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Environmental factors significant to readmission of schizophrenic patients prior to expiration of regular trial visit

Frank Sellers Jr.
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ENVIRONMENTAL FACTORS SIGNIFICANT TO READMISSION OF SCHIZOPHRENIC PATIENTS PRIOR TO EXPIRATION OF REGULAR TRIAL VISIT

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

BY
FRANK SELLERS, JR.

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JUNE 1959
ACKNOWLEDGMENTS

The work entailed in this writing could not have been carried out if the writer had not been helped in this, his first research experience, by Dr. Leon Cohen, Chief, Vocational Counseling at Northport Veterans Hospital.

The writer is particularly grateful to Mr. William Sculthorpe, case supervisor of Northport Veterans Hospital, for showing a deep personal interest in the writer's research, and giving him much needed encouragement.
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CHAPTER I

INTRODUCTION

Significance of the Study

One of the most distinctive qualities of this contemporary period is the ardent interest in mental disturbances which are being investigated in a methodical and exhaustive manner by students and scientists in many disciplines. Every medium of communication seems to be concerned with the depiction and analysis of personality with its baffling relationships, conflicts, and discords.

Ironically enough, with this accumulation and deepening of knowledge, the people (in the community) who most often produce the adverse conditions which thwart and prevent the transition of patients from the hospital to the community, have little of this new surge of knowledge and interest in mental problems. One writer\(^1\) has observed that after painfully slow improvement achieved through years of hospitalization, a patient may leave the hospital improved only to return shortly thereafter, possible more severely disturbed than he was at the time of admission.

Therapeutic victories achieved by the hospital personnel are always subject to disastrous, disheartening reversal by various extra-mural factors. These extra-mural factors show their consequences in the number of readmissions to mental hospitals. In the United States approximately 200,000 patients leave mental hospitals each year and 30 per cent to 50 per cent

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of them return. In New York State it has been estimated that one-third of all admissions to mental hospitals in 1947 were readmissions. At Northport Veterans Administration Hospital, in which the writer conducted this research, more than 30 per cent of the patients placed on trial visits are returned to the hospital.

The magnitude of the problem may further be seen in its economic implications to both the government and to the individual patient. The 1950 daily per capita cost in the Veterans Administration Psychiatric hospitals was $6.91. However, the average daily population of the neuropsychiatric patients in veterans' hospitals alone in 1950 was 52,000, costing $130,000,000 annually. Thus, the cost of caring for the mentally ill is enormous. On the other hand, the economic loss of patients with mental disorders is even greater. An estimate of this loss for a group of 9,000 male patients admitted to New York State hospitals and licensed private hospitals in 1948 was made by Benjamin Malzberg. He determined that each patient would lose on the average of 8.3 working years, amounting to an average net future loss of $10,000 per patient.

It becomes increasingly evident that if any genuine headway is to be made in the prevention of environmental maladjustment and promotion of positive aspects in environment, professions especially responsible for the study,


training, and guidance of personality must share in the process. The profession of social work has an obligation to study and participate in accumulating information relative to the adjustment of patients in the community. For the field of psychiatric social work, the significance of this study may well lie in its specific re-examination of those aspects which handicap and prevent patients' readjustment.

The writer's interest in this subject was first aroused during childhood. He had the unfortunate experience of observing the injurious effects of community attitudes toward mental illness as expressed in derision, ridicule, isolation, and lack of employment opportunities for two mental patients discharged from the state mental hospital. If this weren't pathetic enough, the families' attitudes toward these patients further aggravated matters. In less than six months subsequent to their release, the patients had relapsed to their earlier mental states and were correspondingly readmitted to the state mental hospital. Since that time the writer has maintained a keen interest in the environmental factors possibly contributing to recidivism.

**Purpose of the Study**

This study sought to uncover and describe some environmental factors which contributed to the rehospitalization of schizophrenic patients who were on trial visits with their relatives.

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1 For a more elaborate description of professions' obligation in studying mental health, see Clara Bassett, *Mental Hygiene in the Community* (New York, 1954), pp. 1-16.
Method of Procedure

The case study method was the major research technique employed. It consisted primarily of an analysis of case records of ten schizophrenic patients who were placed on trial visit from the hospital, and were later readmitted because of recurrence of their earlier mental states. The writer secured from the clerk in the Social Service Department a list of patients who were returned to the hospital from regular trial visit between the dates of January, 1958 and November, 1958. The list obtained from the clerk yielded fifty-seven names. The selection of the study sample was based on the following factors: (1) diagnosis of Schizophrenic Reaction, (2) patients who went on trial visit with their relatives (known as regular trial visit), (3) those who were hospitalized at the time of this inquiry. After excluding those cases which did not meet the requirements for investigation, ten remained. The following table shows the reasons as well as the number of cases eliminated.

TABLE 1
REASONS AND NUMBER OF CASES ELIMINATED

<table>
<thead>
<tr>
<th>Reasons for Exclusion</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Different Diagnoses</td>
<td>9</td>
</tr>
<tr>
<td>On other Trial Visit Programs</td>
<td></td>
</tr>
<tr>
<td><em>Such as Foster Home or Member-Employee</em></td>
<td>6</td>
</tr>
<tr>
<td>Returned to Trial Visit During Period of Investigation</td>
<td>18</td>
</tr>
<tr>
<td>Not Enough Data</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
</tr>
</tbody>
</table>
The eleven months period was selected for several reasons: (1) It insured that those patients still receiving treatment could be interviewed; (2) It provided a sufficient number to furnish the basis for the study; (3) It was not very difficult for social workers who had assisted the patients in the sample to recall essential information in completing the schedule.

For the purpose of obtaining relevant data, the author read and utilized professional literature. Schedules were also formulated to facilitate the research. Whenever the case records were sparse in material needed about the patients, the writer interviewed the staff members who carried the cases.

Scope and Limitations

All of the patients were male adult veterans who were considered well enough by the medical staff to be placed on trial visit. They carried a schizophrenic diagnosis and were still under treatment at the hospital during the six-months period in which the writer was a student social worker at the Veterans Administration Hospital, Northport, New York.

The small sample may not have described all of the factors which impinge upon patients outside the hospital and help to cause their return. There are conditions in community life whose damaging effects need not be demonstrated through research because there is already in our culture an almost unanimous acceptance of the fact that they are detrimental to the individual. The conditions referred to are: bad housing, lack of medical care,

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1 This method of inquiry was based on Leon Cohen's "Vocational Planning and Rehabilitation of Schizophrenic Patients," (Unpublished Doctor's Dissertation, Department of Psychology, Columbia University, 1953), p. 3.
low wages, and so forth.¹ No data relevant to these conditions were compiled or analyzed because of their general acceptance. However, it has been proposed that whether or not a given environment may be considered conducive to mental health depends upon the barriers it erects against the maximum value of the adjustability of the patient.²

When the writer's initial examination disclosed the intricacies of these environmental or extra-mural factors precipitating a mental relapse on the part of patients, he found himself dubious of his ability to fully decipher the meaning of them.

The interviewing method, whenever employed by the professional staff, did not at all times afford full comprehension of social influences. The patients' own reticence, unawareness, repression and confusion about conflicting social situations impinging upon them obscured recognition of baneful environmental influences.³

²Ibid., p. 566.
³For a detailed analysis of general methodical limitations confronted by writer in social work, see Janet Thornton, The Social Component in Medical Care (New York, 1930), pp. 3-13.
CHAPTER II

DESCRIPTION OF THE SETTING

General View

The Veterans Administration Hospital at Northport, New York is a 2500 bed neuropsychiatric hospital for the treatment and care of the mentally ill veterans. The greatest number of patients in the hospital are those receiving treatments for mental disorders of the schizophrenic reaction category, but patients suffering from other psychiatric conditions are treated. The physical plant of the hospital is arranged so as to provide comfort for the patients within the institution setting. This protective setting is believed to be one of the ways of helping patients make the necessary physical, social, and emotional changes and gains which will enable them to make a more satisfactory adjustment upon their return to their community.¹

The hospital comprised three basic treatment services: (1) Acute Intensive Treatment Service which included the admission service and was designed for the treatment of short-term cases; usually those patients who needed or would need less than one year of hospitalization; (2) Continued Treatment Service which was for the patients who required long-term care and treatment; (3) Medical-Surgical Service which served the outpatients from the first two aforementioned basic treatment services. Outpatient care was an important part of the hospital's work; and a clinic was maintained for the purpose of follow-up care and treatment to all neuropsychiatric patients who were on trial visit status and who resided in Suffolk County.

¹This general information about the hospital was adapted from Dorothy M. Cumming and Stuart Howell, "A Study and Description of Some of the Factors Contributing to Readmission of Patients to the Northport Hospital From Foster Home Placement," (Unpublished Master's Thesis, School of Social Work, Adelphia College, 1957).
The organizational structure of the hospital consisted of twenty-six units, namely: manager, assistant manager, registrar, fiscal division, personnel, engineering division, supply, canteen, special services, chaplaincy service, contact division, office of professional services, acute intensive treatment service, continued treatment service, medical service, physical medicine and rehabilitation service (which included occupational, educational, corrective, physical therapy, and manual arts therapy), radiology service, laboratory service, pharmacy service, social work service, dietetic service, clinical psychology, and vocational counseling service.¹

Within a day or two after a patient's admission to the hospital, the medical staff made a preliminary diagnosis and designated a tentative treatment plan for the patient. During the next four to eight weeks, the patient received a physical and psychiatric work-up. Following this procedure, he again appeared before the medical staff for confirmation of his diagnosis and treatment plan based on the findings of his physical and psychiatric examinations, social history and evaluation, psychological report, etc. During hospitalization, the patient received somatic and/or milieu therapy, and sometimes psychotherapy. The patient was released from the hospital in several ways: (1) Maximum hospital benefits; (2) Against medical advice; or (3) Trial visit. This particular program will be discussed in detail later in this chapter.

Social Services

Social work was an integral part of the medical care program. It contributed to medical treatment a skilled appraisal of the source and

¹Organizational Manual of the Veterans Administration, as revised, October 20, 1955.
significance of the social, emotional, and economic problems of the veteran's disablement. It also provided a resource for reducing the force of their impact upon him as a sick individual. Such service as developed in VA Hospitals provided an opportunity for the trained clinical social worker to function with maximum utilization of his professional competence and to translate into daily practice current theories of social casework.

The maximum number of personnel for Social Work Service was twenty-three employees and four students. This included one chief social worker; three casework supervisors; one social worker for the member employees; two foster home social workers; twelve ward social workers; and four clerical workers or clerks who performed non-professional facilitating services.

A social worker in a neuropsychiatric hospital had the following responsibilities:

1. Under the leadership of the psychiatrist, the psychiatric social worker provided a variety of services to patients and families throughout all phases of hospitalization - from admission to discharge. These services were designed to facilitate the patient's constructive use of his hospital environment and resources, and to improve his social adjustment to the community.

2. The social worker had responsibility for contributing to the diagnostic understanding and treatment of the patient through social histories, and sharing with the psychiatrist and other professional

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2Social Service Program in Veterans Administration Hospital, Veterans Administration, Department of Medicine and Surgery, 1953.
staff the nature of social service contacts with the patient and his family.

(3) The social worker assisted psychiatric patients directly by sharing and later helping them to resolve their mixed feelings about the hospitalization and treatment; by mobilizing their strengths to assume some responsibility for getting well; by fostering contact between them and their families, and by preparing them for the most appropriate kind of social life in the community when they were ready to leave the hospital.

(4) The role of the family was often an important factor in total treatment process. The social worker interviewed relatives at the time of admission and on subsequent hospital visits to assist them with their feelings about mental illness and most effective ways of helping the patient in his post-hospital adjustment. Plans for his release on trial visits were discussed with them at the point when it appeared that he would soon be able to leave the hospital.

(5) The hospital social worker supervised patients at home on trial visit when they lived near the hospital, or arranged for the regional office social worker to provide such supervision for patients whose homes were at a distance. Social workers also had responsibility for location and supervision of foster homes for patients who could not go on trial visit to their own homes.

**Trial Visit Program**

Trial visit was the term used for a period of time the patient spent out of the hospital with expectation of final discharge pending his satisfactory adjustment in the community. The patient was placed on trial visit
status in or of several different situations: in the custody of parents or relatives, a foster home, in a protective job placement (working home), or on member-employee status which meant that he would become a paid employee at the hospital and would live in the employees' quarters on the hospital grounds. The patient was discharged from trial visit status after three, six, nine, or twelve months, or returned to the hospital, depending upon the nature of his adjustment.

The following passage extracted from the "Job Description - Social Worker" showed the role of the social worker in helping patients on trial visit:

The Social Worker is responsible for supervising the social adjustment of veterans on trial visit leave from psychiatric hospitals. He is required to visit these veterans and discuss with them and their families any problems arising out of veterans' trial visit status. He is required to evaluate the factors in the total environmental situation which might prevent adjustment, and should be prepared to take steps to alleviate them. He must be capable of discussing with members of the psychiatric staff, both in the regional office clinic and in the psychiatric hospital the case factors which might be preventing adjustment. He must be prepared to evaluate for the psychiatrist the total adjustment picture and make appropriate recommendations for continuance, termination of trial visit, or return of veteran to the hospital. He must be equipped to prepare adequate reports covering this phase of his activity. In some instances the social worker will be called upon to prepare a psychiatric work-up of the case factors for use by the psychiatric staff prior to release of veteran on trial visit.

As the above passage indicates, veterans released on trial visit from the neuropsychiatric hospital presented a special challenge to the social service worker. During this period he offered casework services to the veterans and to members of their families. He represented the line between the hospital and the home, helping the veterans in their efforts to
rehabilitate themselves, both economically and socially. He developed a keener understanding of the meaning of mental illness and of hospitalization as he assisted these veterans through their uncertainties and fears of meeting the demands for social adjustment.
CHARTER III

SCHIZOPHRENIC REACTIONS

Schizophrenia is the most common form of psychosis. One person out of five admitted for the first time to a mental hospital is given this diagnosis. Starting early in life, often during adolescence and still more often in the decade of the twenties, it can wreck the person's whole adult career and prevent him from making any useful contribution to society. If spontaneous recovery does not occur, or if treatment is not successful, the patient may become a public charge for forty or fifty years. Because the disorder has a chance to last so long, schizophrenics accumulate in mental hospitals and constitute something like fifty per cent of the patients at any given time.1

**Definition**

Generally, schizophrenia is a severe emotional disorder of psychotic depth characteristically marked by a retreat from reality with delusional formations, hallucinations, emotional disharmony, and regressive behavior.2 Clinard3 has given an elaborate description of schizophrenic behavior. He observed that the most characteristic symptom of a schizophrenic is his withdrawal from contact with the world around him and his inability to play the roles expected of him. Even before institutionalization becomes necessary, the schizophrenic may show a great deal of emotional indifference and inattention. He does not show the expectations and interest of the group, and there is a great indifference to things previously considered

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important. In addition, the emotional tone is passive, often even negative, so that the patient has little interest in activities. Finally, his thought processes are so disturbed that he builds a world of his own imagination including false perceptions and hallucinations of various kinds, such as ideas, voices, and forces which enter his daily living and which he cannot control. Schizophrenics undergo a collapse in their personalities which involve a detachment of their emotional selves from their intellectual selves. It is for this reason that the term "schizophrenia" or "split personality," as it is often called, is used to define this illness.

History

The term demence precoce (meaning "deterioration at an early age") was first used by Morel, a Belgian psychiatrist, in 1860. He used it to describe the case of a young adolescent boy who had been very brilliant in school; but who, in later years, gradually became withdrawn, seclusive and taciturn, and appeared to have forgotten everything that he had learned.

This term was later adopted by the German psychiatrist, Kraepelin, to refer to a group of rather dissimilar conditions which all seemed to have the common feature of mental deterioration beginning early in life. Actually, however, most of these cases do not develop during childhood or adolescence but during adulthood and there is no conclusive evidence of permanent mental deterioration. Thus dementia praecox proved an unfortunate term.¹

In 1911, Eugen Bleuler, a Swiss psychiatrist, introduced the present and more acceptable term for this disorder. He called it schizophrenia because he thought the disorder was characterized primarily by lack of coherence in association and thought processes, emotional blunting, and

inward orientation from reality.\textsuperscript{1}

Classification

In the Diagnostic and Statistical Manual published by the American Psychiatric Association, schizophrenic reactions are classified as follows:

SCHIZOPHRENIC REACTIONS

Schizophrenic reaction, simple type
Schizophrenic reaction, hebephrenic type
Schizophrenic reaction, catatonic type
Schizophrenic reaction, paranoid type
Schizophrenic reaction, acute undifferentiated type
Schizophrenic reaction, chronic undifferentiated type
Schizophrenic reaction, schizo-affective type
Schizophrenic reaction, childhood type
Schizophrenic reaction, residual type\textsuperscript{2}

For purposes of diagnosis and treatment, schizophrenic reactions are subdivided into several types (as listed above). These subdivisions are made rather arbitrarily on the basis of the salient characteristics of the disorder. The four major types will be described briefly.\textsuperscript{3}

Simple Type

The distinguishing characteristics of a simple schizophrenic reaction are impoverishment of human relationships, seclusiveness, an attitude of

\textsuperscript{1}Ibid.


\textsuperscript{3}Herbert A. Carroll, Mental Hygiene (Englewood Cliffs, 1956), pp. 235-240.
indifference, or, in advanced stages, extreme apathy. This disorder usually develops very gradually.

Hebephrenic Type

A hebephrenic schizophrenic reaction comes much closer than the simple type to the layman's conception of insanity. The disorder is characterized by inappropriate behavior, including smiles and laughter which appear seemingly without cause, childish behavior and mannerisms, hallucinations and disorganized delusions, and usually by progressive deterioration. This behavior develops gradually, frequently beginning in adolescence.

Catatonic Type

This disorder is characterized by extreme fluctuations in emotional behavior. Usually the patient is between stuporous depression and hyperactivity in his overt behavior.

Paranoid Type

The principal characteristics of a paranoid schizophrenic reaction are delusions of persecution and grandeur. The disorder develops rather slowly, and is likely to appear somewhat later in life than the other schizophrenic reactions.

Etiology

The fundamental nature of schizophrenia has yet to be explained. Some authors have raised serious questions as to its fundamental nature. Many questions regarding the causation of the disorder have not been fully or validly answered.

Responsibility for development of disorders has been attributed to
such biological factors as heredity, endocrine and other physiological dysfunctioning, constitution, and cerebral birth trauma. Although, there is a definite possibility that the predisposition of this disorder is inherited, the organic basis in the etiology of schizophrenia has not been fully proven or established.

At the present time, attention is given to the interplay of such psychological factors as: (1) frustration and conflict; (2) early traumatic experiences; (3) parental and sibling influences; (4) faulty socialization, etc. In general it can be said that sharp downward steps on the paths to schizophrenia occur in connection with events that lower the patient's feeble self-esteem or challenge in some way his adequacy. Anything that makes him feel more different from others, or less competent than he already thinks himself to be, has a devastating effect upon his control with reality. The sexual changes of puberty, and such major challenges as engagement, marriage, or heavy vocational responsibilities, often serve as precipitating factors.¹

### Treatment

There is no panacea for schizophrenia. At the present time there are three main types of therapeutic procedures, namely: (1) physical, surgical, and chemical therapies; (2) psychotherapy and re-education; (3) "adjunctive" therapies, such as bibliotherapy, music therapy, occupational therapy, drama therapy, and so forth. In the well-planned attack on mental disorders all three therapeutic groups are used. Together they constitute the "armenitorium" of the therapist. Any or all of these therapeutic methods may be

¹White, op. cit., p. 5ff.
applied to a specific case, depending on the patient's problems, the type of therapist consulted, the facilities afforded by the hospital, and a host of other variables.\footnote{Lawrence I. O'Kelly and Frederick R. Hukler, \textit{Introduction to Psychopathology} (Englewood Cliffs, 1955), p. 157.}
CHAPTER IV

CHARACTERISTICS OF SAMPLE

Numerous investigations have been made in order to correlate psychotic disorders with such factors as age, sex, marital status, occupation, religion, etc. We did not attempt in this chapter to show such a mutual relationship; however, several tables illustrating distinguishing features of the sample have been presented to help the reader form a clearer picture of the group studied.

Diagnosis

Schizophrenia, the most common of the various psychotic disorders, accounted for the largest per cent of first admissions and readmissions to Northport hospital. All of the patients included in this study were schizophrenics. The number of patients in the various sub-groups was as follows: Hebeephrenic type - three; Catatonic type - two; Paranoid type - three; Chronic Undifferentiated type - two.

Age

The majority age of the patients in the sample was between thirty and thirty-nine years of age. This was understandable since, in most cases, schizophrenics do not show marked symptoms of their diseases until thirty or even older. Because this illness develops early in life and continues for a long period of time, prolonged hospitalization is required. Such patients, then, tend to accumulate in the hospital, making their successful return to the community doubtful.
TABLE 2

AGE RANGE OF PATIENTS

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 29</td>
<td>1</td>
</tr>
<tr>
<td>30 - 39</td>
<td>7</td>
</tr>
<tr>
<td>40 - 49</td>
<td>1</td>
</tr>
<tr>
<td>50 - 59</td>
<td>0</td>
</tr>
<tr>
<td>60 - 69</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>

Religion

All of the patients studied had some religious affiliation. Six of the patients were Roman Catholics. This fact should not be misconstrued to mean that this religious denomination places greater mental stress upon its members and, therefore, promotes a higher incidence of mental illness. Neither should it be misinterpreted to mean that religion had proven to be a negative force in the lives of the patients. Religion becomes a negative force when it stresses fear. Many ministers in our present-day society talk much less about hell and the wrath of God than used to be the case. The concentration of Roman Catholics in the sample was perhaps related to the fact that 80 per cent of the patients in this hospital were from the Metropolitan area where there was a vast number of Catholics. Table 3 shows the religious affiliation of the group studied.
TABLE 3

RELIGIOUS AFFILIATION

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>6</td>
</tr>
<tr>
<td>Protestants</td>
<td>3</td>
</tr>
<tr>
<td>Hebrew</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Marital Status

It was statistically significant that no married patients were among the returnees as Table 4 reveals. At least one factor may have operated to explain and account for this. Perhaps the emotional security and social stability afforded by married life of the non-returning patients influenced their personal adjustment. The following table shows the marital status of the study group.

TABLE 4

MARITAL STATUS

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>0</td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

21
The educational status of the patient group represented a wide range, with all of the known patients having had some formal training. Table 5 shows that four patients did not complete high school. In a society which places a high premium on education, the level of a person's learning, more often than not, determines his ability to develop skills that will make for vocational, social, and individual success. If education aids in eliminating insecurity, one might have expected that the educational level of the patients would be generally low.

Education affects the child by virtue of its conscious or unconscious desire to compensate him for his insecurity by schooling him in the technique of life, by giving him an educated understanding, and by furnishing him with a social feeling for his fellows. All of these measures, whatever their source, are means to help the growing child rid himself of his insecurity and his feeling of inferiority.1

Table 5 shows the educational level of the group studied.

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TABLE 5
EDUCATIONAL LEVEL

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 8th Grade</td>
<td>1</td>
</tr>
<tr>
<td>Completed 8th Grade</td>
<td>1</td>
</tr>
<tr>
<td>Some High School Education</td>
<td>2</td>
</tr>
<tr>
<td>Completed High School</td>
<td>1</td>
</tr>
<tr>
<td>Some College Education</td>
<td>1</td>
</tr>
<tr>
<td>Completed College</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>

**Occupation**

Five of the ten patients studied had no job skills. This figure nearly agreed with the number of patients in Table 5 who had not completed high school. One patient was semi-skilled and three were skilled in some line of work. Another patient was a white collar worker. The foregoing was a determination of the major occupational areas, not the specific jobs in which the patients were engaged.
CHAPTER V

EXTRAMURAL FACTORS SIGNIFICANT TO REHOSPITALIZATION

More than two decades ago Sullivan\(^1\) stated that an increase in the institutional recovery rate of schizophrenia will be attended by a corresponding increase in the relapse rate, "for our improving patients will be hurried out into bed situations before they have consolidated enough insight, enough personality reorganization, and ego strength to withstand and survive the morbific personal situations to which they must return." In many instances these situations withstand despite the vigorous efforts of psychiatric social workers to modify them. This is not an argument for the continued institutionalization of mental patients; however, the foregoing statement does serve to support the premise that negative environment or extramural conditions can contribute to rehospitalization.

In this chapter the writer will discuss factors which contributed to the patient's maladjustment. Although the writer has attempted to categorize them according to the areas in which a preponderance of difficulty occurred, extramural factors do not operate independently or in a vacuum. Other factors concur (constitutional, physiological, individual, etc.) to give expression to patients' problems.

The respective adjustments of patients were evaluated from the emotional and economic standpoints. The understanding, patience, and consideration shown the patients by their families, while on trial visit, and the emotional

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security and stability within the home situation were deemed prominent factors in adjustment.

Generally speaking, the quality of the relationship between the patient and his relatives was, in the majority of cases, not a constructive one. In many instances, the relatives appeared to have been making only a marginal emotional adjustment themselves.

The main factors which played a part in the patients' return to the hospital were: (1) emotional instability within the family group and (2) economic pressures within the family group. The former factor, found in the majority of cases, was manifested in mentally disturbed relatives, controlling siblings, overprotective and domineering parents, guilt-ridden and unaccepting parents. Financial and unemployment pressures within the family group appeared to have been important in relation to the latter factor. Other factors were undoubtedly involved in the patients' rehospitalization; however, in the aforementioned ones the patient experienced a generally preponderance of difficulty. The specific degree to which they operated in each case is unknown by the writer, even though they appeared to have been very significant in some cases.

Emotional Instability Within Family Group

Of all the groups of which the person is a member, the most important in regard to his destiny is the family. Research by various disciplines shows the paramount importance of the family in shaping personality. Students of personality perceive in disturbances and maladjustments of the relations between father and mother, parents and patients, and between siblings, the genesis and recurrence of mental illness. This is particularly true of the present-day American family which is becoming increasingly
unstable. For two generations, divorce has steadily increased with an average increment in rate of one divorce to every four marriages. An undetermined but large proportion of other families suffer unhappiness arising from other conditions inimical to the mental health of their members. They involve tension between husbands and wives, parents and patients, parental overprotectiveness and over-indulgence, denial of the illness of their sons, sibling rivalry, and feelings of insecurity and rejection.¹ Let us now look specifically at the emotional instabilities in patients' families which affected their rehospitalization. The writer was not interested in the question of the germinal or hereditary transmission of mental disease; however, two patients left the hospital in the custody of mentally disturbed parents. A review of the case records clearly pointed out that the abnormal parent-patient relationship and the identification process were the main determinants of the maladjustments. The following case illustrations show how the effects of emotional instability of parents or siblings contributed to the rehospitalization of patients on regular trial visit.

Case 1

Mr. P., a sixty-two year old, white, widowed, Hebrew patient, was diagnosed Schizophrenic Reaction, Catatonic Type. His nearest of kin was his sister, who accepted custody of patient during trial visit.

Trial Visit Evaluation.—While on trial visit, this patient made an eccentric, marginal adjustment in the custodial care of a controlling sister. She impressed the worker as being a very disturbed person who verbalized

paranoid ideation. She wanted her brother home because the hospital "might murder him." She described the hospital staff as being anti-semitic and incarcerated normal patients by hypnotizing them. Earlier she had requested the F. B. I. to check into the "mysterious" disappearance of a patient whom she suspected was murdered at the hospital. The sister firmly believed that her brother was made mentally ill by a "white serum" injected into him at a V. A. Clinic. She told the workers how this serum together with the other medications he received in the hospital made him "more crazy" and resulted in his attempting suicide on several occasions.

Three months later, it was apparent that the patient was very servile and deteriorated. His speech was incoherent, irrelevant and he laughed and smiled inappropriately. He did not appear in contact with reality. The sister continued to express grandiose, paranoid ideation. She claimed her massages and numerous pills cured the patient. She treated the patient like a child. At his every comment to the worker, the sister showed annoyance. She became very upset whenever the patient spoke of recovery. She interrupted, told the worker not to listen to the patient, glared at the patient, and defended that she used the patient's money only for him, although nothing to the contrary was mentioned. On several occasions she refused to allow the worker to speak alone with the patient, claiming that he (patient) couldn't be believed.

In such an unwholesome environment, one would hardly believe that this patient would last over an extended period of time. Less than eight months following his release on regular trial visit, the patient had regressed to the point where he required further hospital treatment.

Case 2

The diagnosis of Mr. P. was Schizophrenic Reaction, Paranoid Type.

**Trial Visit Evaluation.**—During the first trial visit period, the patient's social and vocational adjustment was a tenuous one. He made little progress in any direction toward self-mobilization. Fear of being hurt prevented him from moving out into his object world. He defended himself by automatic thinking, somatization, and suspiciousness. During the second period, the patient's adjustment continued to be precarious. His parents had no understanding of his needs. They were both ill and rigid in their expectations and demands. The mother was
extremely overprotective and domineering of the patient. She was emotionally unstable and appeared mentally ill herself. She had an almost overwhelming type of relationship with the patient, treated him as an infant, and related to him entirely on the basis of her own needs. The parents' suspicion of the patient tended to increase his suspiciousness of them as well as of other people. Shortly following the second trial visit period the patient was returned to the hospital with the recommendation that some other plan be considered for his possible return to the community.

Case 3

A thirty-eight year old World War II Veteran carried a neuropsychiatric diagnosis of Schizophrenic Reaction, Paranoid Type. He had a post-lobotomy condition, chronic, severe. Patient resided with his brothers.

Trial Visit Evaluation.—This patient was the center of a very conflicting, confused, and disturbed family situation particularly, his two brothers, J. and H., who accepted the patient in their custody only to exhaust his finances for their own purposes. It seemed that the family constellation was one of a series of conflicts, of which the veteran was the focal point for all concerned. In the worker's contacts with his brothers, he found them to be rather sick and problem-producing individuals. J., the youngest, tended to be the most manipulative, controlling, and hostile of the brothers. H., next to the oldest, tended to be somewhat dominated by J. In all, both brothers were impulsive, unrealistic, anti-social, aggressive, and exceedingly defensive. They were of somewhat below average intellectual capacity, with no insight and very little comprehension and understanding of the interactions within their own family group and their brother's disability. They were involved in a number of intra-family conflicts, with apparently each one accusing the other of taking advantage of the patient, taking the patient's money, gambling, drinking, etc. The brothers were quite distorted in their description of the patient's adjustment. As far as they were concerned, they felt that the patient had been getting along exceptionally well, even though the patient's mental and physical conditions had deteriorated to the point where rehospitalization was apparent. They tended to be quite vigorous in the relating how well they had and could control the patient. For example, J. mentioned that he could order the patient to jump off a roof and the patient would comply out of love and respect.

Due to the fact that the siblings were unable to adequately supervise him, the patient was returned to the hospital.
One often encounters anxiety-ridden and confused parents who give the impression of being genuinely interested in the patient. In many cases the anxiety is actually due to a strong unconscious guilt feeling. The parents try to exert pressure on the medical staff, to get reassurance that the patient is not ill. These guilt feelings often lead parents to more irrational actions. In a vain attempt to undo what they have done or what they feel they have done, they take the patient home from the hospital, in spite of an advanced state of regression. Consequently, the activities of the family are thwarted or actually paralyzed, and care of patients at times is curtailed because of the enormous amount and unusual kind of care that the psychotic at home requires. When these parents really learn of the extent of the patient's illness, guilt feelings are reinforced and confusion characterizes the treatment at home.¹

Case 4

Mr. R., a thirty-five year old, marriage-annulled, Jewish World War II veteran, carried a diagnosis of Schizophrenic Reaction, Catatonic Type. Patient was placed on trial visit in the custody of his parents.

Trial Visit Evaluation.—During the first three months of the patient's trial visit, he appeared not to be in contact with reality some of the time. He was fearful and withdrawn, but denied that he had any problems. Therefore, he saw no need to keep in touch with the worker. In response to a few simple questions, he cocked his head to one side and looked at the worker questioningly. Most of the worker's efforts to speak to the veteran were usually interrupted by his mother who answered or commented on anything the worker said to him. She tried to impress the worker with how well and how "brilliant" the patient was. Both parents were quite confused regarding how to live with the

patient, and seemed unable to accept the fact that the son did, indeed, become sick. The mother (who appeared to be the dominant parent) talked in terms of employment for the patient, who was obviously unable to engage in such an understanding. During the second trial visit period the patient's condition deteriorated. He had delusions of worthlessness, but he refused to return to the hospital.

Through casework services, the mother became aware of the fact that the son was in need of further hospital care. She blamed both her husband and herself for taking him home prematurely. She also recognized the fact that she overprotected the patient, and that she was quite confused over the way the patient should have been handled. A short time later the mother reached the height of her tolerance and returned the patient to the hospital.

**Case 5**

Mr. K., a forty year old single, white, Catholic, World War II veteran, carried a diagnosis of Schizophrenic Reaction, Hebephrenic Type.

**Trial Visit Evaluation.**—Mrs. K, an extremely anxious, guilt-ridden woman made attempts at the outpatient clinic and through the hospital to obtain medication for her son, even though she was warned by medical supervision against giving the patient thorazine medication without the medical staff's approval. It appeared, however, that even if she had obtained the medication, the patient might not have taken it, but the mother felt she could "slip" it in his coffee or other beverages. The patient's progress was uneventful. During the worker's visits, he was unable to focus on any topic and made many irrelevant and contradictory remarks. He told the worker that he heard voices which told him to kill and when his mother repeated bafflingly, "kill," the patient elaborated for her in no uncertain terms that to kill was to murder. He appeared to have at this moment a great deal of suppressed hostility toward his mother who had no understanding of the meaning or extent of his illness. She felt that he was only a little stubborn in not taking his medicine, and was unable to see that much of his behavior and his verbalizations were symptomatic of his illness. Casework treatment was geared to the inevitability and acceptance of rehospitalization of this markedly withdrawn, confused, and psychotic patient. When the mother was last seen in
the presence of a younger son, E, she mentioned the possibility of obtaining medication from a private physician. E, who was fed up with his mother's pattern of taking the patient out of the hospital before he was well enough to return home, told his mother of his dislike of her taking the patient out of the hospital before he is ready.

Mr. K. apparently had intense feeling of guilt around returning the patient to the hospital. She objected to rehospitalization on the grounds that the implication would have been that she had failed. The patient was obviously too sick to remain in the community, and for this reason the worker recommended that he be recalled.

In the case which follows, a parent was so preoccupied with her own needs for security and identification with the patient that she deliberately attempted to prevent casework services to him while he was on trial visit. She feared that the hospital wanted to alienate the affections of her son.

Case 6

Mr. A., a thirty-six year old single, Catholic, veteran of World War II, was diagnosed Schizophrenic Reaction, Paranoid Type.

Trial Visit Evaluation.—Neither the patient nor the mother kept their first appointment with the worker. However, the mother telephoned and advised the worker that her son had not taken his medication and did not want "to have anything to do with hospital." (The mother at this point actually attributed her own feelings to the patient). In an excited fashion, she ventilated at great length, over the telephone, her feelings of resentment and anger because the hospital staff had suggested a foster home placement for the patient. She saw this plan as being calculated to take her son away from her and she chose to interpret it as a direct reflection on her ability to take care of her son "as only a loving mother could." The worker advised the mother that a home visit was necessary in order to evaluate the situation. Mrs. A., reluctantly agreed to a home visit, but pointed out that she would not tell the patient of it "as it would upset him too much and he would probably not be home if he knew the worker was coming." A week later, the worker made a home visit and interviewed both the patient and his mother. It
was extremely difficult for the worker to get any spontaneous response from the patient as his mother had a great need to control the situation and would constantly interject, interrupt, and answer for the patient. The mother became particularly indignant and upset when the patient indirectly stated that perhaps a foster home plan might have been better for him. She immediately accused him of being ungrateful, threw up to him the fact that she had invested a great deal of money in order to buy completely new furniture and move into a more expensive apartment, all for the purpose of "making him feel better." She kept stressing that she was a good mother and wanted only the best for her son. Whenever she made a point of saying this, the patient stated that he had no intention of coming to the clinic, for any reason, because he felt that would cause him to become more ill if he had contacts with the clinic or the hospital. The worker was shown several full bottles of thorazine capsules which the patient had accumulated on previous trial visits. The mother indicated that she did not check on whether the patient takes his medication because she doesn't "want to force him to do anything." The worker went through the process of interpreting and clarifying the meaning of trial visit to both the patient and his mother. Even so, both the patient and the mother insisted that he be fully discharged from the hospital.

Neither the patient nor his mother accepted trial visit. A short time after the worker visited the home, the mother telephoned in a hysterical fashion and accused the worker of deliberately upsetting her son by his trip out to the home. She accused the worker and the V.A. Hospital staff of deliberately trying to alienate her son's affection from her and trying to make her sick as well. She urged that neither the worker nor the hospital try to have any further contact with them unless they were seeking "a slow death" for her. As a result of the mother's own needs, she seemed to have reacted to the patient inconsistently, vacillating from rejection to overwhelming acceptance of the patient. Because of the nature of the patient's dependency upon his mother, he reacted almost impulsively to any expression of acceptance on her part. The patient being a withdrawn individual, preoccupied with guilt feeling about his relationship with his mother, seemed to have expended a great deal of energy controlling hostile impulses that he was unable to cope with. Although he was generally in good contact, his anxiety made it almost impossible for him to relate to people in a meaningful manner.

In the following case, a patient's inability to resolve his great dependency on his wife, who was living with another man, proved to be one of
the causes of his rehospitalization.

Case 7

Mr. S., is a twenty-seven year old, Negro veteran of the Korean Conflict. He was certified and carried a diagnosis of Schizophrenic Reaction, Catatonic Type. The patient and his wife had separated, although not legally. It had been confirmed that the patient’s wife was living with another man in New York City, and also had the patient’s two children with her. His wife gave birth to a child out of wedlock by the man with whom she was living.

Trial Visit Evaluation.—Patient went on trial visit with his mother. An evaluation of patient’s trial visit revealed that his adjustment was adequate at the time of the appointment. He arrived friendly, in excellent contact, and under pressure to please and be considered a “good” person. He was preoccupied with his separation from his wife and felt for his own welfare it would be best if he did not have any contact with her. The veteran was not particularly interested in what custody arrangement was made for the children, and he seemed to have been trying very hard to block the entire incident out of his life and leave the decision up to other people. The veteran indicated he might accept his wife back if she took the initiative to contact him. The worker was impressed with the veteran’s struggle against his own dependency upon the wife, in that he was trying to carve a life for himself without her, but had an underlying need to accept her back if she showed any interest. The veteran seemed to have been doing satisfactory; however, he was beginning to think about finding a job either as a hospital aide or a factory worker, since he has had experience in both these lines of work. Upon the initial appointment, the veteran touched upon his fear of giving expression to his dependency for fear of becoming a nuisance to the other person, and a fear of not having a right to what he may ask for and, therefore, of being rejected.

In the interview with the mother, she was satisfied with his adjustment during the past week, but felt her son was very tense and “jumpy” when he first came out of the hospital, especially when a conversation was held about his wife. He also was very critical of many of the things she attempted to do for him. The mother seemed to have realized that in many situations it was best to leave him alone since he resisted any suggestion she would make. A few weeks later, the worker received a telephone call from the mother stating she could not do any more for her son and wanted to rehospitalize him. The veteran would not sleep or eat, drank almost continuously and spent most of his time outside of the house. He brooded over his wife’s separation from him and regressed to psychotic behavior.
Economic Pressures Within the Family Group

The psychological aspects of extramural stress can be of prime importance in mental relapse. If a patient continues for an extended time in a situation in which he feels seriously inadequate or dissatisfied, life becomes intolerable and he regresses. For purposes of this study, stress is a state of unpleasant emotional tension engendered in an individual when he feels that he is unable to satisfy his needs within his situation.1 In case 8, the patient experienced stress over being out of the protective environment of the hospital, and tended to react to this situation with excessive dependency feelings on his mother, who was unable to give the patient the care and time he needed because of marginal financial or economic income of the family. In case 9 the family's pressure on the veteran to secure employment presented a very stressful situation to him.

Case 8

Mr. B., a thirty-four year old veteran of World War II, had a history of previous trial visit failures. He had a diagnosis of (1) Schizophrenic Reaction, Hebephrenic Type, chronic severe; (2) Scoliosis Dorsal Spine.

Trial Visit Evaluation.—The veteran's overall adjustment appeared to have been a very limited one and after the first few weeks it was evident that he would be returned to the hospital. While the patient was at home, he was talkative and frequently referred to people the family had met in the past. The mother felt that her son had improved very little. She stated that she could not leave him alone except to do some marketing in the neighborhood, and to visit her brother who was hospitalized for a physical difficulty. Whenever the mother was away from the home for long periods of time, the veteran regressed. It appeared that the central problem for the veteran and his mother was a financial one. Although things were progressing satisfactorily in view of the veteran's limitation, it was clear that they could not have continued

Herbert A. Carroll, Mental Hygiene (Englewood Cliffs, 1956), pp. 5-7.
this way as the mother was unemployed and was unable to live on the veteran's monthly compensation checks. The mother knew that later during the months she would have to work. Because she could not leave the veteran alone and there was no one to supervise him, the veteran was forced to return to the hospital before he regressed too severely.

Case 9

Mr. C., a thirty-two year old, single, Jewish veteran, had an admission diagnosis of Schizophrenic Reaction, chronic undifferentiated type with depressive trends. The veteran was placed on leave of absence which was changed to trial visit. He resided with his father.

Trial Visit Evaluation.—The patient came to V.A. Outpatient Clinic accompanied by his brother requesting help with vocational planning while the patient was still on LOA (Leave of Absence) status. At that time the worker's impression of the brother was that he was uncomfortable about the patient's vegetative home adjustment and saw employment as a ruse for the patient's problems. During the first month of trial visit, the patient pursued for employment. However, he apparently was not cooperative enough to discuss vocational planning and could only repeatedly state that he wanted a job. However, he revealed that he had registered with N.Y. State Employment Service and that he had applied to one private employment agency, but to no avail. During the first month of trial visit the patient denied that the family was pressing him to obtain employment. He insisted that work was strictly his own idea. Although worker did try to get the patient to understand that if he were to be of any help to him around vocational planning, it was important for them to discuss these matters in more detail. The patient felt that there was nothing to discuss although he admitted that he had no idea of what kind of employment he would be interested in at this point. A few weeks later the patient came to the clinic on regular appointment and angrily demanded that the worker give him a reference to some employment agency. In addition he wanted to have some kind of activity with which to pass the time. He would not discuss anything further and insisted on the referral to an employment agency. He was referred to the Federation Employment and Guidance Service. During the second month of his T.V., the patient impressed the worker as being just a shade more verbal than he had been previously. He seemed to respond a little to worker's support and was able to reveal that his family pressured him to go to work. Speaking for himself, however, he was not convinced that employment was the solution to his problem, although he did state that he should be engaged in some kind
of activity rather than stagnate at home. The patient could not go beyond this point in discussing his relation to his family.

The patient led a rather socially isolated existence, except for an occasional movie, trip to the theater, watching TV, and engaging in frequent social pursuits with his family. He shied away from contact with others and interpersonal relationships. A few weeks prior to his readmission, the patient revealed strong paranoid ideations around being constantly followed by F. B. I. agents for some "unknown crime" he never committed. He also revealed feeling that his former employer attacked him and turned his co-worker against him. At this point, the patient refused to further discuss his feelings with the worker and he requested to be seen by a doctor who later advised the patient to return to the hospital.
CHAPTER VI

SUMMARY AND CONCLUSIONS

It has often been said that more has been learned about mental illness in the last ten years than in the last century. Nevertheless, much research remains to be done in this field. Psychoanalysis, which might provide an insight into the patient's personality, is available to only a select few, and there is some question as to its value with psychotics. Actually all the hospital can do is treat the patient's symptoms. If these can be modified to the extent that the individual is no longer a threat to himself or the community, the hospital has accomplished its purpose and he is ready to be released. This does not mean that treatment is complete or that this is all that can be done for the patient. The patient released to the community is still convalescing on trial visits and needs much support.1

This study was made at the Veterans Administration Hospital, Northport, New York, in an attempt to describe the environmental or extramural factors contributing to the readmission of schizophrenic patients from regular trial visit.

The sample for the study consisted of ten patients who were readmitted to the hospital between January 1, 1958 and November 31, 1958. The study revealed that two major factors contributed to the patients' return: these were: (1) emotional instability within the family group, and (2) emotional pressure within the family group. As stated earlier, these factors did not operate in a vacuum, they represented only a part of the total situations of patients. However, the writer was only able to isolate these along with their various manifestations.

1Alfred L. Kasprowicz; "Trial Visit Patient; Challenge to Community Agencies," Mental Hygiene, XXXII (January, 1958), p. 20.
As a result of this study, the writer has concluded that the role of the family can be an important one in the rehabilitation process. Many patients, though able to function in the protected environment of the hospital, have difficulty in living in the unprotected environment of the community. Directly or indirectly, hospitals, throughout the nation as was done at Northport Veterans Hospital, might aid the transition process from the hospital to the community and at the same time reduce extramural risks for patients by developing or strengthening the follow-up programs: (a) providing orientation to and training for extramural living; (b) encouraging relationships between patients and persons in the community; (c) preparing the patient's relatives for his return. It has been observed that such therapeutic programs as psychodrama, group therapy, and patients' discussions have frequently been oriented toward the extramural problems which the patient will face when he leaves the hospital, and such programs, therefore, constitute direct preparation for community living.

As far as encouraging relationships between patients and persons outside the hospital are concerned, a number of proposals have been made. Most modern hospitals have all, or at least some of these programs: (1) visits by relatives and friends; (2) various outings for patients; (3) the use of volunteer workers to encourage socialization.

The most important program, as far as the writer is concerned, is the one with relatives. In a number of cases presented in this study, the writer found that the behavior of parents was the chief variable affecting the patient's adjustment. Thus, it quickly becomes apparent that in rehabilitating patients, hospitals are responsible for strengthening patient-
While hospitals are of great importance in carrying out a positive program to help patients toward recovery, they should not be alone in their efforts, for as Rennie and Woodard say:

Mental health cannot be developed in a social vacuum. Powerful factors operate against it as our present society is constituted. To promote positive mental health will, therefore, require the cooperation and help of many individuals and groups. Medical and social scientists need to look squarely at these factors and, abandoning professional isolation, cooperate in an attempt to counteract them. Mental health can only be achieved in an environment which provides opportunities for self-expression, social usefulness, and the attainment of human satisfactions. Preventive psychiatry is only beginning, and its only sure tool at present lies in educating the public in the meaning and causes of mental disorders and the ways of developing positive mental health.

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1 These proposals as well as additional ones have been suggested in a bulletin of U. S. Department of Health, Education, and Welfare, Rehabilitation of Mental Hospital Patients (Washington, 1953), pp. 41-57.

RESEARCH SCHEDULE

I. Identifying Data:
   A. Patient's registration number or name
   B. Date of birth
   C. Religion
   D. Marital Status
   E. Education
   F. Occupation
   G. Dates of Military Service
   H. Onset of Illness
   I. Diagnosis
   J. Number of hospitalizations
   K. Length of current hospitalization prior to latest trial visit
   L. Placement on trial visit to family? Own custody? or foster home care?
   M. Date of return to hospital

II. Background Data on Hospitalization:
   A. Adjustment to hospital environment (explain)
   E. Casework preparation for trial visit (explain)

III. Problem Areas During Trial Visit:
   A. Family adjustment (explain)
   B. Vocational adjustment (explain)
   C. Interpersonal relationships (outside the family) (explain)
   D. Others

V. Hospital Experience Since Trial Visit:
   A. Forces of casework with patient (explain)
   B. Casework with family or others (explain)
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