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Readmission of mental patients to the Boston State Hospital

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

READMISSION OF MENTAL PATIENTS
TO THE BOSTON STATE HOSPITAL

A Thesis

Submitted by

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CHAPTER I
INTRODUCTION

Recent advances in the treatment of mental disorders, especially the use of drug and shock therapies in modern mental hospitals have made possible return to the community an increasing number of patients. However, many of these patients subsequently require readmission. For example, at the Boston State Hospital, although sixty per cent of newly admitted patients leave within the first year after admission, during the year ending June 30, 1956 eighty-one per cent of all admissions to the hospital were readmissions.¹

Individuals may become mentally ill from disturbed human relationships, as well as from organic, metabolic and psychologically traumatic sources. This disturbance can also, then, be a factor in inhibiting a readjustment in the community after a period of hospitalization. Therefore, a study of the social and emotional factors contributing to the readmission of patients who were on trial visit, should be of concern to those who are engaged in the rehabilitation of the mentally ill. New breakdowns could be prevented many times, if more consideration could be given to the emotional preparation of patients and to the social settings in which they will be in

1. Boston State Hospital, 116th Annual Report for the Year ending June 30, 1956.

their trial visit. Psychiatric social workers in mental hospitals can play an important role helping patients in their adjustment to the community by preparing them to face the problems they encounter after being hospitalized.

Purpose of the Study: Very often patients are allowed to go on trial visit with little preparation of what returning to community living will entail. This is true also of the families. Many patients return to the hospital from their trial visits before the time has expired because they wish to or because the family has insisted. The writer attempts to investigate the social and emotional factors which contributed to the readmission to Boston State Hospital, of patients who were placed on trial visit, and were returned between the dates of October 1, 1955 and November 30, 1956. Answers are sought to the following questions:

1. What were the social and emotional problems which contributed to the readmission of these patients?
2. Were these patients helped by the Social Service Department before they went on trial visit?
3. Are there some factors that are more prominent in causing a recurrence of mental illness than others?

Scope and Method: The monthly readmissions were studied from the hospital statistical records during the year mentioned above. From 201 patients who had been readmitted after being on trial visit, a random sample of fifty cases was selec-

ted. The sample represents patients from all the different sections of the hospital.

The material on the fifty patients discussed in this study was obtained from examination of medical records, personal interviews with the patients and discussion with psychiatrists and social workers to whom the patients were known.

Limitations: Some of the patients studied were not known to the psychiatrists and social workers at the present time. Another limitation is that it was not possible to interview all of the fifty patients; some of them had been discharged and a few of them were too sick to be interviewed when the material for this study was gathered. Since the sample represents the total population there is a wide range of ages in patients of both sexes. One more limitation was the fact that medical records have little information about the patients' adjustment to the community while they are on trial visit.

CHAPTER II
SETTING OF THE STUDY

Boston State Hospital is the largest of twelve institutions for the mentally ill operated by the Commonwealth of Massachusetts. It has an average daily population of 3000 patients. During 1956 the total number of admissions was 7957, of which 1493 were new admissions and 6464 were readmissions; 1166 patients were placed on trial visit, 776 were returned from it and 761 were discharged into the community.² The hospital has three sections: (1) Receiving Service, which admits new patients for intensive study and treatment; (2) West Continued Treatment Service for men and (3) East Continued Treatment Service for women. There is a separate unit for those suffering from tuberculosis, which is located in the west side of the institution.

Admission to the hospital is exclusively for those who have lived in the city of Boston during twelve years immediately preceding hospitalization. This can be done on any of several legal bases. Provisions of law permit a short observation period on recommendation of competent, legal or medical authority, at the end of which, the medical staff determines whether or not a patient requires a longer period of treatment which the hospital can provide. Patients may also enter the

2. Boston State Hospital, op. cit., p. 1.

hospital voluntarily, or may sign voluntary commitments at the end of the observation period. Voluntary commitments may be terminated with the required notice to the superintendent of the hospital, and the decision of the medical staff that the patient will not be dangerous in the community. Patients on regular commitments are released on trial visit, to be discharged at the end of one year if they have adjusted satisfactorily in the community.

Voluntary patients may leave the hospital on an "extended visit" which is usually for six weeks, to test their ability to go home, or they may be discharged outright if this seems more feasible.

For patients on trial visit there is an Out-patient Department staffed by two psychiatrists, who are responsible for seeing patients on monthly return visits to the hospital for evaluation of their ability to maintain themselves outside. Referrals are sometimes made to Social Service from these physicians for specific reasons to help these patients in their adjustment.

The Social Service Department of the Boston State Hospital has a professional staff of twelve workers. Six of them are assigned to the Receiving Service; three work in the East Service and the other three in the West Service.

The duties of the social worker are the following:³

3. Walter Barton, Policy Letter 35, 1947, p. 37.

Work with relatives, interpretation and understanding of mental illness and in solution of personal problems.

Problems of environment: social and environmental problems as they contribute to the historical background of patients.

Community work in relation with social agencies and the Family Care Program.

Investigation to supplement anamnesis, when the patient or his family cannot give the social history at the time of admission.

Secure commitment permits.

Work with patients.

In trial visit cases:

The social worker will insure that there is a satisfactory home situation, a place for the patient to sleep, financial support, etc. She will estimate the attitude of the family, insure patient's welcome and that there is a constructive plan for the patient at home.

She will search out and find available resources for patients who are ready to go out on visit. She will attempt to get the family to give their cooperation and help.

Social workers at the State Hospital do not take part in routine intake interviews. As an experiment, this is being done by students for the first time in the present academic year. Besides the duties mentioned above, workers are doing group psychotherapy both in the role of leader and observer.

Trial Visit: Trial visit, called parole by some institutions, is the period of time the patient spends under the supervision of the hospital after he has been released to the community. Patients go on trial visit for twelve months, and if this period is covered, they are discharged from the hospi-

tal.

Before a patient goes on trial visit a careful review is made of his progress and his adjustment in the hospital. The plan for his return to the community is thoroughly discussed by the doctor with the relative or friend who will take care of the patient. Patients on observation on the decision of a court may not go out on trial visit. Physicians can designate patients to return once a month to the Out-patient Department if it seems advisable.

Patients who are returned from trial visit do not need to be recommitted.

Patients who are not wanted by their families or lack any relatives, may go on trial visit under the Family Care Program. Actually this program is not being carried on because of lack of personnel.

CHAPTER III

SOCIAL PROBLEMS OF MENTAL ILLNESS

Trial visit is a critical period in the rehabilitation of the mentally ill. It implies the opportunity given to the patient to try to make a successful adjustment in the community. It is a testing period in which patients are usually fearful, suspicious and doubtful about the ability to reinstate themselves as persons no longer suffering from mental disorders.

4

De Witt has stated:

Return to the community is indeed a threatening experience for the recovering mental patient. He may approach it with all the insecurity of a person recovering from an illness, or he may prefer to regard himself as never having been sick, but in either event he is fearful of the rejecting attitudes of society and the overprotection that the hospital seems to afford him.

The role of the relatives frequently proves a vital factor in the patient's adjustment on trial visit. This is particularly true in situations in which the patient feels needed and has a real place in the home. There are many instances where the relatives are no longer interested in the patient, or in which the patient has been hospitalized for so many years that they of necessity have had to plan their lives without him. In good faith they have kept unpleasant facts from him and as a consequence their relationship has grown progressively unreal.

Rehabilitation of mental patients requires comprehension of the patient's social background and understanding of the

4. Henrietta B. De Witt, "Hospitalization and the Mental Patient; What Hospitalization Means to the Mental Patient, The Community and the Hospital Social Worker," Symposium, Mental Hygiene, 31: 274-5, April, 1947.

situation to which the patient will return. The writer considers three main problems, which very often prevent the mentally ill patient from a successful rehabilitation. The first one concerns the patient and his family. If the patient on trial visit feels accepted by his relatives, his period of illness may become a minor facet of his life. If, on the other hand, this does not occur, the patient is more likely to be doomed to continual relapse. Federn has stated: "No patient can be cured unless his family wishes it....."⁵ Very often patients find that the environmental conditions they met upon returning to society, were never the same as when they were first hospitalized. They can sense the fear and embarrassment they are causing to the relatives with whom they have to live after being released from the hospital. The negative attitudes which patients find in their families after release, are often the product of the cultural reactions toward mental illness. The popular saying: "Once insane, always insane" still exists in modern society and marks the mentally ill person as somewhat of an outcast.

Traditionally the social service staff at mental hospitals has had the responsibility for supervising patients on trial visit, but the intensive service which most patients need to maintain their improvement is difficult for hospital

5. Paul Federn, "Psychoanalysis of Psychoses, Errors and How to Avoid Them," Psychiatric Quarterly (1943), 17: 3-19.

social service staffs to render in all cases because of realistic limitations of time and personnel. Shortage of staff and heavy case loads make it difficult for social workers in mental hospitals to be more effective in planning for discharge, involving relatives helping them to understand that mental illness is a way of behaving that can be understood. Freudenthal⁶ suggests how community agencies can help in orientating patients after discharge, in their adjustment to the extramural world.

The second problem, the writer thinks the mentally ill patients have after they are released from hospitals is in the area of work. Psychiatrists refer patients to Social Service, very often with the purpose of giving them, through case work, motivation to find jobs in the community. Many patients succeed in getting themselves a position; but oftentimes, they feel unsatisfied with their work and keep on changing jobs. Repeated failures in work and the passive tendencies that hospitalization encourages lead to the development of job phobia in many patients. Deutsch mentions five types of runaways from work:⁷

1. The one who is being too successful.

6. Kurt Freudenthal, "Participation of the Community Agency in Hospital Discharge Planning," Journal of Social Casework, December (1949), 30: 394-399.

7. Felix Deutsch, "Job Phobia," Journal of Social Casework, April (1947).

2. The "nobody type," who feels inefficient and depreciates the value of his own achievements.
3. The "grandeur type," who overvalues his achievements, feels he is not appreciated in his job.
4. The "over-worked type," who exhausts himself, works too much and breaks down.
5. The "sensitive type," who leaves when he thinks he is not treated kindly enough and finds his co-workers are not friendly enough toward him.

In many patients who need to be readmitted to mental hospitals, and are of a workable age, job phobia has made them become unemployed or irresponsible in their jobs.

The third social problem that often causes readmission is the result of an over-attachment to the hospital. Bettelheim⁸ calls this "psychological institutionalism," a deficiency disease, caused by the absence of meaningful continuous interpersonal relationships.

Hospitalization is an interruption of regular patterns of living. During it, since all activities are arranged, food and shelter are safely provided, patients find themselves in a subordinated position in which there is no need for making independent decisions. Rehabilitation of mental patients then, should include not only giving the patient motivation to get well and go back to the community, but also help him to develop independence, to stay out of the hospital and make his own decisions.

8. Bruno Bettelheim, "A Therapeutic Milieu," American Journal of Orthopsychiatry, 1948, 18: 191.

9
Sabat, tells of how casework is being offered to patients on trial visit at the Regional Office of the Veterans Administration in Kansas City, and has helped patients to complete that testing period and therefore the number of readmissions has decreased. The service in this case is only supportive casework with the purpose of helping the patient to achieve the best possible adjustment in the community. To give each patient who is on trial visit from a mental institution a similar kind of service, would be impossible because the great number of patients discharged into the community is in disproportion with the number of trained workers. But it is desirable that the social worker's participation in the rehabilitation of the mentally ill should begin at the time of admission, continue throughout the patient's hospitalization and in the post-discharge period.

9. Charlotte Sabat, "The Mental Patient Released on Trial Visit," Journal of Social Casework, February, 1957.

CHAPTER IV

THE PATIENTS

In this chapter the writer will describe the patients. These will be divided according to their marital status into three groups: the single, the married, and the divorced and widowed (which will be studied together because they form a very small section).

The fifty patients selected for this study were discharged on trial visit, sometime between January, 1955 and September, 1956. Only the present hospitalization and the last trial visit were considered in this study. Of the fifty patients, seventeen were men and thirty-three were women.

All of these people readmitted were native born, with the exception of two males: one was born in Canada and the other in Lithuania. The rest were the first generation born in this country from foreign parents. The parentage was of a large variety, as there were: eighteen Irish, eleven English, five Italians, four Hebrews, three Russians, three Canadians, two Negroes, one Polish, and one Armenian.

As to religion on readmission there were thirty-two Catholics, ten Protestants and eight Jews.

With the exception of two colored females, the rest of the patients studied were white.

Economically, forty-seven were of marginal^a level and three were dependent.

According to their intelligence quotients, four were on the superior level, thirty-five were average, and eleven were considered on the dull level.

The occupation of the patients prior to admission varied greatly: fifteen were housewives, five students, three laborers, three factory workers, two paper boys, two worked in a restaurant, two were clerks, one was a baker, one a nurse, one a saleswoman, one a hairdresser, one a show dancer, one a chef, one a manufacturer, one a presser in a laundry, one a dietitian, one an attendant, one a machinist helper, and in seven cases it was unknown.

The distribution of the sexes in relation to age and marital status is shown in Table I.

This table shows that almost fifty per cent of readmitted patients were single, that women outnumber men twice as much, and that seventy-four per cent of readmissions fall between twenty and fifty years of age, while thirty-four per cent are between fifty and eighty.

The educational levels were scattered as greatly: one had finished college, one had a year of it, eighteen had finished high school, two had three years of high school,

a. At the Boston State Hospital the word "marginal" is used to indicate that a patient has just a limited income for his subsistence.

TABLE I

Marital Status in Relation to Age and Sex.

Ages	Single		Married		Divorced		Widowed		Total		
	M	F	M	F	M	F	M	F	M	F	T
20--29	7	3	1	2	0	0	0	0	8	5	13
30--39	3	4	2	3	0	0	0	0	5	5	12
40--49	1	6	0	3	0	2	0	0	1	11	12
50--59	0	0	0	4	1	1	0	0	1	5	6
60--69	0	0	0	2	0	1	0	0	0	3	3
70--79	0	0	1	0	0	0	1	0	2	0	2
80--89	0	0	0	1	0	0	0	1	0	2	2
Total	11	13	4	15	1	4	1	1	17	33	50

ten had two years, eighteen had grade school.

This readmission was the first for thirty-nine patients; the second for six, the third for three and the fifth for two.

The total length of time the fifty patients had been hospitalized before going on trial visit varied considerable. One patient had been in the hospital only one month, while another had been twelve years.

As to the length of time these patients were able to stay out of the hospital varied from three days to eleven months.

The length of time the fifty patients spent hospitalized and out in the community will be seen in Table II.

TABLE II

Length of Hospitalization and Duration
of Trial Visit.

Length of Hospitalization	Duration of Trial Visit				Total
	Under 1. mo.	1--3 mos.	4--6 mos.	7--11 mos.	
Under 1 year	7	9	6	4	26
1--3 years	3	4	3	5	15
4--6 years	1	1	1	2	5
7--9 years	1	1	0	1	3
10-12 years	0	1	0	0	1
Total	12	16	10	12	50

From this table it can be seen that fifty-two per cent of the patients had been hospitalized for less than a year, thirty per cent had been from one to three years, ten per cent between four and six years, six per cent had from seven to nine years and two per cent had been hospitalized from ten to twelve years.

The majority of the fifty patients, thirty-two per cent, could stay out of the hospital from one to three months, while the next largest group remained out between four and eleven months. This table also shows that the shorter the period of hospitalization, the shorter the trial visit was.

The diagnosis of the various mental disorders in relation to sex and marital status will be indicated in Table III.

TABLE III

Marital Status of Readmissions with Reference to Principal Psychoses.

Psychoses	Single		Married		Divorced		Widowed		Total		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	T.
Schizophrenia	8	8	2	5	1	3	0	0	11	16	27
Manic Depressive	0	3	1	2	0	0	0	0	1	5	6
Involitional Psychotic Reaction	0	0	0	1	0	1	0	0	0	2	2
Psychotic Depression	0	0	1	3	0	0	0	0	1	3	4
Psychoneurotic Depression	0	0	0	1	0	0	0	0	0	1	1
Brain Disorders	2	2	0	3	0	0	1	1	3	6	9
Mental Deficiency without Psychoses.	1	0	0	0	0	0	0	0	1	0	1
Total	11	13	4	15	1	4	1	1	17	33	50

Table III shows that fifty-four per cent of the readmissions suffered from schizophrenia. The types of this mental illness were eleven paranoid, five catatonic, four undifferentiated, three schizo-affective, two hebephrenic and two of simple type.

Twenty per cent had affective disorders: manic, involutional and psychotic depression. Eighteen per cent had brain syndrome. Four per cent were not psychotics: the mentally deficient and the one who suffered from psychoneurotic depression.

This table also shows that forty-eight per cent were single, thirty-eight per cent were married, ten per cent were divorced and four per cent were widowed.

As to the use of Social Service as preparation for these patients before they were released on trial visit, the data collected gave the knowledge that forty-one patients did not have any help before being discharged. Nine of them had casework services; in three cases the reason for referral had been help to locate positions in the community. In the other six cases, casework had been offered as a preparation for trial visit. In four of these six cases, relatives had also been prepared to receive the patient in their homes.

The Out-patient Department did not hear from thirty-one patients while they were on trial visit. Seven patients were seen regularly by their psychiatrists.

The average per patient of the duration of trial visit, hospitalization, number of readmissions, number of contacts with the Out-patient Department and where the patients spent their trial visits will be shown in Table IV for the single patients, Table V for the married and Table VI for the divorced and widowed patients.

Table IV indicates that the average length of hospitalization was two years. The average duration of trial visit was 3.6 months. The number of previous admissions in this group was very small; as a total they had fourteen readmissions. The average number of readmissions, per patient, was 0.6.

This table also shows that ten patients, five males and five females lived with their mothers during trial visit, four males and two females lived with both parents. Two females lived with their sisters; five women and one man lived alone and one man lived with his father.

According to the medical diagnosis, the group of schizophrenics had longer trial visits, and the group with brain disorders had longer hospitalizations.

The average number of contacts with the Out-patient Department was 0.7 per patient.

Table V shows that the married patients had as an average, two years and three months of hospitalization and four months of trial visit per patient. The average number of

TABLE IV.
 DIAGNOSIS, HOSPITALIZATION AND TRIAL VISIT
 OF TWENTY-FOUR UNMARRIED PATIENTS

	Av. No. Readm.	Av. Length of Hosp.	Av. Length of Trial Visit	Av. OPD Cont.	Location During Trial Visit					No.
					Alone	Mother	Sister	Parents	Father	
Schizophrenia	0.4	38 mos.	4.8 mos.	2	3	7	1	5		16
Manic Depressive	1.6	3 mos.	1.8 mos.	0.6		2	1			3
Brain Syndrome	0.3	45 mos.	4.5 mos.	0.3	2	1		1		4
Mental Deficiency	2	10 mos.	2.5 mos.	0					1	1
Total	4.3	96 mos.	13.6 mos.	2.9	5	10	2	6	1	24

TABLE V.
 DIAGNOSIS, HOSPITALIZATION AND TRIAL VISIT
 OF NINETEEN MARRIED PATIENTS

Diagnosis	Av. No. Readm.	Av. Length of Hosp.	Av. Length of T.V.	Av. OPD Cont.	Mother	Alone	Spouse	Friend	No Home	Daughter	No.
Schizophrenia	1.1	33 mos.	2.5mos.	2	4		2			1	7
Manic depressive	1	25 mos.	5 mos.	1			3				3
Psychotic depression	0	19 mos.	5 mos.	1.2		2	1	1			4
Involuntional psychotic reaction	0	19 mos.	7.5mos.	2						1	1
Psychoneurotic depression	2	42 mos.	1.5mos.	0		1					1
Brain syndrome	0	29 mos.	3.5mos.	3			1	1	1		3
Total	4.1	167 mos.	25 mos.	9.2	4	3	7	2	1	2	19

readmissions was 0.6 per patient; the number of contacts with the Out-patient Department was 1.5.

This table also indicates that four patients, three females and a male spent trial visit with their mothers. Two men went home with their wives. Five women returned to their husbands. Two women lived with their daughters. An elderly woman lived in a rest home. One male and two females lived alone and a man and a woman lived with friends.

It can be seen in Table VI that the divorced and widowed patients had as an average, nine months of hospitalization and spent four months in trial visit. The average number of readmissions, per patient, was 0.5. None of these seven patients had any contact with the Out-patient Department.

Two females lived with friends during their trial visit. A male patient lived alone; a woman lived with her mother. One female returned to her former husband; a widow lived in a nursing home and a widower with a friend.

Summarizing the findings from the last three tables, the reader can see that fifteen patients lived with their mothers, six with both parents, five lived with friends, two with their offspring, two lived in rest homes, two lived with siblings, nine lived alone, eight went with their spouses and one lived with his father.

The group of divorced and widowed patients had shorter hospitalizations. The single patients had shorter trial

TABLE VI.
 DIAGNOSIS, HOSPITALIZATION AND TRIAL VISIT
 OF SEVEN DIVORCED AND WIDOWED PATIENTS^b

Diagnosis	Av. No. Readm.	Av. Length of Hosp.	Av. Length of T. V.	Location During Trial Visit					
				Mother	Friend	Alone	Spouse	No Home	No.
Schizophrenia	0.5	18 mos.	8.5 mos.	1	1	1	1		4
Involuntional psychotic reaction	0	2 mos.	1 mo.		1				1
Brain syndrome	0	9 mos.	2.8 mos.		1			1	2
Total	0.5	29 mos.	12.3 mos.	1	3	1	1	1	7

b. None of these patients had any contacts with the Out-patient Department.

visits. The married patients had more readmissions and more contacts with the Out-patient Department.

The writer will describe very briefly each one of the fifty cases in order to indicate some of the social and emotional problems these patients had after they went on trial visit.

Cases numbered one to twenty-four were the unmarried patients. Cases numbered twenty-five to forty-three were married. Cases forty-four to forty-eight were divorced. Cases forty-nine and fifty were the widowed patients.

- Case 1. A forty-seven year old female, schizophrenic paranoid, Protestant of Armenian background. Her family did not want to take her when she was released. This patient was unable to work in her occupation, as a hairdresser. During trial visit lived alone and worked doing housecleaning; was returned to the hospital by her brother.
- Case 2. An Irish, Catholic woman, schizophrenic paranoid forty-one years of age, who had been a foster child. During trial visit worked as a cashier, was very seclusive and did not have any social life. Was readmitted on her own request.
- Case 3. A schizophrenic paranoid Irish man, twenty-six years old, of Catholic religion, who did not have any friends and could not get along with his mother. His mother asked for his readmission.
- Case 4. A schizophrenic paranoid Jewish man, thirty-seven years old, without any definite occupation. His mother rejected him and was unable to help him in his adjustment to the outside world.
- Case 5. A thirty-eight year old woman, schizophrenic catatonic of Catholic religion, who lived with both parents. Her father was an alcoholic. This fact and her epilepsy made her get worse at home. Asked to be readmitted herself.

- Case 6. An Irish, Catholic woman, schizophrenic catatonic, thirty- six years of age, without any occupation. During trial visit lived with her sister who did not want her at home because she demanded too much attention. Sisters asked social worker for her re-hospitalization.
- Case 7. A schizophrenic catatonic Italian man of Catholic religion and thirty- one years of age. His occupation was construction laborer. At home was over dependent on his mother and had homosexuality problems. His mother asked for his readmission.
- Case 8. A forty-five year old, Catholic man of Canadian background who suffered from simple schizophrenia and worked as a dietitian during his trial visit. This patient was seen by his psychiatrist regularly and was very resistant to come to his social worker. Was readmitted on his request when only four days were left to complete his trial visit period. It was felt that he was too dependent on the hospital.
- Case 9. A Jewish man of Russian origin, with simple schizophrenia; laborer, twenty-seven years old. During his trial visit worked in a hotel. From early childhood suffered from spasticity, which led to physical deformities of which he was self-conscious. At home was very seclusive and his father's drinking made him ask his social worker for his readmission.
- Case 10. A twenty year old Jewish girl who had suffered from simple schizophrenia, a student who was afraid of coming to the Out-patient Department. At home was too dependent on her parents and could not get along with them. Parents asked for her rehospitalization.
- Case 11. An Irish man with schizophrenia of undifferentiated type, student, Catholic, twenty years old, who felt rejected at home and had problems with sibling rivalry.
- Case 12. A Protestant boy, age twenty, student of English background and schizophrenic undifferentiated type. His parents' constant quarreling and his father's drinking precipitated a new breakdown of his illness. This patient was returned by his father.

- Case 13. A schizophrenic woman of undifferentiated type, forty years old, without any occupation and of Catholic religion. During her trial visit did not have any social outlets, drank and was a vagrant. This patient was returned by the police.
- Case 14. A Polish girl, twenty-four years old, student, of Jewish religion, who suffered from schizophrenia of undifferentiated type. Lived with her mother who was very dominant and expected too much from her. At the same time her mother was overanxious and afraid of this patient. This girl stated that she did not want to be at home and was readmitted on her request.
- Case 15. A Protestant man, twenty years of age, student, who had suffered from schizophrenia of hebephrenic type and was released on trial visit against advice. His parents felt very guilty having him in a mental hospital and asked for his release, but at home they could not handle him and brought him back to the hospital.
- Case 16. An Irish, Catholic Woman, twenty-eight years old, college student, schizophrenic hebephrenic, who was seen by a psychiatrist while on trial visit. Her mother was afraid of having her at home and returned her to the hospital.
- Case 17. An Italian nurse, forty-three years old, of Catholic religion, whose diagnosis had been manic depression. Her mother was very reluctant to take her on trial visit. This patient felt rejected and asked for her readmission herself.
- Case 18. A thirty-one year old woman of Russian parentage and Jewish faith, manic depressive, who had worked as a finisher of sport clothes in a factory. On her trial visit lived with a sister who felt unable to meet her dependency needs and returned her to the hospital.
- Case 19. A manic depressive woman, aged thirty-two, who worked as a presser in a laundry and was Catholic. After her release was very seclusive and failed to come to her social worker. An outburst of temper at work made her come back by herself to the hospital.

- Case 20. A Protestant woman, who suffered from chronic brain syndrome and alcoholism, worked in a factory and was forty-five years old. Was very seclusive and did not have either relatives or friends. This patient had been a foster child. Was readmitted on her own request.
- Case 21. A Catholic woman who had suffered from chronic brain syndrome, forty-nine years of age. During her trial visit worked as a waitress; felt lonely and drank heavily. Was returned by the police.
- Case 22. An Irish, Catholic paper boy, twenty years of age. His diagnosis had been chronic brain syndrome. At home became a behavior problem; his parents were too anxious and could not help or understand him. They asked for his readmission.
- Case 23. An Irish, Catholic man, thirty-six years old, without any occupation, who suffered from chronic brain syndrome. Asthma and epilepsy prevented him from being able to work. These handicaps made him very shy and on his trial visit never went out, fearing he might have a seizure. He lived with his aged mother who is tired of taking care of him and angry because he cannot contribute to his own maintenance. Was readmitted on his mother's request.
- Case 24. A twenty-nine year old, mentally deficient paper boy of Jewish faith who lived with his father but could not get along with him. This patient stated that he preferred to live at the hospital. He thought having to report to the Out-patient Department was an injustice.
- Case 25. A schizophrenic paranoid, colored married woman, thirty-eight years old, mother of a small child, who was a drug addict and drank while on trial visit. Promiscuity and marital conflicts caused a relapse of her illness.
- Case 26. A schizophrenic paranoid Italian, Catholic woman, twenty-six years old, mother of a child. Her husband was also a patient in another mental hospital. This patient had many problems in her marital relationship. Her family insisted on keeping her away from her husband. She was abusive with her child. Her brothers brought her back to the hospital.

- Case 27. A Canadian woman of Protestant religion, sixty-seven years old, who had been diagnosed as a schizophrenic paranoid. On trial visit she lived with her daughter who rejected her and asked for her re-admission.
- Case 28. A schizophrenic paranoid, alien, born in Lithuania, thirty-six years old, Catholic, who had worked as a baker. This patient had come to this country only six years ago and had a language barrier which prevented him from working. During trial visit was cruel with his wife and four children. His wife was afraid of him and could not help him in his adjustment after being released from the hospital.
- Case 29. A schizophrenic paranoid, twenty-seven year old man who worked as a machinist's helper and was of Protestant religion. This patient had been released on trial visit against advice on his mother's request. At home felt unwanted and rejected by his mother and wife. He asked for his readmission.
- Case 30. A schizophrenic catatonic Catholic woman of Italian background and forty-four years old. Both she and her husband suffered from deafness and had been on public welfare for many years. During trial visit was seclusive, did not have any friends and could not find a job because of her hearing problem.
- Case 31. A Catholic woman of Irish descent, mother of two children, whose diagnosis had been schizophrenia, schizo-affective type, forty-seven years old. After being released she was unable to regain her position in the home. Marital discord made her ask for her readmission.
- Case 32. A manic depressive Irish woman aged fifty-seven, a dietitian. Her father had been a mental patient. Her husband was unable to take care of her after her hospitalization because of his drinking. Her marital problems and her own addiction to alcohol precipitated a new breakdown of her psychoses.
- Case 33. A thirty-four year old woman, Catholic, mother of four children, who had suffered from manic depression. During trial visit she neglected her home and children. Her living conditions were then unsatisfactory because she lived in a crowded basement with her in-laws. Her father had been a mental patient and her brother had been in a penal insti-

tution. This patient was pregnant at the time of her readmission.

- Case 34. A seventy-eight year old man, manic depressive, who had been a waiter. Because of his old age he was unable to work on his trial visit, which he spent with a friend. Loneliness and the lack of interest on the part of his own family made him return to the hospital.
- Case 35. A twenty-eight year old woman who had suffered from psychotic depression, Catholic, was released under the care of her alcoholic husband who was unable to take care of her in her post-hospitalization period. Her own drinking was also a factor in her new breakdown.
- Case 36. A Jewish man, thirty-eight years old, who had a psychotic depression. His occupation was manufacturing. During his trial visit lived by himself in boarding houses. A hearing deficit prevented him from finding a job. His wife did not want to be responsible for him when he was released.
- Case 37. An Irish, Catholic woman, mother of three children, forty-six years old, who had a psychotic depression. At home she could not get along with her husband and children. Seclusiveness and marital conflicts were a factor in the recurrence of her symptoms.
- Case 38. A Catholic fifty year old woman of Irish origin whose diagnosis was psychotic depression. She was the mother of three children and drank heavily. Her husband asked for her readmission because he wanted to protect their children from her abusiveness.
- Case 39. An English woman, aged fifty-five of Catholic faith, who suffered from involuntional psychoses. Sex problems related to the menopause disturbed her greatly when she returned home. Her husband was attending group psychotherapy meetings for husbands of mentally ill women. Both of her parents had been alcoholics. One of her sons had also drinking problems. This woman was readmitted on her own request.
- Case 40. A forty-three year old female of Protestant religion who had a psychoneurotic depression. Her occupation was show dancing. Her husband drank. When on trial

visit was lonely, without any social outlets. Her only relative was her grandmother.

- Case 41. A Southern colored, Catholic woman, aged seventy-nine, who suffered from chronic brain syndrome. This woman was released under the care of her elderly husband. Marital discord was the main reason for her readmission. This patient also suffered from arterioesclerosis.
- Case 43. A Protestant woman, who suffered from chronic brain syndrome and hypertension, had no relatives and was very seclusive.
- Case 44. An Italian divorced man, schizophrenic paranoid, aged forty. During trial visit he tried to find a position but could not.
- Case 45. An English woman, thirty-five years old, of Catholic religion, who had been diagnosed as a schizophrenic paranoid. She had one child and stated on readmission that she did not want to be at home because she could not find employment.
- Case 46. A Russian woman, fifty years old, of Jewish religion. Her diagnosis had been schizophrenia of catatonic type. When on trial visit worked as a saleswoman but felt inadequate in her job. She did not have any friends.
- Case 47. A thirty-five year old woman, typist, of Irish descent, who had suffered from schizophrenia, schizo-affective type. On trial visit felt rejected by her mother and asked for her readmission.
- Case 48. An Irish, Catholic waitress, aged forty-one, whose diagnosis was involuntal psychoses. Her daughter had problems with delinquency while she was on trial visit. This patient lived with a friend but could not get along with it.
- Case 49. A Canadian man, widowed, seventy-nine years old, who suffered from chronic brain syndrome, senile type. On trial visit lived with a friend, was very seclusive and had economic problems.
- Case 50. An Irish widow, seventy-nine years old, who lived in a nursing home during her trial visit. Her diagnosis had been chronic brain syndrome with alcoholic intoxication. Her constant drinking was the

main cause of her readmission.

The following table indicates the various social and emotional problems these patients had during the time they spent on trial visit, which were a predominant factor in causing their readmission.

Table VII shows that the most common problems these patients had when they were on trial visit was in the area of interpersonal relationships. By this, the author means the inability these patients had in getting along either with their parents, children or spouses. The second main problem they had to face outside of the hospital was the inability of their relatives in those who had them, in helping them to readjust to family life. Overanxious and fearful parents made some of these patients feel uneasy at home. The third important problems was the lack of social interests in these patients after they were released from the hospital. Lack of relatives interested in the patients' rehabilitation was present in ten cases. Drinking, rejection by relatives and problems in finding work were also of considerable importance. Physical illness was a handicap in securing jobs and in achieving social adjustment in a small number of cases.

TABLE VII.

SOCIAL AND EMOTIONAL PROBLEMS OF THE FIFTY PATIENTS

Problems	Single	Married	Divorced and Widowed	Times Mentioned
Seclusiveness	6	4	2	12
Rejection from family	5	2	1	8
Relatives unable to help	11	3	0	14
Employment	2	3	3	8
Drinking:				
In relatives	3	5	0	8
In patients	2	3	1	6
Drug addiction	0	1	0	1
Sex problems	1	2	0	3
Illnesses:				
Epilepsy	2	0	0	2
Spasticity	1	0	0	1
Deafness	0	2	0	2
Asthma	1	0	0	1
Premature dis- charge from hospital	1	1	0	2
Dependency on hospital	2	1	0	3
Mental illness in family	0	2	0	2
Lack of relatives	4	4	2	10
Interpersonal relationships	14	8	3	25

CHAPTER V

SUMMARY AND CONCLUSIONS

This study of readmissions to the Boston State Hospital, of patients who were released on trial visit and were returned to the hospital between October 1, 1955 and November 30, 1956, was undertaken to determine the social and emotional factors which contributed to the rehospitalization of mental patients.

Fifty cases were selected by random procedure from 201 readmissions occurring in the time mentioned.

The study group included patients whose ages ranged between twenty and eighty, although the majority fell into the age grouping twenty to fifty. Sixty-six per cent of the fifty readmissions were women; thirty-four per cent were men. Forty-eight per cent of the group were single, thirty-eight per cent were married; ten per cent were divorced and four per cent were widowed. Ninety-six per cent were white; four per cent were colored. Sixty-four per cent were Catholic; twenty per cent were Protestant and sixteen per cent were Jewish. The fifty patients readmitted were of families in the low income level.

Diagnostically, the group of schizophrenics made fifty-four per cent of the total population. Affective disorders were present in twenty-four per cent. Eighteen per cent suffered from brain disorders and two per cent were not psychotics. These were a mentally deficient and one who suffered a psychoneurotic depression.

The patients came from nine different cultural backgrounds. The most predominant were Irish, English and Italian.

The length of hospitalization these patients had varied between one month and twelve years. Fifty-two per cent had less than one year; thirty-two per cent had from one to three years, ten per cent had from four to six years, six per cent had spent from seven to nine and two per cent had from ten to twelve years.

The duration of trial visit varied between three days to eleven months. Thirty-six per cent stayed out of the hospital from one to three months, twenty-four per cent spent from seven to eleven months; twenty per cent had from four to six months and twenty per cent stayed out less than a month.

Eighty-two per cent of these patients had been placed on trial visit without the help of the Social Service Department.

Sixty-four per cent did not report to the Out-patient Department while they were in the community.

Sixty-eight per cent of the fifty patients spent their trial visits with their families. Sixteen per cent were by themselves.

As to the number of previous hospitalizations, twelve per cent of the patients had one; twelve per cent had two; two per cent had five and two per cent had six.

Comparing these findings with those made by Belson at the Veterans Administration Hospital in Bedford, Massachusetts in

mitted to the Boston State Hospital seemed to have a wider range of mental disorders and religions. Almost twice as much as in the Veterans Administration Hospital patients went into the community without any preparation from Social Service.

The patients readmitted to the Boston State Hospital seemed to have been older; since fifty per cent were under forty while at the other hospital, sixty-five per cent had been of that age.

There were more single patients readmitted at the Veterans Administration Hospital. Also the patients at this hospital had longer hospitalizations, since seventy-four per cent had been at the hospital for four years or less; while at the State Hospital fifty per cent had been for less than one year and thirty-two per cent for less than four years.

Belson did not study social and emotional factors which contributed to the readmission of mental patients, so these findings cannot be compared.

The questions the writer proposed in Chapter I were:

1. What were the social and emotional problems which contributed to the readmission of these patients?
2. Were these patients helped by the Social Service Department of the hospital before they were placed on trial visit?
3. Are there factors that are more predominant in

10
1951¹⁰ in her study of readmission of mental patients who had been placed on trial visit status, the results are the following:

Sixty-five per cent of sixty-eight patients studied were single. Seventy-two per cent were of Catholic faith. Sixty-nine per cent had fallen into the category of schizophrenics. Forty-four per cent of the patients did not have pre-release planning or preparation by the Social Service Department before going on trial visit. Sixty-two per cent had been hospitalized twice before the readmission studied. Forty-six per cent were over forty years of age; sixty-five per cent were below forty. Thirty-five per cent of the readmissions had been hospitalized for less than one year. Seventy-eight per cent had been at the hospital for four years.

In this study the findings comparable to the ones mentioned before are that at the Boston State Hospital forty-eight per cent of the readmissions discussed were single; sixty-four per cent were Catholic; fifty-four per cent were schizophrenics. Eighty-two per cent were not helped by the Social Service Department before going on trial visit. Fifty per cent had been hospitalized for less than one year; thirty-two per cent were hospitalized for four or less years.

From these details it can be seen that the patients read-

10. Harriet Belson, "A Survey of Readmissions to the Veterans Administration Hospital, Bedford, Massachusetts," Simmons College, 1951.

causing a recurrence of mental illness than others?

The main social and emotional problems these patients had during their trial visits was in the area of interpersonal relationships, either because they were too dependent or because they were unable to function in their family roles.

Lack of social interests and seclusiveness were present in many cases. Seclusiveness in several cases was due to physical illness and lack of relatives or friends, but in most cases, patients were lonely even when they were in their own homes. Relatives were not prepared to cope with the insecurity and fear released patients have when they return to the community. Drinking by parents, husbands and wives contributed to several patients having to return to unhealthy social environments.

In relation to the second question, the findings were that Social Service at the Boston State Hospital had little, if any, contact with the fifty patients readmitted. Sixteen patients were referred to Social Service after they returned from trial visit; before this, forty-one patients were found having been released on trial visit without any preparation. This indicates that eighty-two per cent of the total population of patients released on trial visit, leave the hospital in this situation, which doubtless leads to new readmissions because neither patients nor relatives have any help in trying

to understand each other's problems.

As to the third question, it was felt that a lack of real understanding of the patient's illness and needs by members of the family and pressures created by the family and patients to have the patient granted a trial visit, as well as fear of people and fear of new situations were some of the factors which were more directly responsible in causing a recurrence of the mental disorder.

¹¹
Feggans, in her study of readmissions of mental patients to the Boston State Hospital in November, 1946, found that the lack of understanding of the patient by his parents, relatives, spouses and/or children and lack of economic security were the main factors causing the readmission of the twenty-five patients studied.

¹²
Dwinell, in her study, "Factors in the Readmission of Married Women to the Boston State Hospital," found that the most important social and emotional problems which led to the readmission of twenty-two married who had been released from the acute wards, were: lack of continued help to facilitate adjustment in the community, marked dependency upon the hospital, unhelpful attitudes toward patients on the part of

11. Gwendolyn Feggans, "A Study of Readmissions of Mental Patients to the Boston State Hospital in November, 1946," Boston University.

12. Margaret Dwinell, "Factors in the Readmission of Married Patients to the B. S. H.," Boston University, 1956.

relatives and problems in accepting life roles.

Comparing those findings with the ones found in this study, it seems that lack of cooperation from relatives and difficulties in interpersonal relationships are the main causes of readmission of mental patients. In this study there were not many cases which showed over-dependency on the hospital and, though all patients were of marginal economic condition, only one had been under public welfare, so it cannot be said that lack of economic security was one of the main factors causing rehospitalization in these patients.

The findings in this study indicate many areas in which Social Service might play a greater part in assisting patients who are or will be on trial visit to adjust to life away from the hospital.

The most obvious need is for routine participation of the social worker at the point of admission to provide the hospital staff with a more complete psychosocial diagnosis upon which to base treatment procedures. In this way the social worker would learn what problems were present in the home situation which might be modified either through help from the hospital services, or through the cooperation of social agencies in the community. In this way relatives could be involved in planning for the patient's release from the beginning with a view toward helping to change their unhelpful attitudes, providing a communication link with the medical

staff, and regarding the patient at all times as a part of the family unit.

Optimal services to patients and their families might also include wider use of group psychotherapy. The socializing potential of group psychotherapy would be particularly valuable as well as the function of these groups in preventing patients from needing to be rehospitalized. The group approach in helping relatives might be helpful in acquainting them with treatment facilities and allowing them to discuss common problems encountered in having at home patients on trial visit.

Patients who go on trial visit under their own care should be encouraged to attend social events. These people need perhaps more than any one else constant supervision while they are on trial visit. Referral of them to community centers where group work is practiced could be helpful in preventing that seclusiveness characteristic of patients who lack relatives and in whom mental illness has caused more self-consciousness because interpersonal relations have been absent in the greater part of their lives.

The patients studied in this thesis came from various cultural backgrounds and were the first generation born in this country from foreign parents. It would be interesting to study the relation of mental illness to that particular condition in the background of people who have to adjust to

social settings different from the ones they originally came from.

Accepted
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SCHEDULE

1. Age on last admission: Diagnosis: Sex:
2. Religion: Cultural background:
 Occupation:
3. Social factors:
 Marital status:
 Education:
 Economic condition:
4. Dates of admission:
5. Length of hospitalization:
6. Length of trial visit:
7. Use of Out-Patient Department:
8. Help by Social Service Department:
9. Precipitating factors of readmission: