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Factors contributing to the readmission of Alcoholic patients to the veterans administration hospital, Newport

Frances Clyburn Avery

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FACTORS CONTRIBUTING TO THE READMISSION OF ALCOHOLIC PATIENTS TO THE VETERANS ADMINISTRATION HOSPITAL, NORTHPORT

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY
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SCHOOL OF SOCIAL WORK

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ACKNOWLEDGMENTS

The writer wishes to acknowledge with gratitude the assistance of all those persons who made this study possible.

I am especially grateful to my advisor, Mr. Warren Moore, for his unfaltering support, guidance and helpful criticisms.

For his encouragement, patience and understanding, I am indeed grateful to my beloved husband.
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CHAPTER I

FACTORS CONTRIBUTING TO READMISSION OF ALCOHOLIC PATIENTS TO VETERAN HOSPITALS

Significance of Study

It has been estimated that there are one and a half million people in the United States who have economic, vocational, physical and marital problems by reason of the excessive use of alcohol.¹

There is no group of persons in greater need of understanding than the alcoholic because of the adverse effect which drinking has on his life. Five out of six alcoholics are men between the ages of 30 and 55 - the most productive years. Alcoholism, therefore, constitutes a major health problem.²

Today, treatment of the alcoholic is based on the firm belief that he can be helped and is worth helping.

The modern approach is very different from the therapy afforded the drinker in the past. Our present understanding of the specific detrimental effects of alcohol upon the central nervous system has opened new avenues for the future care of the alcoholic individual.³

The origin of the disorder can ultimately be found in acute disturbances of early family relationships. Histories of alcoholic parents, or of rejection by or separation from parents, are common in the alcoholic

person. Even when pathological home backgrounds are not evident, inquiry usually reveals that more subtle disturbances took place in the home.

Out of such miscarriages of early development, to which must be added the modifying influences of later experiences comes the final picture of the problem drinker, characterized by difficulties in all phases of his life adjustment.¹

Alcoholism is a symptom of an illness and not a disease by itself. It is a symptom of deep or deeper underlying personality – emotional reactions of varying degrees and types.

The alcoholic's use of liquor – plus its resulting nervous strains and reactions, and his own nervous pressure – interferes directly or indirectly with one or more of his important life activities. That is, his drinking harms himself, his family, or his standing in the community.²

Every person with an alcohol problem has a personality conflict. The alcoholic is usually an immature, insecure, over sensitive, and anxious person who is suffering from marked feelings of inferiority; unable to meet and enjoy people socially or unable to get on with his work without the support of alcohol in fairly large quantities. This indictment against the alcoholic sounds serious but with rare exceptions it is true.³

One finds that the alcoholic patient very frequently has difficulty in establishing and maintaining mature, constructive interpersonal relationships. In addition, many psychiatrists believe that alcoholism is a

² Robert V. Seliger, Alcoholics Are Sick People (Baltimore, 1945), pp. 2-3.
³ O Spurgeon English, and Gerald H. H. Pearson, op. cit.
symptom of an unpleasant or frustrating period of infancy undergone by the particular individual involved. Thus, references are made to alcoholism as being symptomatic behavior wherein the individual is attempting to meet some otherwise unmet oral need.¹

Likewise, authorities agree that the individual's excessive use of alcohol is an escape from a reality situation which is too threatening for this individual to face.²

The psychiatrist conceives of psychogenic characteristics as those formed in the early emotional development of the infant and the child in the family environment. He assumes that psychogenic reactions are constructs which are complicated as genetic traits.

The above reference to psychogenic characteristics is often spoken of as a "psychiatric personality" in connection with some definitions of the psychogenic components of personality. The psychiatric personality is defined as a total configuration of reactive tendencies determined by heredity and by pernatal and postnatal conditioning up to the point where cultural patterns are constantly modifying the child's behavior. It may be conceived of as a system of reaction patterns and tendencies to reaction patterns appearing shortly after birth and going into the life pattern of the individual.³

The psychogenic traits thus formed include tendencies to extraversion or introversion, dominance or submission, optimism or pessimism, emo-

² Ibid.
tional independence or dependence, self confidence or lack of self confidence and egocentrism or socio-centrism.

Psychogenic traits develop in the interpersonal relations of the family. They arise more or less spontaneously in the social interactions of the child with parents and brothers and sisters. The earliest distinctive responses of the child to persons in his social environment may be said to be a resultant of: (1) his genetic traits, (2) of parental responses to him, and (3) of special factors in the situation, such as illness.

The protective setting and treatment at the Veterans Administration Hospital at Northport is believed to be one way of helping the patient work through his social, emotional and physical problems so he can adjust satisfactorily upon his return to the community.

As physical vigor, mental alertness, and emotional comfort enfold upon one who a few months since was enslaved in a deceptive maze, the future becomes a subject of deepening importance. What to do with the new-found strength? What protection will be necessary to maintain present self-mastery? How will the home help? To what will the patient return that will uphold the good he has gained?

The patient has spent six months, a year or longer in surroundings rich in the vitamins of normal life. His attitudes are now inspiringly different. Usually earnest, sometimes overconfident, he returns to mingle with his family, friends and fellow men. Is he cured? Ah, how many of those who have worked beside him these months follow him in honest hope! Will he relapse? We think of cases where the patients have tried themselves out to see if they could adjust and after a short time were returned to the hospital. The defects in his acceptance of the principles taught him were revealed, and he was shown the fallacy of utilizing the faults of others as his own alibi. An added period of self-searching treatment was again undertaken in fuller recognition by all concerned of

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the weaknesses and difficulties which were to be overcome by the patient.

Another type of patient who returns is that of the rebellious, stubborn patient who, resenting his enforced institutionalization and the deprivation of what he considers his rights, has never surrendered a hidden determination to show the family who was the stronger; and he promptly and defiantly returns to drink and is sooner or later readmitted to the hospital.

The alcoholic patient who is required to face continuous periods of hospitalization are those who do not realize that the crutch that once supported them, "alcohol," has failed. The beginning of the failure first appears with the inability to obtain pleasure from drinking. Eventually he must drink to be comfortable. Undisturbed, he may remain superficially good natured, but fear and irritability are close beneath the surface. He loses friends. His wife leaves him. He is fired from his job. His alienation deepens as in his heart he charges all and sundry with being envious of him, of not giving him a square deal, of not appreciating his ability, and the flames of suspicion smoulder within his deforming mind.

Among the returned alcoholic patients, an effort has been made at self-emancipation with resulting periods of self-control and orderly conduct over weeks and months. Then some situational form, some depression or the tension of social pressure, and a retreat of good resolutions will result in a relapse. Even after periods of reconstructive treatment, the capacity to hold fast to their attainings wanes. Returned for supervised care, a new analysis brings to the surface the usually unconscious compromises which existed even throughout the original treatment, or some failure to assume an unequivocal attitude of pride in obstinence, or to maintain the newly acquired emotional maturity as he returned to former influences.

Such relapses may prove the needed opportunity to solidify the principles of therapy.1

This study was concerned with the factors which influenced the patient after his first hospital discharge and his readmission.

It is the desire of the writer that this study will prove helpful to the social worker who gives casework services to the alcoholic individual.

Purpose of Study

The purpose of the study was to describe the causes apparent or obtainable which seemed to contribute to the readmission of the alcoholic

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patient to the hospital.

Method of Procedure

All records of patients with a secondary diagnosis of alcoholism who were discharged and readmitted to the hospital during the period from September 1, 1956 through September 1, 1957 were taken from the files. There were twenty such cases. From this group those currently active or having been active with social service were selected. A total of ten cases remained. A schedule was utilized in the collection of the data from the case records. Interviews were held with individual social service staff members and other hospital personnel who had known the patients during hospitalization.

Reading material concerning alcoholism was also utilized.

Scope and Limitations

This study was limited to a six months period during which time the writer was at the Veterans Administration Hospital, Northport, Long Island, New York.

The study was further limited in that there was a small sample which was taken from one hospital, which receives its patients from a limited area in New York State.

Records varied as to the amount of information which could be obtained. Some of the records were more detailed than others, thereby giving the writer more material with which to work in some instances.

The hospital only handles male veterans thus excluding the use of female patients in the study.

The experience of the writer, the use of only cases known to social
services and readmitted to the hospital from September 1, 1956 through September 1, 1957 were further limitations of the study.

A larger study including more than one hospital might have revealed a different set of data.
CHAPTER II

DESCRIPTION OF SETTING

The Veterans Administration Hospital at Northport, Long Island, New York, is the largest veterans' hospital in the United States. "Devoted primarily to neuropsychiatric service, it has a bed capacity of 2,488 and is currently operating at its maximum capacity under a staff of 1,395 employees." The hospital is situated on 450 acres just outside the village of Northport. This institution is comprised of 120 buildings of which 17 are living quarters for patients.¹

The hospital was opened in November of 1928. It has its own power and heating plants, water supply, laundry, fire and police department, and sewer disposal facility. There are 10 miles of roads traversing the grounds.²

The hospital is equipped to meet any type of psychiatric, medical, surgical, dental, neurological or tubercular problem. There are thirty-six full-time physicians on the staff, twenty-five in psychiatric service. The others occupy administrative and medical posts. Supporting the regular staff is a panel of thirty-five consultants representing all specialties of medicine and dentistry.³

Out-patient care is an important part of the hospital's work, and a clinic is maintained for the purpose of follow-up care and treatment to all neuropsychiatric veteran-patients who are on trial visit status and

¹ Station Handbook - HB - 10, Veterans Administration Hospital, Northport, New York (1957), Section A-1.
² Ibid., Section B-1.
³ Ibid., Face Sheet 1.
who reside in Nassau and Suffolk counties.

There is a total integration of all the hospital departments with the view of helping the patient with his internal and external conflicts with which he is confronted.

The hospital is divided into two services, namely: administrative and professional. Included under administrative services are the Manager and departments of Supply, Finance, Engineering, Personnel, Communications, Records and Registration. The professional services are Chaplaincy, Dietetic Service, Dental Service, General Medical and Surgical Service, Nursing Service, Pharmacy, Physical Medicine and Rehabilitation, Laboratory, Special Service, Neuropsychiatric Service, Psychology and Social Work Service.¹

The psychiatric treatment program of the hospital is divided into Acute Intensive Treatment Service (AITS) and the Continuous Treatment Service (CTS). AITS is for patients with little or no previous history of psychosis whom the doctors feel can respond to intensive treatment and leave the hospital within a short period. CTS handles patients whose illnesses are of longer duration.²

All admissions to the hospital are handled by the Admission ward of AITS. Within a day or two after admission, new patients are seen briefly by the Medical staff who request from social service whatever material (life and family history) they need in order to diagnose the patient’s illness and decide upon treatment.³

¹ Station Handbook, op. cit.
² Ibid.
³ Ibid.
The hospital utilizes the "team approach" in terms of collaboration of the psychiatrist, the psychologist, and the social worker, in addition to any other professional personnel working with the patient. "Specifically the social worker, with his knowledge and understanding of the patient's social situation, is able to help the Medical staff become cognizant of the social factors with which the patient is confronted."\(^1\)

The social casework process which is carried out at this hospital consists of:

1. Explaining the veteran's past and current situation to identify those social facts and features in his interpersonal relationships and cultural setting and those attitudes and feelings on the part of the veteran himself or others that appear related to his health and that may have diagnostic or treatment significance in the VA's care of the patient.

2. Formulating the social diagnosis showing the veteran's social and emotional problems and strengths and, insofar as possible, identifying the courses or mechanisms behind them, determining in conference with the physician which of these components have the most direct bearing on the patient's condition -- causal, precipitating, perpetuating, concomitant, or resultant.

3. Establishing goals in social treatment and designing and carrying out social treatment measures through appropriate methods and techniques.\(^2\)

In the final stages of working with the psychiatric patient, it is the responsibility of the social worker to prepare the patient and his family for his return to the community.

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CHAPTER III

FACTORS CONTRIBUTING TO THE READMISSION OF ALCOHOLIC PATIENTS TO THE VETERANS ADMINISTRATION HOSPITAL, NORTHPORT

Personality, as an all inclusive term, encompasses the sum total of the individual's behavior which is peculiar to him. The individual personality is greatly influenced by his environment. In order to gain a better understanding of the veteran, one should have basic factors that can be isolated which might contribute directly or indirectly to his readmission to the hospital. The wide range of social and personal data that might have influenced the patient's adjustment was not attempted in this study, but presentation of some isolated characteristics may be helpful.

Age and Marital Status

Grown people cannot remain dependent in attitude if they are to be successful with life's problems. It is this attitude of dependency that is present in the relation of the alcoholic who attempts marriage. He senses he is going to be excused for his neglect of obligations and responsibilities.

It is believed that the earlier in life the alcoholic person recognizes his problem, the greater his chances for improvement. "Five out of six alcoholics are men between the ages of thirty and fifty-five - the most productive years. The adverse effect which alcohol has on their lives is seen in their total life adjustment."

In regard to age and marital status of the patients studied, there

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1 Arthur P. Noyes, op. cit.
appeared to be some association in that the forty-one and over age group had the largest number of married patients.

There were more patient readmitted with a secondary diagnosis of alcoholism between the ages of thirty-six and forty.

Although there were no instances of divorce in the patients studied, three separations were indicated.

**TABLE 1**

**AGE AND MARITAL STATUS OF PATIENTS**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Patients</th>
<th>Married</th>
<th>Single</th>
<th>Sep.</th>
<th>Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 30</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>31 - 35</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>36 - 40</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>41 and above</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
<td><strong>3</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

It is interesting to speculate that in regard to age of the alcoholic patient that more patients between thirty-six and forty years of age recognized their need for treatment and returned to the hospital.

The alcoholic's inability to form adequate interpersonal relationships is seen in the number of patients who attempted marriages which ended in separation.

**Level of Education**

Learning of academic subjects and the use of such learning can acquire for the individual the potentials of a successful life, and help to render him able to take responsibility for his daily life, and to be self
confident.

The level of one's learning determines to a great extent his ability to develop skills that will make for vocational, social, and individual success.

Although the problem of alcoholism was not present in the patients' earlier years of learning; the deep underlying emotional problems which are common to the alcoholic existed. Confronted with the emotional problems, he was not able to overcome; a feeling of insecurity, sensitivity and restlessness resulted, followed by poor adjustment and often withdrawal from school.

TABLE 2
EXTENT OF EDUCATION

<table>
<thead>
<tr>
<th>Education Completed</th>
<th>Number of Patients</th>
</tr>
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<tbody>
<tr>
<td>No schooling</td>
<td>0</td>
</tr>
<tr>
<td>Some grammar school</td>
<td>0</td>
</tr>
<tr>
<td>Grammar school graduate</td>
<td>4</td>
</tr>
<tr>
<td>Some high school</td>
<td>4</td>
</tr>
<tr>
<td>High school graduate</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
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The level of education achieved by the patients in this study was low. Only two of the patients were able to finish high school with four having some high school training and four completing grammar school. We were not able to find any study or figures with which this finding is completely comparable. However, if we base our findings on the assumption
that the alcoholic has deep underlying emotional problems which stem from early development, it would appear likely that an educational difficulty would be experienced by the particular individual.

Medical Diagnosis

All of the patients included in the study had a diagnosis of schizophrenic reaction, paranoid type with a secondary diagnosis of alcoholism.

Some alcoholics suffer from a major type of mental illness, but every form of mental illness has been found among alcoholics. In other words, the alcoholism is a symptom of their illness and not a cause, and they would need psychiatric care even if they never touched alcohol.¹

Race and Religion

When we studied the effect of differences in race and religion on the patient's problem, we were not able to find any situation where these factors alone or even primarily could be held responsible for his return to the hospital. However, there were five Negro and five white patients. The sample was composed of five Catholics and five Protestants.

Family Relationships

A friendly family relationship, if it can be maintained, demands tolerance, patience, and understanding of all its members.

The primary patterning of personality within the family conditions responses to life situations, thus from all the patterns established from infancy and childhood are determined the following:

1. Attitudes to men and women, superiors and subordinates.
2. Identification of self with ideals, emotionally motivated, attitudes and beliefs which lead to development of techniques for

¹ Robert V. Seliger, op. cit., p. 22.
the achievement of success or failure.

(3) Ethical and moral attitudes.\(^1\)

Since the family plays an important role in the development of the individual and his future adjustment, we feel some consideration should be given to the attitudes of the patients' families.

**TABLE 3**

**FAMILY ATTITUDES**

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Number of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>3</td>
</tr>
<tr>
<td>Negative</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
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</table>

In evaluating family attitudes the writer attempted to establish a composite family attitude in regard to the families of the patients studied. Needless to say, various gradations were found in the attitudes of family members.

For the purpose of this study, the family attitude in the instance of a particular patient was considered the relationship of the dominant member of the family in terms of closeness in marital and blood relationship.

A positive family relationship was considered one in which attitudes expressed were acceptance, cooperativeness and tolerance.

A negative relationship was considered one in which attitudes were

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1 Genevieve Alston, "Social Concepts of Course" (Lecture delivered to class in Social Case Work 505, Atlanta University, Atlanta, Georgia, March 7, 1958).
hostile, non-accepting and intolerant.

The ten cases represented varied family groups in terms of relationships, numbers and compositions.

In most instances, the dominant member was either the patient's mother, wife, an adult sibling or various combinations of these relationships.

Seven of the family attitudes were negative and three were positive. This finding is significant in that it would appear that the family relationships of the patients studied had some influence on their future emotional problems.
CHAPTER IV

CASE PRESENTATIONS

In the various data, it was discovered that the factors contributing to the patients' readmission to the hospital stemmed from two major areas of adjustment. These areas were, namely: economic adjustment, including occupational and financial stress; and social adjustment, including inter-familial and social relationships. It was true that elements stemming from both of the areas were present in all of the cases, however, for this study, the predominance of the influence of the factor upon the patients' post hospital adjustment served as a basis for determining into which category the patient fell.

There were four patients in which economic factors, as afore described, seemed to have the predominant precipitating influence in the patients' readmission. In the six remaining cases the predominant influence appeared to be in the area of social adjustment and was considered the contributing factor in the patients' readmission to the hospital.

Economic Adjustment

Of the four patients who were having difficulty in the area of economic adjustment, two of the patients' problems were related to occupation and the other two were financial pressures.

Case No. 1 is an illustration in which difficulty in occupational adjustment was the predominant precipitating factor for the patient's return to the hospital.
Mr. A., a 29 year old, Negro, separated, World War II veteran, protestant, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 5-10-57 with a Maximum Benefits hospital discharge on 12-5-57.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

The history revealed that the patient was pampered by the mother and rejected by the father. Throughout childhood he was shy and timid and in adolescence was a poor mixer with no special interests. In adulthood, the same behavior was manifested.

The patient's first job after discharge from the hospital was secured through the influence of his brother at an auto wrecking shop. Since the patient had engaged in this type of work before, it was felt that could adjust. He remained on the job approximately two months before he found it uninteresting and monotonous, and his fellow workers congenial. The patient complained that the work was fatiguing and that he felt strange and apart from the other workers. He gave this job up, hoping to find something more to his liking. Patient was hired at a steel plant; which employment lasted for only two weeks. On this job, the patient could not adjust to working with a partner and requested a job he could perform alone. Such request was granted but he soon found the work "tiresome" and "boring" than the first job. Patient was hired next in a chemical plant shortly thereafter. He soon began to worry that he was not working fast enough to satisfy his foreman and that his fellow workers did not like him. Becoming disinterested in his work, he began taking days off and being tardy when he did show up. On one occasion when he was reprimanded by his superior for being late, the patient became verbally abusive and was fired. A series of jobs followed, each one being more tiresome and boring than the next. The patient, becoming dissatisfied and discouraged in his employment difficulty which had carried over into his family life, soon became a daily drinker.

This case is an illustration of the patient who had extreme difficulty in his occupational adjustment because of his emotional immaturities. When cooperation, altruism, and stability were demanded of him, he was not able to meet these requirements. He became a floater, one who never makes good anywhere, who never stays on one job long enough to find himself.

For this patient, the strain and stress of adjusting to work and its routines created many tensions, anxieties, fears, and resentments which resulted in his poor adjustment and ultimate attempt to escape through the medium of alcohol.
Case No. 2 is a typical example of the patient who experienced difficulty in the economic area but the predominant precipitating factor was one of financial pressures.

Case No. 2

Mr. B., a 39 year old, white, married, World War II veteran, protestant, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 9-4-56 with a Maximum Hospital Benefit discharge on 4-10-57.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

The patient was overprotected and pampered in childhood. He was described as excitable and prone to temper tantrums as a child. In adolescence and adulthood, he had few friends and was withdrawn.

When the patient was discharged from the hospital, he returned to live with his wife and sibling. Unable to secure employment immediately, the patient began to get restless and tense and felt that no one wanted to hire him. He wanted the routine of the home changed to please him. The teenage sibling was punished when he crossed the patient. The patient accused the wife of being overprotective of the child and of not caring for him. He was able to secure employment as a part-time janitor which paid little. Unable to meet his current family financial obligations, the patient borrowed money from a relative. The patient's wife who had a physical ailment needed medical attention at this time. In a reduction of workers at the office where the patient was employed, he was released from his job. When he was relieved of his job, the patient became anxious and even physically abusive in his relationships with his wife. The wife, attempting to appease the patient, would try to help him understand how his behavior was not helping the difficult situation but she was met with hostility and rage resulting in his leaving the home and returning under the influence of alcohol.

On one occasion, the neighbors summoned the police to the home fearing the safety of the patient's family. Although the patient's family appeared tolerant of his behavior, he was not able to withstand the economic pressures.

This case is an illustration of the patient whose financial problems caused him to become anxious, hostile and unable to function adequately in his home. While an impairment in social adjustment can be seen in this case, the loss of self-confidence resulting from the inability to support his family appeared to have been the predominant factor. The patient's low tolerance to stress situations was exhibited in his overt behavior and
his negative relationship with his family. However, his inability to provide financial support increased his sense of inadequacy and resulted in the excessive use of alcohol as a means of escape. In other cases of alcoholism the manifestations may be reflected in a number of ways. It would appear that this patient had not been conditioned to withstand pressures and with the loss of his job, his future financial status seemed hopeless.

The writer felt that these two cases were typical enough of the pattern to provide an adequate generalization with respect to the other two patients who experienced difficulty in the economic area in regard to financial and occupational adjustment.

Social Adjustment

Of the six patients who had difficulty in the social area, four of the patients' problems related to the inter-familial relationships and two stemmed from inter-social relationships.

Case No. 3 is an example of difficulty in which the family relationship was the predominant precipitating factor in the patient's return to the hospital.

Case No. 3

Mr. C., a 32 year old, single, white, protestant, World War II veteran, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 8-17-57.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

The record indicated that the patient had a rejecting mother and a passive-aggressive father. In both childhood and adolescence, he was withdrawn, passive and had difficulty in relating to people. As an adult, he was a poor mixer and remained alone most of the time.

After the patient was discharged from the hospital, he lived in the home with his sister and brother-in-law. The patient appeared
to have difficulty in his relationship with his brother-in-law because he believed him to want to dominate him. Any attempt by the relative to help the patient was met with hostility. The patient was unemployed and lived off the funds he received from his army disability. He could not be depended upon to share in any of the responsibilities around the home. Whenever he was asked to perform some job around the house, he quickly replied that he paid for his lodging and that nothing else should be expected of him. The patient had difficulty in getting along with his sister and often accused her of discussing him with her husband. Each time the patient received his checks, he would first satisfy his own wishes and desires and then gave his sister whatever was left which frequently was a small amount not in proportion to his living expenses in the home. Most of the patient's funds were being used for his alcoholic cravings. He was brought home on two occasions in a drunken stupor in a week's time. When the sister faced him with his behavior, he lost control - struck her, cursed and left the home for two days. The patient's negative relationship with his family was becoming more intense to the extent that his family was not able to accept his behavior and he was returned to the hospital.

The patient who had difficulty in his inter-familial relationships is illustrated in this case. His resentment and feelings of being misunderstood reflected in extreme hostility toward his family. This hostility was seen in various ways; sometimes being focused directly on family members and through his refusal to assume his financial obligation to the family. The patient's negative relationship with his family became so intense that they were not able to accept his behavior.

This hostility which prevailed was no doubt an accumulation of his frustrations garnered during his early development and had become his way of coping with his pent-up emotional feelings. Unable to adjust sufficiently to the normal course of life, the patient turned to alcohol to narcotize his tension, restlessness, and hostility.

Case No. 4 is another illustration of the patient who had difficulty in his inter-familial relationships which resulted in his ultimate return to the hospital.
Mr. D., a 51 year old, married, white, Catholic, veteran, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 7-18-57 with a Maximum Hospital Benefits discharge on 1-8-58.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

History of the patient indicated that the patient's mother was over-protective and indulgent in her relationships with him and the father was indifferent to him. In childhood and adolescence, he was self-centered, aggressive and unable to share with others. As an adult he was described as a poor mixer with no particular interests.

After the patient was discharged from the hospital, he returned to live with his spouse and four siblings. The patient was not able to adjust to the family routine. Patient's wife had secured employment during his hospitalization but he demanded her to leave her job and remain in the home. He assumed complete control over the television programs the family watched, without regard for the interests of the other members of his family. The wife was scolded for her attention and affections toward the children. The patient had secured employment as a laundry truck driver and was making a fair adjustment employment wise. All the monthly bills of the household were paid by the patient but he furnished his wife with little funds to run the home on a daily basis. Whenever his wife attempted to discuss household situations with him, he threatened to leave the home unless he was allowed to continue in his own way of doing things. The patient continued to be difficult, dominating, hostile and disagreeable in his relationships to his family with the wife responding to the situation by submissiveness rather than revolt. A portion of the patient's money was being spent for alcoholic beverages each week but his wife, fearful of his actions, had never discussed this with him. The patient had begun coming home quite late from work and often with alcohol on his breath. He would demand his meals and often became abusive to the wife when they were not ready. The eldest child, a son, had threatened to strike the patient if he did not improve in his attitude toward the mother. The patient, after this episode, accused the wife of fostering the children's attitude against him and threatened her with bodily harm if this happened again.

At this point, the wife was becoming more fearful of what the patient might do because of his increased negative behavior and heavy drinking. She suggested that he return to the hospital for treatment. The patient initially refused his wife's idea but a month later returned to the hospital.

This case is an example of the patient who experienced difficulty in his relationships with his family. The patient's emotional immaturity was so marked that he was not able to contribute positively to the family.
relationship. Although he was able to remain on his job, little emotional satisfaction was being derived from his work. The patient appeared to have ignored the potential pleasures in the enjoyment of his wife and family. He was lacking in self-confidence and is an example of the alcoholic who has a weak ego and attempts to support it through his excessive use of alcohol. Whenever this type of individual feels guilty about anything, he rides himself temporarily of these feelings through this medium.

Case No. 5 is an example of a patient who had difficulty in the social area of adjustment with the problems related to his inter-familial relationships.

Case No. 5

Mr. E., a 34 year old, white, single, Catholic, veteran, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 11-5-56 with a Maximum Hospital Benefits discharge on 6-12-57.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

In infancy and childhood the patient was overprotected and pampered by an aunt. Both of the patient's parents were killed in an accident shortly after his birth. The patient was described as shy and timid in adolescence and withdrawn in his adulthood.

Upon discharge from the hospital, the patient lived with his aunt and uncle. The patient had secured a part-time job in a store as a shipping clerk. The relatives demanded little of him in the line of responsibilities in the home. His relationship with his uncle was one of constant hostility and arguments. It was the patient's opinion that the relative was attempting to dominate him and run his life. Although the patient was quite dependent on his aunt; turning to her for all kinds of help and advice, he felt that she resented his being in the home and was quite hostile to her at times. On one occasion, the patient complained to the aunt about the uncle's domination and when she failed to agree with him, the patient accused both relatives of being unfair to him. He constantly humiliated his family when they had company with his loud and argumentative manner of behavior toward them. The uncle attempted to discuss the situation with the patient but was faced with insults and the threat to leave him alone or take the consequences. Failing in their attempts to help the patient, who by this time was consuming large quantities of alcohol; the Regional Office was contacted and the patient was returned for treatment.
Case No. 5 well illustrates the patient who had problems in his inter-familial relationships. It would appear that this patient had not developed enough security in himself to move beyond childish dependency. When negatives arose in the actions or feelings of his family toward him, he responded with great hostility. This hostility was focused directly upon one particular family member. A serious impairment in social adjustment can be seen in this case with the predominant difficulty reflected in the patient’s inability to form a relationship with his family. Over-protection in the formative years usually results in a seeking of the continuation of this state of dependence in adulthood. The patient apparently created a situation in which he felt very deprived and dominated by his family and rejected their efforts to help him in his adjustment. Unable to meet the realities of daily living, the patient used alcohol as a means of escape.

The following is the case of a patient whose predominant difficulty was in the social area but fell in the category of his inter-social relationships outside the family. Case No. 6 is a typical example of the patient who fell into this category.

Case No. 6

Mr. F., a 39 year old, Negro, single, World War II veteran, Catholic, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 12-2-56 with a Maximum Hospital Benefits discharge on 5-9-57.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

The patient’s history indicated that he was rejected by his mother and that the father deserted the family shortly after his birth. He was described as sensitive, moody and withdrawn in both childhood and adolescence. In adulthood, the same pattern of behavior was evidenced.

When the patient was discharged from the hospital, he returned to the home of his mother. Most of his time during the first few
months after discharge was spent in trying to secure employment or in his room reading and listening to the radio. He was finally able to obtain a job in a bowling alley as a pin setter. A worker on his job invited the patient to dinner and reluctantly, he accepted. The evening proved upsetting to the patient because he did not feel socially accepted by the others present. The next day, he complained to his fellow worker who had invited him that he had been snubbed by his friends and made to feel uncomfortable.

The patient's mother, becoming aware of his inactivity and restlessness, encouraged him to join the YMCA. This was done but shortly thereafter, he "exploded" at a group meeting because the fellows did not accept his suggestion.

Some of the fellows on the job encouraged him to join the bowling club. The patient adjusted fairly well in the group until one of the members criticized his way of playing the game. Although a usually passive individual, the patient acted with conspicuous overemphasis of voice and gestures in this situation. A similar behavior was exhibited in the YMCA group. The patient withdrew from the bowling group and accused the fellows of being unfair in their relationships with him. He soon became exclusive, hostile and refused to allow himself to become a part of any social activities. Restlessness and boredom soon caused further anxiety, tension and hostility. Unable to settle down to do anything, he sought to escape from himself in an alcohol-induced activity.

This case illustrates the patient who experienced difficulty in his inter-personal relationships in his social environment. In this case, the patient was unable to adjust in his relationships with other. Because of his extreme sensitivity, he was forever being made miserable. He also appeared to be suffering from strong feelings of envy and inferiority. The patient's failure to adjust harmoniously in his social life was apparently due to or aggravated by an abnormal set of influences in his early development in the family.

Another case which fell into the area of social adjustment was Case No. 7 in which the predominant problem was related to the inter-social relationships outside the family.

Case No. 7

Mr. G., a 34 year old, Negro, separated, World War II veteran, protestant, had two admissions to the Veterans Administration Hospital, Northport. The second admission was on 9-4-56 with a
Maximum Hospital Benefits discharge on 5-11-57.

The immediate precipitating factor for his readmission was the excessive use of alcohol.

The records revealed that the patient was reared by a domineering mother and a passive, indifferent father. In childhood and adolescence, the patient was viewed as withdrawn, a poor mixer and deeply interested in his studies. In his later years, the patient remained to himself most of the time but did attempt to become involved in some group activities in his community.

After discharge from the hospital, the patient lived in the home of his widowed mother. The patient worked as an attendant in a relative's Animal Hospital. He was apparently quite interested in his work and was able to carry out his responsibilities adequately. The patient was encouraged to become a part of a group of attendants who had formed a club in the community. After much persuasion, he attended a meeting but was not able to participate actively in the group's planning. He refused to serve on any committee with the excuse that he wanted to know the members better before he could work with them. Whenever the group carried out an idea or plan that he was not in agreement with, he became upset and even more negative in his relationships in the group. He soon began to feel that the group was incongenial and decided to sever his membership. When his mother asked why he had quit the club, she was told that the members got on his nerves and that they were always plotting against him.

Little interest had been shown in the opposite sex since the patient's separation from his wife. Recently he had become interested in the clerical worker on his job but had failed to make his feelings known to her. He had discussed it with a co-worker who had arranged for them to attend a social affair as his guests. Because of the patient's shyness and inability to act on his own, the evening passed with only his being introduced to the young lady. When he was kidded about the situation on his job the next day, he became very defensive and demanded that he be left alone. Becoming aware of the patient's restlessness and seclusiveness in the home, the mother in an attempt to help him, suggested that he join the Veterans Organization. The patient related to her what had happened in the other groups. He did, however, manage to take out membership in the organization but attended only a few of the meetings. The group was strongly criticized and the patient felt it a loss of his time to attend any future meetings. Under the pretense of still belonging to the group, the patient was leaving the home but frequenting a tavern across town. Returning home one evening quite intoxicated, he confessed his activities to his mother. Becoming concerned about the patient's activities which included only leaving the home for alcoholic reasons, complete withdrawal from outside contacts and loss of time from his job, the mother suggested that he return to the hospital for help.

This case illustrates the patient who experienced difficulty in his social relationships. The patient was not able to extend himself in an
ever widening circle and seek to take a part in contributing to the wel-
fare of the groups he had attempted to become a part of. His strong feel-
ings of insecurity and inferiority prevented him from being able to form
relationships with others. The patient allowed his social relationships
to dwindle because of his lack of enthusiasm, lack of patience or generos-
ity, and unintentional slight, or lack of the understanding of the im-
portance of making the effort necessary to keep friendships alive.

When the patient failed in his attempts to become active in groups,
his tendency to want to be alone, to avoid others, was evident for he had
not learned the wisdom of deliberate, self-forgetful social contacts. The
patient possessed no special training or interest and his social activi-
ties were so drab that he broodingly accepted an attitude of inferiority.
His sense of failing to fit admirably or self-satisfyingly into any situ-
tion or opportunity caused the patient to futilely surrender to drink in-
stead of building other outlets for social adjustment.

The five cases presented were believed to be representative of the
other one remaining case that fell in the category of difficulty in social
adjustment.
CHAPTER V

SUMMARY AND CONCLUSIONS

This study was made at the Veterans Administration Hospital, Northport, New York, in an attempt to discover the factors apparently contributing to the readmission of alcoholic patients to the hospital.

The sample for the study consisted of ten discharged patients who were readmitted between September 1, 1956 through September 1, 1957. Excessive use of alcohol was the immediate precipitating factor in the readmission of all the patients studied.

It was discovered that the contributing factors stemmed from two major areas of adjustment. These areas were: economic adjustment, including occupational and financial stress; and social adjustment, including inter-familial and social relationships.

There were six patients whose social adjustment seemed to have been the predominant influence in the patients' readmissions. Of the six patients who had problems in the area of social adjustment, three were related to inter-familial relationships and three to social relationships.

In the remaining four cases, the patients' return to the hospital appeared to have been influenced by their economic adjustment. Two of the patients had difficulty related to occupation and two had problems due to financial pressures.

While the immediate factors which apparently contributed to the alcoholic patients' return to the hospital could be isolated, it was obvious that these factors were only half the picture.

Alcoholism is a symptom of deeper underlying personality-emotional reactions of varying degrees and types.
Alcohol comes into the picture as a narcotic, a pain killer. In other words, the underlying disorder causes tension, anxiety, restlessness or hostility, which the alcoholic, without realizing it, soon learns to reduce with alcohol.

One of the tragedies of the general misunderstanding of alcoholism is that the individual permits himself to get into real trouble before he knows what is happening to him. That is, his drinking harms himself, his family, or his standing in the community. It is at this point that the immediate factors can be isolated which was our concern in this study.

The individual who is emotionally dependent and immature and has extreme tension or a low degree of tolerance for anxiety and frustration usually resorts to excessive drinking, even to intoxication and its blotting out of reality, as an easy means of relief and handling of his difficulties.

In working with the alcoholic patient, since it is difficult to determine the underlying conflicts, we must individualize each case and be alert to all the possible causative elements that might be present.

If the underlying conflict is to be discovered, it must be attempted through careful, systematic psychiatric study, observation, analysis and therapy.

It would appear that the initial concern in work with the alcoholic individual would be one of reducing in some measure the immediate contributing problems. Difficulties of whatever sort - in social adjustment, inter-familial relationships or social relationships; economic adjustment, occupational or financial pressures which lead to fears, tension, resentment, or threat of failure, prove too much to face for the alcoholic.

The alcoholic individual also has certain things that he must do for
himself. He must possess the "will to get well" coupled with the "will to carry on." He must learn to withstand failure as well as success, since both are part of one's every day living.

Insofar as any possible combination of therapeutic influences can incorporate a mature acceptance of life into the warp of any character, that man's problem with alcohol may be reduced.
1. Case Name:
   Age of Patient - Race - Sex - Religion

2. Marital Status:
   Single, Married, Divorced, Separated, Widower

3. Military Service:
   Branch (Dates)

4. Number of Hospitalizations (Northport V. A.):
   A. Diagnosis  B. Treatment

5. Family Background:
   A. Relationship within the family
   B. Position of patient in rank of siblings (Family Pattern)

6. Education

7. Occupations:
   A. Adjustment

8. Social Adjustments:
   A. Types and constancies of friendship cultivated.
   B. Group Activities.
   C. Pursuit of hobbies and special interests sought.

9. Marital History: Before and after hospitalization
   A. Age married
   B. Marital adjustment
   C. Siblings
   D. Reaction to stress situations
      1. Financial
      2. Physical (illness) - Emotional
      3. Social
      4. Employment
10. Type of Discharge:

A. Maximum hospital benefits — including trial visit and member employment.

B. Against Medical advise — includes those patients who elope from hospital.

11. Follow-up Treatment after Discharge:

A. Medication
B. Private care
C. Alcoholics anonymous
D. Referral to Regional Office
E. Outpatient Clinic
F. No follow-up treatment

12. Adjustment in home after discharge

A. Satisfactory                B. Unsatisfactory

13. Occupations and adjustment

14. Social adjustment after discharge:

A. Types — Constancies of friendship already cultivated and new friendships.
B. Group activities.
C. Pursuit of hobbies and special interests sought.

15. Living arrangements after discharge:

A. Patient's family
B. Own custody
C. Foster home
D. Relatives

16. Alcoholic influences after hospitalization

A. Total abstainer
B. Periodic or steady drinker

17. What does case illustrate as factors contributing to the patient's readmission to hospital?

(Note: — Number 17 will be derived from the result of the findings in the schedule, particularly after discharge data.)
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