt feelings on the part of the father. Those fathers who actually visited less than they said they did might have chosen this way of expressing guilt because they did not visit more frequently. Fathers who visited more than they themselves indicated may have been indicating their feelings that they did not visit enough. Therefore, their number of visits seemed to them less than it actually was.

Eight of the fathers found the visiting experience to be unsatisfactory. Four of these visited very frequently and four visited seldom. These fathers seemed to visit only out of a sense of obligation to the patient. Six fathers found the visiting experience to be satisfactory. Three of these were very frequent visitors and three were frequent visitors. Therefore, it would seem that the frequency of visiting is directly related to the satisfaction or dissatisfaction experienced by the father. Satisfaction or dissatisfaction was generally explained in terms of the patient's behavior during the visits.

Evaluation and Recommendations

From the findings of this study, there emerged a general picture of the father as being interested and concerned but bewildered and somewhat frightened by his son's illness. In addition, he seemed to be confused about the hospital's role in treating the illness. Under informed guidance, these complexities could be reduced.

One of the roles of the social worker is to act as a "link" between the physician and the patient and his relatives, and it is here that the social worker can be of help in interpreting the nature of treatments to

the relative who is asked to authorize them. Better understanding of other aspects of the patient's hospitalization would also be helpful to relatives, and this points up the need for help in using the hospital as a source of obtaining information.

With the eventual return of the patient to the community as the primary goal of the hospital, it would seem that the father should be helped to accept the patient's return to the family setting. Lack of understanding of the patient's illness (and his behavior as a part of this illness) seems to be directly related to the problem of accepting him home.

In the first stages of this study, it was hoped that some information could be learned about the relationship that existed between father and patient before and during hospitalization. Because of the difficulty involved in obtaining this material, it was decided to eliminate this aspect from the study. Since the relationship between father and patient is important to many aspects of the patient's hospitalization, especially in relation to plans for the patient's return home, research in this area should prove valuable. Further, it is known that the father's relationships to sons differ substantially from their relationships to daughters. This too should prove to be a fruitful area for future study.

As this s tudy progressed, it became apparent that many of the fathers had their own problems which limited their ability to offer love and understanding to their sons. Therefore, it is recommended that some sort of treatment, either in the form of group therapy or out-patient clinics, be available to relatives.

It is also recommended that more attention should be directed towards seeing that hospital records are more adequately maintained. For example, provision should be made to secure complete information on the patient's living family. This would not only be of substantial value to the hospital but would also aid future researchers in obtaining their material.

Although in this study there is no basis for comparing fathers' attitudes toward the patients' illness with the attitudes of other relatives, especially mothers, it is possible to speculate upon some of the differences which may exist. The results from a study recently made on relatives' attitudes, which included primarily mothers, differ in some respects from the findings of this study on fathers' attitudes. This would lead to the conclusion that there is a substantial difference between the way mothers and fathers view the mental illness of their children, and that in some degree this might be due to a difference in roles. Fear or non-acceptance of the patient's behavior, which seemed to be a major reason why the fathers were reluctant to take their sons home, was not as strongly indicated in the studies concerning mothers.[1] These are questions which would be interesting to explore in a study that compares fathers' and mothers' attitudes as it could shed light on how parents' unique roles contribute to their attitudes. Most of what is known today about parental attitudes is in relation to the mother. The findings of this study point out that the mother is not alone in facing the problems

---

[1] Rose, op. cit., p. 16.

of a mentally ill child, that hospitalization of a child in a mental institution, despite his age, is a problem also shared by the father. The findings further indicate that more information is needed about the father's feelings and attitudes.

Accepted
Katherine Spencer
5-26-58

# APPENDIX

## APPENDIX A: APPOINTMENT LETTER

Mr. John Doe
111 Main Street
Boston, Massachusetts

Dear Mr. Doe:

Through our Social Service Department, the hospital is interviewing fathers of some of our patients in order to find out their views and ideas about the hospital. The information will be used to improve our service to relatives. We have already interviewed a group of mothers and now we want to talk to fathers in order to complete the survey.

One of our social workers, Mrs. Lerner, would like to talk with you when you visit the hospital. The enclosed card indicates suggested dates. Please fill this out and return in the enclosed self-addressed envelope which requires no postage.

If you are unable to keep an appointment at the hospital, please write Mrs. Lerner at the hospital. Mrs. Lerner can also be reached by telephone on Wednesday, Thursday and Friday, between 8:00 a.m. and 4:30 p.m., telephone Crestview 4-7500, extension 376.

Thank you very much for your cooperation.

Very truly yours,

REBECCA GLASMANN,
Chief, Social Service.

## APPENDIX B: SCHEDULE I

## IDENTIFYING INFORMATION

Patient's Code Name:

Registration Number:

Building Ward:

Age:

Marital Status at Admission:

Number of Children:

Date of First Hospitalization:

Date of Last Hospitalization at Bedford:

Number of Days Patient Visited Home in Past Year

## APPENDIX G: SCHEDULE II

### FAMILY DATA

Father's Code Name:

Father's Address:

Father's Age

Father's Place of Birth

Father's Marital Status:

Father's Occupation:

Family Composition:

1. Patient's Mother--age:
2. Patient's Siblings--ages:

Number of Times Father Visited Patient During Past Year:

# APPENDIX D: SCHEDULE III

## INTERVIEW GUIDE

I. Attitude of Father Toward Hospital Personnel and Treatment

a. Nature of contacts with hospital staff:
   1. Doctor
      a. Father knows doctor's name: yes___ no___
      b. Type of contact with doctor: (personal, phone, letter, none)
      c. Reason for contact with doctor: Describe
      d. Father's reaction to contact: Describe

   2. Nurse
      a. Father knows nurses' names: yes___ no___
      b. Type of contact with nurses:
      c. Reason for contact: Describe
      d. Reaction to contact: Describe

   3. Ward Aides
      a. Father knows ward aides' names: yes___ no___
      b. Type of contact with aides:
      c. Reason for contact: Describe
      d. Reaction to contact: Describe

   4. Social Worker
      a. Father knows social worker's name: yes___ no___
      b. Type of contact with social worker: Describe
      c. Reason for contact: Describe
      d. Reaction to contact: Describe

b. Father's Attitude Toward Treatment:
   1. Father's attitude toward patient's physical care and hospital environment:

   2. Father's attitude toward therapeutic treatment patient is receiving:

   3. Father's attitude toward signing papers authorizing treatment:

II. Attitude of Father Toward Mental Illness in General and the Illness of the Patient

a. Father's attitude toward mental illness in general
   1. Understanding of mental illness:
   2. Sources of understanding:

b. Father's attitude toward illness of the patient
   1. Factors which father thinks contributed to patient's illness.

   2. Father's sense of stigma as a result of patient's illness:
      a. Father's attitude toward discussing patient's illness with relatives and friends:
      b. Father's attitude toward relatives and friends being in personal contact with the patient:

   3. Father's expectations of patient's recovery:

   4. Father's attitude toward patient's return home:
      a. For possible discharge:
      b. For short term visits (weekends, etc.):

   5. Economic changes resulting from patient's hospitalization:
      a. Changes in the family's economic resources as a result of patient's hospitalization:
      b. Economic dependence of father on patient, if any:

III. Visiting

a. Father's opinion of frequency of visiting:

b. Father's attitude toward visiting:

IV. Evaluation of Father's Behavior in Interview Situation:

# BIBLIOGRAPHY

# BIBLIOGRAPHY

Aichorn, A. Wayward Youth. New York: Viking Press, 1935.

English, O. S. "The Psychological Role of the Father in the Family," Social Casework, vol. 35 (October, 1954), pp. 323-329.

Greenblatt, M. et al. From Custodial to Therapeutic Care in Mental Hospitals. New York: Russell Sage Foundation, 1955.

Haggard, H. W. Devils, Drugs and Doctors. New York: Harper and Bros. 1953.

Lyons, J. F. "A Study of Casework with Relatives of Mental Patients." Unpublished Master's Thesis, Boston College School of Social Work, Boston, 1955.

Modell, S. "Family Relationships and Relatives' Attitudes Affecting Improvement or Lack of Improvement of Improvement of Hospitalized Schizophrenic Patients." Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1957.

Noyes, A. P. Modern Clinical Psychiatry. Philadelphia: W. B. Saunders Co., 1956.

Richardson, H. B. Patients Have Families. New York: The Commonwealth Fund, 1945.

Rose, G. L. "Relatives' Attitudes and Mental Hospitalization." Report given to the general staff of the Bedford Veterans' Administration Hospital, 1955.

Veterans' Administration. Oval Mirror, Silver Anniversary, 1928-1953. Veterans' Administration Hospital, Bedford, Massachusetts, June, 1953.

_____ Handbook of Information. Bedford, Massachusetts, April, 1956.