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The effectiveness of tranquilizing medication as an aid to patients in their community adjustment

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THE EFFECTIVENESS OF TRANQUILIZING MEDICATION AS AN AID
TO PATIENTS IN THEIR COMMUNITY ADJUSTMENT

A THESIS
SUBMITTED TO THE FACULTY OF THE SCHOOL OF SOCIAL WORK, 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

ATLANTA, GEORGIA
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CHAPTER I

INTRODUCTION

Significance of the Study

Various methods of treatment have been given to mental patients prior to the use of tranquilizing medication. The most widely used forms of physical therapy for the mentally ill include shock treatment, which has been given a great deal of public attention. "The theory behind the giving of insulin, metrazol, and other drugs or the use of strong electric current to produce shock is that the patient, if physiologically highly disturbed thereby, may come out of the shock period much improved." Insulin has been used with some success in the treatment of paranoid schizophrenics, however, in cases of catatonia the effect has been less apparent.

In 1933 Manfred Sakel presented the first report of his work with insulin. Sakel was not the first to use insulin in psychiatry, before it had been used as a sedative in excited patients, and in case of delirium tremens. It was also used to overcome refusal of food and to build up run down patients, but the dosage in these treatments was small, and shock was not produced.

Sakel is credited with being able to see that the shock produced through increased dosage improved the condition of the psychotic patient.


The selection of patients for insulin shock treatment is extremely important. All patients receiving this form of treatment should be in reasonably good health. The most important contr-indications are active pulmonary tuberculosis, acute or chronic kidney or liver diseases, diabetes, etc. The most important of all is the exclusion of patients suffering from a cardiovascular disease. The age should also be considered when insulin shock is administered. Patients around 50 years of age do not tolerate insulinization very well and therefore should be treated only if their cardiovascular apparatus is in good functional condition. In young schizophrenics under 18 the technique of inducing insulin coma in somewhat modified.

In addition to physical examinations, the patient should also be given a detailed psychiatric examination before treatment. (This is true in any type of treatment given for mental illness.) The patient's reaction during treatment and his ultimate grade of recovery can be ascertained reliably only if the mental symptoms prior to treatment are accurately described and the patient's personality, social and sexual adjustments are investigated. The psychodynamics of the patient's psychosis should be described in detail if possible for comparison with his altered mental attitude during and after treatment. The recovery of the patient should be judged on the basis of this material, and not on superficial impressions alone.

The selection of patients for insulin treatment from the psychiatric point of view is relatively simple. Insulin shock treatment was

1Ibid., pp. 10, 11.
2Ibid., p. 11.
introduced for the cure of schizophrenia; in manic-depressive, and involutional psychosis, insulin is far less effective.

When insulin treatment is recommended, it is advisable to discuss the results and dangers with the responsible relatives. A written consent is required in most cases. The patient himself should be informed about the treatment without describing the unpleasant details. He should be reassured that treatment is painless and without undue discomfort. Many patients fear the treatment because they have read and heard that it is dangerous. Some patients do not want treatment because it renders them unconscious, and they expect to be experimented upon or possibly raped or castrated.

In the framework of our present set up the job of preparing the relatives and patient for a new form of treatment rests with the social worker.

Metrazol and Electro-Shock therapy can be discussed in the same light, both are convulsive therapies. "Von Meduna introduced convulsive therapy of the basis of theoretical considerations, choosing the pharmacologic provocation of convulsions. However, his method was never meant as a new drug treatment for mental diseases. Its primary objective was to utilize the effect which convulsive seizures may have on the schizophrenic disease process." Cerletti and Bini replaced chemical convulsive agents with electric current. This was merely a technical modification of the original convulsive treatment.

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1Ibid., p. 12.
2Ibid., p. 91.
Since the advent of ECT, convulsions by pharmacological means have taken a secondary place in treatment. It is, however, still used in combination with insulin, and there are many who prefer it to electric convulsive therapy, giving as reasons that the results are superior with metrazol than with ECT.\(^1\)

One of the greatest drawbacks to pharmacologic convulsive therapy is the fear the patient experiences between injection and the onset of convulsion. The patient does not lose consciousness as long as no convulsion takes place. Even though the interval between injection and convulsion may be a relatively short period, the patient has what is described as a feeling of impending death and sudden annihilation. In one instance this worker heard a patient ask, as he was being prepared for ECT, "are you going to kill me this time". After electric convulsive therapy the patient does not remember the treatment itself.

There are three reasons why electrically induced convulsions have replaced the pharmacologic method. (1) The method is simpler and cleaner than the repeated injections of a relatively large amount of fluid which easily leads to thrombosis of the veins; (2) there is an immediate loss of consciousness which spares the patient any recollection of the application and makes refusal of treatment a rare occurrence; (3) even though metrazol has been used with considerable success in the treatment of schizophrenic patients the convulsions are usually of such violent

\(^1\)Ibid.

\(^2\)Ibid., p. 92.

\(^3\)Lothar B. Kalinowsky and Paul H. Hook, Shock Treatments, Psychosurgery and Other Somatic Treatments in Psychiatry (New York, 1952), p. 94.
nature, that the patients often injure themselves seriously during seizures, because of these injuries there has been considerable professional and lay reaction against this method.

Another method of physical therapy that has been widely publicized is psychosurgery. This method of treatment is a highly delicate operation where the mental disorder is treated by sectioning parts of the cerebral cortex. Lobotomy is generally considered a procedure of last resort to be tried only after all other methods have failed. The patients who were assembled to undergo surgery, in the early stages of the use of lobotomy, represented hopeless, and chronic forms of mental disease, for the most part relegated to custodial care. Follow up studies indicate that large clinics and hospitals use lobotomy as a last resort only, doubtlessly because irreversible brain destruction is implicit in this form of treatment.

Doctors Freeman and Watts offer the opinion that results of prefrontal lobotomy are slightly better in females, Jews, and Negroes. Better results have been reported for mental disease of short duration than for disease of long duration, but, especially in the effective disorders (manic-depressive and involutional psychosis), duration of illness is not so important as the clinical picture or the degree of tension. Patients with a higher education are likely to make a better postoperative adjustment than those with a meager education.


3Ibid., p. 21.
Today the most widely publicized method of treating mental illness is in the use of tranquilizing medication. The most widely publicized and perhaps used drugs are chlorpromazine and reserpine. These drugs are used separately and together in treatment of the mentally ill. The basic ingredient of reserpine has been known for centuries; it is the root of the plant called Rauwolfia Serpentina Bentham, found only in India and known as the "insanity herb."

In India it is commonly called the snake-root plant. There are fabulous legends about this plant. According to one legend, a Mongoose would first chew upon its leaves to gain strength before engaging a cobra in combat. Another states that its leaves when freshly ground and placed between the toes could serve as an antidote for poison. According to a third a demented individual might eat slices of the root and thereby be relieved of his madness.

The plant, a small shrub, with smooth leaves, with pink or white blossoms, has lost much of its legendary powers, but none of its interest to medical science and the field of social work. It is the subject of one of the most fascinating stories of modern medicine.

This plant was known to European scientists as early as the 17th century. The plant was named Rauwolfia Serpentina, in honor of the 16th century German botanist, physician and explorer, Dr. Leonhard Rauwolf.

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1 Arthur P. Noyes, Modern Clinical Psychiatry (Philadelphia, 1955), pp. 593, 599.
3 Ibid.
Throughout the centuries Rauwolfia has been used for a great number of man's illnesses. It was used for epilepsy, insomnia, and insanity. It was prescribed for dysentery, diarrhea and cholera. It was considered valuable in headaches and blindness. It was a standard treatment for a variety of fevers, applied as an antidote for insect and snake bite; it has even been used as a sleeping potion for infants.

In the western world Rauwolfia, later named Reserpine, was first used to reduce high blood pressure. At first there seemed to be no remarkable result after the use of the drug; it was later found that this drug was a relatively slow acting agent and would take weeks or months before any results were shown.

Reserpine, the pure crystalline alkaloid, was formally announced and introduced to the medical world, as Serpasil, by CIBA Pharmaceutical Products, Inc., Summit, New Jersey, in September 1953. Oddly, one of the last applications of serpasil to be tested by modern investigators was in the control of severe mental disease. This was the area in which Rauwolfia had achieved such fame in India for at least five centuries. However, outside of India the values of Rauwolfia in psychotherapy were not enthusiastically received. In March of 1953 it was reported that a gold medal had been awarded to Dr. R. A. Hakim of India for the presentation of a paper on the cure of schizophrenia. The doctor claimed a recovery rate of approximately 31% in psychotics treated with electric shock alone, 51% with Rauwolfia alone, 80% with combined drug and shock

\[1\text{Ibid.}\]
\[2\text{Ibid.}\]
treatment.

Through intensive research and experiments, done at Rockland State Hospital, Orangeburg, New York, it was found that Rauwolfia (serpasil) greatly reduces anxiety, and obsessive-compulsive drives, and overcomes excessive inhibition and reticence. Similar findings were soon reported from other mental hospitals. "At the Modesto State Hospital in California, daily administration of serpasil over prolonged periods resulted in a dramatic quieting effect which was noted through entire wards."

In general the doctors felt that the use of serpasil had reduced the number of disturbances, restraint orders, improved morale of both patients and staff, thereby giving the staff more time to spend in treating the patients since less time was required in restraint. From the social worker's point of view this meant that he would be able to sustain a closer contact with the patient in handling problems of a social nature, both in and out of the hospital. It gave new hope to the family and relatives of the mentally ill. In this researcher's opinion it has also helped to reduce the stigma once attached to mental illness.

Serpasil is by no means the only tranquilizing medication in use in mental hospitals. As previously stated, the other widely known and publicized drug is chlorpromazine, this drug being more generally known by its trade name of Thorazine. Chlorpromazine was developed by the Rhone-Poulenc Specia Laboratores in France, as a possible sedative.

\[1^{Ibid.}, \text{p. 35.}\]

\[2^{Ibid.}\]
This was an extension of the already well-known sedative action of anti-histaminics. Clinical evidence shows the value of thorazine in controlling nausea and vomiting due to a variety of causes including motion-sickness, drugs, radiation and pregnancy.

As with reserpine, the largest investigations have been made in hospitals for the mentally ill and have involved thousands of patients. Thorazine is very effective with the schizophrenic patient. There is doubt and confusion in this writer's mind as to who is more benefitted by the use of these drugs, the patient with the prolonged illness or the patient who has been ill for less than a year. Publications that I have reviewed to date seem to differ on this point. Serpasil and thorazine have much the same effect on their users.

Although chlorpromazine and reserpine differ greatly in their chemical make-up, the effect is much the same. Reserpine has an action that is slower, more irregular, less constant, and generally less powerful than chlorpromazine. Nevertheless, these two drugs have in common certain special effects that distinguish them from previously known drugs. The most remarkable effect from the psychiatric standpoint is the sedative and the inducement of sleep without narcosis, at whatever dosage is used.

Both of these drugs have some side effects. Occasionally Rauwolfia produces nasal congestion, and may cause increase in appetite. In some emotionally sensitive patients, reserpine may cause depression. This can

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1 Howard D. Fabing, M.D., The ATARACTIC Drugs: Their Uses and Limitations in Psychiatry (reprinted from American Professional Pharmacist, May, 1956).

be serious enough to include suicidal inclination. The use of reserpine should therefore be carefully controlled, and it should be stopped promptly if depression occurs. Quite as serious is evidence of sodium and fluid retention. This may be enough to cause congestive failure. In chlorpromazine the most common side effect is drowsiness. Hypotensive reactions also occur and care should be used to avoid untoward effect in cardiac disease. There are several other effects of this drug, but the most serious is jaundice.

There are derivatives of these two drugs now in use. They have not been mentioned in this chapter because their effect is much the same as the two drugs accorded space. Other drugs that are presently in use and have not been accorded space is due to the fact that their use at this hospital is limited.

This writer has taken thorazine, in order to ascertain the effects that this medication might have on a patient. To date the medication has acted as a mild laxative, it has not caused this writer to become drowsy, but has caused a very deep sleep when the writer decided to relax.

Purpose of the Study

The purpose of this thesis was to determine what bearings the use of tranquilizing medication had on the mental patients in terms of community and family adjustment and what part the use of these drugs played in the role of the social worker. Through the use of this form of medication, how readily does he adjust to his past life in the community.

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¹Chauncey D. Leake, Drugs Affecting Mood and Behavior (Reprinted from Texas Reports on Biology and Medicine, Vol. 13, No. 4), pp. 806-808.
This research was not conducted to attempt to prove or disprove that tranquilizers are the answer to the problem of curing the mentally ill.

Method of Procedure

The case study method was employed in this research; the researcher used the case histories of mental patients granted trial visits during the period from January 1, 1955 through December 31, 1955. In order to secure the data needed it was necessary that the researcher obtain the daily tally sheets for the above dates. After obtaining the daily tally sheets the researcher examined them in order to ascertain the universe for the period being used. The universe consisted of 335 patients granted trial visits during this period. The method used in selecting the sample was to list the patients' names alphabetically and select every 30th case folder as part of the sample (a random sample of 3% was taken from the universe.)

The schedule was the primary tool used in this research, it was used as the medium in governing information taken from the patients' records.

Scope and Limitations

This research has been limited to the study of patients of the Veterans Administration Hospital, Chillicothe, Ohio only, and deals with patients granted trial visits after the use of tranquilizing medication for the above period. There was a further limitation in that there were patients who had received drug therapy, but were discharged rather than granted trial visits.

Agency Setting

The setting for this research was the Veterans Administration
Hospital, Chillicothe, Ohio, one of the largest VA Neuropsychiatric Hospitals in the country, equipped to care for 2,116 patients daily. While primarily for the care of neuropsychiatric patients the hospital is completely equipped for general medicine, surgical and tuberculosis patients, also having ample acreage for outdoor therapies as well as recreational activities.

The professional staff includes specialists in all major fields of medicine and surgery. This staff is further augmented by social service, clinical psychology, and the various other therapies required to run a hospital of this type and size.

The hospital personnel are of the opinion that no particular discipline is all important or is responsible for the patient's improvement. The sense of unity found at this hospital might be considered unique for organizations of this size. There are approximately 1,250 employees, these employees forming one gigantic team; working together toward the day that a patient might be released. It has been stated that here we understand that no one type of medication or device is solely responsible for the end result, it is the combination of medicines and service through the co-operation of the various disciplines, which help in achieving the goal of preparing the mentally ill patient to return to his community and make an adequate adjustment.

\[1^{\text{Veterans Administration Hospital, Chillicothe, Ohio, Fact Sheet.}}\]
Chapter II

The Meaning of Tranquilizing Medication to Social Work and Its Role in Trial Visits

There have been a number of researches done on the use of tranquilizing medications. The use of these drugs has caused more and more mental patients to return to the community; their ability to do so has been the results of successful chemotherapy. As the number of patients leaving the hospitals increases, many of them after a long period of hospitalization, questions arise regarding the use of drug therapy; as time moves on, the importance of these questions become progressively greater.

While some investigators allowed their enthusiasm about the effectiveness of modern chemotherapy to run out of bounds, and others showed a definite reluctance in admitting that they had any efficacy, a point has been reached where the value of this new approach to treatment in psychiatry is more or less generally accepted. Various authors have described the changes inside the state hospitals as a result of large scale drug therapy: the transformation of wards full of noisy, uncooperative, disturbed patients, into halls where quiet well behaved people live, who take care of their personal needs, show interest in their appearance, and take part in various occupational and recreational activities.

The increased use of these drugs has meant an increased demand for casework services. However, the use of these drugs has not changed the basic functions of the profession but rather highlights its importance.


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In the area of therapeutic case work the lessening of confusion and the enabling of the patient to discuss the nature of his conflicts make an entirely new group of individuals available for case work services.

At the Veterans Administration Hospital in Murfreesboro, Tenn., tranquilizing drugs have been in use since June 1954. The first patient, a manic, was well aware of the nature of his drug therapy and derived considerable satisfaction from engaging staff members for long periods, describing the changes he experienced and making a comparison from his voluminous notes with the previous form of therapy which he had received. This pointed out the first implication for social work services: there was an increased desire to talk with personnel. This desire to talk marked the patient's first attempt to establish contact with the social worker. Since this pilot study it has been noted that an increased number of patients have the desire to talk to the hospital staff, concerning their problems and treatment.

As large groups of patients have been treated the number who were too confused to make use of case work services has diminished and there is an ever increasing stream of referrals not only from ward personnel but from patients themselves. "Previous contacts with one patient had been limited to his request for help in securing legal assistance to "break the commitment," but are now the results of his fearful suggestion that his family may not want him when he is ready for trial visit."

"An awareness of the patients probable progress under drug therapy will


\[2\] Ibid., p. 549.
make it possible for the social worker to intervene therapeutically at
the proper time to build a productive relationship. This not only frees
psychiatrists to work with the more seriously disturbed patients but also
offers the social workers an opportunity to expand their role as auxiliary
therapists. This does not imply the use of the Social Worker as a psycho-
therapist but rather increases the emphasis on effecting the maximum utili-
zation of the social worker's clearly accepted means of treatment. In light
of drug therapy the social worker's roles in "environmental modification,"
"psychological support," "clarification" and "insight development" shift
as these case work techniques are applied to social work's differentiated
functions. It is felt that this is equally true whether the service is
hospital admission, emotional and personality adjustment, trial visit plan-
ing and supervision or out-patient care."

Before the patient leaves the hospital gradual preparations are made
for his return to the community. He is placed on an open ward and allowed
to choose a work assignment in accordance with the type of work that he ex-
pects to do after leaving the hospital. After a period of undefined time
on open ward, if the patient shows that he is capable of making an adequate
adjustment, and he has a family to which he might return he is encouraged
to seek passes, and later to request a trial visit. If a trial visit is
agreeable to the responsible relatives; prior to the patient's release from
the hospital, the responsible VA Regional Office is informed of the hospital's
actions, and Social Service requests that this patient receive Trial Visit
Supervision.

Often patients report to out-patient clinics feeling that they are

1Ibid., pp. 548-549.
reporting to a parole board, and that if they give the slightest indication that they are not feeling well that they will be returned to the hospital. Many patients because of this fear have a reluctance to discuss any of their problems, and will attempt to avoid contact with social workers, or else be evasive in their discussion. The social worker must be prepared to remedy such attitudes and put the patient at ease. The Social Worker must show the patient that the clinic, as well as the hospital, is a place where they will find understanding and help, not only for their social problems, but their personality problems as well. They must be encouraged to discuss these problems in light of family and community situations. The family should also be educated as to the patient's limitations; hence close family members should be encouraged to visit hospitals and clinics to discuss any problems the patient or family might have in connection with his adjustment or hospitalization. The patient and his family must be assured that the discussion of problems or the recurrence of psychotic symptoms will lead to maximum effort for continuation of their treatment on an ambulatory basis rather than to their return to the hospital. The only way by which the social worker might accomplish this is to establish an atmosphere of mutual confidence.

It has been shown that social work has graduated from the stage of simply determining whether the family will take the patient back into the home to how the family will help him. In the event that the patient has no family to which he might return he is placed on the exit service program. This service provides extensive rehabilitation services, and in

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many instances secures a place of employment and residence. If warranted
the patient is then granted an administrative trial visit. Once the trial
visit is granted the patient receives the same type of supervision, and/or
out-patient treatment as those who are returning to their families.

This hopeful outlook for the patient has caused the problem of Trial
Visits to become increasingly important to the social worker and the rest
of the hospital staff. From the social work point of view the following
are of great importance when preparing patients to be released from the
hospital. (1) In many cases patients will not continue drug therapy when
released from the hospital, because of the fear of the stigma being at-
tached to the requirement of their continued use once released from the
hospital. In still fewer cases patients will request that they be given a
supply when it is not needed or required. If it appears that they will be-
come overly excited or anxiety ridden, the hospital will usually give the
patient a week's supply of the type of medication taken. (2) Many patients
wonder if they will receive out-patient care maintenance dosage free of
charge, and if not how much will the medication cost. (3) Many patients
are afraid to continue medication because of side effects or complications
which might arise. It is the duty of the social worker to be able to re-
duce the anxiety on the part of the patient concerning the above, by being
able to explain and answer fully the questions raised by the patient. The
worker should assure the patient that his treatment, and continued treat-
ment on an out-patient basis is confidential, and that the rising level of
the public's education reduces the possibility of stigma being attached to
his illness. In the VA settings it must be explained to the patient that
the continuation of his treatment depends on whether or not he is a service
connected veteran, but that in most cases he will continue to receive aid from Social Service if such is indicated, and that in the event he is not a service-connected veteran, social service will attempt to make arrangements for him to receive medication from a non-VA Organization. The worker must be able to explain the side effects of tranquilizing medications, and to interpret the general reactions seen to date with the use of these medications.
CHAPTER III

FOSTER HOME PLAN AND THE SOCIAL WORKER'S ROLE

The patient who is placed in a foster home for trial visit is carefully studied. It is social service's job, working with the physician, to determine the patient's mental and emotional needs, finding the family who can most nearly meet these needs, building up the patient's confidence and curiosity about a new way of life. These all require case work intuition and skill. So does the maintenance of a relationship with the patient and foster family that will stimulate him to his best efforts, and maintain their interest in increasing their insight into his problems and their patience in fostering the best that is within the veteran.

The responsibility for social supervision rests upon the social worker. He establishes and maintains a relationship which will assist the patient in achieving his best possible level of personal, social, and vocational adjustment in the community; for giving counsel and service designed to enable the members of the household to understand, accept, and live agreeably with the patient; and for developing helpful attitudes toward the patient on the part of the relatives, and when necessary, others in the community, such as law enforcement agencies, service organizations, and so forth. Encouragement of relatives in some cases, to keep in touch with the patient, may result in their eventual acceptance of the patient on trial.

1Roger Cumming, "Foster Home Trial Visits for Patients with Mental Illness," Department of Medicine and Surgery: Information Bulletin Psychiatry and Neurology Division, 1810-40 (April 1953), p. 3. Office of the Chief Medical Director, VA, Washington 25, D.C.
visit in their own home, and promote his permanent adjustment. The assistance of the social worker in the regional office should be secured in fostering, whenever possible, relationships and adjustments in the patient's own home which will be favorable to his return there.

Surveys have shown that many patients placed in foster homes have moved on from helping around the house to actual part-time or full-time employment outside the home, at which point they are no longer counted as an "foster home trial visit" but as on "regular trial visit." Other patients while not showing marked improvement or perhaps any change at all, have been able under the guidance of the foster parent, working closely with the hospital social worker, at least to live outside the hospital in the foster home."

Further, it is reported that the interest of relatives has often increased when they see patients living happily in homes other than their own. Relatives sometime become willing, in fact really interested, in taking the patient under their own care after seeing this first community test.

In order to achieve the primary objective of helping the patients attain an optimum adjustment in the community, the social worker will need to maintain a continuing relationship with the patient, his relatives, and

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3Ibid., p. 4.
the family with whom he is living. The frequency of contacts will be determined by such factors as the patient's condition and capacity to adjust, the attitudes of the relatives, and the skill of the persons in the home. To ensure the adequacy of social supervision throughout the trial-visit period, monthly visits to the patient may be required. During the early days of a patient's trial visit, these should be more frequent.

Trial visit placement in a home other than the patient's own should be terminated whenever it has served its primary treatment purpose, or it becomes clear that the purpose cannot be accomplished.


2Ibid.
CHAPTER IV

THE MEMBER (CANDIDATE) EMPLOYEE PROGRAM

Candidate or member employment is that type of employment whereby a patient is considered for employment by the hospital on a limited scale, taking into consideration, all factors regarding possible employment, or foster home placement in the community.

Today the mentally handicapped patient is visualized in much the same light as the physically handicapped patient. The mentally handicapped person is able to contribute to the overall production in industry as well as the physically handicapped, but is often frowned on and totally rejected in some instances.

To disregard such people is a blight on the humaneness of the nation, since both nation and person suffer; the nation by loss of production and increased taxes, and the person by loss of self-esteem and relegation to care by the taxpayers' money.

The problem of reintegrating the capable cured or mentally handicapped patient back into production and society is of major importance to the social worker.

The social worker must inform prospective employees that mental patients are people; they are likewise citizens of their respective states. Simply because a patient has entered a mental hospital does not mean that he has ceased to be a citizen; thus the mental patient as a citizen is entitled to

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all privileges and concern accorded any other citizen. Many of these pa-
tients have been released from the hospitals, and later returned because of
increased anxieties, and failure to secure employment. In many instances
the patient's failure to secure a job was due to the employers' concern about
the safety factor connected with employment of the mental patient. In other
cases the patient and the social worker were handicapped in their approach
to the prospective employer, because they could not produce a work record
for the patient.

To help meet this problem hospitals were permitted to provide job de-
scribed as "member-employee" jobs, those patients who are a part of this
program are entitled to full care keep and laundry. The social worker is
responsible for much of the preparation in arranging for the patient to be
considered for this employment. In addition the worker also has the respon-
sibility of getting the patient interested in such employment.

The program works in the following manner. The patient is discharged as
a patient and assumes the title of "member-employee." He lives with regular
employees in the hospital aides quarters. He has full access to his salary
at each pay period and comes and goes as he pleases. He cares for his own
room or dormitory space and cares for his clothing. The jobs are regular 8-
hour, 5 day-a-week jobs and these members are "docked," et cetera, if they
fail to show up for work. In other words, the same problems they face in jobs
and community are put into practice in the hospital setting. Thus, a fur-
ther and significant step has been taken in the readjustment of patients to
community and job stimulated conditions. After such placement the social
worker can approach a prospective employer, and report upon a patient with

\[1\text{Ibid.}\]
actual work experience. The worker no longer has to beg for a trial period for a patient, but, instead the patient can be placed in a shop, greenhouse, farm, et cetera, as a tried and proven employee. True, some of them may talk to themselves once in a while or may talk peculiarly; may smile when there appears to be no reason to smile, but any patient who becomes a member-employee and is later made available for a job outside of the hospital has long been studied and psychiatrically and socially evaluated so that there is no reason to fear such an employee. He is given aptitude tests and is assigned as near as possible in accordance with such findings. It is the job of social service to interest potential employers in some of these numerous employees. Social service may accomplish this through education on the part of potential employers. A group of such interested individuals may be brought together and have explained to them this program, and the patient's potentials as a member of the labor force in their respective communities. However, even after such group meeting the social worker should have as much individual contact with prospective employers as possible before actual placement is begun. This is not done to coerce the prospective employer to hire the former patient, but to keep him well informed of the patient's abilities, and the fact that this patient will become a worthwhile addition to the community if given the opportunity.

\[1\text{Ibid.}\]
CHAPTER V

FINDINGS

This study consisted of twelve sample cases granted trial visits from the VA Hospital, Chillicothe, Ohio during the period from January 1, 1955 through December 31, 1955. The writer was interested in learning the degree of readjustment patients were able to make to community and family life, both socially and economically once released from the hospital. Improvement of their psychotic condition was taken into consideration in their readjustment to their past lives. In determining whether or not the patient was able to adapt to these factors of adjustment were given prime importance from the social work aspect:

(a) Has the patient been able to take part in the social activities of his family?
(b) What does his family think of his return?
(c) Does the family notice a change in the patient's behavior since the use of tranquilizing medication?
(d) What are his living conditions?
(e) Has he been able to take part in the social activities of the community?
(f) What does the community think of his return?
(g) Has the patient been employed regularly since being granted trial visit?

In consideration of what the patient's family thought of his return, it was necessary to take into consideration the patient's marital status.
The following is a classification of the veteran's marital status:

#### TABLE 1

**MARITAL STATUS OF VETERANS**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>5</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
</tr>
</tbody>
</table>

It was also necessary for the writer to know the extent of the patient's participation in out-patient treatment.

Four of the twelve patients studied in this sample failed to show an improvement in their psychotic condition, or to adequately adjust to family and community living. Of these four patients who failed to show improvement, one was married, one was single, one separated, one divorced. Three of these four patients were not able to take part in family or community activities because of excessive drinking, and abuse toward family members. In the case of the married patient who failed to show improvement, his wife was understandably afraid of his behavior, because of his abusive behavior toward her, and his paranoid ideas. The fourth patient who failed to show improvement or make an adjustment was the single patient in this group. His parents were over protective and guarded against his taking part in community activities. This patient, like the other three mentioned, also had a history of excessive drinking, however, during his trial visit period there was no indication that he returned to his old habit of excessive
drinking. Two of these four patients were cooperative in reporting for
out-patient treatment, but were resistive toward the treatment itself.
They refused to take medication received, failed to become interested in
the rehabilitation program or accept employment. The others failed to
cooperate with out-patient treatment, at all, they would not visit the
out-patient clinics or consent to see the social worker when he called at
their places of residence. Three of the places of residence occupied by
these veterans were inadequate. The one married veteran, and his wife
lived in a third rate hotel in a slum area. The divorced and separated
veterans had no fixed addresses, and constantly moved around in the slum
areas. The one veteran for whom an adequate home was provided, in some
sense of the word, was the single veteran, who lived with his parents;
however, even this environment was not healthy toward his readjustment, be-
cause of their over protective attitude.

The following is a table showing the marital status, responsible rela-
tive, and individual with whom the patient lived during trial visit.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Responsible Relative</th>
<th>Individual Lived With During Trial Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>1 Parents</td>
<td>1 Parents</td>
</tr>
<tr>
<td>Married</td>
<td>1 Wife</td>
<td>1 Wife</td>
</tr>
<tr>
<td>Divorced</td>
<td>1 Mother</td>
<td>2 Mother</td>
</tr>
<tr>
<td>Separated</td>
<td>1 Other</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

TABLE 2
MARITAL STATUS AND TRIAL VISIT PLACEMENT OF PATIENTS WHO FAILED TO SHOW IMPROVEMENT
The following is an example of the patients who failed to show an improvement in their psychotic condition, or readjust to family or community living. This example is an extract taken from the records of the single veteran, who failed to show improvement or readjustment to family or community living.

This patient is the second born of seven siblings, and the oldest of five boys. His first known psychotic break occurred at the age of twenty three. His parents were very protective toward him, his father excessively so, the father moved his family from one section of the country to another in order to be close to his son. This necessitated his selling the family home, and giving up a lucrative livelihood. When granted a trial visit, his parents did not insist that he continue his treatment on an out-patient basis, for fear that it would result in his being returned to the hospital. This patient had been granted a number of trial visits prior to his discharge. While on trial visits the patient became withdrawn and seclusive. The family attempted to hide his behavior from the social worker, because of their fears around his being rehospitalized, and their hopes that his behavior would improve. His behavior grew progressively worst, until he was again presenting the symptoms for which he was first hospitalized.

During his last trial visit the social worker was able to show the family the importance of out-patient treatment, and the need to know the behavior shown by the patient. This was explained to the family in such a manner that they were able to see that by knowing of any behavior that appeared to be "odd or queer" it was possible to offer such treatment that might continue then as ambulatory rather than cause him to be rehospitalized. Through the efforts of social service in gaining the confidence of the family, in this area, the patient was able to remain on trial status, and was later discharged. However, the family continues to over protect and not allow him to participate in community activities. Because of family fears, and over protectiveness on their part there is little hope that the patient will ever make more than a marginal adjustment.
It is important when planning for trial visit or release of the patient to know where he is living and with whom; is he living with parents or spouse, who is assuming the position of responsible relative? The case of the separated patient graphically depicts this, the following is an extract from his record.

This marriage was the veterans third, his first ended in divorce, and his second wife died of tuberculosis. He met his third wife while he and his mother were living in a second class hotel. This meeting took place shortly after the death of his second wife. Much to the dislike of the wife's parents, the patient's mother encouraged their relationship. A year after their first meeting the patient and the young lady were married. He was thirty-three at the time, and his bride was seventeen. Shortly after his marriage the patient began to drink heavily and abuse his wife. The patient's mother would 'laugh' the problem off and state that an occasional drink was good for the patient, and that he had the right to chastise his wife. The wife was disappointed that her married life was not turning out as she had hoped. After the birth of twins she informed her husband that she had married him because she felt sorry for him. During the course of this argument the wife 'struck' back, and attempted to defend herself with a knife. Because of her behavior the patient was able to have her placed in a hospital for observation, this observation lasted four days, and then the wife was released. The patient and his wife remained together for eight years and were the parents of three children, during this eight year span, the patient was hospitalized four times. Shortly before his last hospitalization the patient and his wife were separated. Upon his return from the hospital the patient's wife refused to resume their married life because of her fear of her husband, and the fact that she did not feel that hospitalization had done him any good. The patient had been released from the hospital five months before he met his death by drowning; it is believed that his death was suicidal, in that an individual answering his description was seen jumping from the bridge a few days before his body was found. The patient was discharged from trial visit due to his death.

In our society the family is a legally wedded pair. Sociologically a family is a primary group made up of this pair and their immediate offsprings. Despite the very evident loss of reduction of many subsidiary functions of family life, interspouse relations and child bearing remain the focus of the family. According to the proceeding all four of these patients were

members of a family of some type. Who was the responsible relative, with whom did they live, were their living conditions conducive to adjustment? In the case of the divorced and separated patients it was seen that their wives had ceased to function as the hub of their lives, and family life was practically non-existent.

In the case of the separated patient the wife had effected a separation, which was a constructive one from her point of view. The wife was given some freedom from fear, as far as abuse from her husband was concerned. From what material that was available, it appears that this patient was over-protected as a child, and that his upbringing had given him little preparation for the responsibilities of later life. As a child he had not learned to care for the well being of others in an adult sense or carry the value of affection over a period of frustration. Protected by his mother, it appeared that he was seeking a continuation of dependence in his marriage. His mother condoned his drinking by "stating that a little drink was good for him once in a while." She sanctioned his abusive behavior toward his wife by indicating that he had the right to chastise her.

Also in the case of the single veteran over-protection was a large factor. The patient's parents attempted to shield him from the hurts and ills of the outside world. It is possible that when this patient met the slightest defeat he felt rejected, and tended to become withdrawn and seclusive. Surely the number of times he was required to return to the hospital was looked upon as rejection by the patient.

Of the eight patients who showed improvement and the ability to readjust

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1Florence Hollis, Women in Marital Conflict (New York, 1949), p. 27.
to family and community living the same criterion was employed, as that used in establishing the failure to show improvement, and the ability to readjust, in the four preceding cases. The eight patients who showed improvement, had taken part in family activities in varying degrees. These families were happy to have the veteran back in the home and felt that he would improve further, and be an asset to the family and community. Family members reported that since the use of tranquilizing medications, they had noticed that the patients were less withdrawn, and seclusive; they also showed fewer abusive tendencies toward their families. In each case with the exception of one patient the family appeared to have great interest in the patient's welfare, and desired that he live in the home. The living conditions for these patients were adequate, both from the family's standpoint, and that of the community. They were accepted back into their communities with a minimum amount of friction, and took active part in community affairs. Community members were willing to accept them as part of the community, and give them status as such. Each of these patients before the termination of their trial visits were gainfully employed. Table 3 shows the improved veterans marital status, responsible relative, and individual with whom the veteran lived during trial visit.

The following is an extract of the case of the patient who did not return to his family or community:

This patient was the third born of three siblings. The other two siblings died in childhood and adolescence. Prior to his admission to the VA Hospital, Chillicotte, Ohio, the patient had a history of violent rages, in which he beat his aged mother, and attempted to run down neighborhood children with his automobile. Shortly after his hospitalization his mother was placed in a home for the aged and their private home was sold. When it was felt that this patient was ready for trial visit, there was no place to which he might return, no evidence was found that VAH, Chillicotte, Ohio had used
TABLE 3
MARITAL STATUS AND TRIAL VISIT PLACEMENT OF PATIENTS
WHO SHOWED IMPROVEMENT

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Responsible Relative</th>
<th>Individual Lived With During Trial Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>4 Parents</td>
<td>2 Parents</td>
</tr>
<tr>
<td>Married</td>
<td>3 Wife</td>
<td>3 Wife</td>
</tr>
<tr>
<td>Divorced</td>
<td>0 Mother</td>
<td>0 Mother</td>
</tr>
<tr>
<td>*Separated</td>
<td>1 Siblings</td>
<td>2 Siblings</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1 Other</td>
</tr>
<tr>
<td></td>
<td>Alone</td>
<td>0 Alone</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

*After a number of trial visits with his wife the patient was not able to make an adequate adjustment. Later he moved to his sister's home. This sibling provided an adequate home for the patient and their mother.

the foster home plan since 1952. This patient was placed on the exit service program and considered for employment. However, social service and psychology felt that this patient would be a good candidate for the member-employee program. The patient expressed his willingness to be a part of such a program. Since being placed on the candidate employment program, the patient has made an adequate adjustment in his social and employment sphere of life. Where formerly he was violent, combative, and refused to participate in gainful employment, he is now friendly, outgoing and gainfully employed.

It would have been a simple matter for the hospital staff to "give up" as undesirable the above named patient. He had no home to which he might return, he was not wanted in his community because of his previous behavior, and the hospital had no established foster home plan in action at that time. The VA Hospital, Chillicothe, Ohio, along with a number of other VA stations were reported to have successfully used the foster home
plan in 1952.

All the potentials of this patient were taken into consideration and he was placed on the member-employee program. This is the program employed by VA in limited cases, where placement of the improved mentally ill veteran cannot be arranged. He is given employment within the scope of his educational abilities, and his limitations. He is given treatment the same as any veteran receiving out-patient treatment. This patient is in his own care, and is faced with the same responsibilities that he would face if placed in any other community.

In the cases of the other three single veterans two lived with their parents, who were also the responsible relatives. These families were very willing and happy to have the patients return to their homes, they felt that more could be accomplished, toward the patients' improvement, while at home. In both cases these families were frequent visitors to the hospital, inquiring about their sons' progress, and their plans, once he returned home. These parents were cautioned to not attempt to do all the planning for the patient, but to let him share in family planning also. These parents, noticed that their sons' were not suspicious as they were when they just entered the hospital, and that once more they were interested in their personal appearance. They attributed this to the use of tranquilizing medication.

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1Roger Cumming, "Foster Home Trial Visits for Patients with Mental Illness," Department of Medicine and Surgery: Information Bulletin Psychiatry and Neurology Division, IB10-40 (April 1953), pp. 3-5. Office of the Chief Medical Director, VA Washington 25, D.C.

They insisted, when the patient seemed to falter, that he continue his outpatient treatment. These families provided an adequate home for the patients which appeared to be happy and relatively free of family conflicts. These patients were gradually re-introduced into the "swing" of community affairs. They were for the most part accepted by their community, and felt safe and happy with the manner in which their community accepted their return.

Neither of these patients were employed immediately upon their release, but before their trial visit expired they were both regularly employed. The following is an example of one of these patients.

This patient was hospitalized for fifteen months prior to his trial visit. During his attack the patient had visual and auditory hallucinatory experiences. While a patient at the VAH, Chillicothe, had received drug therapy. He was granted a trial visit and lived with his family on a small farm. He is a large family, and from all indications a closely knit 'bunch.' The patient works on the farm, and has made an adequate adjustment with his family, friends, and community. His friends and community have accepted his return, and appear to be happy to have him back. However, he has not sought employment off his family's small farm. It is indicated that the family is very protective, toward the patient and have encouraged him not to seek employment elsewhere. The patient has been discharged from trial visit, psychotic condition improved.

In the case of the single veteran who lived with siblings, the means of his improvement and adjustment were not the same as the above. Although this sibling provided an adequate home, the patient was not content to remain, and felt that he should be on his own and living by himself. At the start of his trial visit the patient was making a poor adjustment because of this feeling. Finally with the consent of the sibling the patient moved out of the home. He made an adequate adjustment, and was later discharged from trial visit as improved. The situation of the married patients was very much the same as the single patients with the exception that the patients returned to their wives and children, rather than to the homes of their parents. The case of the separated patient was not unique, but there was quite a bit of
conflict in each family concerning the patient.

This patient had been mentally ill for a number of years. His marriage occurred after his first attack of mental illness. At the time of his last trial visit he had been married to a widow, with six children by a previous marriage for ten years. The patient had been granted a number of trial visits that had proven unsuccessful, because of his inability to get along with his wife's children, and because he refused to seek employment. His family on the other hand contended that his wife was interested only in his disability compensation, and that he was not able to progress while living with her. It actually seemed the patient was not showing any signs of improvement while living with his spouse and her children. During his last trial visit he was prevailed upon, by his relatives, to leave his wife. Once out of the home occupied by the wife and her children, the patient was able to make an adequate family and community adjustment. He is regularly employed, and seeking a divorce in order to remarry. The patient was discharged from trial visit as improved.

A mental patient recently wrote a letter to one of the local newspapers, which quite adequately sums up the feeling of the mental patient toward his illness, and his family.

Dear Miss Van Buren: I was so glad to see a letter printed in your column telling the person not to be ashamed of her brother who was in a mental institution. I am in a mental institution (state-operated) and I am proud to say that my family isn't ashamed of me. They visit me and make me feel like a human being instead of a criminal. Some of my friends here are not so fortunate. I can tell you this - if the families of mental patients ignore them, the patients will never get well. The doctors can do just so much for them but if their families don't make them feel loved and wanted, the mental patient will just rot in the institution. This letter will be censored as all outgoing mail is. I hope they let me send it. If I see it in print I will bless you in my prayers because it might give a lot of relatives something to think about.

A Mental Patient

The sample used in this study represents a cross section of the patients at the VA Hospital, Chillicothe, Ohio granted trial visits, after the use of tranquilizing medication, during the period of January 1, 1955 through December 31, 1955.

1"Dear Abby:", The Atlanta Journal, March 25, 1958, p. 31.
CHAPTER VI

SUMMARY AND IMPLICATIONS

The purpose of this thesis was to determine what bearing the use of tranquilizing medication had on the mental patient in terms of community and family adjustment, and what part the use of these drugs played in the role of the social worker.

Various methods of treatment have been given to mental patients prior to the use of tranquilizing medications. The most widely used forms of physical therapy for the mentally ill included shock treatment, which employed the use of insulin, metrazol and other drugs, or the use of strong electric current to produce shock in the patient. The theory behind producing shock in the patient, was that if physiologically highly disturbed by the experience, he may emerge from the state of shock improved.

Another form of physical therapy which was given wide publicity was psychosurgery. This method of treatment is a highly delicate operation where the mental disorder is treated by selecting parts of the cerebral cortex. Lobotomy is generally considered a procedure of last resort, to be tried after all other methods have failed, patients who were assembled to undergo surgery, in the early stages of the use of lobotomy, represented hopeless, and chronic forms of mental disease, for the most part relegated to custodial care.

Today the most widely publicized method of treating mental illness is the use of tranquilizing medication. The most widely publicized and perhaps used drugs are reserpine and chlorpromazine. These drugs are used separately and together in treatment of the mentally ill.
The basic ingredients of reserpine has been known for centuries; it is the root of the plant called Rauwolfia Serpentina Bentham, found only in India, and known as the "insanity herb." There are fabulous legends about this plant. These legends stated that this plant is useful for serving as an antidote for poison, when ground and placed between the toes, to the eating of slices of the root by a demented person to relieve madness.

Through intensive research and experiments, done at various hospitals, it was found that reserpine greatly reduces anxiety, and obsessive-compulsive drives, and overcomes excessive inhibition. However, there is no evidence that this drug in any way alters the schizophrenic process nor any of the other major psychoses, but rather it serves principally to make the patient more tractable, counteracting confusion and facilitating psychotherapy.

This changing focus of psychiatric care implies certain modifications of the social worker, but it does not imply that the social worker will become a psychotherapist nor does it imply that psychotherapy is on the way out. It has been said that about one-third of the patients who consult a physician do not have any definite bodily disease to account for their illness and approximately another third have symptoms that are dependent upon emotional factors. These individuals can reasonably be assumed to be clients of various social agencies, and are in frequent contact with case workers, and social group workers. Thus the advent of a drug to reduce tension and anxiety with a minimum of ill effects can be viewed as a boon, not only to the psychiatrist, and general practitioner, but also to the social worker.

In general the researchers felt that the use of reserpine (Serpasil)
had reduced the number of disturbances, restraint orders, improved morale of both patients and staff, thereby giving the staff more time to spend in treating the patients since less time was required in restraint. From the social worker's point of view this meant that he would be able to sustain a closer contact with the patient in handling problems of a social nature, both in and out of the hospital.

As previously stated the other widely known and used tranquilizing medication is chlorpromazine, this drug being more generally known by its trade name Thorazine, was developed in France, as a possible sedative. This was in extension of the already well-known sedative action of antihistaminics. Thorazine was found to be very effective with the schizophrenic patient. Although thorazine and serpasil greatly differ in their chemical components, the effect is much the same. The most remarkable effect from the social work standpoint is that the patient becomes tractable.

The course of behavior for a patient under reserpine therapy follows a pattern of a sedative period, a turbulent period, and finally a period of integrative behavior. This type of behavior must be understood by the hospital personnel and interpreted to the patient's family. The stage of increased turbulence may be quite anxiety provoking, the patient may become more delusional and hallucinations often become more pronounced. During this period the patient may have dreams which are emotionally upsetting. Our attitudes as social workers are only part of the therapeutic work with the patient. As has been indicated previously the patient's family must be oriented to expect such behavior, as described above, as a part of the patient's long and tedious fight to readjustment. The family
attitudes must be free of "judgmental or retaliative" actions which imply punishment, confinement or disapproval of treatment, because of the patient's behavior. It is again the job of the social worker to orient these family members to the type of behavior that can be expected from the patient, and the type of behavior they themselves should strive to achieve. It is only when the patient sees that his behavior is being tolerated and he is treated with kindness and patience, that he realizes that he is wanted and accepted by his family.

As more and more patients leave the hospitals on trial visits the problem of supervision becomes one of prime importance. Not only will the social worker be required to plan for the patient who returns to approximately the same family unit, but there will be family units that have undergone drastic revisions, families who have become accustomed to his long period of absence, families composed of individuals who have no memory of his pre-psychotic state. Then too there is the foster family to which the patient, who has no family to return to, will be going for the first time. The social worker is in a position to better help these various families understand the problems, which will confront the patient and his family more so than any other group of workers. The social worker is in a position to explain how their behavior will effect the patient's behavior, both good and bad, and what the continuation of out-patient treatment and supervision will mean in terms of his continued improvement and readjustment while on trial visit.

These individuals must be helped to realize that the mental patient is an individual, who more than likely is sensitive to his illness, but desires to be treated as everyone else, and not shown undue sympathy or
pity. He must not however be treated in a callous manner, nor should it be implied that he was an inmate of an institution, rather than a hospital patient. However we are not attempting to imply that the patient should be over protected or babied. Many a patient is returned to the hospital, from trial visit, simply because he failed to receive understanding or proper care. Through lack of understanding the patient is often not required to continue, by his family, to take the prescribed tranquilizing medication until it is finally discontinued. Many patients return to the hospital from trial visits for essentially the same reasons they were first hospitalized. The return of their acute stages of psychosis can be said to be a number of factors. One is the reduction of tolerance built up to certain anxieties. This reduction could be due to not properly accepting out-patient treatment, and to failure on the part of the family to maintain a home that has as little friction between family members as possible. "In other words they are either unable to accept their environment or their environment is not able to accept them with their problems and limitations.

The continued use of medication on the part of the patient makes him more tolerant toward his problems, and the problems of his environment, by reducing his anxieties. It is felt by some doctors, and others in the care of mental patients, that the family should also receive tranquilizing medication, while the patient is on trial visit and still taking medication himself, in order to reduce the anxiety of the family caused by the patient's return, and also to make them tolerant of the patient's problems and limitations.

In order to insure a successful trial visit for the patient, careful planning and appraisal of the readiness of the family to accept the return
of the patient to the home should be accomplished before the patient
is granted a trial visit. In planning and the appraisal of the home the
patient should be considered in terms of individual emotional growth, and
improvement of his particular psychosis. How far can he participate in
family and community affairs? Many families through lack of understanding,
but a genuine desire to help bring about an improvement in the patient,
have thrust too many responsibilities on the patient at too early a date;
thereby causing confusion and lack of confidence on the part of the patient
if a minor mistake or failure is made.

These failures are usually looked upon as failures on the part of the
patient wherein they are really failures on the part of the family and/or
community. In helping the patient to adjust we should be conscious also
of the fact that the family also needs to adjust to the return of the pa-
tient. The mental patient is usually looked upon with suspicion or scorn
when he returns to his family and community. If he speaks out of turn or
behaves in any way that is not the standard set up by his family, this is
looked upon by the family as indication that he is "still off his rocker."

There is also the problem of employment for the chronic patient who
has not been a member of the labor force for a number of years. The chronic
patient, more so than other mental patients, must prove to his employer that
he is capable of holding down a job. Usually his first problem is that of
securing employment. Many a prospective employer will not hire a former
mental patient. If such is the situation, the patient is faced with the
problem of informing the employer that he is a former mental patient, and
being denied the opportunity of working, or not informing the employer,
being accepted for employment, and anxieties being built around losing
his job for fear that the boss might learn that he was a mental patient. Once he has secured employment the patient might have fears around continuation of medication. He might fear that the medication will reduce his ability to act in certain employment situations. Rather than to cease taking medication at the time of employment the patient should be instructed to talk over his employment plans with his doctor, and social worker. It may be indicated that the medication can be reduced, ceased altogether, or some other type of job or medication arranged for the patient.

In order that the patient's trial visit might be a successful one, the worker must be familiar with the medication received by the patient, and the patient's reaction to the medication. The worker must also be able to interpret the use of the medication, its reaction, and the importance of its continued use to the family members. The use of tranquilizing medication has played an important part in the role of the social worker, in the care of the mental patient and the interpretation of that care to family members.

With tranquilizers as with other forms of therapy, we must remember that treatment does not end in the hospital or out-patient clinic, nor does it stop with the various staff members of these agencies. The family and community are most important, and without their support and help much of the effectiveness of tranquilizing medication will be lost. This study indicates that for tranquilizers to be more effective and for improvement on the part of the patient, the family and friends must be able to understand that these new drugs, even though at present they appear to be the best form of treatment we have for mental illness, will not effect a cure nor work miracles. From the result of this study it appears to the worker that tranquilizers are more effective in the aid of adjustment of the mentally ill than any other
form of treatment we have today. With proper maintenance dosage for a period of time after release from the hospital, the patient is ready to cope with the anxieties he might encounter because of his return to the community.

The writer feels that the conclusions reached as the result of this study should only be looked upon as tentative. From admission dates and trial visit or discharge dates as compared with the receiving of drug therapy and other forms of treatment it appears that the patient is able to leave the hospital at an earlier date than before the use of tranquilizers. The writer does not feel that he is qualified to say that tranquilizers are a cure for mental illness, nor does this study indicate that it is, however, it does indicate that through the use of tranquilizers the hospital staff is better able to meet the patient on common ground. Through the use of tranquilizers the patient has become amenable to various therapies and treatments.

"We must learn all we can of this new therapy, sharpen our case work skills, learn to function at a more complex level of interpersonal therapy and re-evaluate our specific services. Trial visit planning must move out of the realm of will the family take him? and into the area of how will the family and community help him? Trial visit supervision must offer real case work help to the patient and his family and at the same time activate the community in his behalf. Checking up on the patient is no longer sufficient."

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Identifying Data

1. Name: _______________________________ 2. Sex: __ Race: __
   last first middle

4. Date of Birth: ________________________ 5. Place of Birth: ____________
   City State

6. Address: ______________________________ 7. Religion: ____________
   St. # City State


Hospitalization

10. Date of Commitment or Admission: ____________ 11. Reason for Commit-
    ment or Admission: ____________________________________________

12. Action Taken At Time of Commitment: __________________________________

13. Age at onset of Illness: _____ 14. Length of Illness: __________

15. Number of Attacks: _____ 16. Were Attacks Sudden or Gradual: ______

17. Describe Behavior during Attacks: ____________________________________

18. Type of Mental Disorder: _______________ 19. Duration of Present
    Attack: ______ 20. History of Prior Hospitalization: ______ Yes
    ______ No

21. When: _____ Where: ______ Type of Medication received ______
    How long Hospitalized: ________________________________________

22. Dosage received: ____________ 23. How long did patient receive
    medication: __________________________________

24. Did patient receive medication other than tranquilizers: ______ Yes
    ______ No 25. If so what type: ____________________________________

26. Did Patient receive a combination of medication: ______ Yes ______ No

27. If so what were they: ________________________________________

28. What was patient's reaction to medication (describe) ________________
Trial Visit Information

29. Has it been necessary for the veteran to see a doctor since hospitalization: ____ Yes ____ No ____ Unk. If yes, explain ____________________________

30. Has it been necessary for the veteran to be hospitalized any any other hospital: ____ Yes ____ No. If so, where: ____________________________
   When: ____________________________ If answer is yes give facts leading to hospitalization during T.V. ____________________________

31. How long was patient on T.V. before hospitalized: ____________________________

32. Has patient been receiving out-patient treatment: ____________________________
   If medication kind and dosage received: ____________________________ Duration of treatment received ____________________________

33. Has it been necessary for the patient to be re-admitted to this hospital: ____ Yes ____ No. If so, when: __________ What were the symptoms noticed: ____________________________

34. Has he been granted a trial visit or discharge since re-admission: ____ Yes ____ No If so, when and for how long ____________________________

35. Has the patient been employed regularly: Yes ____ No ____ Indicate if the patient has a good work adjustment (did he go to work every day and apparently do his work well) ____________________________
   fair work adjustment (did the patient make only intermittent attempts to work) ____________________________
   Poor work adjustment (No work done at all give reason) ____________________________

36. Has he been able to take part in the social activities of his family: Yes (explain how he has taken part) ____________________________
   No (what is the reason behind his not participating in family activities) ____________________________

37. What does the family think of his return: ____________________________
38. Do they notice a change in the patient's behavior since the use of tranquilizing medication:  Yes  No. If a change was noticed explain

39. What are his living conditions: Poor  Fair  Good
Adequate  (explain in detail the living conditions, is he living with his family or elsewhere)

40. Has he been able to take part in the social activities of the community:  Yes (explain how he has taken part)
No (what is the reason behind his not participating in community activities)

41. What does the community think of his return:

Family Composition

42. Father  Age:  44. If deceased age at time of death

45. Cause of death:  46. Education:  47. Occupation:

48. Mother  49. Age:  50. If deceased age at time of death:

52. Education:  53. Occupation:  54. Parent's or Guardian's Address:

55. Number of Siblings:
(a) females (by age)
1. 
2. 
3. 
4. 
5. 
(b) males (by age)
1. 
2. 
3. 
4. 
5.

56. Patient's order of Birth**
57. Patient's Marital Status __ Single ___ Married ___ Separated __ Divorced


63. Finances: ______ Wage: ______ Rent: ______ Utilities: is wage adequate: ______ is medication furnished free of charge:

History of Mental Illness of Family Members

64. Have any family members required hospitalization: ___ Yes ___ No If answer is yes give complete details:


68. How long hospitalized: ______ 69. Type of mental illness:

70. Age at onset of illness: ______

71. Type of medication received:

72. Dosage received: ______ 73. Is relative present in the home: ______ 74. Is relative still ill: ______

75. Remarks: