McGill University

THE USE OF PROTECTIVE ENVIRONMENTS FOR GIRLS AND WOMEN DISCHARGED FROM MENTAL HOSPITALS

A Thesis Submitted to

The Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

for

The Master's Degree in Social Work

by

Rena Dean

Montreal, January, 1949

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

PREFACE

I should like to take this opportunity to express my thanks to those persons without whose generous help this study would not have been possible.

I should like to thank first Miss Dorothy King, Director of the McGill University School of Social Work for letters written in my behalf, and in the name of the school, to the directors of the hospitals from which I wished to collect material.

I should also like to thank the directors and the chief psychiatric social workers of both the Illinois Neuropsychiatric Institute in Chicago and the Allan Memorial Institute of Psychiatry in Montreal for their kindness in allowing me access to the cases which made this study possible. I should like to give particular mention to Miss Dorothy Large of the Illinois Neuropsychiatric Institute and Miss Margaret Burns and Mrs. Phyllis Poland of the Allan Memorial Institute of Psychiatry.

I am very much indebted to Miss Eva R. Younge, Assistant Professor of Social Work for her careful guidance in the many aspects of scientific research.

Finally, I would like to acknowledge the invaluable assistance of Miss Barbara E. Judkins, Assistant Professor of Social Work and Supervisor of Field Work in Psychiatric Social Work. She offered continuing guidance from the first beginnings of this study to its completion.

LIST OF TABLES

CHAPTER I

INTRODUCTION

The use of protective environments for girls and women discharged from hospitals for the mental and nervous can be a therapeutic device. However, in order for this to be the very real part of treatment that it can be, both the patient in need of a protective environment and the community institutions which class as protective environments must be carefully studied. The professional staff considering placement must be as fully cognizant as possible of the personal needs of the patient to be discharged to a protective environment. The staff, or at least the person making the placement, must be well aware of the facilities offered by the community which may meet the patient's needs. In this way the best possible placement may often be made on the first trial. This may give success and encouragement to the patient who is attempting to satisfy her life needs while she is meeting community standards. It may also give the community successful education and experience with its participation in a mental health program.

There are many facets to be considered if we are to use protective environments as part of treatment. The questions aroused by the thoughtful consideration of placements have doubtless been considered by the medical and social work staffs of most mental and nervous hospitals. However, this subject seems not to have found its way, to any appreciable

extent, into research projects. One reason may be the lack of staff to devote to such studies. Another reason is that placement and after-care of the mentally and emotionally ill are relatively new endeavors in the United States and Canada. Therefore, the establishment of home-finding services for these patients is in its early stages. Because of the many factors involved, home-finding may require a separate division in the psychiatric hospital's social service department. Neither of the hospitals in this study, that is, the Allan Memorial Institute of Psychiatry in Montreal and the Illinois Neuropsychiatric Institute in Chicago, had such a division. Both were interested, however, in after-care.

Until recent years mentally and emotionally ill people were put into "asylums" with much secrecy and shame by fearful relatives and there they remained to their dying day. If they were discharged as improved, or simply as harmless, it seemed more or less miraculous for few treatments were known. Hospital facilities were often far from good. The person who was discharged often could not assume a normal place in the community. He who tried to take his normal place often found existing community attitudes toward him were very discouraging. It would have been easy for him to give up his endeavors toward living a normal life.

The "asylum" has now begun to become an institution of the past. As the medical profession has developed new psychiatric and medical tools and as psychiatric social work has grown

and developed, physical and psychotherapeutic treatments have been instituted in state and provincial hospitals throughout the United States and Canada. Patients who are admitted to what we now call mental and nervous hospitals are recognized as ill persons entering for treatments. Treatments given may be very effective. Patients are encouraged to seek hospital admission in the early stages of their illnesses when they are apt to be most treatable. Very often these patients may be discharged some weeks or months later as much improved.

When it is felt that the patient's illness will not be increased by his returning home and when he has a suitable home to go to, there is no problem of home-finding. Many patients, however, either have no homes or else come from homes where the environmental conditions contributed largely to the personality difficulties which originally caused their hospitalization. Psychiatrists feel that these patients must have a temporary or permanent placement.

Patients in this category who have sufficient ego strength to find a satisfactory home independently will obviously not need help in this particular area. The patients who need our help in home-finding are those with whom we are concerned in this study.

These patients, we find, need not only a new home but also particularly need a home which may offer certain protections from environmental uncertainties. These homes are classed as "protective environments". For the purposes of this study

we consider as protective environments those homes and institutions which provide, for a moderate rate, a fairly good standard of living, available companionship of residents of a similar age group, the security and protection that house rules give, care for minor illnesses, and some protection, for example, in the form of advice, against disturbing environmental forces outside the residence. Foster homes are included in this classification. They may not be able to provide companionship of others of a similar age but they may be especially useful when the patient needs more than the usual amount of personal attention. However, the writer wants to stress that in no case do we consider any of these protective environments as offering, or needing to offer, custodial care.

Not every protective environment is satisfactory for every patient who needs such a placement. If we are to achieve optimal therapeutic ends we must attempt to fit the patient to the environment so that the advantages a particular environment has to offer may contribute toward, not against, the patient's recovery, and so that a minimum of re-placements need result. In this study the writer has made an analysis of the placements made for the sample group of nineteen cases.[1] It is hoped that this analysis may help to clarify the placement process and in some measure facilitate future placements.

The writer became interested in this topic while she was a resident at a Chicago club for women where several form-

---

[1] Described under "Sources of Data and Methods of Collecting Them", page 6.

er patients of mental and nervous hospitals had been placed. In this residence they were enabled to fit in unnoticed among their contemporaries. They were given opportunities to adjust to normal group life and yet they were in a place where they were somewhat protected against environmental uncertainties.

Originally the writer hoped to be able to study the cases of girls and women placed successfully or unsuccessfully in residential clubs and to consider these placements from the viewpoint of the residence as well as from the viewpoint of the hospital making the placement. It was found, however, that few residence directors kept records of patients referred to them. Some directors specifically stated that they would not willingly accept former patients. Some hospitals contacted did not make placements or do follow-up study of their discharged patients who were living in residences.

However, two hospitals, the Illinois Neuropsychiatric Institute in Chicago and the Allan Memorial Institute of Psychiatry in Montreal, were interested in the writer's proposed consideration of placements and after-care where protective environments are used. These two institutions gave the writer access to the cases used in this study. The cases have been studied from the viewpoint of the psychiatric social worker in the hospital from which the patient was discharged. We consider the ways these patients make or fail to make the necessary adjustments, showing always the role the psychiatric social worker has taken, or might possibly have taken, in her

help with these adjustments. The problem has been approached by considering the salient aspects of placement in as far as possible in the same order that a worker might approach one case referred for placement.

Sources of Data and Methods of Collecting Them

Of the nineteen cases which this study comprises, five were selected by the Social Service Department of the Illinois Neuropsychiatric Institute in Chicago.[2] These cases were adolescents who would classify under the neurotic group. Fourteen cases were chosen by the writer from the Social Service files at the Allan Memorial Institute of Psychiatry in Montreal [3] after consultation with the Social Service staff who enumerated the cases of this nature carried during 1946 and 1947. The fourteen cases chosen were the greater part of those mentioned. The writer discarded only those cases where she felt the available data were insufficient. Among these fourteen cases were adolescents and adults with diagnoses which would classify under the neuroses and the psychoses. Some of the cases were closed; some were still open when this material was compiled.[4] Cases chosen from I.N.I. also fell within these years. While all of the cases were active

---

[2] Hereinafter referred to as I.N.I.

[3] Hereinafter referred to as A.M.I.

[4] September, 1947

during 1946 and 1947, some had been opened prior to 1946. The oldest in point of treatment was carried over a six year period and was still active.[5]

It is outside the scope of the present study to consider cases closed while patients were younger than 17 or older than 45. This eliminates younger age groups where consideration of children's institutions and compulsory education would have to enter. It also eliminates age groups where problems of re-employment or questions about training for new types of employment are complicated by the age factor.

Data have been abstracted from these cases after careful reading and analysis of the Social Service records. The psychiatric records on the same cases have been consulted for some supplementary information as diagnosis and dynamics. All of the data used in this study are secondary. The writer has used none of her own cases. No contacts were made with patients as it would be quite inadvisable to consider interviewing patients of other workers. Contacts with residence directors were not made for three reasons. First, some residence directors have shown they were not receptive to psychiatric concepts. Consequently placement of patients with them has been made with little or no psychiatric orientation given to these directors. This type of director would, of course, not be able to supply the type of information that would be useful to this study. Second, interviews made a considerable period after

---

[5] September, 1947.

placement, as these would have been had they been planned, would lack the reliability of written records made during the placement. Third, few residence directors can, or will, keep adequate records of patients placed with them.

Case methods of analysis have been used throughout the study. Emphasis is placed on the use of the protective environments as part of the treatment for the sample group of cases rather than the use of these environments as institutions of custodial care. Therefore, the full treatment of each patient has been considered.

The plan of the presentation of the material follows. In Chapter II we strive to get to know the "Patient Who Cannot Go Home" so that we may understand 1) why these patients need placements away from home, and 2) why placements may be satisfactory for them. This chapter is begun by the consideration of the reasons why the home situations were not satisfactory, that is, the family backgrounds of the patients as these backgrounds have contributed to the illnesses. Next, reasons why placements may be satisfactory for these patients are considered. This entails discussion of the patients' ages, diagnoses, prognoses, and the onsets of the illnesses. Thirdly, the writer has considered the patient's reactions to previous institutionalizations, if any, and the ways these reactions may affect the new placements. The information included here is: where the patients were institutionalized, under what circumstances, and with what results.

The development of our material in this manner parallels the procedure of the psychiatric social worker who is making placement plans for a hospitalized patient. She begins her relationship with the patient early in the period of hospitalization so that she may build rapport and so that she may gain first-hand knowledge of the patient in all of the above-mentioned areas.

In Chapter III we study the ways the patients act 1) at home, 2) in the treatment setting, or hospital, and 3) in the new environment or environments. Comparisons and contrasts of the patient's behavior in the three types of situations are made, taking always into consideration the treatment used to alter the behavior. The study of the types of behavior exhibited by the patients under varying conditions helps the psychiatric social worker evaluate the patients' ability to adjust. It also helps her select the types of environments needed for various patients.

The psychiatric social worker's knowledge of community facilities and her ability to use them to their fullest extents is of almost equal importance to her understanding of the patients to be placed. In Chapter IV we consider how the placement is made. Under this topic we examine 1) the choice of the placement, 2) the ways the patient's finances affect the placement, and 3) the ways the patient's adjustment away from home is affected by the attitudes of her family toward her and toward her placement.

Equipped with some understanding of these patients and of the placements used, we consider next the timing of the preparation of the patient for the placement. Here are shown the difficulties found when placements must be made suddenly. Conversely, we see difficulties expected when patients' placements are postponed.

The second section of Chapter IV is given to some discussion of the advantages and disadvantages of the various available placements. Protective environments may have numerous advantages, but even the best may have disadvantages for the recently discharged patient. An attempt is made to see which of her difficulties may be real and which neurotic. Case material has been used to illustrate ways in which some objectionable situations have been met. A brief sketch is included of the optimal type of protective environment as the writer sees it.

In Chapter V effort is made to compare and contrast these patients' socializations before and after placement. Some attention is given to the role of the psychiatric social worker in this area. The importance of the patients' abilities to socialize cannot be underestimated. The degree of improvement of discharged patients must be measured not only by their behavior in their new homes but also by the degree of their ability to function satisfactorily outside of the new home situation, such as in employment, in school, and in recreational activities.

In Chapter VI the writer considers in some detail common community attitudes toward the discharged patient. The attitudes most commonly encountered have a great deal of effect on the adjustment that patients can make. Likewise, community attitudes determine largely the availability of placements for these patients. Many patients have considerable feeling about prevailing community attitudes. Some of these attitudes are remnants of the community's old superstitions and fears; some are the direct result of patients' failure to adjust; and finally, some are not actually attitudes in the community but are part of the "sick" fears of the patients. The attitudes found and the action required to modify them are studied in the case situations of this sample group.

Chapter VII gives statements by patients and case situations showing the long-time need of the discharged patient for an interested person, as the psychiatric social worker, to help her over difficult spots and to give her an impetus and an example.

The study is closed in Chapter VIII by a brief summary of the writer's findings in the consideration of the use of protective environments for discharged psychiatric patients.

It is hoped that this study will illustrate the use of placement as an integral part of treatment, not as an end goal. It is also hoped that it may evaluate to some extent the existing facilities for after-care in the community as they are seen through the placing or attempted placing of

post-psychotic, psychotic, and neurotic persons in protective environments.

CHAPTER II

THE PATIENT WHO CANNOT GO HOME

In this study of placements we are concerned first with exploring the reasons why the patients in the sample group could not go home. The writer considers that the understanding of the home environments should take precedence over discussion of the diagnoses and over any other consideration. The reasoning behind this is that the patient who does not have a suitable home to which she can go upon hospital discharge must be considered for placement regardless of other features of the case.

The second section of this chapter is given over to reasons why the patients studied may find placements satisfactory. This entails discussion of the ages, diagnoses, and prognoses of the sample group. The onsets of the illnesses are considered briefly. The experiences of patients who have previously been in institutions or in foster homes are considered in some detail. The reactions of the patients to these experiences determine to some extent the reaction the patients have to a new placement.

A. The Reasons Why These Patients Could Not Go Home

The reasons why these nineteen girls and women could not go home fell into two main categories: 1) those who had no homes and 2) those who could not return to their homes. In this latter section we see further subdivision into two

groups: a) those whose homes have contributed to their illnesses to such an extent that there would be a definite increase in pathology if these patients were to return home, and b) those whose relatives for some reason could not provide surroundings which would be beneficial to them during the period in which they are making readjustments to the community.

Patients who would classify under Group 1 not only lacked homes but also lacked interested friends or relatives who could give the emotional support their homes might have offered. The patients who had no homes were, for the most part, without sufficient ego strengths to find new home situations for themselves. Further consideration of these patients and their needs is brought out later in this study.

The writer has not attempted to treat Group 2 by its subdivisions as to do so would sacrifice some of the clarity of the over-all picture. Among those whose home situations classify in Group 2 we find that intra-familial tensions provided an "emotional hotbed of germs for the susceptible patient". The patient's mental health required removal from this environment for hospitalization. After hospital discharge the patient from this type of home can usually not return home. Regardless of how much improvement she may have made, the familial inter-personal relationships which had contributed to her illness remain basically the same. In some cases the home improves because one or more members of the

family have successfully received psychiatric treatment concurrent with the patient's treatment. However, patients whose homes improve enough for them to return home upon hospital discharge do not need protective environments and therefore are not included in this study.

In none of the cases studied was the situation so simple that removal from the home alone could bring about the patient's cure or noticeable improvement. By the time these patients reached the attention of a psychiatrist and a psychiatric social worker the problem was never solely a reaction to a situational abnormality. However, the difficulties in the home lives in all cases were large factors in the illnesses and in the considerations made for placement. Therefore we show specifically the various types of home situations as they have been unsatisfactory for our patients.

1. Those Who Have No Homes

Three of the patients had no home ties whatsoever. Two of these patients were young women in their twenties who not only had no home at the time of hospitalization but who had never had a satisfactory home. One patient (I) had been placed in an institution at the age of two months. By the time of her referral to A.M.I. when she was 22 years old she had had at least twelve placements in institutions or foster homes. For a period of two years she had lived with her father and stepmother. However, the rejection she suffered

at their hands made any institution preferable. On discharge from A.M.I. she had passed her majority. Therefore she did not come under the responsibility of any institution. She had no interested friends or relatives to help her during her re-adjustment period.

A second young woman (K) had spent part of her childhood in a foster home. Although she had relatives, she had no close ties with them. Therefore, she could not look to them to provide a suitable home for her. Furthermore, her relatives were immigrants who lived in the ways of the old country. She, on the other hand, had been away from this life for years and seemed to have neither desire nor ability to identify herself with it any longer.

The third patient (S) had had a home until she was in her twenties. At the time of the study she was 44 years old. She no longer had a parental home and was not able to adjust well in the homes of her siblings. For a period of seven years she had been suffering from epilepsy and also from psychopathological difficulties. She could not live alone as she could not care for herself.

2. Those Who Cannot Go to Their Homes

The sixteen other patients came from homes which had contributed largely to their illnesses. In all of these homes there was a great deal of rejection of these patients in one or more areas. However, in some of these cases this

rejection was disguised under an atmosphere of over-protection.

In fourteen cases it seemed very apparent that unsolvable Oedipal situations were particularly disturbing features in the patients' illnesses. In eight cases (A,B,C,D,E,J,N and O) they were unsolvable in the home situations due to the types of personality structures of both parents. For example, we have in one instance (Case B) a father who was dependent and deeply neurotic. He had an unconscious incestuous attachment to the patient. The mother was drab and weak. Apparently she did not notice the attitudes of her husband and daughter. Actually, she fostered this unhealthy situation by allowing her daughter to take over wifely responsibilities of confidante and housekeeper. The daughter, although still a teen-ager, actively sought treatment for herself. Her conflictual feelings were made particularly apparent by her severe vomiting which was found to be of psychogenic origin. The parents lacked insight into their own and their daughter's roles in the family. In situations like this, a permanent "home away from home" would seem definitely indicated.

Eight patients were endeavoring to solve their adolescent problems and had homes where their adolescent difficulties were aggravated by parental rejection. Some of their resentments toward parent persons would have come out normally but in these environments that were so far from optimal their hostilities were considerably increased. In one case the hostility reached the point of almost complete negativism.

In some cases where little or no direct negative expression could come out, the patients acted out in other ways or turned their resentments inward and expressed them in psychosomatic complaints.

Two of these eight patients were living with foster parents whom they had thought were their own parents. One of these girls (F) was formally adopted; the other (G) was not. In both cases the onset of the illness which brought them to the psychiatrists' attention occurred when these patients made sudden, traumatic discoveries that they did not belong to the "parents" with whom they had lived almost all their lives. However, in neither case was this delayed, traumatic discovery the only factor in the illness. Both sets of parents were particularly lacking in their understanding of the girls' needs. Both patients were trying to solve problems which are more or less normal to adolescence. These problems were intensified and their solutions were made unusually difficult for these patients because of the lack of understanding and acceptance in the home situations.

Six homes were unsatisfactory from a sanitary point of view. One (Case L) was excessively clean, and the patient, under her mother's domination, spent all her time scrubbing. Three homes (Cases A,B, and C) were repulsively dirty. One of these homes (Case C) was in a storeroom. No room was completely partitioned off. Lack of bed space forced uncongenial siblings to sleep together. Another home (Case F) was

very comfortable but was maintained in a manner far above the parents' means and then only by dint of making huge efforts to keep up this standard. The patient was emotionally starved in this environment. While she remained passive, she was accepted. When she sought recognition actively and in a neurotically aggressive manner, she was completely rejected.

In at least five cases sibling rivalry reached significant proportions. However, in only two of these cases was the hostility severe enough to warrant placement on that basis alone. In one case (Q) a sister of the patient was so actively rejecting that she caused the patient two evictions from the home. In another case (C) a younger sister who had to sleep with the illegitimately pregnant patient exhibited such violent hostility that it was feared she would do the patient physical harm.

Four of the patients studied were given lobotomies during the process of treatment in order to relieve their excessive anxieties. One of these patients had never had a home. Three had homes which were unhealthy for them and which could not offer the re-training that the post-lobotomy patient must have. If these patients do not have this training and return to the same home environments that caused or contributed to their anxieties, they relearn their neurotic habits. Post-lobotomy patients are in particular need of a special type of protective environment, such as a good foster home, where they may be given a period of re-education after

their hospitalization.

Three patients (G,N and R) came from homes which fostered dependence. In these cases the patient is seen to be excessively dependent on parent figures whose personalities are such as to increase the dependency situations. In two of these cases the families' excessive protection of the patients somewhat disguised their deep rejection. One patient (G) was in her teens. The other (N) was in her thirties. Neither family had given their daughter opportunities to be herself and to learn to take on an adult role. Both patients found sufficient satisfaction in their infantile situations to be unable to learn to accept themselves as independent adults. However, some of the hostility these situations aroused was brought out in the course of these patients' treatments.

The third patient in this category (R) was married to a very neurotic husband who did not love her. Her husband's rejecting attitude toward her increased her dependence. This, in turn, made him more resentful. She sought to recapture his love by suicidal threats. He, however, reacted to her anxiety and dependence with further withdrawal. She became more ill. He then arranged for her hospitalization and later asked that a home be found for her.

Mental deficiency was observed in only one of these cases. Here it was a large factor in the parental rejection. The parents not only found this condition impossible to identify with but apparently also felt that the problems they

would normally have with their adolescent daughter were immeasurably complicated by her low intelligence. This feeling was particularly noticeable in their fear that she would become sexually involved.

In four of the nineteen cases the patients' psychiatric difficulties were further complicated by epilepsy. In a fifth case there were fainting spells which for a brief period were thought to be of epileptic origin. It seems surprising to find that in none of these cases did the patient's epileptic condition appear to influence the parental rejection. In the attitudes of the general public we find much misunderstanding of epilepsy and very often also rejection to the point of revulsion toward many epileptics. It seemed natural to suppose that among these rejecting or otherwise emotionally ill families we might find a similar attitude toward the sometimes quite disturbing syndrome of seizures. However, in none of these cases did the presence of the seizures make placement plans necessary. The reasons for these patients' placements classified exactly as if these patients had not been epileptic.

For example, one patient (Q) was totally rejected by an antagonistic family even though she was given medication to control seizures. The second patient (S) was accepted with no apparent feeling against her attacks. However, her sister with whom she lived found that the patient's childish demands and hostilities were more than she could manage comfortably.

In the cases of the third and fourth, the homes never considered the patients' attacks as epileptic. One patient (G) was accepted in much the same manner as her siblings. This home, however, was extremely neurotic. The patient could not be expected to function normally. She was treated in a manner devoid of emotional warmth and understanding and she was given no education for adult living. The other patient (H) was rejected chiefly for her mental deficiency as this was a blow to her parents' narcissism. Her "falling spells" were of lesser concern and apparently were not part of the parental rejection.

In the fifth case (E) the patient had a diagnosis of mixed psychoneurosis. She was not epileptic. However, prior to hospitalization, her frequent fainting spells were considered by her friends and most of her family as epilepsy. Apparently the patient lost her job and most of her friends because of community attitudes toward epileptiform attacks. Her attacks affected her family's attitude toward her only in that they caused some concern.

The writer offers the following explanation as a possible reason for the families' acceptance of seizures and rejection of behavior disorders. Seizures can be considered by the family as a medical problem. With such they may not feel the need to identify themselves. Behavior disorders, however, seem to be accepted, consciously or unconsciously, as direct or symbolic manifestations of the patient's dissatisfactions

with his parents or with his own role in the home. They stir up corresponding anxieties in the parent who may consequently find the patient intolerable.

The neurotic elements in all of the home situations cited here were so strong that psychiatrists felt adjustment to these conditions would be impossible. If the patient were to have any chance for improvement she would have to be placed outside the home.

B. The Reasons Why Placements May Be Satisfactory

Psychiatric social workers see a number of patients whose home situations make the patient's placement elsewhere seem definitely indicated. However, the need for placement does not mean that once a placement is made the patient will henceforth improve a great deal. Further study of the patients, including their ages, diagnoses, prognoses, onsets of the illnesses and the patients' previous experiences with placements, can sharpen the psychiatric social worker's picture of the patients and can bring out reasons why these patients may find placements satisfactory. These considerations can also help the psychiatric social worker ascertain what type of patient, with what diagnosis, may adjust the best in a certain environment. The sample group of patients are considered from these standpoints in the following section.

1. Diagnoses According to Age Group

As we see in Table I, "Diagnostic Conditions According to Age Group", the sample group of patients was composed of seven who were in their late teens, five who were in their twenties, six in their thirties, and one in her middle forties.

TABLE I DIAGNOSTIC CONDITIONS ACCORDING TO AGE GROUP

Ages	Totals	Psycho-neuroses	Behavior Disorders	Anxiety States	Schizo-phrenia	Para-noid State
Totals	19	10	2	4	2	1
10-19	7	4	2	1	-	-
20-29	5	3	-	1	1	-
30-39	6	3	-	2	1	-
40-49	1	-	-	-	-	1

Among the teen-agers we have the following diagnoses: four patients, psychoneurosis; two patients, behavior disorders (one of these with possible epilepsy); and one patient, anxiety with panic. The group of five in their twenties were diagnosed as follows: two patients, psychoneurosis (one of these with possible mental deficiency); one patient, a situational neurosis; one with an anxiety state (combined with mental deficiency and possible psychomotor epilepsy); and one with schizophrenia. Among the six patients in their thirties we find; three with psychoneurosis (one of these also with epilepsy); two with severe anxiety; and one with schizophrenia with depression. The patient in her forties had a paranoid state with epilepsy.

Considering the diagnosis alone, the future for these patients in placements looks fairly promising. All but two of the patients had diagnoses which classify under the neurotic rather than the psychotic illnesses. Neurotic patients are usually much more treatable and can make better, that is, more normal adjustments, in placements. The fairly high incidence of epilepsy or epileptiform attacks (four cases) complicates placement because of community attitudes. However, medication can control the seizures of most patients and they may then be considered not only for placement but also for employment. The two with psychotic diagnoses were schizophrenics. This diagnosis is very common among the population of most mental hospitals. However, only one tenth of the sample group had this diagnosis. The patients in the sample group were not chosen according to diagnosis. The low incidence of schizophrenia may be explained in two ways: 1) most patients with a definite psychotic syndrome are apt to be treated in state or provincial mental hospitals rather than in the comparatively short-term institutions from which these cases were taken; and 2) psychotics, having an actual mental illness, are very much less numerous in the general population than those with types of behavior disorders or psychoneuroses, which are the nervous illnesses.

To summarize, we see that ten of the nineteen patients had diagnoses of psychoneurosis; two, behavior disorders; four, anxiety states; two, schizophrenia; and one, a para-

noid state and epilepsy. The last mentioned patient is the only one whose epileptic condition seemed more serious than the mental or nervous condition.

Medical prognoses, with very few exceptions, have not been made for these patients as their future depends on factors in their environment, in their general mental and physical health, and in their ability to handle situations, or to get help with situations that arise.

2. Consideration of the Ages of Patients Studied

On the whole, the group studied is a fairly young group. There are more 17 year olds (three) than any other age represented. The age group from 17 through 24 has nine members, which is only one member more than the group from 25 through 34. However, the group from 35 through 44 has only two members. The sudden drop in this last age bracket is inherent in the statistics for those in this age group who are without homes and/or in need of protective environments are necessarily in the minority. The average age for the whole sample group is 26 (25.9) years. The comparatively large number of teen-agers pull the average age down considerably.

The fact that the average age of these patients is fairly low may be one of the best signs for their favorable adjustments to placements. Patients in their teens may have particularly good chances for successful placements. In the

process of their re-adjustments they may be aided for their instability may be taken for "normal" adolescent instability and their hostilities for "normal" adolescent revolt. Also, young patients may have a strong physique. This is of inestimable value to them in their progress in treatment and in their efforts at re-adjustment. (When physical illnesses enter the picture they may not only hinder the patient's adjustments but they may also prolong the patient's acceptance of psychotherapy. The patient who has physical illnesses may use these illnesses to block the therapist's efforts to help her re-adjust, or she may feel that her psychological troubles are troubles of little importance which will clear up as soon as she is physically well. In any event, psychotherapy is often delayed and hindered when patients have obvious physical ailments.)

3. Onsets of Illnesses

Generally speaking, the sooner treatment is received after the onset of the illness, the better are the chances for effective therapy and successful re-adjustment after hospital discharge. These cases have been examined to see how soon after the onset of the present symptoms the patient received psychiatric care. However, as many of these illnesses are slow and insidious in the early stages, they may be difficult to recognize. Therefore, true onset is often an impossible fact to learn. Recognition of the illness and determina-

tion of onset are further hindered by the frequent delay in the emotional acceptance of the illness on the part of the patient or her family. From what we know of these patients and from our understanding of psychopathology it appears that the true onsets were in their early childhood. It seems that three patients (E,F, and S) started to have difficulty within the first six months of life; five (A,C,D,G, and R) within the first year; three (B,I, andO) within the first two years; and two (K and N) within the first three years. In the remaining six cases (H,J,L,M,P, and Q) difficulties were not complained of until after the fifth year. However, these difficulties were of such nature as to make the writer feel that their troubles began considerably earlier.

Later in life environmental factors further aggravated the patients' difficulties. In several of these cases we find that when the patient's symptoms made her need for hospitalization apparent to her relatives and other laymen, she was hospitalized within weeks or even days. Table II, on pages 29 and 30, entitled "Onsets of Present Illnesses of Patients Studied", attempts to give a rough determination of the lengths of time the patients' symptoms were noticed prior to treatment at A.M.I. or I.N.I.

Consideration of Table II shows that nine patients received treatment at A.M.I. or I.N.I. within a year after their symptoms were recognized. For most of the other patients treatment was delayed. We find that two patients had had

TABLE II - ONSETS OF PRESENT ILLNESSES OF PATIENTS STUDIED

Patient	Age	Diagnosis	Lengths of Time Present Symptoms Were Noticed Prior to Treatment at A.M.I. or I.N.I.								
			To 1 Yr.	2 Yrs.	3 Yrs.	4 Yrs.	5 Yrs.	6 Yrs.	7 Yrs.	8 Yrs.	Over 8 Yrs.
A	17	Behavior Disorder	X								
B	17	Somatic Neurosis		X							
C	17	Psychoneurosis with Schizoid Features					X				
D	18	Anxiety State with Panic	X								
E	18	Mixed Psychoneurosis	X								
F	19	Behavior Disorder with CNS Syphilis	X								
G	19	Psychoneurosis	X			Y					
H I	20 22	Anxiety State Mental Deficiency; Possible Epilepsy							X		
I	22	Psychoneurosis (Lobotomy)		X							
J	25	Psychoneurosis					X				

TABLE II (Continued)

Patient	Age	Diagnosis	Lengths of Time Present Symptoms Were Noticed Prior to Treatment at A.M.I. or I.N.I.								
			To 1 Yr.	2 Yrs.	3 Yrs.	4 Yrs.	5 Yrs.	6 Yrs.	7 Yrs.	8 Yrs.	Over 8 Yrs.
K	28	Schizophrenia			X						
L	28	Situational Neurosis									Life-long Situation
M	31	Schizophrenia with De-pression	X								Y - 16 yrs. earlier
N	32	Chronic Anxiety (Lobotomy)			X					Y	
O	33	Psychoneurosis			X					Y	
P	34	Psychoneurosis (Lobotomy)					X				
Q	34	Psychoneurosis with Epilepsy	X								Life-long Problem
R	39	Severe Anxiety (Lobotomy)	X								Y - 12 yrs. earlier
S	44	Paranoid State with Epilepsy	X								

Legend:

X refers to onset of present symptoms

Y refers to earlier marked manifestations of what seems to be the same ill-ness.

noticeable symptoms for two years; three patients, for three years; three patients, for five years; one, for seven years; and one, for eight years.

The staffs of psychiatric hospitals know that the sooner treatment can be given the better the results may be. One might assume that the nine patients whose treatment closely followed the recognition of their illnesses might have the most successful therapy and the best adjustments to placements. However, as we consider these patients' adjustments throughout this study it can be seen that the best results do not necessarily follow early treatment.

We offer a number of factors in explanation of this apparent discrepancy. 1) Symptoms may not be noticed in some cases until the patient has been ill for a long time. The family or the patient may not be aware that certain types of behavior are symptoms of illness. Also, as mentioned previously, the emotional lack of acceptance of the patient's illness may delay recognition of symptoms. In these instances the onset might have been months or years earlier than reported. Therefore these patients would not receive treatment as early as it might seem. 2) The patient who receives treatment early in the illness is not necessarily as emotionally ready for treatment as the patient whose treatment is delayed. There is no intention to imply that treatment should be postponed. The writer wants to emphasize that there is a great difference in patients' treatability.

3) Patients with similar diagnoses may have widely differing degrees of illness. The patient who is less sick could usually progress more rapidly than those with deeper degrees of illness. Time of onset does not show these differences. 4) The study of onsets cannot show the environmental difficulties a patient may meet. Also it cannot show the degree of emotional support she may need nor the amount she is given. These affect adjustments very much and are considered in detail later in the study.

Some study of onsets has been included so that we might have a more complete picture of the sample group of patients and so that we might isolate, to some extent, the consideration of the onset from other factors in the total configuration. There is no doubt that onset is important. When all else is equal, or comparatively so, the patient whose treatment begins soon after the onset of the illness will have a much better opportunity to be helped than the patient whose treatment is delayed.

4. Patients' Reactions to Previous Institutionalization

In considering patients' previous institutionalizations we find that they are divided into three groups: those with no previous experience in group living; those with some institutional contact; and those with considerable experience in institutions of various sorts. As a rule it seems that those who have had some introduction to group living have an

easier adjustment to placement than those who have never lived outside the family circle. However, those who have spent a good part of their lives in institutions may react negatively toward institution life and yet have behavior patterns so conditioned by group living that they cannot adjust easily in any other type of setting. Those of our patients who have had a great deal of institutionalization within their first five, formative years, seem to be the patients whose personalities are particularly damaged and whose re-adjustments after hospitalization are particularly difficult. Re-adjustments are considered primarily in Chapters V and VI. The remainder of this chapter is devoted to case illustrations of reactions to previous institutionalizations. The purpose of these illustrations is to show the conditioning patients have toward placement in a protective environment.

Seven of the nineteen patients had no previous institutionalization. Of this group three were in their teens, two in their twenties, and two in their thirties. The diagnoses in these cases were all in the neurotic group, i.e., psychoneurosis, anxiety states, and behavior problems. The oldest in this group (R), who was 39, had been hospitalized with severe anxiety neurosis and had been given a lobotomy. It seems preferable that this type of patient should be considered for placement in a foster home rather than in an environment where she will have group living. Not only is she

not conditioned toward group living but she would ordinarily not be able to receive, in a residence, the training for social living and the affectional responses that certain foster homes may offer.

The remaining six patients in this group can be considered, at least, for residence in a girls' club. The outcome of such a placement for these patients seems to depend largely on the home life they have had. They may or may not find it easy to adjust in the new situation. In most cases these patients find adjustment considerably harder than the girl who has had one or two satisfactory or fairly satisfactory homes away from home and whose diagnosis and prognosis are not more serious.

Extreme care in placement is indicated in work with the above cases. The early days of adjustment may be much more difficult than later adjustment in the institution for this group.

Two patients (G and S) had had enough contact with institutions so that they cannot be placed in the classification with those above who had had no institutionalization. Their institutional experience was sufficient to influence their future adjustments. However, in both cases the contact was tenuous enough to prevent classification with the third group who had had fairly extensive institutionalization or a good deal of experience in other homes away from home.

One of these two patients was a girl of 19 (G) who

spent the first few months of her life as a foundling in a crêche in Montreal. She had no subsequent institutionalization and therefore no opportunity to adjust to group living. The fact that she was "adopted" from an orphanage came to this patient in a traumatic way and influenced her feelings toward her foster parents and her feeling of belonging in her home. Although she had no subsequent institutionalization, it is quite possible that the knowledge of her early experience would influence her feelings about placement in a club or residence. As she was never considered for placement in a group setting we do not know exactly what her feelings about later institutionalization might have been. If such a setting had been considered and any feelings that she brought out worked through, it seems quite possible that she might have done well in a club or residence. She seemed to need the experience of group life. As it happened, she adjusted very poorly to the homes of two aunts.

In the case of the second patient (S), a woman of 44, there was no history of institutionalization. However, for seven years she had been an out-patient under treatment at the Montreal Neurological Institute. She had not lived in an institution. It seems that her long, not unpleasant contact with one hospital might have aided her good adjustment in other treatment settings. It may also have been of indirect help to her in her adjustment at foster homes. The writer's reasoning behind this idea of the beneficial influence of the hospital contact is that the patient appears to have accepted

direction much more easily from the hospital staff than from her sister. This patient used her family contacts in a destructive way. She apparently got considerable satisfaction from causing misunderstanding between various family members. However, her contacts with hospitals seem to have been very good. She balked against some of her sister's wishes but was able to accept placements made by the hospital (A.M.I.) psychiatric social worker. Considering her physical disabilities, she was able to adjust quite well.

Ten patients had had one or more placements prior to their hospitalization. Some had had short, pleasant experiences which seemed to augur well for their acceptance of new placements and adjustment to these settings. Some patients had had few homes other institutions and little or no opportunity for a continuing stable relationship. These latter patients seem to need a great deal of help if they are to have a chance to succeed in their next placement. Generally speaking, another institution for these people seems better than a foster home, as they are better set to adjust in institutions than to the more personalized and therefore, more emotional setting of foster homes. However, in all of these cases the types of adjustments made previously to institutional living influence the future adjustments to placements to a great extent. Therefore it seems advisable to consider more specifically where these people were institutionalized, for how long, under what circumstances, and with what results.

Of the ten patients in this classification, three were girls in their teens, three were in their twenties, and four were in their thirties. One was a 17 year old girl (A) who was placed twice at the Institute for Juvenile Research, once at the House of the Good Shepherd, which is for recalcitrant girls, and once at the Chicago Psychopathic Hospital. In all of these institutions her adjustments were fair to excellent. The chief reason for this seems to have been that the patient realized that these institutions were better homes for her than her own home had ever been. Most of these placements had been made because her mother had an extremely neurotic inability to tolerate adolescent behavior. It seemed true that this behavior was somewhat out of bounds. However, it was brought on by neurotic elements in her home. This patient, with her youthful age and with a neurotic rather than a psychotic diagnosis, seemed to have an excellent chance to succeed in future placements made by the hospital staff. It is unfortunate that this girl had been institutionalized so much. However, her adjustment in these institutions stood in her favor for good future adjustments. The greatest point in her favor, however, was that her placements did not take place until she was in her teens. The patient whom institutional life is most apt to affect negatively is the patient whose institutionalization has taken place during her first five years.

The second girl (C), aged 17, had been placed by the Montreal Juvenile Court in a foster home when she was 14 years old. However, she reacted in a jealous and hostile way toward

the foster family. She ran away in two weeks' time and was found doing domestic work. She was returned to her own home but she soon ran away again. Within six months she was sent to the House of the Good Shepherd where she remained for a year and a half. There she made a fairly good adjustment although she was not popular with the other girls. When her stay of a year and a half was over, she was returned home and remained there for eleven months. The home, however, offered a very rejecting environment, and she adjusted poorly. Just prior to admission to A.M.I. she had spent a month as a domestic with an unknown family. Environmental conditions and her degree of adjustment to this family could not be ascertained.

This patient had a neurotic diagnosis and was also illegitimately pregnant. As is found with many other unmarried mothers, this patient was extremely dependent. She adjusted well in the secure atmosphere of the hospital. This is the type of patient, however, for whom, it seems, a good adjustment to the hospital setting may make a good adjustment to an outside placement more difficult. When discharge became imminent, she interpreted it as rejection by the hospital staff. Her ability to adjust fairly well at the House of the Good Shepherd would help her adjustment to other institutions. However, this type of patient, with her strong dependency needs seems to require special help to be able to accept a placement. The techniques used for helping patients with separa-

tion from the hospital and acceptance of a placement are taken up more fully in Chapter IV, under the section entitled, "Timing of the Placement".

The third girl (F) in this group of teen-agers spent the first three years of her life in numerous foster homes. According to her foster parents, her adjustment during these first three years was satisfactory. However, it can be noticed that part of her symptomatology upon hospitalization was composed of feeding difficulties. During her more disturbed periods the patient showed marked tendency to prefer spoon feeding. From our knowledge of psychopathology, we know that feeding problems are caused by difficulties when the child is extremely young. Therefore, it is obvious that this patient's difficulties began during the period that she spent in numerous foster homes. The fact that circumstances required placement in several foster homes within a three year period was itself a traumatic experience. It is unfortunate that this girl had so many placements during her first three years of life. However, extended psychotherapy from a psychiatrist and a psychiatric social worker and excellent supervision from the psychiatric social worker over a long period helped her achieve a progressively good adjustment.

There were three young women in their twenties who had had numerous placements. The oldest of the three (K), aged 28, had spent her childhood in a foster home where, she said, she was never happy. This patient's illness was mental rather than nervous and was first noticed when she was 22

years old. (This was three years prior to her referral to A.M.I.) At that time she was committed to a provincial mental hospital. There she made a good adjustment and improved mentally. She was discharged in less than a year. Subsequently she received treatment at A.M.I. and after discharge was placed in a protective environment and given a good deal of help in adjusting. Even then she seemed to find small responsibilities were too much for her to manage. After five months her condition became considerably aggravated and she had to be committed again. There seems to be little doubt but that this patient's long unhappiness in childhood proved to have an indelible traumatic effect on her later adjustments.

The second in this group who had placements over long periods was a 22 year old patient (I). She had been an institution child since she was two months old. Until her third year she was in a French crêche. Then she was moved to an English-speaking orphanage where she stayed until she was 14 years old. Following this, she was in a foster home for three years. For two years she stayed with her father and stepmother. However, this life was particularly unsatisfactory for her. Next, she lived with her brother for two years. For five months she was in the Armed Forces. During this period she was raped by a soldier. After this traumatic episode her mental illness became apparent. However, before she was admitted to A.M.I. she had further institutionalizations. She was in the Montreal Neurological Institute for two weeks, in a military hospital for two months, in a general hospital and

in jail for two months for attempted suicide, and in a provincial mental hospital for five months. This girl also had spent some period of time at a girls' club, at a convalescent hospital, in a private rooming house, and at the Y.W.C.A. It was necessary to commit her to a provincial mental hospital for the second time, and for the second time she was discharged as improved.

With this type of background, the outlook for future placements is not good. It can be seen by the short length of time this 22 year old girl spent in her various "homes" that it was hardly possible for her to form lasting, stable relationships. Further placement for this girl would have to take into consideration her lack of knowledge of what home life can mean. It also appears that placement would have to be accompanied by a very close relationship with a psychiatric social worker and/or a psychiatrist.

The third and youngest of this group of girls in their twenties was 20 years old (H). Her diagnosis was an anxiety state with mental deficiency and possible psychomotor epilepsy. She was treated at a mental hygiene institute from the age of6 but she was not in residence during this period. In her teens she was sent, at her parents' request, to a girls' reform school because she ran away from home and was gone all one night. Between 1944 and 1946 she had three admissions to a provincial mental hospital at her father's request. This young patient, like the girl in her teens mentioned previously,

(A)[1] found the institutions more satisfactory than her home had been and made excellent adjustments. As this patient had made several previous good adjustments in institutions, she was set to make a good adjustment in a placement, and she did.

Consideration of the experiences of four young women in their thirties ends this discussion of patients' previous institutionalizations. One of the patients (M) was schizophrenic. She lived at a girls' club for a brief period and at one time was referred to psychiatry by the residence director. This patient had worked and lived in a hospital for nine years as a maid. Hospital life is a type of institutional life but it may not provide sufficient opportunity for socialization. This patient's socialization was extremely poor. However, she was very proud of her work and she had emotional ties with the hospital. This patient's adjustment to institutions seems to be very good. However, because of her emotional ties with the hospital and her difficulty in socialization, placement in another setting might prove difficult.

The second young woman in her thirties (N) had a diagnosis of anorexia nervosa.[2] Her only "homes away from home" were the considerable periods she spent in general hospitals

---

[1]Supra page 37.

[2]A psychoneurotic symptom characterized by loss of appetite, loathing for food.

on four different occasions. These hospitalizations were prior to her admission to a mental and nervous hospital. As she was always a hospital bed patient and so could easily take an extremely dependent role, she had no opportunity to learn the normal give-and-take that she might have learned in institutions where group living prevails. Her home was particularly unsatisfactory for her as it was over-protective and rejecting. Her experiences outside the home were essentially negative. Treatment received in the hospitals as a bed patient might seem to have repeated her home's over-protection. Hospital discharges may have seemed to her to repeat her home's rejection and therefore, she may easily have interpreted these discharges as further rejection.

Another patient in her thirties (P) had a diagnosis of psychoneurosis and during her hospitalization was given a lobotomy to relieve her intense anxiety. She had five previous hospitalizations which must have been essentially negative experiences for her since she became progressively worse. This patient had taught in a convent for a number of years prior to her hospitalizations. This conditioned her against, rather than for, group living as she felt these convent years were particularly lonesome and unhappy.

We have seen in this review of previous institutionalizations many types of conditioning toward and against homes away from home. This prior conditioning must be definitely taken into consideration in preparation for placement, but it

is only one group of elements in the total configuration. If the patient's condition has been improved by hospitalization we may find even the most negative reaction toward placement considerably ameliorated.

In order to ascertain to some extent the degree of improvement the patients have experienced from the psychiatric treatment we must consider their behavior at home compared and contrasted with their behavior in the treatment setting, and lastly, in the new environment. This is covered in some length in the following chapter.

CHAPTER III

THE WAY THEY ACT

In this chapter we consider the behavior of the patients at home compared and contrasted with their behavior in the treatment setting and with their behavior in the new environment or environments. In order to make this comparison and contrast, we must also consider the treatments used to alter the behavior.

Before treating these specific data we give consideration to certain general aspects of these patients' behavior as they come to the worker's attention soon after the patients are admitted to the hospital. We also attempt to see to what extent we may expect similarity between the patients' degrees of adjustment to the hospital setting and their degrees of adjustments to placements.

We know that behavior is not a chance phenomenon and that changes in behavior can be brought about scientifically. If, in the study of the behavior of our sample group we are able to point out some of the factors that have made behavior change after a patient has been admitted to the hospital, we may find that use of some of these same factors may help us to help the patient as she goes back to the community after hospital discharge.

Some of the improvements in behavior were wide-spread among the sample group of patients and were brought about by almost identical elements in their treatment, e.g., removal

from the home and a period of concentrated therapy. Other changes in behavior were noticed particularly in certain age groups. These factors seem quite important and are shown more specifically in this chapter in the material which illustrates the patients' behavior according to age groups. However, it is obvious that the greatest improvements in the behavior of each patient are brought about by her individualized treatment, e.g., the psychotherapy she is given and the environmental manipulation that her needs require. This is also elaborated in the case material used in this chapter.

The study of behavior in general shows that there are all gradations of acting out and withdrawal, - multiple ways of trying to adjust or refusing to adjust to reality. At the opposite ends of this scale we have, first, the patient who acts out extensively, showing in almost every way that she is ill, trying desperately and often unrealistically to solve her problems by very active methods. Secondly, we have the withdrawn patient who shuts herself away from life and lives in an unreal world of her own imagination. Both of these patients are very ill. The active one, by her very activity, often comes first to the attention of psychiatrists and psychiatric social workers. Her "asking" for help by acting out has succeeded in getting her into a treatment situation. The withdrawn patient seems to deny the possibility of help by her very withdrawal, which denies the existence of a world which has been too hard. She is often not considered sick until

she has been sick for a long time. By and large, the behavior of most of the patients in this study would classify in the very large area that lies between the two extremes of behavior just illustrated.

The importance of studying behavior and its changes is obvious. As we know, the way patients act shows to a large extent the way they feel. As they get better their behavior improves. The remainder of this chapter is given to the discussion of how and why the patients' behavior changes or fails to change in various settings.

A. General Consideration of These Patients' Behavior During and After Hospitalization

For most patients one of the most beneficent factors is hospitalization which involves removal from the home and separation from the responsibilities of day-to-day living. Benefit received from hospitalization *per se* is particularly noticeable among these patients whose home lives figured largely in their illnesses.

It is not possible to weigh the factor of removal from the home at this point as in no case has treatment been limited to removal from home to hospital. The difference removal makes can only be evaluated when it is isolated. For example, later in the treatment, that is, after placement, the patient may be moved from an unsatisfactory environment to a comparatively satisfactory one. At that point the value of removal may be gauged more precisely.

As beneficial as hospitalization may be, it may also often be a large threat. However, during recent years its threat seems to have diminished. One reason is that the results of mental hospital treatments have now become more widely known. Consequently, some of the fear of hospitalization has been dispersed. A second factor is that efforts are being made to interpret to many patients that hospitalization is an opportunity for their concentrated treatment. Therefore, patients are helped to enter the hospital in a hopeful frame of mind and with some readiness toward treatment. Among the sample group of patients, only three of the nineteen had negative or markedly ambivalent feelings toward hospitalization. Two others were never hospitalized, but were treated only in clinic. These two, however, seemed to have positive feelings toward the clinic and one of these also actively sought hospitalization.

In this study the effect of the original attitude toward hospitalization on the behavior in the hospital setting seems comparatively negligible. Of the three patients who had some degree of negative feeling toward hospitalization, one made an excellent adjustment both in the hospital and in placement; one made a good adjustment only in the hospital; and one made only a fair adjustment to hospitalization and to placement.

It also appears from the consideration of the cases in this study that length of hospitalization, <u>per se</u>, has little

effect either on these patients' adjustments to the hospital or on the attitudes shown toward hospital discharge. The writer feels that these patients' adjustments to hospitalization were primarily dependent on the patients' readiness for treatment and on their needs that were met by their removal from their home environments.

Interest in hospitalization does not necessarily imply readiness for treatment. The patient may use hospitalization to serve neurotic ends rather than to get treatment. This patient may not want discharge. Patients may react negatively toward parts of their treatment and so, adjust poorly or ambivalently.

The nature and intensity of treatments the patient is given is determined to a large extent by the patient's condition upon entering the hospital. Her physical condition may effect her reactions toward treatment and her feelings about discharge.

Patients may have all degrees of positive or negative feelings toward hospital discharge. However, fear of separation from the hospital need not mean failure of placement if the worker is alert to the reasons behind the patient's fears. She must not only seek to relieve these fears but should also endeavor to help the patient consider her placement, whenever possible, as a "promotion" from concentrated treatment rather than as a rejection from her hospital "home". The patients' attitudes toward discharge seem to be primarily dependent on

the timing of their preparation for placement. This point is treated further in Chapter IV, Part E.

The material at hand shows a definite positive relationship between ability to adjust in the hospital setting and ability to adjust in a placement. Reasons for this seem manifold. The writer enumerates here a few of the reasons that seem most obvious. Patients whose adjustments in both settings seem good may be less deeply ill than patients whose adjustments are less good; or, they may have received more help. In some cases the value of additional help after discharge is made particularly apparent by the fact that some of these patients required several placements before they achieved a satisfactory adjustment to placement. Patients whose adjustments in both settings leave room for improvement may need further help during hospitalization and after discharge. The patient whose hospitalization period is more satisfactory than her placement experience may not have a placement that is satisfactory for her. In a few cases, she may find that no environment but a hospital can give her the security and protection she needs, or, she may not have been given sufficient preparation for discharge.

The similarities as seen in the ability to adjust in the hospital and in the placement are illustrated in the following brief consideration of good, fair, and poor adjustments in the hospital and after discharge. The degrees of adjustment are the writer's evaluations. "Good adjustment" may vary

in meaning from an excellent adjustment to one where no complaints were made. "Fair adjustment" denotes some improvement in adjustment but also included negative factors. "Poor adjustment" refers to adjustments which may be said to have failed.

1. Good Hospital Adjustments and Their Relationship to Adjustments to Placements

Of the nineteen patients, fourteen adjusted well in the hospital. For eleven of these patients it was seen that a good adjustment in the hospital setting meant a good adjustment in the protective environment. If the first placement was not successful because of the patient's lack of ability to adjust or because of reality factors in the environment that were hindrances to the adjustment, subsequent placements resulted eventually in a good adjustment.

Among the three patients who responded well to hospitalization but poorly to their placements, two seemed to have placements which did not meet their needs. One patient, age 25, (J) was handicapped financially. She was not trained for the type of work she thought she might like and could not afford this training unless she returned home. Her placement was a convalescent home, which in itself may be considered a negative placement.[1] The other patient (K), age 28, had apparent-

---

[1]Disadvantages of convalescent homes are discussed in Chapter IV.

ly never known a satisfactory home life. This alone would make "normal" adjustment fairly difficult for her. She had a diagnosis of schizophrenia which, also, contributed to the difficulty she would have in making adjustments to placements. It seems that any setting which requires this type of patient to exhibit more than a minimal amount of responsibility might prove unsatisfactory.

It seems interesting to note that in both of these cases the attitude toward leaving the hospital was negative. Both had entered in quite poor condition but had taken positive attitudes toward the hospitalization. Their adjustments in the hospital, as stated above, were good. One had remained in the hospital, for two to three months and the other for eight months.

In the case of the third (D), an 18 year old, the first reaction to the hospital was one of panic. Later she adjusted quite well but had recurrent attacks of anxiety. During her hospitalization no responsibilities were required and very few restrictions were imposed. A good measure of her inability to adjust to her placement (which was an extremely good one, carefully made) was her inability to accept responsibilities or to live within any restrictions.

This is one of the three cases where the first reaction toward hospitalization had been negative. Her attitude toward discharge, after three months' hospitalization, was very ambivalent.

In all three of these cases the hospital environments offered the patients "advantages", of real or neurotic value, which the patients missed in the protective environments and without which they were not prepared to function. Part of these three patients' negative feelings about discharge may have been due to a realization of the ways the placements would differ from the hospital setting.

2. Fair Hospital Adjustments and Their Relationship to Adjustments to Placements

Two patients (I and M) adjusted only fairly to the hospital setting: that is, we saw some improvement but this improvement did not extend into enough areas to be called good. There were also large negative factors to be reckoned with. One of these young women (I), a 22 year old patient, was given a lobotomy during her hospitalization to relieve her intense anxiety. In the hospital her behavior was lonely and depressed. She feared insanity. However, some improvement was seen over her low level of functioning prior to hospitalization. This is classed as fair adjustment to hospitalization. Her adjustment to placement is also classed as fair. Some favorable elements could be seen, but it was difficult for her to maintain stable living or employment arrangements. The other patient (M), who was 31, was a schizophrenic. She was fairly cooperative during hospitalization, but she was worried and upset. She did not want to talk and had little interest in her surroundings. This seemed to be some improve-

ment over her very withdrawn behavior prior to hospitalization. Therefore, it is classed as a fair adjustment. After discharge she held a job well but was still withdrawn and was very poor in socialization. This is also classed as a fair adjustment.

Fair adjustments may be partially explained in the following ways. Both of these patients had been in institutions for years. Hospital admission did not remove them from a traumatic home situation and so did not bring the relief that such removal can offer. Both of these patients had been ill for a long time and so would be slower to show improvement.

3. Poor Hospital Adjustments and Their Relationship to Adjustments to Placements

Three patients (G, N, and P) adjusted poorly to the treatment setting and also to their placements. One (G) was a clinic patient who was never hospitalized but who gained a good deal of satisfaction from the dramatic use of her neurosis. She showed no improvement during placement. Another patient (P) was a lobotomy case who actively resisted treatment and who, although in need of a protective environment, found herself a furnished room and retreated emotionally to her mother. The third patient (N), another lobotomy case, could never free herself emotionally from her very neurotic home. (The remaining lobotomy cases classify under Good and Fair Adjustments.) All three of these patients who had poor adjustments in the treatment setting and in placement had had

receptive attitudes toward hospitalization. All three were handicapped by degrees of emotional lack of readiness for treatment. The latter two were further handicapped as they had entered in poor condition. The second case mentioned in this group (P) was the only one of those who made poor adjustments who did not want hospital discharge.

B. General Consideration of Treatment

Before discussing the patients' behavior in various settings we want to consider briefly the nature of the treatment offered these patients. It seems necessary to state that the treatment is considered, not evaluated, as it is not within the province of this study to evaluate treatment in the hospital. One reason is that the diagnosis and a good measure of the treatment always belongs to the physician. In some hospital settings all of the treatment of the hospitalized patient is solely within the psychiatrist's realm, the patient's contacts with social service being limited to consideration of environmental factors. In other hospital settings, psychiatric social workers working with psychiatrists do psychotherapy not only all during the time of the patient's hospitalization but, when indicated, also after the patient's discharge from the actual physical setting of the hospital. Treatments other than psychotherapeutic case work are never given by the social worker.

In mentioning the treatments patients have received, all treatments must be considered if we are to understand even

in a small way how and why behavior manifested at home changed when the patient entered the hospital and how and why hospital behavior changed or carried over into the outside environments. If this aspect were dealt with fully, it seems this could be a study in itself. It is touched on only lightly here as it is not the focus of this study. However, its consideration seems indispensable to us.

All of the patients studied received psychotherapy from a psychiatrist and either therapy or case work from a psychiatric social worker. Occupational therapy is also offered in both of the hospitals from which these patients came. Medication, of course, was always given by the doctors for physical ailments. Series of electric shock treatments, coma insulin treatments, and somnolent insulin treatments were also prescribed in the treatment of some patients. Surgeons performed lobotomies on four very anxious patients.

C. Consideration According to Age Group of These Patients' Behavior in Various Settings

In order to study the behavior of these patients more fully we consider them according to the age groups in which they classify. In general, division into age groups is an arbitrary classification and may seem to disguise facts rather than clarify them. However, it seems that certain broad statements can be made in regard to some elements of the behavior if we use this type of classification. For this chapter, we

have divided our patients as follows: (a) the older group (ages 39 through 44); (b) the teen-agers; and (c) those in their twenties and thirties. The age groups are discussed out of their consecutive order so that contrasts in the behavior of the various groups may be more apparent. The patients' behavior is considered in three types of environments: at home, in the treatment setting, and in the placements. The treatment received is found at the end of each case illustration.

1. Behavior of the Older Group

The two patients in this group (R and S) are of an age when their habit patterns have had considerable opportunity to be established. They would not generally need the type of treatment and re-education that seems so often required by the adolescent patients. Therefore behavior in the treatment setting and behavior in the new environment do not usually differ startlingly from behavior at home except that the sick ways of acting out would, hopefully, gradually disappear. Some situations, however, can be expected to be improved considerably by hospitalization and the treatment it brings. Optimal placement can help the improvement to be sustained or to progress. Specific data on these patients' behavior are included at this point.

Patient: S Age: 44 Diagnosis: Paranoid State with Epilepsy

Behavior at Home: This patient was reluctant to eat and to take medicine to control her seizures while she remained at home. Her paranoid tendencies showed up in familial relationships by playing one member off against another.

Behavior in the Hospital: In the protective environment of the hospital she made a good adjustment except when she was transferred, during an emergency, to the Day Ward. This meant she would have to go home at night. Her behavior at nights was again difficult.

Behavior at the Placements: When she was ready for discharge a foster home was found so that she might have physical care in a protective environment that would also offer home life. Some of her anxiety was again manifested by her behavior in this placement. She had said, ambivalently, that she would "try it out". Here again, although less noticeably than at home, she was difficult about meals. She was also very talkative about sexual delinquency. A good deal of her difficulty in this first placement was doubtless due to this patient's difficulty in adjusting, but some of it was brought on by this particular foster mother's lack of acceptance of this patient. Placed for a second time, she ate better and socialized quite well. This placement had to be terminated because her frequent seizures made the placement troublesome for her foster mother who was pregnant. Her third placement was apparently satisfactory from the viewpoints of all.

Treatment Received: During her hospitalization and

placement, the patient was receiving psychotherapy, medication for seizures, and case work by a psychiatric social worker who was also doing supportive work with the patient's sister.

Patient: R Age: 39 Diagnosis: Severe Anxiety Neurosis

Behavior at Home: While at home this patient was extremely anxious, quarrelsome, and made suicidal threats in order to recapture her husband's attention. She complained of a feeling of unreality. She had considerable over-concern for her twelve-year-old daughter and she was quite hostile toward her in-laws.

Behavior in the Hospital: Hospitalized at her husband's request, she showed improvement, losing her depression and becoming less agitated and tense. She was discharged to be readmitted "worse than before" due to worry over an impending separation from her husband. As she felt her anxiety was so severe that she could not stand it, she was given a lobotomy. During her period of convalescence she showed loss of emotional affect but also, loss of anxiety. She became gradually more interested in the future.

Behavior at the Placement: On discharge, she was placed in a foster home. There, it was hoped, the middle-aged foster mother and father, acting as parent surrogates, might give her re-training for life in the community. Her behavior in the placement, while somewhat unpredictable, was sociable. She took her husband's death with little apparent emotion. Al-

though seemingly still interested in her child, she could say to her, "We are not supposed to live together."

Treatment Received: During this patient's earlier hospitalization she received psychotherapy with sodium amytol and adrenalin desensitization. On her second hospitalization she was given a lobotomy. Case work done by the psychiatric social worker was primarily directed toward arranging a satisfactory foster home where this patient could receive re-training. The foster mother required considerable support and advice from the social worker over a long period.

While both of these patients will always need protective environments, they are able to function fairly well by means of them. In both cases we can foresee adjustments to placements by the considerable change for the better which was made during hospitalization.

The behavior and treatment of the teen-age group differ considerably from the behavior and treatment of the older patients. Data from the cases of five of the seven teen-agers are used to illustrate specifically the behavior manifested and the treatment given.

2. Behavior of the Teen-age Group

In this group we have adolescents whose patterns of adult conduct were still in the process of being formed at the time of their hospitalization. The worker has an added role here as an educator as well as a mother, companion, confidante, and therapist.

Patient: F Age: 19 Diagnosis: Primary Behavior Disorder; CNS Syphilis[1]

Behavior at Home: The onset of the illness occurred six years previous to this study when the patient came home from school and asked if she were adopted. When told she was and the circumstances surrounding the adoption she cried uncontrollably and was ill for several days. She was emphatic about not wanting to see her own relatives. According to her adoptive parents, before this time she was independent, friendly, and had many girl friends. Her behavior just prior to her hospitalization at thirteen was recalcitrant: she had violent tantrums; she had severe photophobia; she screamed and refused food.

Behavior in the Hospital: Her sick behavior in the treatment setting was partly due to her hospitalization having been forced. For the first month she lay in bed screaming, her hands over her eyes, frequently with her face buried in the pillow, resisting all attempts to passify her. Sometimes she was force-fed intervenously. Sometimes she had to be isolated because she was a disturbing element. She hated everything and everybody.

Within six weeks she had made an excellent ward adjustment, although, and apparently partly because, she was ten years younger than most patients. (This patient was an only

---

[1]Syphilis of the central nervous system.

child, who, it was found later, reacted poorly toward other children in her immediate environment.) She preferred being spoon-fed by the nurses, but would feed herself. She still had somatic disturbances, i.e., considerable photophobia. Her improvement continued within the next three weeks, although she screamed when her parents visited her on Sundays.

Behavior in Placements: She was returned home for two years. For a few months she made a quite good adjustment although there were physical clashes in the home with the patient as chief combatant. Her unhappiness, however, increased during the period that she was at home. Both the patient and her adoptive parents desired placement.

Since she continued under treatment at the hospital as an out-patient, the psychiatric social worker was able to consider placement for her. She was placed twice in foster homes. Removal from the first was necessary because of the patient's poor adjustment to other children. She was removed from the second home because the foster mother was inadequate.

Successive placement in two clubs for girls resulted in excellent adjustments at first. However, she had to move from one because they did not accept her and she removed herself from the other because other girls in the residence were much more sophisticated than she and she reacted toward them with jealousy and criticism. She returned home, but was definitely not welcome now and within six months she was placed in another home for girls. She was accepted although she was under

the age specified by the residence rules. With continued supervision by the psychiatric social worker, she seems to have made an extremely good adjustment in this placement.

Treatment Received: This patient was given considerable medical attention as she had syphilis of the central nervous system. She was no doubt given a good deal of extra attention by the nurses, as in spoon feeding. This patient has been carried by a psychiatrist over a six year period and has been under the close supervision and guidance of a psychiatric social worker who has helped her adjust where necessary and who has removed her from situations that were unhealthy.

The outstanding adjustment this girl has been able to make in spite of numerous handicaps can in a large measure be attributed to the following facets of her treatment. She received psychotherapy often at first, and later, once a month. She received continued acceptance from the psychiatric social worker and from the psychiatrist and was praised for any achievement. Her goals were set within her reach, i.e., to learn to set her own behavior standards, to learn some way of earning, and to learn to get along with people. The worker did nothing without telling the patient what she was doing and why she was doing it, thereby building up an especially strong confidence of the patient in the worker.

Patient: A Age: 17 Diagnosis: Behavior problem; Situational Reaction

Behavior at Home: This patient, with an extremely bad home situation, withdrew from family life within one year following the permanent institutionalization of a brother to whom she had been devoted. She did not bathe, washed her hands excessively, would not eat with the family, was exhibitionistic, and would not keep jobs. She was very hostile toward her mother who was hostile toward her. She was encouraged by her father in surreptitious misbehavior.

Behavior in the Hospital: In the hospital her behavior was good. However, she was withdrawn at first, and later, she withdrew whenever she was hostile. She showed only small vestiges of exhibitionism, - these pretty much within normal limits (extensive sun-bathing in a new bathing suit).

Behavior in Placements: In the placement we see some of her former behavior exhibited again. One reason, we believe, is this girl's age. In adolescence she is apt to be more difficult in a home situation than in a hospital. Another factor is that this patient, like most patients early after discharge, was still working though the conflicts that had brought her into the hospital. A third factor was that her home situation had been so poor that any placement was a good deal above her level. Therefore, she would find a difficult initial adjustment. Fourthly, any new home reactivates

to some extent the behavior patterns formerly manifested in the patient's own home. Consequently, we would expect to see, as we did, some of this patient's old patterns of behavior showing up again.

However, she made a fair adjustment to her placement. Her difficulties were that she still broke some rules surreptitiously; she had a tendency to withdraw somewhat; and she was not good at managing her money. Her exhibitionism and adolescent lack of judgment came out when she told the entire assembled group of girls in the club all about her private life.

She felt too restricted in the first club in which she was placed. This was a reality situation. However, she stayed one month longer than was necessary, saying that she did not mind the rules so long as she knew them beforehand. It is interesting to note that there was no complaint from the second club where she moved. This shows the amount of adjustment the patient had begun to make and the success of the therapy which was used by the psychiatric social worker as well as by the psychiatrist.

Treatment Received: The psychotherapy given this patient by the psychiatric social worker and the psychiatrist comprised catharsis, reassurance, and mild discipline. Hypnosis was used occasionally by the physician. During hospitalization the patient was also given occupational therapy and ground privileges. She made a positive response to help and interest.

Patient: D Age: 17 Diagnosis: Anxiety State with Panic

Behavior at Home: In her behavior at home this patient showed considerable acting out of hostility. She refused to go to school, stayed out late drinking, had temper tantrums, and was destructive toward herself and others. She swore, was restless and excitable, and did not fulfill her household duties. She related well toward many of her contemporaries and toward most adults. Although she had many boy friends, there was no history of sexual delinquency.

Behavior in the Hospital: Here we saw considerable change in her behavior. However, at first she had panic states in which she grabbed a knife to commit suicide. The panic subsided into recurrent anxiety. Otherwise she got along well. She was given almost no restrictions and was treated with continued acceptance no matter how she behaved.

Behavior in the Placement: This behavior was remarkably similar to her behavior at home. She refused to go to school or to go to work. She did not refuse directly unless pushed, then she refused with guilt. She considered marriage to avoid responsibilities, but did not want the sexual responsibilities that marriage entailed. She had quite good relationships with other girls in the house, except for some question over her stealing money. She had many late dates, did not keep house rules about hours, and did not receive the usual rebuke for not keeping house rules. Tension was not now apparent except

when school or work was considered.

Returning home, she continued her behavior patterns. She showed no self-destructive tendencies, but was now extremely hostile toward her mother who was extremely rejecting. The patient was determined to carry out a glamorous, unrealistic plan of joining a circus troupe.

Treatment Received: Treatment given by the doctor was psychotherapy three times a week with moderate reassurance and continued interest and confidence. The psychiatric social worker gave her friendship and *laissez faire*.

Here we see an adolescent caught in her own patterns of behavior. When restrictions are removed, hostility is still evident in her passive refusal to work or go to school, in her lies to her mother and to the worker, and in her refusal to obey rules. Panic is still evident in her desire to escape situations, even to escaping a world of reality for a world of tinsel glamor. One wonders if a girl of this age, with as poor super-ego structure as this girl seems to have had, is capable of setting her own behavior standards.

Patient: E Age: 18 Diagnosis: Mixed Psychoneurosis; Mixed Conversion and Anxiety Hysteria

Behavior at Home: While at home this patient had fainting attacks. She showed intense hostility toward her mother but was fairly close to her father. He also reacted neurotical-

ly toward the mother's domination and could not offer the patient emotional support. She was very close to her sister who served as a mother substitute. However, this sister's support was withdrawn from the patient a short time before the patient's illness required hospitalization. She had lost her boy friend about the time of the onset of the fainting spells. Her mother apparently needed to attribute the patient's attacks to the loss of the boy friend. It seemed true that she had lost her girl friends because of these attacks.

Behavior in the Hospital: Her behavior in the treatment setting showed similarities to her behavior at home in that she continued to have some fainting spells. She was cooperative with the doctor but much less so with the worker. In this way she carried out the pattern she had used at home of being closer to the father figure than to the mother surrogate. As her sister continued to play a fairly prominent part in her life, although a much less prominent part than she had prior to the patient's hospitalization, the patient may have devoted her efforts to trying to intensify this relationship rather than to form a new relationship with the worker. Her socializations, in general, lagged somewhat.

The patient wept frequently over babyish matters. She was inclined to have immature, impulsive reactions which she recognized later as poor. She lacked insight into her difficulties.

Behavior in the Placement: When discharged to a placement she still fainted often. However, she was able to hold a job despite her fainting and despite her dissatisfactions with its monotony. She planned to go to night school to prepare herself for something better. Although still slow to socialize, she joined a co-ed club. She was not interested in occupational therapy while in the hospital but returned to join this group after discharge. This continuing relationship no doubt gave her added security in her efforts at post-discharge adjustment.

Treatment Received: Treatment was uncovering, supportive, and directional psychotherapy. It was given with considerable improvement in the hospital setting. However, she was regressive with permissive attitudes and resistive with direction. This is typical for all adolescents to some extent. When discharge was contemplated there seemed to be a definite increase in anxiety. However, under continued psychotherapy this patient's anxious behavior showed further modification in her placement.

In view of the fact that this girl did not gain insight it would appear that her adjustment was as well as could be expected. Her sick behavior pattern that she carried from home to hospital to placement seemed to show progressive modification as her treatment continued.

Patient: B Age: 17 Diagnosis: Somatic Neurosis with Psychogenetic Vomiting

Behavior at Home: This patient, while at home, showed displeasure and fear by reacting with vomiting. She had free-floating anxiety. Her home environment was extremely bad and she was involved in a very disturbing, unsolvable Oedipal situation.

Behavior in the Hospital: In the treatment setting we find the patient had much insight. However, she continued to have much difficulty in her relationships. She showed an ambivalent transference with the psychiatrist. She made her first attachments on the ward. These, however, were not strong.

This patient had made her own hospitalization. She was able to make her own placement.

Behavior in the Placement: In the placement her adjustment was on the whole quite favorable even though her relationships with people, men especially, were quite disturbing to her. Her ability to get away from the home situation and to make her own placement away from the hospital setting seemed particularly favorable signs. The home environment, however, had been so bad that, once out of it, she was able to make considerable improvement in her behavior immediately.

Treatment Received: This patient was given an intensive amount of psychotherapy during her hospitalization and after her discharge.

3. Behavior of Patients in Their Twenties and Thirties

Generally speaking, the ten patients who were in their twenties or early thirties showed considerable change of behavior in the treatment setting from the behavior at home. This was much more noticeable than in the cases of the adolescents. The change of behavior appeared to hold true regardless of the patients' diagnoses. They were apt to be more friendly and co-operative and to relate on a much more adult level than the adolescents who showed a certain amount of childish regression. However, behavior in the new environment or environments, for the most part, reflected again the behavior exhibited at home.

The writer illustrates the behavior of only two from this group.

Patient: O Age: 33 Diagnosis: Psychoneurosis

Behavior at Home: This patient's behavior at home was very anxious and nervous. Her father nagged her continually and either objected to her having friends at the house or interfered when she did try to entertain. The patient became emaciated. She showed a great deal of ambivalence toward her father. She feared his verbal attacks but did not want to estrange herself from him.

Behavior in the Hospital: In the treatment setting she was friendly and co-operative. However, she was rigid and tense and required sedation. Her plans for her future seemed

inelastic. Although the patient was receiving psychotherapy, she continued to be extremely anxious and did not respond well to treatment. The doctor felt this was largely due to her lack of a settled and stable environment.

Behavior in the Placement: Financial difficulties made it impossible for this patient to continue to live in a boarding house where she had stayed for a while. She was placed in a convalescent hospital where she had to room with two old ladies. She was extremely unhappy and continued to be emaciated and anxious. Later, the patient found a position in a hospital setting. In this protective environment she seemed to make large gains, physically and emotionally.

Treatment Received: This patient was given psychotherapy by a psychiatrist. Case work help from the psychiatric social worker was first refused rather vehemently by the patient and her sister. Later in the treatment she felt more receptive toward the assistance offered by the worker, at least in the area of helping her find a room to go to upon hospital discharge.

Patient: J Age: 25 Diagnosis: Psychoneurosis with Possible Conversion Hysteria

Behavior at Home: This patient suffered from chills and vomiting spells. She was unable to hold jobs because of the frequency and severity of these attacks. Neither parent could offer her any affection. Her father "cared more for

horses" than he did his children. Her mother was always so cold that the patient felt she had never had a mother. Her godfather's wife gave her more affection than anyone else, but this person lived outside of the home. The patient tried to live with an aunt for a while although she was not wanted and she knew it.

Behavior in the Hospital: Her behavior in the treatment setting was co-operative. She liked the hospital. She enjoyed the periods of occupational therapy and was able to earn $39.00 in one week selling shell earrings she made.

Behavior in the Placement: Placed in a convalescent hospital, the patient again vomited severely. She worked in a factory for three weeks but gave it up because she did not like it. She was unable to find a job that suited her and was unable to adjust to jobs she could get. The patient did not have enough money to maintain herself without working. Placing much of her difficulty on the job situation, the patient decided to return home and to take a typing course. She planned to leave home again after she had learned this type of work.

Treatment Received: This patient was given psychotherapy by a doctor and case work by a psychiatric social worker.

Comment on all of these patients' alterations in behavior is not included here. However, data on all the patients may be compared and contrasted by referral to Table III on pages 74 through78.

TABLE III - COMPARISON OF THE PATIENTS' BEHAVIOR AT HOME, IN HOSPITAL AND ON PLACEMENTS

Patient	Age	Diagnosis	Behavior at Home	Behavior in Hospital	Treatment	Behavior on First Placement	Behavior on Final Placement
A	17	Behavior Disorder	Hostile Withdrawn Exhibitionistic	Good: some tendency for home patterns to continue	Psychotherapy Occupational Therapy Mild Discipline Ground Privileges	Tendency for home patterns to continue, - more mild	Good
B	17	Somatic Neurosis	Free-floating anxiety; vomiting when angry, afraid; poor relationships	Good: slow with relationships; much ambivalence	Psychotherapy	Good: relationships still working out slowly	
C	17	Psychoneurosis with Schizoid Features	Promiscuous Antagonistic toward parents Self-castigating	Good: cooperative	Psychotherapy	Poor: suicidal, demanding emotional support	Good
D	18	Anxiety State with Panic	Hostile Refused to go to school Refused to take responsibilities	Panic at first; later, anxious but good on the whole	Psychotherapy by doctor; friendship laissez faire by worker	Poor: refused to take responsibilities	

TABLE III (Continued)

Patient	Age	Diagnosis	Behavior at Home	Behavior in Hospital	Treatment	Behavior on First Placement	Behavior on Final Placement
E	18	Mixed Psycho-neuorsis	Fainting Intense hostility toward mother; dependence on sister who withdrew support	Fainting Immature, impulsive Co-operative with doctor; less so with worker	Psychotherapy	Good: some tendency to repeat former home behavior; much improved	
F	19	Behavior Disorder CNS Syphilis[a]	Stubborn Fighting Feeding Problem	Tantrums at first; later, very good adjustment	Psychotherapy Medication for physical ailments	Poor	Good (5th placement)
G	19	Psycho-neurosis	Hostile Headaches Crying spells, irresponsibility	Aloof; uncooperative; dramatic; "doesn't care"	Psychotherapy attempted; most information given by aunt	Poor: used old patterns; upset by sexual aggression of one uncle	
H	20	Anxiety State Mental deficiency Possible Epilepsy	Violent aggression against mother; jealous of brother; upset at family quarrels	Co-operative	Psychotherapy from doctor; case work from social worker	Good: uncertain on relationships	

a) Syphilis of the central nervous system.

TABLE III (Continued)

Patient	Age	Diagnosis	Behavior at Home	Behavior in Hospital	Treatment	Behavior on First Placement	Behavior on Final Placement
I	22	Psycho-neurosis (Lobotomy)	Functioning much below level; fearful of men; distrustful of women	Anxious, lonely, depressed, feared insanity. Some improvement	Psychotherapy with doctor; relationship with social worker; lobotomy	Poor: confused, withdrawn, hysterical	Fair, after lobotomy
J	25	Psycho-neurosis	Vomiting No warm relationships	Co-operative	Psychotherapy with doctor; relationship with worker	Poor: upset, vomiting	
K	28	Schizo-phrenia	Very shy; Extremely bad home situation; paranoid trends	Co-operative responsive, easy relationship established	E.C.T.(a Psychotherapy with doctor; case work with worker	Poor at first; improving later	Poor: committed
L	28	Situation-al neurosis	Compulsively clean; poor relationships with parents, mother especially	Co-operative (in clinic, not hospitalized)	Psychotherapy with doctor; case work done with father	Good	

a) Electric shock therapy.

TABLE III (Continued)

Patient	Age	Diagnosis	Behavior at Home	Behavior in Hospital	Treatment	Behavior on First Placement	Behavior on Final Placement
M	31	Schizophrenia with depression	Withdrawn; home situation upset; relationships poor. Lived with grandmother; lost grip at her death	Worried; upset; did not want to talk; less and less interest	E.C.T. Coma Insulin Psychotherapy from doctor; Positive relationship with worker	Fair: steady worker but compulsive; withdrawn	
N	32	Chronic Anxiety (Lobotomy)	Anorexia nervosa; relations with parents poor; waited on constantly	Poor: home patterns continued	Adrenalin desensitization; Psychotherapy; Case work done with mother; Lobotomy	Fair: irritable, feeding situation improved	Poor: regression
O	33	Psychoneurosis	Anxious, emaciated, sexual interests restricted; ambivalent toward father	Good: friendly, cooperative, but rigid and anxious	Psychotherapy	Poor: Unhappy reality situation	Good
P	34	Psychoneurosis (Lobotomy)	Hostile toward very ambivalent family; suicidal	Poor: anxious, depressed, liked hospital but disliked treatments	Psychotherapy; Case work; (Lobotomy)	Poor: made own placement but led vegetative existence	

TABLE III (Continued)

Patient	Age	Diagnosis	Behavior at Home	Behavior in Hospital	Treatment	Behavior on First Placement	Behavior on Final Placement
Q	34	Psycho-neurosis with Epilepsy	Hostile toward very rejecting family; frequent seizures	Co-operative	Psychotherapy with doctor; Case work with worker; Medication for physical ailments	Poor: unhappy reality situation	Good
R	39	Severe Anxiety Neurosis (Lobotomy)	Severely anxious, quarrelsome, suicidal threats, feeling of unreality	Gradually more interested in future, loss of anxiety and emotional affect	Psychotherapy with doctor; Case work with worker; Adrenalin desensitization Lobotomy	Good: sociable, able to do routine work	
S	44	Paranoid State with Epilepsy	Feeding problem, interfering, paranoid tendencies; seizures	Good	Psychotherapy; Medication for seizures; Acceptance by social worker	Poor: tendency to repeat home patterns	Good

It seems that it can be scarcely stressed too much that there is a great difference between ability to adjust in a protective environment in an acceptable manner and ability to alter behavior patterns sufficiently that so-called "normal" people living near the mentally or emotionally afflicted will not notice differences in behavior.

The patient comes in to the hospital setting with certain aberrations in behavior. When she has progressed to such a point that discharge is indicated she is still not "cured". In almost all of the cases studied here, we see a great tendency to repeat in the placement many of their behavior patterns that were noticeable, and objectionable, at home.

Most of these behavior patterns are in the process of changing under treatment. Hopefully, sick behavior will not increase unless given additional stimulus by neurotic elements in the new environment.

The reasons why this behavior continues into the placement or reappears when it has not been particularly noticeable in the hospital setting are numerous and depend to a great extent on the dynamics of the individual patients. Because the continuation or reappearance of this behavior seems so general we may consider some reasons why this should be true.

To some extent any home environment reactivates some of the feelings the patient had about his own home environment. Also, no matter how protective the new environment may be, it is less so than the hospital setting. Since all of these

patients studied need a protective environment and yet since the placement is relatively less protective than what they have grown accustomed to, they are very apt to feel their new responsibilities are heavy. Reacting emotionally, they will naturally be apt to use again patterns that they have used before. Even though these patterns are in the process of change we do not usually see steady progress in change but rather an up-and-down, back-and-forth type of reaction where old patterns are reverted to between the trial and error and re-trial of new modes of behavior.

Patients' behavior in the placement is influenced, directly and indirectly, by many factors which would not classify under treatment. However, some of these factors, if used scientifically, may become part of treatment. We refer specifically to such considerations as the choice of the placement according to the patient's needs, the influence of family attitudes on the patient's adjustment, the effect of finances upon placement, and the feelings of the patients about placements in general, or in particular.

The placements that are used, how they are used, and the reactions the patients make to them are considered more fully in the following chapter.

Other considerations of large importance in the study of changes in behavior include the patients' behavior in settings outside the new home, their reactions to community attitudes and their long-time need for a helping person to give

them an impetus and an example. These factors each require a good deal of discussion and are treated in the order named in Chapters V, VI, and VII.

The placement itself, and the factors involved therein, logically precedes this discussion and therefore follows this chapter immediately.

CHAPTER IV

THE PLACEMENT ITSELF

The psychiatric social worker who does placement has a manifold task. One of her most essential tools is a workable knowledge of the community facilities for placement. She must be aware of the advantages of the various types of protective environments so that she may know the best possible selection of environments for the individual patient. She must also be aware of the weaknesses of each setting so that she may foresee, at least to some extent, in which areas her assistance with the patient's adjustment may be most indicated.

In addition, the worker must do a good deal of work around the placement of each patient. She must do the home-finding or she must more or less actively supervise the patient in home finding, and she must see what financial arrangements for placement need to be made. She must either partially interpret the patient's needs to the foster mother or the residence director, or, decide that the patient's needs should not be interpreted by the worker but left to the patient to interpret. In some cases it seems best that no interpretation be given either by the hospital staff or by the patients. The worker must prepare the patient's relatives for the patient's placement and try to ascertain the amount of financial and emotional support they can give. Most important, she must give considerable time to preparing the patient for placement and to working through the feelings that the patient has about placement which might hinder adjustment.

When possible, it is desirable for the patient to make her own placement. The patient who is well enough to leave the hospital should, generally speaking, be well enough to find her own home. However, it is implicit in the type of cases chosen for this study that many would not be able to make their own placement.

We would, of course, understand that those who use protective environments do not always need them. For example, a patient placing herself might well choose a club or residence. However, those who require protective environments, without exception, also need the active help of an interested person. This usually means the skilled help of a psychiatric social worker. Active help does not imply that the worker necessarily makes the placement for the patient. She may work with the patient as they make the placement together or she may help the patient clarify what she, the patient, wants and to what extent she may reasonably expect these wants to materialize.

These aspects of placement, as touched upon above, are considered more fully in this chapter under six main headings: A. The Compilation of Knowledge of Community Facilities for Placement; B. The Choice of Placements for the Patients Studied; C. The Effect of Finances Upon Placement; D. Contacts with the Patients' Families; E. The Timing of the Placement; and F. Feelings of Patients About Placements. This discussion follows immediately.

A. Compilation of Knowledge of Community Facilities for Placement

It is of immeasurable help if the worker has a list of foster homes and residential clubs which she knows a great deal about. As we shall now see, an enormous amount of work goes into the compilation of a good list.

The worker must have interpreted to the directors of the residence and to the prospective foster mothers the types of illnesses and the degrees of illness they may find in the prospective residents, the roles that the doctor and the psychiatric social worker take, the house rules that the patients in residence must be expected to abide by and those which they may hopefully have modified, the amount of supervision from the house director (usually very small) that they may need when placed, and the particular types of difficulty which the director should report to the hospital. This information, needless to say, should be given only to the degree to which the house mother or foster mother seems to be able to absorb it and use it for the patients' good. Some directors can accept comparatively little; others can be helped to make the new home situation much easier for the patients. The amount any director should be told about a particular patient will vary with that patient's needs.

Most housemothers need to be "sold" on psychiatry or at least on the use of their residences for placement. Part of this "selling" is done through interpretation, and part,

through the very careful placement of the first patient or patients in these new homes. This is not to imply that all placements should not be made very carefully. However, the first few placements in a residence which has not been used professionally may make or break that placement for future use. As the director feels that she has helped to do a nice piece of work with a patient or as she has seen improvement in the patient which has been effected by others she may become more willing to accept the more difficult patients. All discharged patients are, or should be, more or less ready for placement. Therefore, even the most trying should be less trying than some of the residents of the "normal" group whom the director accepts without knowing of their behavior difficulties until after they have lived in the club for some time.

The great advantage that the house mother has, or is entitled to have, with patients who have been hospitalized, is that supervision of the patient will be carried by the hospital staff and that considerable responsibility will be on the psychiatrist's shoulders.

Members of the hospital staff, for their part, have the right to be assured of certain physical advantages in the placement for any patients they place there. Hopefully, the patient should have a cheerful private room, good, balanced meals <u>in</u> the residence, laundry facilities, a place to entertain, and when at all possible, recreational facilities within the residence.

The worker should also be aware of the age group accepted; the average age of the residents, which may be quite different from the average age of those acceptable; the type of resident accepted, as to education and employment; and the extent to which these residents' characters are investigated prior to admission.

In further consideration of placement settings, we discuss to some extent the advantages and disadvantages of the various types of placements used for the patients included in this study.

1. Disadvantages Found in Residences

One of the placement worker's chief considerations in choosing a home for a patient is to find a placement whose standard meets as closely as possible the standard of living set by the patient or by her family, or the standard of living to which the patient can reasonably be expected to adjust.

Most girls' residences maintain a standard which would be, on the whole, acceptable to most girls and women. In this study the writer has found only one case (A) where the patient had difficulty in her placement because of a standard which was too high for her.

In one Montreal residence which is used occasionally the standard is not high enough. The difficulties here are that the neighborhood is very poor and actually unsafe at night; the girls accepted are of an underprivileged group; the rules which forbid smoking and set very early hours for being

in, for example, are very strict, and the residents must do co-operative housework to pay for their lodging. Although girls of an underprivileged group may be able to get along here fairly comfortably, most, if not all, patients would find the atmosphere uncongenial.

One type of residence that is being used in Chicago has the disadvantage from the points of view of both hospital and patient of catering chiefly to girls who have been delinquent. It may be comparatively easy for a patient who is placed there to feel that she, too, is considered delinquent. Or, she may find the residents' degree of sophistication far beyond her. She may find these other residents require, and get, more attention from the housemother than she gets. This may make her feel rejected. She may find these girls more difficult to socialize with or she may be actively discouraged from socializing with them. At a point in the patient's life when her need to socialize is particularly great, this is not a good situation.

Some residences in Chicago and in Montreal are run by religious denominations. If the worker can help the institution directors understand that the patients placed there can generally take little or no religious direction, these residences may be profitably used, all else being equal. Persons in charge of religious institutions, however, may tend to lack understanding of the psychiatric patient. Although they will usually accept her, they may also accept all ages and classes of residents and expect them to get on well with each

other. This can be quite difficult for the girl or woman just out of hospital. These institutions often have few single rooms, which is a further disadvantage.

Patients seem to be able to adjust to numerous things which might ordinarily be disadvantages for them if they have single rooms. Most institutions which do not have many single rooms use particular care in choosing room-mates and will make room changes if one or both occupants are dissatisfied. The psychiatric patient, however, may not always be able to express satisfactorily her need for a change and may either "suffer silently" or be considered unadjustable and be asked to move. If she can be given a single room near others who also have single rooms her chances for adjustment are accelerated. If, however, a single room will isolate her from the other residents, the worker may do better to help her try to adjust to one room-mate. Dormitory life, that is, occupancy in rooms where there are more than two beds seems contra-indicated.

2. Disadvantages of a Convalescent Home

Placement in a convalescent hospital seems to have only negative aspects. It repeats the hospital experience but on a less satisfactory level. The patient's illness is brought constantly to her mind since she continues to be treated as a patient and since she sees others treated as patients. She no longer has the recreational facilities that were offered her by the mental and nervous hospital and she

has no satisfactory substitute. Her socializations are with ill people and around illness or very sedentary pursuits.

3. Disadvantages of Private Homes (Rooming Houses)

There seem to be more disadvantages here when the hospital makes the placement than when the patient is able to make her own arrangements. Psychiatric social workers find that homes that are accepting at all prefer to treat patients as invalids. Another attitude commonly found is that any old room will do for a mental patient. Landladies expect the patient not only to be "grateful" but to adjust well in her bleak surroundings. These landladies may pry into the patient's private affairs. They seem to feel that the patient must be very, very different from "normal" people and that it is their right as landladies and part of their pay from the "grateful patient" to be told just how different.

If the patient finds the accommodation herself, she may be helped to meet these situations much as she may be helped to meet other negative community attitudes. If the worker has made the placement, the problem is more complicated. Questions that the patient might be able to turn off lightly may then be referred to the worker and require not only interpretation but perhaps a fairly lengthy working through of the landlady's feelings in this area.

Even the best room in a rooming house, however, has the very large disadvantage of cutting the patient off from the socializations and recreation she should have, since

socialization and recreation opportunities are not provided.

Rooming houses are certainly not protective environments except in the sense that they do keep the patient from her family. We can expect, and demand, much more from placements than this.

4. Advantages and Disadvantages of the Placement of Domestic Workers In a Hospital Setting

Placement as a domestic worker in the hospital has seemed to work out quite well for those of our sample group for whom this placement was attempted. It has meant that they did not need to have the trauma of a separation from the hospital; they remained close to the treatment center which was physically convenient and emotionally satisfying; they had a job and lived in an atmosphere of more than usual acceptance of the ill and in a hospital whose standards may be far above what is expected generally from the protective environments of the community.

However, the disadvantages may be considerable. Firstly this type of placement is only open to domestics and to a limited number of them. The person who can advance must, be her advance, leave the hospital setting entirely. Separation for this patient is only postponed and may need to be worked through at a time when the patient is no longer under treatment. If the job in the hospital becomes unsatisfactory for any of these persons, leaving the job will also mean leaving the place of residence and hence the separation can be doubly

difficult. Finally, we must realize that recreation, which is of great importance, is not planned for these people. The persons so placed may need a good deal of help in becoming interested in outside recreational activities and general socialization. They continue to need help. Help may be given with the view to enable many of these patients to take places in the community eventually and thus, to leave their positions open to other patients who are considered for discharge.

5. Advantages and Disadvantages of the Foster Home

For those patients who need foster homes the advantages are that they are provided with new parents who are interested in them, a home they can call their own, and inclusion in family life to an extent they could not find elsewhere.

Some of the disadvantages are as follows. The patient must learn to adjust to new parents and will assuredly bring to this home many of the neurotic patterns she used toward her own parents and in her own home. This alone may make the placement quite difficult. The foster parents usually expect some emotional satisfactions from the person placed there. When the patient is first placed, she may seem to be able to give these, but, in the process of her adjustment, she may go through a period, and perhaps a quite lengthy period, in which she gives nothing but trouble. If the case is being well supervised, the worker may be able to help the family and patient adjust to each other or, early in the placement, see that a new placement is indicated. Also, the worker may see that the new relation-

ship does not become such as to keep the patient from growing up emotionally.

Until the last few years, foster homes for mental or nervous patients have been used very little in the United States and Canada. Recently several mental hospitals have begun to see where they might be used. Their use seems to be confined chiefly to the very young patient (in her early teens) who cannot go home or to those older patients who have deteriorated somewhat and for whom we cannot hope for recovery to the point of their being on their own.

6. Advantages in Women's Clubs and Residences

Almost all women's clubs and residences have advantages for the girl or woman who has been a patient. The well-appointed residence has countless advantages. It can offer her a cheery private room with some service so that she has no housekeeping worries, wholesome meals well served, and entertaining facilities both indoors and out for her own private use and for group recreation. She will, hopefully, be in a residence where the other residents are friendly and where friendly relations are improved by plans for social activities made by a social committee comprised of certain residents and certain staff members. She will have the security and protection of house rules that are adequate and well observed but which are not inflexible to the needs of the individual. If the other residents tend to divide themselves into small

groups, she will be introduced chiefly to members of groups where it seems she would have the best opportunity to make her first adjustments. Hopefully, she will have a staff member to whom she can go with little everyday problems and who, she knows, is keeping in close touch with the hospital psychiatric social worker. The psychiatric social worker must take over the bulk of the supervision for a time, at least. The patient must be well supervised. If she is allowed to break numerous rules other residents feel that she is "getting away with too much" and it hurts the morale of the whole house. Or if, because of the lack of a helping person, she can not bring herself to seek the advantages she needs, her adjustment and her mental health may suffer seriously.

7. The Optimal Placement As the Writer Sees It

Many persons who cannot go home can learn to adjust well in a club. However, the clubs in the community can, or will, take such a limited number. Therefore, it would seem advantageous if the mental and nervous hospitals in the community could sponser a club for the use of their own discharged patients for a set, although flexible, period.

This club could bear a name which, in the eyes of the community would not connect it with a hospital. Each resident, while making her initial re-adjustments to community life, would be receiving the amount of supervision and therapy indicated for her particular problem. This would be a "half-way house" between the hospital and the community. With the use

of this type of placement, the patient's first weeks after discharge should be made less complicated.

B. The Choice of Placements for the Patients Studied

Although the choice of the placement depends to a considerable extent on the types of placements available in the community, certain age groups and certain diagnoses seem to do better in particular types of environments than do other age groups and other diagnoses. In this section we consider briefly the types of placements which were used for each of the age groups in which our patients classify.

1. Placements Used for the Teen-Age Group

Six of the seven patients in this study who were between the ages of 17 and 20 were put into some type of group living. However, for one of the six, the placement was a convalescent home which actually provided another hospital setting rather than experience in group living. From there, this patient went to a rooming house. However, as she was a waitress in an officers' mess where she was in contact with large groups of people most of the day, her job provided a type of group environment for her.

There are many advantages in placing teen-agers in girls' clubs, whether or not they have had previous experiences in group living. They take restrictions imposed on the group and by the group much better than they take restrictions imposed by a parent person. They generally want to conform to

a group and will make an easier adjustment because of this. They are apt to have group recreation almost forced on them since many houses have their own recreational facilities. In houses that do not have their own recreation programs there are always numbers of girls who are interested in various forms of play. Therefore, the girl who is trying to make an adjustment will find many opportunities and many playmates. If she cannot get along with one group she can easily switch to another group. If she loses interest in one activity, there are usually numerous other activities available.

Most residences are not maintained for the teen-ager but take the residents of this age group as their youngest members. They are the"babies" of the residence. Aberrations from acceptable behavior may be condoned and even accepted by older members quite easily as they often consider the teen-agers are "just kids". While these patients' behavior may not be normal, it may not be noticeably abnormal. All adolescent behavior is in flux, so aberrations from the "usual" adolescent behavior may not be highlighted.

The one teen-age girl of the seven studied here who was not placed in an institution might have done better in such a place than in a private home. In any event, she did not adjust well in the home of her aunt where she was placed.

The first institution placement, however, is not necessarily a success. One girl had three institutional placements before optimal adjustment was manifested. This girl, who was placed when she was 13, was obviously too young for

acceptance in a girls' club at that age. She was placed unsuccessfully in two foster homes. Later there followed three institution placements. Her adjustments in the first two were moderately successful. Her adjustment in the third, considered generally, was very successful.

2. Placements Used for Patients in Their Twenties and Thirties

In this study there were ten patients in their twenties and early thirties. Two of them stayed at the Y.W.C.A.; five spent extended periods in convalescent homes; seven spent some or all of their readjustment period working and living in a hospital; two stayed in private homes with fair to poor adjustments; and one lived with a relative. This last patient's adjustment swung between fair to extremely poor adjustment. As we can see by the above figures, numerous types of placements were tried by this group.

Patients in their twenties and thirties are acceptable in residences and can often make an inconspicuous adjustment there. However, they are not as inconspicuous generally as the teen-agers for people expect their behavior to be better adjusted at these ages.

Although they are acceptable in residences, these patients do not always want group living. Those patients who can accept institutions seem to progress considerably better than those who take rooms in rooming houses. Although hospital employment and residence seems to have been satisfactory

for those who accepted it, this type of work is obviously limited to those who by training or inclination fit into domestic employment.

3. Placements Used for the Older Group

The two older patients in this study (one 39 and one 44) were placed in foster homes. Both of these people needed care as well as protective environments. More care is available in foster homes than in institutions. Neither of these patients needed the type of socialization provided by residences. Their foster home adjustment was very good, on the whole.

C. The Effect of Finances Upon Placements

The financial problem is extremely serious not only for the psychiatrist and the psychiatric social worker who are trying to make an optimal placement for the patient but also for the patient who must consider the financial situation.

In the Province of Quebec a person who is without funds may be given assistance from the Quebec Public Charities Act (Q.P.C.A.). This may be used to meet expenses temporarily in a "home away from home". However, if the patient needs a room outside the hospital at night but is to remain on the Day Ward in the hospital during the days, the Q.P.C.A. fund can go only to the hospital and cannot be used to pay the patient's room rent.

In both Illinois and Quebec the patient would have to

ask for funds from a social agency and arrangements would usually need to be made whereby this agency would agree that the psychiatric worker in the hospital could continue to carry the case.

In one of the cases studied (J) the patient was not eligible for assistance because of non-residence in the community. She did not feel able to go to work. This patient, therefore, decided to return to the unhealthy home situation which had featured largely in her illness. Some patients can work upon discharge and meet their own expenses. When this is possible, it seems to be very advisable not only from the financial point of view but also from the advantages it may bring to the patient's mental health.

A patient who cannot work is not considered to be without funds if her parents may possibly be expected to provide for her. Here we come up against a whole realm of new problems.

From the legal and social points of view, the adolescents who are minors may certainly expect to get help from their parents. Emotionally, however, thay may have considerable difficulty taking parental help even in the form of money with no "strings attached", or else they may unconsciously use money to resist treatment.

As seen in Chapter II, the parents of the patient who needs placement may often be the least able to give to their emotionally or mentally ill daughter. When the family's fin-

ances are adequate the parents may sometimes use money to ease their guilt over their rejection of the patient, to bind the patient to them, or to show outsiders what good parents they are. This situation can vastly increase the difficulty of the task of retraining the patient and of weaning her from the neurotic parental ties. Some of the case situations which illustrate these points are brought out in the next section under "Contacts with the Patients' Families".

Those patients who are not adolescents may, nevertheless, still be in need of financial assistance from their families. Some of these people have been ill over a period of years. They have been unable to earn or have spent their earnings on medical or psychiatric care. Not all patients studied here can work immediately upon discharge. For these patients a financial backlog from some source is a great necessity. If the family can give to them, and if the patients can accept this help, the placement situation is made simpler from the financial point of view at least. If patients can feel, not parental rejection, but parental willingness to help in this financial assistance, their placements can be much easier for them to accept. (Further indications of parents' attitudes toward money came out in the contacts made with the families. Therefore, they are treated in this manner later in this chapter [Part D, Section 2]).

Of the seven teen-agers in this study, only one (C) was able to start work immediately upon discharge and to pay her own way. Two (A and E) were helped by family funds at

first; later they found employment. Three (F,D, and B) received agency assistance. One of these three (F) received agency assistance over a considerable period before she was able to work; another (D) had agency assistance supplementing family money and did not take employment at all; a third (B) would have been able to work but as it was more to her benefit to continue high school, she did this with agency support.

Those in their twenties (five patients) were all employed by the time their placements were made. One of these (H) also received a small amount of assistance from her family. She made a successful placement with good employment adjustment. Three other patients were entirely on their own. One of these girls (I) made only a fair adjustment to her placement and to the employment that financed it. Another (J) had a recurrence of neurotic symptoms and gave up the placement. The third (K) had a recurrence of psychotic symptoms and was committed. The fifth patient in this group (L) was a young woman who simply needed a job in a protective environment away from her dominating mother. This patient made a good adjustment to domestic employment in the hospital. She did not require financial backing but she benefited from having the emotional support of her father and her doctor as well as from the indirect help given by a psychiatric social worker.

All three of these patients who were "on their own" entirely had suffered from emotional starvation over a period of years. The added strains of maintaining themselves on a new job and in a new home were, apparently, more than they

could adjust to at this point. As we see others with similar diagnoses make better adjustments we wonder if these patients' abilities to make happier adjustments might have been increased by a more extensive use of an after-care program.

The remaining seven patients, who range in age from 31 to 44, managed as follows. Three were employed upon discharge. One of these (M) returned to a job in the hospital from which she had had extended leave. Another (Q) entered upon new employment in the hospital setting. The third (R) had no immediate financial need and was also given considerable emotional support. She took a factory job where she seems to have made a good adjustment. A fourth patient (O) received some help from her family over a period and then found a job in a hospital where she seems to have done well.

One patient (S) who was deteriorating could not work and did not need to work. Two other patients (N and P) who did not work had families who gave to them complainingly, - one of these in such small amounts that private agency assistance was also necessary. One of these patients (N) took the family money defiantly; the other more dependently. Both patients seemed to prefer to use their illnesses to force their families' support rather than to accept treatment and to learn to adjust to the community at large.

However, we must consider money matters not only from the viewpoint of the patient and her family but also from the viewpoint of the staff of placement settings.

Very few placements will accept any resident who can not guarantee her ability to meet her living expenses in the institution. The Y.W.C.A. will sometimes take a girl without funds temporarily, as will both the Salvation Army and the Sisters of Service Residence in Montreal. Few institutions, if any, have the means to care for a girl on a permanent or fairly permanent basis, even if this were advisable from a casework point of view. Many girls are also refused by placements because the staff of the institution have little interest in, or negative feelings toward, the mentally or emotionally ill. Therefore, placement of these patients in residences is often quite difficult even without a question of money arising. If the money question can be settled in some way outside of the residence, those residence directors who have little or no healthy orientation toward this type of patient may not need to be informed of the patient's mental or emotional disability.

However, there are many more elements than money that enter into placement. We shall discuss some of these in the following sections of this chapter.

D. Contacts With The Patients' Families

Contacts with the patient's family often begin prior to the patient's being seen or admitted to the hospital. Some member of the family may be the informant in the social history and may continue to be seen at intervals throughout the patient's hospitalization. In several of the cases studied, this type of

contact was maintained. When plans for the patient's placement were being considered the relative again featured largely and was also often seen after the patient's discharge while the patient was being given after-care services.

1. The Effect of the Family Attitude on the Patient's Ability to Adjust

Among the nineteen cases studied all but four (I,J,K, and P) had other members of their families seen sometime during their contact with the hospital. Two of these four (I and K) had had long periods of institutionalization and were without any interested family members. The other two (J and P) had ephemeral attachments toward their families and had never had strong love relationships. Of these four, none was able to make a good adjustment in her placement.

Of the fifteen remaining patients, only three (E,L and S) had a relative with a good, positive interest in her adjustment. These three patients all made good adjustments to placements, although one required a third placement before she found an environment that was acceptable and accepting.

Of the remaining twelve cases, three (F,M, and R) had relatives whose attitudes classify as largely indifferent. Two of these patients (F and R) made a good adjustment; the third (M), a fair adjustment. For the remaining ten, the prevailing attitude of relatives seemed to be predominantly one of rejection. In spite of these relatives' negative attitudes, or perhaps in these attitudes, the patients felt

degrees of interest sufficient to enable them to adjust well to placement. Six of these nine patients made good adjustments.

The family's attitude toward the patient is one factor; their attitude toward the placement is quite another. Their attitude toward placement is particularly important in the patient's acceptance of placement and in her wish to get well.

Many families consider it a threat and even an insult that elements in their home can aggravate the patient's illness, - or even simply impede recovery. If a family actively hinders placement, however, they do, on the whole, less damage than the family that is indifferent. The family who actively hinders a patient seems often by this hindrance to spur that patient on to defy them by getting better. The family that is indifferent can make the patient feel unloved and unimportant. This may make the patient feel that there is not much use in the struggle.

In only two cases did the family take an interfering attitude. In one of these cases (H) the family eventually agreed to the placement but sent a minister to their daughter to admonish her. They showed their distrust of the hospital staff's placement by their efforts to see whether their daughter had become sexually involved while away from home.

In the other case (A) the father interfered for a time by giving the patient additional money. This case is considered further in the section immediately following.

2. Case Situations Where Finances Were Stressed in Family Contacts

One 17 year old (A) who had suffered marked rejection by the mother and who had been encouraged by the father in her hostile aggressive actions was further hindered for a while by this father's surreptitiously giving her additional money. This patient had never learned to manage money and was finding it emotionally difficult to pay her debts. Money was a large bone of contention in her home. The patient's physical gains acquired from this additional money seemed to be made at the expense of her mother who went without teeth and without other personal and household necessities. Therefore, it would appear that the more the patient got the less the mother would get and the greater would be the breach between herself and her mother.

This patient was unable to stay at a Y.W.C.A. residence because it was too expensive. Another less expensive club was found and in it the patient made a good adjustment. We usually think of a Y.W.C.A. as being particularly inexpensive, but for this patient it was financially "out of bounds". If another less expensive club had not been available this patient's placement would have been considerably complicated and might have failed.

In the case of another 17 year old (B) we find a family history of a very long dependency (about 14 years) on social agencies. The parents had a very negative attitude to-

ward the patient's hospitalization and placement, both of which the patient was able to carry through by herself. Much of the parental negative feeling was based on the fact that the patient's leaving home was a great threat to their adequacy. The reality factors here were large. They thought their relief money might be very adversely affected by their daughter's leaving home as they feared the social agency under whose care they were might feel they were "bad parents" and punish them financially. They had some basis to this fear. Their social agency wrote to the hospital suggesting that if the home situation were considered quite bad they would remove the rest of the family from the parents. This move was discouraged by the hospital. When the parents were reassured they became gradually less fearful although they were still eager for the patient to return home. The patient was able to go ahead with her plans but showed anxiety because of her parent's feelings.

The placement of another 17 year old (D) was affected by finances in the following manner. Her parents, the mother especially, had very negative feelings about the patient and readily consented to placement. Although they were hopeful about the placement, some financial stress was felt because of it. Both the mother and the step-father were working. Therefore, it would seem that a good deal of the financial stress they felt may have been from emotional rather than reality factors. However, partial assistance was given the patient from an available fund. When this was used up and the patient

had still not improved, the mother agreed that the patient should give up the placement as a failure. Home again, the mother-daughter relationship became so bad that the mother accumulated all the money she could to give the patient to go on a rattle-brained venture. She said she never wanted to see her daughter again. Here we see money being used to salve the mother's guilt over her rejection of the patient, to prove what a good mother she was, and to show how "hopeless" the patient was who could take everything the mother had and fail with it.

In the case of one 19 year old (G) successive placements were made at two maternal aunts' homes. The mother and one of the aunts showed jealousy because the patient preferred another aunt to them. They simultaneously showed hostility toward the patient by commenting that the mother could only keep the patient in a home away from home by going out to work. The mother expected to be repaid by much love and appreciation. The patient's plans for further study were hampered by the family's feeling, which was largely emotional, that they could not afford to keep her in school. She was forced into taking a business course for which she did not seem suited and in which she did not continue.

E. The Timing of the Placement

Ideally every placement would be timed very carefully by the psychiatrist and the psychiatric social worker. The separation from the hospital should be made at a point in the patient's treatment when it is evidenced that she no longer

needs the benefit of full-time care at the hospital and when she may be expected, with help, to begin to relate herself once more to community life. The patient who is discharged from the hospital to a protective environment for more or less permanent residence will generally need, and generally has, fewer emotional resources than the patient who is discharged to herself. However, all of these patients may need protection against, and help with, relatives whose demands or whose well-meaning efforts in their behalf would hinder their adjustment.

For many reasons a placement may not always be made at an optimal time. Due to hospital overcrowding or long hospital waiting lists, for example, a patient may be discharged sooner than she expects. Sometimes the reverse situation occurs. The patient expects discharge for a considerable period before it can be arranged. Often these are medical problems and hence out of the province of the psychiatric social worker. Sometimes, though, they are problems that belong particularly to the psychiatric social worker who is concerned with placement. If a suitable placement is not immediately available for the patient, a poorer substitute may have to be used or the patient may have to remain in the hospital for a considerably longer period. Either solution may prove very detrimental to the patient's adjustment.

The worker and the doctor both have responsibility in helping the patient to leave the hospital comfortably and to accept the idea of placement. Even though in short-term hos-

pitals the patient may enter with the knowledge that she will not be there long, separation from the hospital may mean rejection to her. Her feelings will depend largely on the following factors: her previous experiences inside and outside of the hospital, her diagnosis and prognosis, her progress in treatment, and her use of relationships.

Hopefully, the worker will allow as much time as is indicated in the treatment of the individual patient to work through feelings of leaving one setting and going to another and to formulate some plans for placement. If plans for an advantageous placement are well toward consummation by the time the patient is emotionally prepared to accept placement, we have an optimal situation.

When a placement must be made suddenly the worker does not have time to prepare the patient nor does she have time to do good home-finding. No matter how good her knowledge of community facilities, nor how adequate her list of usable homes, the psychiatric social worker cannot place any patient in any home. She must consider which home may best meet this patient's needs. When a placement is made without this consideration or without adequate preparation of the patient, there may be unfortunate results. Anything can happen from fairly minor disturbances to the permanent loss of the use of a placement and to considerable regression of the patient.

The patient is upset by a sudden discharge and also by a sudden placement. The patient who expects discharge and placement and who is retained long after she expects to leave

will also be upset unless she can be helped to accept emotionally the reasons for the delay.

Difficulties encountered in the timing of the placement can be seen in several of the cases studied. Two teenagers (B and E) had expected discharge to a girls' club for a considerable period before this could be arranged. Both of these girls were upset over this situation. Another teenager (C) had to have temporary care at a convalescent hospital. She thought placement was premature and that she should still be at A.M.I. She ran away from her placement and tried to commit suicide. Later she adjusted better, although she would not eat at the convalescent hospital and insisted that she be fed at A.M.I. or at home. This patient, and the two just mentioned, seemed to make good adjustments later. All were given considerable help throughout their initial adjustments by psychiatric social workers. The patients' relationships with their workers helped them leave the hospital and go to their new homes.

Three patients in their thirties (M,Q, and P) had difficulties in this area. One (M) expecting a much shorter hospitalization, feared she would lose her job and home as well by the delay. (This patient worked in the Nurses Home.) The other two patients felt their discharge was very premature. This is a large emotional problem whether or not it is based on reality. One of these women (Q) was suicidal; the other (P) was complaining. This latter patient was not receiving complete discharge but rather was being changed from being a

full-time patient to being in the hospital during the day time only (Day Ward).

Another, older patient (S) was much upset by a sudden emergency transfer to the Day Ward. The only facility available for her at that time was to return to her sister's apartment in the evenings. She showed anxiety over the transfer by considerable acting out during the evenings. As she became adjusted to the change, her behavior at night modified.

Whether the discharge is too sudden or too delayed or whether the patient only feels that it is, the worker has definite problems to work through. Of these, the sudden move seems the most fraught with pitfalls.

Sometimes the patient makes her own discharge in a sudden manner. While this can be a difficult situation, it may often be less difficult than when the hospital staff makes the move. In the case where the patient creates the emergency herself, this action may be treated as part of her problem and she can be helped by the constant accepting attitude of the staff.

When the patient is returning to her own home (as these patients, of course, are not) she may be helped to return emotionally to her family. When the patient is otherwise discharged, the worker may hopefully continue in the case considerably beyond discharge. Therefore, the worker may use her skills to interpret to the patient that her discharge separates her from the hospital but not from treatment, from full-time care but not from interest and help. Where the con-

tact need not be broken on discharge, the patient can be helped over the separation more gradually. Simultaneously she can be helped to begin to help herself in the community.

F. Feelings of Patients About Placements

One of the most important factors for the worker to consider is the feelings the patient has about placements in general. These will color to a great extent the patient's emotional acceptance of a placement or placements where the worker hopes she will adjust.

In this study we often find patients have an impossibly perfect idea of what the new home should be. It seems that part of this unrealistic ideal is part of the patient's denial of her illness; it is a feeling that if she could get away from her unhealthy home situation she would also get away from the effects that it has had on her personality. She seems to feel that in a placement she would somehow miraculously shake off identifications which she has made with family figures. In hoping to shake off the negative (which is, of course, impossible) she apparently fantasies that only the happy elements will remain and that they will be intensified and meet all her needs. The love she has never had enough of will surely be waiting for her. Her illness and sick ways of acting will be no more, or, if they are evidenced, they will be sympathized with, not just condoned. She hopes for an environment which will have the favorable qualities of her hospital ward plus the favorable qualities of her "ideal

home". These desires seem to be verbalized chiefly by the rather naive and perfectionistic patient. Some patients of adolescent age may give the worker the impression that they are looking forward to placement with the mixed dread and longing of the young girl about to go to boarding school.

Rosy ideas of placement may come out when the worker-patient relationship has been good, the hospital treatment favorable, and when the worker has been able to assure the patient that the worker and doctor will continue to offer support and therapy for a considerable length of time after the patient's separation from the hospital.

Some of the unrealistic, perfectionistic ideas will be verbalized and may be worked through, partially, at least. Other ideas will not be verbalized, or perhaps will not come at all into the conscious thinking of the patient but will be evidenced later in her reaction to the reality situations of her placement.

With older patients who have had many institutionalizations we may find no reluctance to leave the hospital but also no positive feelings about any placements. Rather we may see an apathy or a dejection, - an inability to believe that any person or any place can be good enough to help them. They may show an inability to believe that they themselves are able to adjust or worthy of adjusting.

The following sections show fairly specifically some of the patients' feelings about placement. For uniformity and to facilitate comparison, the patients are presented according

to age group.

1. Feelings About Placement Among Patients in the Teen-Age Group

One 17 year old (A) wanted very much to be independent. She saw in her placement a chance to achieve this independence. Her residence placement was of considerably higher standard than her home. Although she had some difficulty meeting usual standards of cleanliness, she over-compensated in other ways by arranging for expensive dentistry and better clothing than she perhaps needed. With a childish naivete and a rather over-developed sense of the dramatic, this patient told her history to a group composed of all the other residents. (The patient had been exhibitionistic in other areas.) Emancipated in many ways, she showed some need to cling to her parents by asking for extra money during her early days of placement.

This placement had been made very carefully. The attitude toward the patient in the residence was accepting on the whole, although the housemother was inclined to be over-active and too directive. The hospital psychiatric social worker was able to give constructive case work help to the patient throughout her early days of adjustment to her placement.

Another 17 year old (B) held out for some time for a certain placement which, to her, seemed the only place where she would be able to get along well. Its positive features were that it was a "nice place near school", it was near the

hospital where she had felt secure and protected, and it had already well accepted another patient who was this patient's friend. This patient's dread of leaving the hospital and her fear that people in the community would not accept her were expressed in many ways, directly and indirectly. Her feeling that only one placement would meet her needs, and this a placement which proved to be impossible to get, seemed not so much a neurotic expression of her desire to stay on in the hospital as it seemed an adolescent approach to her problem. As she began to find, through her efforts to make her own placement that other residences also had positive features and that she could well handle the negative elements, she was willing and able to leave the hospital and to make a good adjustment in her new home.

A third 17 year old (C) who was going to have to work shortly after her discharge and who had had a long history of great deprivation gave considerable evidence that her hopes were for a foster family where she would be the loved child. She told the worker that she would like another mother and father and fun, saying that she was "only 17 you know".

This patient had had to deny her family's rejection of her by actual statement and by virtually forcing her mother to prepare her meals while she was in a convalescent hospital. Their rejection of her was apparently much easier to bear when she could feel that she was the dissatisfied person who was looking for loving relatives.

The worker's efforts to place her at two residences failed. The patient found a room and a job for herself where she was accepted well and where she apparently made a good adjustment. However, moving from the hospital meant rejection to her as did transfer on the job from one division to another. For optimal results it would appear that this girl would require a long-time positive relationship with a worker. This continued acceptance of her would meet some of her love needs and so, gradually, dispel her fear of, and expectance of, rejection.

Another teen-ager (D) wept at leaving the hospital but was very animated about her placement. The good physical set-up of the residence and the whole-hearted acceptance shown by the staff and the girls in residence were very pleasing to this patient. She was aided in her move by the knowledge that she would continue to see both the worker and the doctor.

Auspicious as this beginning was, the placement was a failure. This patient was not helped to learn to consider her being away from home as anything but a vacation.

One 19 year old (F) had placements from the time she was 13. Her needs made her ready for placement, but she was always prepared emotionally for these placements by the careful work of the psychiatric social worker. Her first foster h ome was a failure through her own inability to adjust. She was not apprised of this as her treatment was not far enough along to have enabled her to do better. However, transfer was

arranged. One subsequent placement at a foster home and two at girls' residences failed but as unfavorable reality factors figured largely in these failures we can scarcely judge the patient's degree of adjustment here. Her fifth placement also had some negative factors but this time the patient was far enough along in her treatment to be able to handle these with the help of the worker. Her readiness for placement seemed to be always shown by her girlish eagerness to go to a new "home" and to find all the positive factors there.

Another 18 year old (E) wanted very much to be independent. She simultaneously questioned her own ability to know what to do. Her psychosomatic symptoms increased sharply with the prospect of discharge. They were evidenced again when there was any need for her to assume responsibility. The support of her sister and of the psychiatric social worker were used and were very much needed during this period. Once she almost went home. However, she held out and did, all in all, quite well. She had considered her hospital period the happiest two months of her life. Although she had not attended occupational therapy while in the hospital, she kept a hospital connection by attending occupational therapy after her discharge.

One 19 year old (G) who could not continue to live at home went to the homes of two aunts. Neither place offered an optimal environment for her. Her use of the first, in particular, was quite neurotic. This placement increased

rather than decreased her difficulties. Full recognition of her feelings about placement was not attained. The social worker was not requested to do placement here. Neither the patient nor the homes she went to were emotionally prepared for the placement.

2. Feelings About Placements Among Patients in the Older Group

With the older group of two (R and S) we see some resistance toward hospital discharge and placement. This showed up in the patients' initial complaints about the idea of a foster home or about the distances these homes were from their own homes or from the hospital. However, in each of these cases the patient sooner or later adjusted well.

3. Feelings About Placements Among Patients in Their Twenties or Thirties

The group of ten patients in their twenties and early thirties had neither the joyful expectancy seen in some of the adolescents nor the comparatively easy adjustment of the older patients in this study.

Here we seem to see generally greater uncertainty in the move from hospital to placement. This was intensified for those who had no relatives behind them. One patient (I) who was without people stated that she wanted a home more than any thing. At the orphanage where she had been brought up she had been told that a father and mother were everything.

Lacking these, and with an all-or-nothing attitude, she refused placement help from the worker. She made several placements for herself but was unhappy in them and responded with depression, silence, and confusion. She had a day dream to return some day to the orphanage (her only home) as a dressmaker. Her best adjustments have seemed to be in domestic work where she was assured a "home" with her job.

Another patient (K) who had never had a home and who was restless and fearful over placements, also seemed to prefer domestic work because she, in this way, was assured a "home" as well as a job.

The degree to which this group of young women were eager for homes showed up in various ways. Perhaps the clearest examples of their feelings that homes were the epitome of all good things (and, as such, out of their reach) showed up in their statements. One patient (Q) said, "I am lonesome for my own." Although she was glad to go to the placement made for her, there were many undesirable features and she made a very poor adjustment. She returned to the hospital, but this time as a domestic employee. Here her adjustment seemed good. The hospital setting was the nearest thing to a home she had ever known. Her being "lonesome for her own" seemed to be simply an expression of a long desire for someone or some place that would meet some of her love needs.

Another patient (P) feared discharge. She was reluctant to accept the psychiatric social worker's service because they were directed toward home-finding. The worker, un-

fortunately, was not called into the case until discharge had to be arranged. Therefore, the patient connected the worker in her mind with hospital "rejection". The depth and hopelessness of this patient's feeling about placement may be shown to some extent by her statement, "The doctor cannot make a substitute family for me."

With only the most tenuous of home ties, we find these patients bringing up considerable feeling about home around the time of discharge or later when the going gets rough in the new home. One girl (J) returned to her own home when she found adjustment too difficult. Another patient (M) had more emotional ties with her job and room in the hospital than with her own home. She returned to her job considerably ahead of schedule. In this case the return interfered with her hospital treatment rather than with placement, as the placement, in this case, would have been back to the same job.

Two other patients (O and N) resisted placement actively. One (O) rejected the psychiatric social and the help she could offer. She insisted that her sister would help her find a place to live. When help from her sister was no longer possible, this patient accepted the worker's help with placement but in a very passive way. Later, she was dissatisfied with the placement, which did have numerous disadvantages. She used her feelings about the placement as a focal point around which to ventilate her feelings about discharge.

The other patient (N) who resisted placement went to

her aunt's home where her recovery did not go forward. Although she needed to leave home, she could not bear the separation. We would say that she was not emotionally ready for placement. Her parents were also not ready for her placement. They took her home rather than try to help her adjust in a new environment.

One patient in this age group (L) had a positive feeling toward placement but was not self-starting. The work of the psychiatrist and the psychiatric social worker helped to procure the emotional support of her father. The psychiatric social worker then found hospital employment and living quarters for her.

As can be seen by these illustrations, there is much variance in the feelings of the patients about placement. These feelings need to be ascertained and worked through so that the patient may become better able to adjust to placement and to situations outside the placement.

Chapter V is given to the discussion of the patients' behavior outside the new environment. This can give us a broader view of the patients' abilities to adjust. By the behavior manifested outside the new protective environment we can see to what degree the patients may achieve a "normal" life adjustment. We also see in what areas they need the help of the psychiatric social worker if their behavior is to continue to show progressive emotional maturity.

CHAPTER V

BEHAVIOR OUTSIDE THE NEW HOME SITUATION

The work of the psychiatric social worker is not finished when a patient has been placed satisfactorily in a protective environment. As a general rule the worker is very much interested in gauging the patient's adjustment in the new environment. By this means, she may test her own work in making the placement and see, further, the abilities the patient has to adjust in this setting.

However, she is interested in much more than the patient's ability to adjust in a residence. The great majority of the persons studied in this paper may not need protective environments permanently. When help is given, they can be expected to learn to adjust with almost constant improvement in their employment, in recreation, and in general social contacts. When these latter adjustments have become fairly smooth the patients will, in all probability, no longer need a protective environment.

However, the first requisite for the patient is comparatively good adjustment in the new home setting. During the time she is making this one good adjustment, she is gaining assurance and is learning ways of behavior that she may use in making adjustments elsewhere. As she progresses, the amount of energy she originally had to put into her new home adjustment is no longer needed in the home. It can be freed to use on adjustments outside the new home situation.

When the patient was placed in the protective environment, she had, hopefully, some of her adjustments in this setting made easier for her by the conveniences, protection, security, and friendly spirit of the new home. Even under such conditions, some of the adjustments made were, for a considerable period, only fair. Additional help was required from the doctor and the social worker.

The patient's responses to factors outside the new home are made under less protection. Hopefully, the patient continues to receive help. We see in this phase of our study that good adjustments in the new homes are not necessarily indications that good adjustments in other situations will follow. We find that many patients who seem to need help are left to work through their adjustments to friends, employment, and school without supervision and support from the psychiatric social worker. This lack of supervision may be partially due to the pressure of many other demands for the services of the hospital staff. Possibly, it is also partially due to the lack of studies on what happens after discharge from the hospital. Because of this there may be some lack of preparation on the part of the hospital staff to meet these needs.

It seems that most discharged patients have difficulties in socialization because of: 1) their unresolved conflicts, 2) the community's lack of acceptance of those with mental or nervous illnesses, and 3) the patients' lack of education or re-education in how to work well, play well, and get along well with others.

Continued psychotherapy can meet some of these needs. Further community education can help to meet other situations. Continued active supervision directed toward giving concrete help in socialization can meet other needs. Given these helps the discharged patient has a better chance of being, not a candidate for re-admission to the hospital, but rather, a good example of what psychiatry can do.

During her first adjustments the patient needs a good deal of support from a member of the hospital staff. A very much interested friend or relative can also provide stabilizing influence. In order for the friend or relative to be able to give the most constructive help, it is of great value if this person can talk with the doctor or social worker. Such interviews may help interested persons understand why the patient may have difficulties in adjusting and what they may be able to do to help her.

As brought out earlier in this study, relatives of all but four of the patients studied were seen in private interviews. In this way the home situation could be better evaluated and the amount of co-operation to be expected from the relatives could be ascertained. If the relatives will work along with the hospital and with the patient after discharge, they can help to give the patient some of the security she needs in her new adjustments.

When the worker-patient relationship has been good, the worker is able to continue to help the patient through

any vicissitudes that may, and will, arise. Also, and this is even more important, the patient who has been able to establish one warm relationship, i.e., her relationship with the worker, is better able to form other good relationships. In fact, in this study we see that indications of later socialization can be found in the relationship the patient has been able to establish with the worker during hospitalization. The evidence to hand in this study suggests there is positive correlation between the patient-worker relationship and the patient-community relationship. Part of this may be explained, of course, by the fact that the patient who is able or becomes able during treatment to relate well to one person can be helped to move from that relationship into other satisfying relationships. However, the writer believes that an almost equally important factor is that a good worker-patient relationship established <u>while the patient is in the hospital</u> can do a great deal toward helping that patient constructively use that worker's help, or supervision, during the first few, often trying, months after discharge. In cases where the worker gave supervision of high quality and where the patient could accept this supervision well, we still see good results in socialization. This was true even when the rapport seemed only fair.

The following tables have been inserted so that the reader may quickly and easily see case comparisons. Table IV is used to illustrate our statement that an apparently good

adjustment at a placement does not necessarily mean that good adjustments elsewhere will follow. Table V attempts to show the correlation between the worker-patient relationship and the patient-community relationship. For the purposes of these tables we consider the "community" to comprise the patient's employment, school, and recreational contacts.

The evaluations of the adjustments were made by the writer in the course of the analysis of these cases. In Tables IV and V a "good" adjustment in the placement may mean that there were no serious adverse criticisms either by the patient or by the residence staff. It may also mean that the placement was very well received by both staff and patient. In either case, we refer, of course, to the adjustment at the final placement.

"Fair" adjustment means that the patient had considerable occurrance of sick responses during her adjustment, or attempted adjustment at the final placement.

"Poor" adjustment means that the sick responses were frequent enough or severe enough to cause failure of the last placement made.

"Good" rapport with the worker or doctor means that the patient was able to form a warm, workable relationship with these members of the hospital staff.

"Fair" rapport refers to a working relationship that is much less warm or one that vacillates.

"Poor" rapport describes a noticeable difficulty in the worker-patient relationship.

The qualifying statements of "good", "fair", and "poor" when applied to the supervision designate not only the quantity and quality of supervision offered by the worker after the patient's discharge. They also denote the degree to which the patient seemed to be able to use this supervision. As the supervision is considerably affected by the rapport and as it also affects the rapport, both are placed under the column entitled "Relationship with Worker".

The writer believes the descriptive phrases used under the other columns are, on the whole, self-explanatory.

Table IV, which illustrates the patients' adjustments at the final placements as compared with their other socializations, logically precedes Table V, which compares the patients' socializations with their relationships with the worker and supervision by her. The worker's relationship with, and supervision of, the patient must begin during the hospitalization and therefore, in point of time, must precede the placement. However, the writer wants to emphasize here that the relationship and supervision must continue <u>after</u> the placement is made if the patient's socialization is to improve. The columns on socialization in both tables refer to the patients' adjustments in these areas after hospital discharge, and therefore, after placement.

Comparison of the findings in the two tables shows that in twelve cases (A,C,E,G,H,J,M,O,P,Q,R, and S) the adjustments in other socializations seem to depend both on the adjustments

TABLE IV - ADJUSTMENT AT PLACEMENT COMPARED TO OTHER SOCIALIZATION

Patient	Age	Diagnosis	Adjustment at Final Placement	Adjustment in Employment or School	Other Social Adjustments
A	17	Behavior problem; Situational Reaction	Good	Instability - more adolescent than neurotic	At first, exhibitionistic; later, good
B	17	Somatic Neurosis	Good	Excellent (in girls' school)	Fair (Immature with boys)
C	17	Psychoneurosis with Schizoid Features	Good	Very good on job	Not known
D	18	Anxiety State with Panic	Poor	Very poor; would neither work nor go to school	Fairly good but rather immature
E	18	Mixed Psychoneurosis	Good	Over-dramatic but quite stable; planning for future	Uncertain how to mix. Still at the hospital occupational therapy classes
F	19	Primary Behavior Disorder; CNS Syphilis	Good	Some instability, more adolescent than neurotic, - with large reality factors	Quite steady improvement
G	19	Psychoneurosis	Poor	Neurotically unstable but with large reality factors	Quite good with boys; poor with others

TABLE IV (Continued)

Patient	Age	Diagnosis	Adjustment at Final Placement	Adjustment in Employment or School	Other Social Adjustments
H	20	Anxiety State Mental Deficiency; Possible Epilepsy	Good	Good, although affected by mental deficiency	Very good considering intellect
I	22	Psychoneurosis (Lobotomy)	Fair	Poor; vacillating	Fair in protective environments
J	25	Psychoneurosis	Poor	Fair for very short period; then very poor	Poor; socialization undeveloped
K	28	Schizophrenia	Poor	Quite good, but very fearful	Good, at first; later, no money so no recreation
L	28	Situational Neurosis	Good	Very good	Not known
M	31	Schizophrenia with depression	Fair	Quite good but withdrawn and depressed occasionally	None; very withdrawn
N	32	Chronic Anxiety (Lobotomy)	Poor	Very poor; neurotically unable to work	Very poor

TABLE IV (Continued)

Patient	Age	Diagnosis	Adjustment at Final Placement	Adjustment in Employment or School	Other Social Adjustments
O	33	Psychoneurosis	Good	Very poor at first; unable to work; later, good adjustment	Unknown
P	34	Psychoneurosis (Lobotomy)	Poor	Very poor; wanted to be taken care of	None
Q	34	Psychoneurosis with Epilepsy	Good	Good in protective environment	Good in protective environment
R	39	Severe Anxiety (Lobotomy)	Good	Good in protective environment	Good in protective environment
S	44	Paranoid State with Epilepsy	Good	Not physically able to work	Good, considering condition

TABLE V - COMPARISON OF SOCIALIZATIONS WITH RELATIONSHIP WITH THE WORKER

Patient	Age	Diagnosis	Relationship with Worker	Adjustment in Employment or School	Other Social Adjustments
A	17	Behavior problem; Situational Reaction	Good rapport Good supervision	Instability - more adolescent than neurotic	At first, exhibitionistic; later, good
B	17	Somatic Neurosis	Fair rapport with worker; Better rapport with doctor; Fair supervision	Excellent (in girls' school)	Fair (Immature with boys)
C	17	Psychoneurosis with Schizoid Features	Good rapport with worker; Placement not supervised	Very good on job	Not known
D	18	Anxiety State with Panic	Fair rapport Very poor supervision	Very poor; would neither work nor go to school	Fairly good but rather immature
E	18	Mixed Psychoneurosis	Fair rapport Good supervision	Over-dramatic but quite stable; planning for future	Uncertain how to mix. Still at the hospital occupational therapy classes

TABLE V (Continued)

Patient	Age	Diagnosis	Relationship with Worker	Adjustment in Employment or School	Other Social Adjustments
F	19	Primary Behavior Disorder CNS Syphilis	Excellent rapport with worker; excellent supervision	Some instability - more adolescent than neurotic, with large reality factors	Constant improvement
G	19	Psychoneurosis	No contact with worker by patient; poor rapport with doctor; no supervision	Neurotically unstable but with large reality factors	Good with boys Very poor with others
H	20	Anxiety State Mental Deficiency; Possible Epilepsy	Good rapport Good supervision	Good, although affected by mental deficiency	Very good, considering intelligence
I	22	Psychoneurosis (Lobotomy)	Fair to poor rapport; fair supervision	Poor and vacillating	Fair in protective environments
J	25	Psychoneurosis	Fair rapport Fair supervision	Fair for very short period; then very poor	Poor; socialization undeveloped
K	28	Schizophrenia	Very good rapport; fair supervision	Quite good, but fearful	Good at first; later, no money so no recreation
L	28	Situational Neurosis	No contact with worker; no supervision	Very good	Not known

TABLE V (Continued)

Patient	Age	Diagnosis	Relationship with Worker	Adjustment in Employment or School	Other Social Adjustments
M	31	Schizophrenia with Depression	Fair rapport Little supervision	Quite good, but withdrawn and depressed occasionally	None; very withdrawn
N	32	Chronic Anxiety (Lobotomy)	Fair rapport Little supervision	Very poor; unable to work	Very poor
O	33	Psychoneurosis	Poor rapport Little supervision	Very poor at first: unable to work. Later, good adjustment	Little progress
P	34	Psychoneurosis (Lobotomy)	Poor rapport Little supervision	Very poor: wanted to be taken care of	None
Q	34	Psychoneurosis with Epilepsy	Good rapport Good supervision	Good in protective environment	Good in protective environment
R	39	Severe Anxiety Neurosis (Lobotomy)	Good rapport Good Supervision	Good in protective environment	Good in protective environment
S	44	Paranoid State with Epilepsy	Good rapport Good supervision	Good in protective environment	Good in protective environment

at placements and also on the patient-worker relationship. In five additional cases (B,D,F,I, and K) the socializations had closer relationship to the degree of rapport and supervision established by the worker than on the patient's adjustment to the placement. In only one case (N) did the socialization adjustment appear to have closer relationship to the adjustment at the placement than to the relationship with the worker. In one rather exceptional case (L) the employment adjustment was apparently good but other adjustments were unknown. In this case the patient had no direct relationship with the worker as the worker was not asked to see the patient.

The case material at hand appears to show that in only two cases (N and L) did contact with the worker seem not to influence the later socialization. In the twelve cases where the adjustment to placement, the relationship with the worker, and the outside socializations all seem to take similar ratings, further study seems to show that there is no doubt of the influence of the worker's help on both the adjustment to placement and also on the socialization.

A review of the employment histories of this group of patients shows that, prior to hospitalization, only one patient had a recent favorable employment history, and in this instance, it was the employer who noticed strange off-the-job behavior. After hospitalization, nine of the nineteen were able to hold jobs satisfactorily. A tenth went to school. One other patient was physically unable to work. The eight

remaining patients seemed to need further help in the employment area. Five of these patients seemed to have more than usual difficulty in finding and adjusting to employment. Two patients would not work and one patient changed jobs often.

The consideration of the socialization difficulties of these patients showed that, prior to hospitalization, all of the patients had marked need for help in this area. Among the adolescent group there was only one patient who seemed to get along well with her contemporaries and with most adults. This patient, however, was very negativistic toward parent persons. Among the others in this age group there was a wide variety of difficulties and much vacillating behavior.

One girl, age 17, (B) was inclined to be withdrawn. She was also exhibitionistic and had tantrums. She showed considerable ambivalence toward men and had only one close girl friend. She would not continue in school and would not or could not keep any job longer than a few weeks.

This girl was helped through psychotherapy given by the psychiatrist and by the psychiatric social worker. A careful placement was made in a girls' club. When this proved unsatisfactory, a change was made in residences. By means of continued interest and help, the patient was aided to remain in one job, save money, plan for night school, buy better clothes, and socialize on a higher level. Some instability remained, but this was felt to be more adolescent than neurotic.

The patients in their twenties showed a good deal of withdrawn behavior prior to their hospitalization. One of these patients (H) was a mental defective whose parents did not want her to have social contacts. When parental restrictions in this area were removed by the patient's placement, her socialization seemed to progress quite satisfactorily. The other four patients in this group seemed to need a great deal of help in their relationships. One of the four (K), a girl with a diagnosis of schizophrenia, had lost interest in everything and felt she had to get away from people. She had a very marked emotional rigidity. However, the worker was able to establish an easy relationship with her. A job was found for this patient in another section of the hospital. Arrangements were made for her to join a group at the Y.W.C.A. She made a good adjustment for a while, although she was constantly fearful that people would find out that she had been mentally ill. For a time she kept herself constantly in debt to buy little luxuries for herself. When she was encouraged to save, she put money aside but then neglected her recreational needs. This girl, one of the few in this study who would never be able to do without a protective environment, found even this much responsibility too difficult. She became worse and had to be committed to a provincial mental hospital.

Of the seven cases remaining, six were in their thirties and one was in her middle forties. All had had quite poor degrees of socialization. Most of them actually had no friends and enjoyed no recreational activities. Four of these

seven were given little, if any, supervision directed toward helping them establish social contacts. There may be many reasons for this. For example, none of these women established a very warm relationship with her worker. Furthermore, three of this group felt that they could not work after hospital discharge. Therefore, most of them might feel that they were definitely handicapped financially from making social contacts. Since they did not have fellow employees with whom they could associate, they would be further limited. From the worker's viewpoint, we find that the pressure of work does not always allow time for this type of follow-up care.

The three patients (Q,R, and S) in this age group who had considerable after-care supervision were persons who were somewhat handicapped physically as well as psychologically. Two had diagnoses that were complicated by epilepsy and one was a post-lobotomy case. All three formed good relationships with their workers and were helped to form relationships outside the hospital setting, although still almost wholly within protective environments. As these three patients will probably always need protective environments, their present adjustments seem optimal for them.

There is no intention to imply that either the relatives or the hospital staff should necessarily take full responsibility for helping a patient achieve adequate socialization. There are other professional people with whom the psychiatric social worker can work and who can offer the patient a great deal of help. This is particularly true in

the area of recreational activities.

Almost all, if not all of the patients in this study were given occupational therapy while they were in the hospital. While we have no question about its value per se we know that the patient who participates in occupational therapy classes does not necessarily socialize during these periods. However, because of interests that are aroused in this activity during hospitalization, the worker may help the patient become interested in doing something similar after discharge.

This could bring about a referral to such institutions as settlement houses or the Y.W.C.A. and Y.M.C.A. recreational departments. (Four of the patients studied were referred to the Y.W.C.A. for recreation. Others might have been referred but were not interested.) In these institutions, recreational activities are provided particularly to help people enjoy play and to help them enjoy meeting other people. The activities are led by trained group workers. The psychiatrist and/or the psychiatric social worker can facilitate the patient's adjustment immeasurably by explaining something about the patient's illness to the group worker and by suggesting what might be some of the goals in socialization that the patient might be able to meet.

The recreational worker's need for this information is well expressed by Davis and Dunton.[1] They write as follows:

---

[1]Davis, John Eisele and William Rush Dunton. Principles and Practice of Recreational Therapy for the Mentally Ill. New York, 1936, p. 81.

> Many failures result from attempts to coerce the patient into activity first and establish a sustaining and motivating interest afterwards. The interest field should be utilized as the content for the first stage of the reconstruction approach. Interest should be sought in a study of the whole personality.

They also state: "Activity per se is not the desirable objective. Activity must subserve the greater principle of social growth by leading to further social activity." [1]

This book concerns the work of the recreational therapists. They can be of immeasurable help to the discharged patient. Recreational therapists, however, are not found in most communities. In communities where they are working, they may not be available for general professional use. However, we do have group workers in all large centers. Many of them could do work similar to that described by these writers.

It seems very important that the psychiatric social worker, through such professional contacts, help the patient make full use of whatever recreational facilities the community may offer. Many patients seem to know neither how to play nor how to work. We find that many a patient has not only a host of unrealistic ideas and perfectionistic ideals but he often has an "intolerable feeling of loss of self-respect, due to his failure to meet his own personal standards". [2]

In order to learn to measure their standards and themselves against reality, patients need to feel that they are

---

[1] Ibid. p. XV.

[2] Hoskins, R.G. "Dementia Praecox, A Simplified Formulation", Journal of the American Medical Association, April,1931.

well accepted. They must accumulate a backlog of happy experiences so that they may know that trials do not necessarily mean that errors will follow, but that success can also come. As the patient herself, or with the worker's help, finds success, she must be helped to see why she was successful so that she may begin to abstract new principles by which to measure achievement.

The patient, like all other human beings, has basic needs for recognition, affection, and security. Learning skills that she can use to meet recreational or economic needs will help increase her self-esteem and build her interests.

In addition, her degree of health will be judged by how she acts. Dr. E. Bleuler[1] expresses this idea quite well. Although he is writing of psychotic conditions what he says can, it seems, be applied to the neuroses, as well. He writes: "Nowhere is the question 'sick or not sick' put so often in such an inexorable manner and with such weighty consequences as in the judgment of mental conditions . . . . so far as the concept of insanity has become at all practicable, it rests not upon medical or psychological criteria but on the idea of social incapacity." (Italics are the writer's.)

In the next chapter we treat more fully the community attitudes which the above quotation has touched upon. We try to show what causes some of the adverse community criticism and what may be done to improve this situation.

---

[1]Bleuler, E. Textbook of Psychiatry. The MacMillan Co., 1924, p. 71.

CHAPTER VI

COMMUNITY ATTITUDES

The attitude of the general public toward those with mental or nervous illnesses is still very far from one of acceptance. It is true that we have come a long way from the day when the "queer" relative was banished to an attic room and spoken of in hushed tones by her jailor family. The educated public no longer thinks that the mentally ill should be forcibly restrained and only kept alove by inferior, limited food and unlimited sedation. As a people, we believe in mental and nervous hospitals for these patients, but too often our attitudes suggest that we believe they should stay there.

Although psychiatrists can help a large number of patients toward normalcy, many people do not accept this fact whole-heartedly, and they show it by their negative attitudes toward the discharged patient. Sometimes these attitudes seem to be based on justifiable complaints against the behavior of the unsupervised or the prematurely discharged patient. On other occasions it seems that the attitudes exhibited are burdened by the superstition and fear that have been passed down from past generations. These may place an almost immovable stigma on the discharged patient.

In this section of our study we are interested in the community attitudes encountered during the placement or attempted placement of the sample group of patients in homes and in jobs. This chapter also attempts to show, to some ex-

tent, how the attitudes encountered have been handled. Some suggestions are given which might help improve community attitudes further.

The writer is aware that "general public" and "community" are words of large and often indefinite meaning. It seems that we must state specifically the parts of the community to which we refer if we are to consider what the community attitudes are, what effects they have, and how we may modify them.

The members of the community with whom we are most concerned are those with whom worker and patient come most into contact during placement. These are the patients' families, the staff and residents of the protective environments, and employers and employment interviewers. Among these people negative attitudes may often be dealt with directly by the psychiatric social worker. The patient, however, is usually in touch with a much larger circle of people than those mentioned, for she also has friends and acquaintances whose opinions matter to her. The patient's social worker can usually help with these only indirectly. Her greatest service in this area may be to analyze the patient's feelings about community attitudes and to plan her work with the patient accordingly.

In this study we find that most patients have some degree of negative feeling about community attitudes. This feeling may be based on what appears to be unfounded rejection by members of the community; it may be based on the patient's inexperience and naivete; or it may be primarily part of the

patient's neurotic pattern. No matter how these feelings classify, they must be worked through, at least partly, if the patient is to make adjustments in the community.

When patients' feelings about community attitudes are primarily neurotic, they may be helped through psychotherapy. Those feelings, however, that are based on reality require further efforts on the part of psychiatrists and psychiatric social workers to educate the community to be more accepting.

In the following examples we shall see some illustrations of the patients' feelings about community attitudes. For the sake of uniformity and in order to facilitate comparisons, the writer continues to present the patients by age groups.

A. Responses Toward Community Attitudes Found Among the Teen-Age Group

In our group of seven teen-agers we find two outstanding types of responses toward community attitudes: naivete and fearfulness. Two girls, one 18 years old, the other 19 years old, had very childish outlooks on life. They achieved a good deal of pleasure from dramatizing their illnesses and were uncooperative with the hospital staff who were trying to help them. Both girls manipulated their environments, doing everything possible to gain their own way. Unfortunately, neither of these girls seems to have been helped to greater maturity during her treatment.

One of these patients (G) was placed, without the help of a social worker, in the homes of two aunts, successively.

One aunt complained that the patient did not volunteer to help her. She had difficulty in realizing that she could hardly expect the patient to volunteer since the patient had never been trained to do her share in her own home. She would neither teach nor discipline the patient herself and she said would have had a rift with her husband if he had disciplined the patient. Because of this unfortunate placement and the patient's continued unco-operative behavior, we find that the family conditions became worse. One of the daughters of the patient's aunt became angry because she had to work and the patient did not. This aunt's husband became seductive toward the patient. This was disturbing for the aunt and her family. It was also very disturbing for the patient. Another result of this placement was that the patient's parents were somewhat alienated from the aunt's family when this aunt took the patient. The writer feels that if this patient could have been put in a girls' residence, when she was ready for placement, familial conflicts would have been much less apt to occur. As it happened, it seemed little was accomplished toward helping this patient to adjust or toward helping her family to evaluate their feelings toward her.

The other girl whose outlook was particularly childish, (D) was placed with considerable care by a psychiatric social worker working with the residence director of a Y.W.C.A. residence. The placement was not well supervised, however, and resulted in failure.

This patient had a domineering, narcissistic mother and a seductive step-father. She had reacted with almost complete negativism toward her parents, particularly toward the mother. She would not accept direction as she was very hostile toward parent figures and had very unrealistic ideas of the criteria the adult world would demand from her. However, neither the doctor nor the social worker set up standards for her guidance. The residence director accepted her very well, but, according to the agreement before the placement was made, she would not give supervision.

This patient broke house rules by staying out late at cocktail bars. She was suspected of stealing a sum of money from one of the other girls in the house. She told other residents that she was mentally ill. By this behavior she gained a good deal of attention for herself but she aroused alarm and suspicion. She made excuses not to go to school or to work. When pressed by the worker she refused with guilt. She was very angry when her worker and her doctor opposed her idea of joining an acrobatic troupe. She said she did not want to see either of them again. This patient went home. Then she ran away and had to be picked up by the police. She forced her mother by means of actual physical combat to give her the money to join the circus troupe (for which she was not at all prepared professionally) and left home again. Her mother hoped she had seen her for the last time.

In both of the above cases we see placements made with

no supervision directed toward helping the patient grow up. These patients apparently had little fear of community attitudes as they did not realize, and were not helped to realize, how far they veered from accepted standards. Whenever they had difficulty in making one of their neurotic adjustments they reacted in very sick ways. The former went into "trances". The latter became panicky and once pretended suicide.

Although neither of these girls were co-operative patients, the writer feels that both might have been helped to a greater extent. The former, a clinic patient, actively sought hospitalization and showed considerable evidence of looking for mother figures. The latter, although resistive to direct suggestion, gave several evidences of wanting rules to live by. At one time she stated, "You should not bother with me." On another occasion she said, "I should have been spanked."

Three teen-agers, it seems to the writer, showed a mixture of naivete and fear of community attitudes. One of these (E) resisted authority by being moody and depressed. However, she simultaneously wanted help with adjustment to adult patterns. She did not know how to make friends and had decided, until the worker discouraged this idea, that she would not make them until she "needed them". She did not want a job and succeeded in not being hired by telling employers unfavorable things about herself. Part of this behavior, however, might have been a reaction against the worker's telling

her that she must tell her prospective employer that she had fainting spells. When the patient was confronted with the idea that other people believed that she did not want a job, she found a satisfactory job within the hour. She acquired this job without mentioning her fainting spells. Although she often fainted during office hours, she found that this did not jeopardize her job.

It seems possible that because she did not know how to make friends during her early post-discharge days, she maintained an aloofness that was a protection for her against some people who might not have been understanding. It seems to the writer that the facts that this girl was very young and was quite co-operative were advantages to her. The community often seems to tolerate aberrations in behavior from the adolescent, especially when that young person is generally conforming and co-operative.

Another teen-ager (F) had the usual adolescent difficulties in adjusting to adult standards of work. For example, she would take jobs that were not at all adaptable to her needs. She would become angry if her work was corrected and would give up the job. She showed uncertainty as to what community standards were.

Part of this patient's difficulty was religious. She was half-Jewish. She felt hostile toward Jews and inferior toward Gentiles. This was a neurotically based difficulty, to be sure. However, the director of the religious home where she was placed tried to convert her. The patient found such

an attitude almost unbelievable. The skilled help of the psychiatric social worker was needed here not only to help the patient, but also to help the community, in the person of the residence director, understand that a patient may have religious difficulties without necessarily wanting conversion to another faith.

In another instance the worker helped the patient to avoid the housemother's disturbing questions by reminding the housemother that there were a number of things the patient would want to forget and that talking about them would serve to bring them to her memory.

This same patient had a number of unfortunate experiences with community attitudes toward her illness. However, during a six year period, whenever help was indicated, she received help from her social worker in meeting these attitudes.

The third girl (A) was naive in that her ideas of what she wanted in the way of employment were considerably different from her natural abilities and the amount she thought she should earn was considerably higher than what was logical for her to expect. She was fearful about the Juvenile Court workers' knowing her history as from then on, she felt, they expected her to be delinquent. However, with adolescent inconsistency, she did not feel that her record at a State institution for girls and at a psychiatric hospital would hinder her getting a job.

Although this girl was badly in need of help, she jeop-

ardized this and her adjustment at the club where she was placed by saying that her doctor tried to rape her. The doctor transferred the case immediately after explaining to the patient and to the housemother his reasons for doing this.

The doctors and the social worker had to help this patient adjust to community standards. They also had to interpret some of her behavior to the residence staff so that, by understanding her, they could accept her.

Two girls had an almost entirely fearful feeling about leaving the hospital and going into the community. One of these (C) was a 17 year old unmarried mother who felt she should leave Montreal as "everyone" knew her. She had been very much rejected by her family and she had been turned down summarily by two girls' residences. The only place she had actually been well accepted had been at the hospital where she knew she could not stay indefinitely. While we would not say that she would have to leave town, this girl had reasons based on reality situations for believing that she would be better off elsewhere. She procured a job outside the city and from last reports was adjusting well.

Another girl (B), in whom fearful feelings predominated, also had had traumatic experiences in the acceptance of her illness. Her parents, who had been on relief for a long time, had shown great fear at her entering the hospital. The worker felt that this was based on their fear that there would be repercussions from the agency that was helping them. This proved to be true. The agency wrote to the hospital asking if

this home were bad enough for the other children to be removed from the parents. The removal of the other children could have caused the patient a severe guilt reaction and would have caused the parents and the other children a great deal of difficulty. The psychiatric social worker was able to interpret immediately to the welfare agency that the home was actually unhealthy only for this patient.

At the parochial high school which the patient attended during her hospitalization, she found the teaching staff opposed to her living away from home and opposed to her being in a psychiatric hospital. She also found the director of a girls' residence felt very strongly against taking girls whom she knew had been hospitalized. The social worker who was helping the patient to locate a residence found many times that she received a negative reaction as soon as she introduced herself as one of the hospital staff.

This patient was not able to meet the objections of her parents and of the nuns at school until she had found a home outside the hospital. Through trial and error she learned how much she needed to tell of her illness and how much she need not mention.

Her chief remaining difficulty was that she felt she could not tell her schoolmates of her emotional upsets. As a result she made no real friends at school. At the hospital her socialization was quite good since she "knew" that when she was sick these friends would understand.

Here we have seen a patient whose fear of community attitudes was based largely on reality factors. Because of her illness she or her family met additional problems in their dealings with a welfare agency, a school, and a girls' residence. We note that all of these were institutions where we might ordinarily expect the greatest acceptance of emotional illnesses. As this patient's only outward manifestations of an emotional disorder were attacks of nausea, a reaction not uncommon in the general population, it appears that in this case we must blame the community for lack of understanding. This seems to differ from most of the preceding cases where there were some elements in the girls' behavior which, without interpretation, could generate community intolerance.

B. Responses Toward Community Attitudes Found Among Patients in Their Twenties

In this study we have five patients who were in their twenties. Among these we see very little naivete, except, to some extent, in one 20 year old girl who was mentally deficient. For this group the dominant reaction toward going into the community was one of considerable fear.

One patient in this age group needed social service to help her break away from her mother's domination. The worker elicited the father's emotional support and obtained a job for the patient in the hospital. By living and working in the hospital, this patient retreated from the community. Thus she did not have to face community attitudes toward her

illness. (She was a compulsive neurotic.) Also, as she was never hospitalized, she would not bear the stigma the public attaches to so many hospitalized patients. We feel that she might have had considerable difficulty in meeting adverse community attitudes at this point since she seems to have been entirely unable to cope with her mother's domination.

The three remaining patients in this group seemed to show a great deal of strain over leaving the hospital for the community. The case material at hand seems to show that these patients' difficulties were not brought on, as might be assumed, by their emotional ties to the hospital. Although all three had had good acceptance there, their fear of leaving seemed to be caused by their previous experience as sick persons in the community. They had learned that community attitudes were often far from accepting.

These patients all had financial difficulties which prevented them from making optimal adjustments. One (J) could not afford to prepare for the kind of work which seemed suitable for her. One (K) had difficulty in saving enough money to pay for the recreation that she really needed. The third (I) seemed to have artistic talents but was equipped to do only domestic work. Because of her Army service, the government paid for her education as a dressmaker. On completion of that course, she found that there were no particular openings. This patient had neither the initiative, the money, nor the emotional strength to set up business for herself.

Her specialized training, therefore, might be useful to her personally. However, as it did not help her support herself, it seemed to be another unfortunate happening. She had spent months preparing for a job that did not materialize.

This type of situation may also have its effect on community attitudes. The government office was originally very much surprised that a mentally or emotionally ill girl might be considered for further education. The fact that a patient cannot or does not make use of the training after completion can give rise to further questions in the community about the advisability of giving persons like her the instruction at all.

It seems that a patient's re-training in employment skills should help her to learn a way of earning primarily. If this will develop her particular talents, so much the better. If it will not, then the way of earning should take precedence over the talent development. The latter may be encouraged later as an avocation. For her own economic good and mental health, the patient should, primarily, learn that she can earn her daily bread in a manner not too distasteful to her.

All three of these patients also lacked friends who could help them to re-orient themselves socially and occupationally. Two of the three might have had considerable difficulty making friends because they had extreme fear over having their illnesses known.

One of these girls (K) had previously been in a provincial mental hospital with a diagnosis of schizophrenia.

She feared general knowledge of this would exclude her from social gatherings. The other patient's mother had been an alcoholic, mentally deficient prostitute and had died in a provincial mental hospital when the patient was very young. This patient had great fear of becoming insane. She thought other girls felt that she was like her mother whom she could not remember, but of whom she was very much ashamed. This patient had been an institution child in her infancy. She had suffered marked rejection in the foster homes where she spent much of her childhood. In all settings in which she found herself as an adult she was either rejected or she constantly feared rejection. When one realizes the many rejections this girl had suffered, her feeling that the community attitude was not friendly can be well understood.

As defenses against these attitudes, she considered leaving the community physically by trying to enter convents. She also tried to protect herself emotionally by mutism. She tried to be quite protective of her brother, and thus gave love by giving protection. Love and protection were apparently what she herself had most lacked and most desired.

C. Responses Toward Community Attitudes Found Among Patients in Their Thirties and Forties

In the older group of seven cases, all but one were in their thirties. The exception was in her middle forties. This patient (S) had paranoid tendencies and was an epileptic. She found fault with her first placement, but a part if not all of

her complaints was based on actual, severe rejection by her "foster mother". In her subsequent placements we see a growing ability, in view of her limitations, to get along well in the community. Her rejection by the community was intense.

There is no custodial care available in Montreal for epileptics of her type. She was rejected strongly at her first placement, and less strongly at her second. She was vehemently refused work at a convalescent home. She was not hired by the provincial mental hospital. She was alienated from her family and was not tolerated by most of her siblings. If she had not had three very much interested people working with her, i.e., her older sister, her psychiatrist, and a psychiatric social worker, and if the third placement had not proven successful, one could not possibly conceive of her getting along in the community at all. As it was, her adjustment seemed quite good.

Another patient in this age group was a lobotomy case who would have been entirely unable to get along in the community without the care and guidance of a "foster mother". Her foster mother had needs to over-protect and to over-direct, but she could give a good deal of warmth. The patient was easily influenced and had some rather unrealistic ideas. (For example, she took a cashier's job without being able to make change. She also considered taking another patient with her into her own apartment, although she lacked the sense of responsibility to rise of her own accord in the mornings.) By careful placement and by supervision she was protected from acting in ways which might elicit unfavorable community accep-

tance. Therefore, to some extent, at least, she was kept from meeting unaccepting attitudes and from having to adjust to them.

Three patients in this age group were very fearful of community attitudes. Their families had rejected them. They continued to expect that everyone else would, also. All three had had long difficulty in socialization. They had been in very protective environments before they were hospitalized. One of these (P) had spent many years in a convent as a lay teacher. Another (N) had been kept at home and, it seems, kept ill by a very neurotic mother over a period of 8 years. The third (M) had left home to work as a domestic in the hospital 9 years previously. All three wanted others to take a great deal of responsibility for them. To them the community was an unknown quantity against which they dared not measure themselves.

One of these patients (M) left treatment prematurely to return to her domestic employment. She shut herself off again from social contacts. The other two (N and P) had lobotomies. One of these patients was not re-trained. Instead she returned to her parents and to her old sick pattern. The other actively resisted re-education. She found her own room and a part-time job, but she continued to feel that she should be taken care of. She complained that her life was finished and that nobody loved her.

The two remaining patients in this group (O and Q) felt, at first, that they could adjust in the community. Both

of these patients had been ill a long time and were discharged from full-time care while they were still in the process of receiving fairly intense treatment. Both patients found considerable community rejection and they reacted in sick ways. (Patients who have been ill a long time and who are continuing to need fairly intense treatment usually do not have the available ego strengths necessary to cope with difficult situations.) One patient (O) was refused two places of residence and was not allowed to return to her former position. For a time she had to share a room with two old ladies in a convalescent home. In this situation she did not make improvement. Instead, she seemed to be overwhelmed by her reality situation. She acquired another position but, because of her experiences since discharge, she feared constantly that her new employer would find out about her hospitalization and let her go. She felt that if people knew about her hospitalization they would look for peculiarities and treat her differently.

This patient became more ill, possibly because her adjustment seemed too difficult. She was re-hospitalized. Upon her next discharge she left the city and found a position in another hospital. In this protective environment, she improved considerably.

The other patient in this classification (Q) was accepted outwardly by a women's hostel. She went gladly but found their restrictions too difficult and she reacted neurotically at once. The staff of the hostel became violently rejec-

ting and called the police. This same patient was refused at another residence and at one possible place of employment. It was entirely impossible for her to return home as she had been ejected twice by her very hostile family. She was hired by another section of the hospital where she had been treated and seems to have made a very good adjustment.

D. Consideration of Community Attitudes from the Viewpoint of the Psychiatric Social Worker

In this chapter we have seen patients who have many adjustments to make before they can get along satisfactorily in the community. Many of them have no history of good adjustment, no ideas about what the community will, or can, expect from them, no training in employment skills, and finally, no experience in getting along with others. Most of the patients who were going out into employment and community residence showed considerable fear. Some of these women had foresight based on previous experience. Others learned immediately upon discharge that people inside the hospitals and people outside may have entirely different viewpoints toward mental and emotional illnesses. A number of these patients reacted with an exacerbation of symptoms upon discharge. This difficult period was eased when considerable supervision could be given.

When we consider the patient alone, we find there are several reasons why the discharged patient should be supervised during her initial period of adjustment. These we discuss to

some extent now. (There are other reasons for supervision which are particularly for the good of the community. These are considered later in this chapter when the emphasis is on the community rather than on the patient.

In a successful psychotherapy defenses are often broken down and hostility is aroused. In these cases we do not see consistently acceptable behavior until hostility can be handled in manners that are acceptable to the patient and to his environment. In learning to handle hostility new and more acceptable defenses must be built up. These may be still in process when the patient is considered for placement outside of an institution. Therefore, since hostility is not under control and sufficient defenses are not made, the hostility is very easily turned in other directions. For example, if a patient has not been able to get along well with her mother, she may displace her hostility to the mother figure in the new household.

Similarly in the matter of defenses, we find that if the patient has become accustomed to telling her doctor and her psychiatric social worker everything, she may carry over this habit of complete confidence into her new environment. She may tell complete situations in her background to people who cannot understand or who have no need to understand. These people, not being psychiatrically trained, may not only misinterpret this information but, because of their own needs, they may use it against the patient. Many confidantes, however,

try very hard to be accepting. People in this group may fancy themselves to be lay therapists. They can do a great deal of damage within a very short period if the discharged patient has no defenses, or only poor defenses, against them. The patient who has made the mistake of confiding too fully in an authoritative person in her environment, such as the housemother or the employer, usually requires the skilled assistance of her doctor and her social worker to help her extricate herself satisfactorily.

The constant support and guidance of the psychiatrist and the psychiatric social worker are also needed to help counteract these forces in the patient's new environment which tend to foster anxiety. In meeting the attitudes of her new friends and room-mates, the housemother, her employer, and fellow employees, the patient must learn how to answer certain questions that are bound to arise. She may learn how to avoid certain others. Often she may not need to tell the new housemother or new employer about her illness. In many cases that may be the best plan. Many people do not know that they should accept these patients as normal people and yet give allowance for difficulties that arise. Since they react toward discharged patients in an abnormal way, they may easily get an abnormal response. The patient may then feel that she has regressed. The employer or the housemother may feel that here is another instance where he or she should not have accepted a patient discharged from a psychiatric institution.

Sometimes the patient's adjustment, and consequently the community attitude toward her, is adversely affected by the standard of living provided in the placement. The house rules may be too strict, the advantages too few, or the general standard too high for the patient to be able to adjust to at her stage of maturity. While these situations are comparatively rare, they do exist as illustrated in this study.

Psychiatrists and psychiatric social workers find that certain patients, such as adolescent girls, older women whose intelligence level is quite low, and post-lobotomy cases all need education or re-education in many aspects of day-to-day living. We refer here to instruction in such things as budgeting, etiquette, choice of clothing, and need for dental care. When this kind of help is indicated and not given, we may find many members of the community reacting negatively toward the persons we have put in their midst and not eager to accept persons discharged later. Thus we can see that the longer we put off doing adequate after-care, the more prejudice, justified or unjustified, we will have to break down among community members.

The community attitudes encountered in these girls' and women's adjustments have been seen to some extent as we have considered the feelings of these patients about community attitudes. However, there are several other factors in the community's attitude that have not been mentioned and those which have been seen need some further elaboration.

Although we have talked about relatives' attitudes earlier in this study, we will mention them very briefly here. Relatives are members of the community and are influenced by the feelings of the community in general toward mental or emotional illness. In all of these cases the home situations were such that the patients could not return home and maintain the gains they had made. In most instances the homes were accepting of, or even eager for the patient's placement. The mother of one patient, who was subsequently very satisfactorily placed, had feared for a time that the patient was returning home. She was quoted as having said, "Oh dear, what will we do then?" This mother seems to have expressed the helplessness to help that we see in most of the parent people in this study. She also seems to have expressed the feeling held by many residence directors who are urged to consider taking in one or more discharged patients.

When the psychiatric social worker can provide supervision of the patient plus some psychiatric interpretation for these relatives and these residence directors, she can allay some of their fears. She can also help them see ways in which they can help the patient.

Other residence directors, however, seem definitely unreceptive toward the idea of taking discharged patients. One worker called six residential clubs to try to get a room for a patient. While most of the directors of these clubs said they had long waiting lists or would consider only women much older than the patient (who was 17), all were very reluctant

to consider the patient at all. They asked for considerable explanation before they would even put her name on a waiting list. This patient, at this time, required almost immediate placement. The worker wrote, "I would just have to introduce myself to get their negative reactions."

The patient herself who was a very intelligent, fairly aggressive girl attempted to make her own placement. The writer has included part of the interview to illustrate one example of an unfortunate patient-director interview. At one club where she inquired (not one of the six where the worker had been cross-questioned) the patient found a residence director who seemed sadistically inquisitive. According to the patient, this director was dubious about the patient, telling her that she was abnormal and not like others. She wanted to know all about this patient, saying that if the patient did not tell she would get it from her one way or another. She asked the patient if she were nervous. When the patient said she was, - a little nervous, the director said she knew it from the patient's eyes. She thought the patient should return home. The patient explained her reason for not going home. The director said that one gets another story when one talks to parents and that generally neither patient nor parents are right.

The culmination of this interview was that the director thought she would need several hours to consider whether or not she could take the patient. She assured her that if she were

accepted, she could not have the late-hour privileges given to other residents. The patient told the worker that she was glad she had had this experience as she had learned from it. However, she would not consider living at this club. She was subsequently able to contact the director of another club, telling her only what was absolutely necessary and gaining acceptance.

This patient was quite an unusual 17 year old. Her experience with the first residence director could have been so traumatic for her that it might have paralyzed further efforts to make or to accept a placement.

Fortunately, not all directors have this kind of attitude. We illustrate from another case how a well-oriented residence director may react toward a discharged patient's being placed in her club.

This director is in charge of a club for about 90 girls in a residential district on Chicago's South Side. The ages of the residents range from 17 to 35 years. Most of them are employed in business or professions, but a small percentage attend school or university. The great majority of rooms are adequately furnished, single rooms. There are about three double rooms and three suites. There is adequate maid and waitress service, good laundry facilities, and pleasant entertaining rooms. The house, of course, has certain rules, but these are flexible. Recreational facilities are provided by plenty of play space inside and outside the building. Although

comparatively little social activity is planned, the club has some ceremonial traditions in which all participate. This is an international, inter-racial house. There are about six Japanese and six Negroes in residence. All residents must supply references before acceptance.

Due to careful selection by the director most of the residents are very congenial. They have been able to absorb into their midst several girls at a time who have had need for considerable psychiatric care. The director expects to know something of these discharged patients' backgrounds so that she can see to what extent each patient considered may be able to fit in among the regular residents. She also expects to know the depths of the patient's illness so that she may know when it is desirable for her to contact that patient's doctor or social worker.

The residents, in general, do not know that any girls among them have been hospitalized. The incoming girl is accepted for herself. She is introduced first to girls who are about her age and who may have similar tastes. If the patient chooses to tell people of her hospitalization, she does so at her own discretion. The residence director does not expect to supervise the patient. She will, however, give her extra consideration when indicated and will help to settle any day-to-day problem which arises.

This director was contacted in regard to the placement of one teen-ager. She brought up questions about the patient's

degree of maturity and stability, stressing the fact that little residence supervision was given. She also questioned how well this patient, a high school student, would fit in with girls her age in residence, since most of them were working. However, she invited the worker to dinner to see the residence and to discuss further whether she might be able to help in this case.

The psychiatric social worker explained the financial arrangement planned for the patient and promised supervision. The director brought out that she had previously taken others who had not adjusted because they had not been supervised and she feared being left "holding the bag" with the patient. She asked the patient's background and family history. The worked gave the director some of the pertinent information. It was agreed that the patient could plan on acceptance. Her introduction to the club was at dinner in the residence, with the hospital psychiatric worker, the residence director, and two residents of about the same age as the patient, all seated at the director's table.

The placement started off beautifully. The patient, however, did not keep house rules. She would neither work nor go to school. She did not lose her home in the club because of this behavior. Instead the director brought these facts to the hospital worker's attention as they were all destructive to the morale of the rest of the younger residents. The worker, however, continued her policy of <u>laissez faire</u>. Other factors in the patient's life caused her to leave this residence and return home.

Although the director had emphasized to the worker that this patient would be an exception and that she would not want to have the residence considered a possible resource for other patients, the writer feels that this club provides an almost perfect setting. When a patient is carefully supervised, some aberrations of behavior would go unnoticed and the patient might well be helped toward excellent social adjustments.

Some residence directors have quite explicit reasons for refusing to take a discharged patient. In most of these cases it seems that the psychiatric social worker may pave the way toward acceptance of discharged patients by, first, trying to meet the specific objections and second, by the careful placement and supervision of one patient. We enumerate, briefly, some of the objections that are made.

Some of the residence directors who had been contacted for or by members of the sample group turn down patient-applicants because the patients had lived there before hospitalization and did not adjust well. If the patient has made good improvement during her hospitalization, the objections of the residence may be easily met. On the other hand, residence directors who are having or who have had unfortunate experiences with disturbed persons may quite understandably be hesitant about accepting discharged patients. If they can be assured that a new patient will not act out objectionably and that she will be supervised adequately, some of their hesitancy may be overcome.

Some clubs will not consider a patient unless she has a job as they do not feel assured that the girl will be able to pay her own way otherwise. In two of the cases studied, the patient was told by the hospital staff that she could continue to live in the hospital for the first few weeks that she was employed. This could have helped with financial objections from a residence. In neither of the cases did the patient use this opportunity. Possibly they could realize the difficulty they might have in getting a job if they had to use the hospital address as their home address.

One solution to this problem might be a small fund in the hospital social service department to be used to "tide over" a patient until her first pay day. If a residence could be assured of payment, other problems of acceptance could be worked through on an individual case basis.

When the worker can suggest to the patient various residences where the staff's psychiatric orientation is good, it often seems advisable for the patient to make her own placement. She may tell the directors herself only what they need to know and she may rely on the hospital worker as a person with whom to take up problems of adjustment privately.

The writer has mentioned that the worker suggest to the patient that she tell residence directors only what they need to know. It seems important to remember that outward acceptance by residence directors, or by employers, does not necessarily mean true acceptance. It may mean instead that

these people, because of their personal difficulties, have defenses against further education of what this psychiatric patient needs.

Even the few instances reviewed here suggest that psychiatric social workers have a large job to do in community education so that people may accept the discharged patient and so that they may recognize illness and help to get treatment for others in the community whose aberrations from the "normal" are particularly striking.

At the Allan Memorial Institute in Montreal, relatives of patients attend group meetings conducted by psychiatrists. There psychiatric difficulties are explained to some extent. In some hospitals this group work might be taken over by a psychiatric social worker. In most of the cases studied, individual work with relatives has also been done by the psychiatric workers.

Education can be given profitably to other groups, also. The residence directors could use particular education given by a psychiatric social worker who specializes in placement. Many residence directors might be glad to have this help for future discharged patients who may come to their residence. The residence director may also need to use the psychiatric placement worker as a consultant in the adjustment of residents who have emotional difficulties and who are not under psychiatric care.

In the employment field, it would seem that the worker

who is doing community education would achieve her best results by lecturing groups of employment interviewers and by inviting employment interviewers to lecture to social work staff meetings. Inter-professional help in this area, it would appear, would be one of the best ways to achieve mutual understanding. The employment interviewers who do job placement already have good working relations with employers. They know business needs and how fast business can be expected to learn to accept the idea of hiring discharged patients. At present, in Montreal, most employment placements are made without the employer being told anything about the patient's illness. While this seems to be the best way for most patients and most employers, many of the hospital staff feel that this is making a placement under false pretenses. Certainly, it is not contributing to the general community acceptance of mental and emotional illnesses.

As it can be seen by the study of these nineteen patients, the feelings they have about community attitudes are such as to prevent them from doing community interpretation. Even if they did not have fears, realistic or neurotic, about their acceptance in the community, their emotions would be sure to enter their interpretations and they would give somewhat biased versions of psychiatry.

In helping patients through psychotherapy and through re-education and environmental manipulation, we do not teach them psychiatry. We do not, and cannot, in the process of their psychotherapy, prepare them to be community interpreters.

Therefore, we cannot expect them to do a community interpretation job. In this area, it seems to the writer that it is as much as these patients can do to take the therapist's help in meeting questions they themselves must answer and in setting up defenses against those questions they need not answer. If these patients upon discharge can begin, with help, to adjust to a few new situations and to a few friends, they are doing, it seems, as much as can be expected from them toward modifying community attitudes. Also, since many negative feelings in the community are based on real complaints against the discharged patients, our help is doubly indicated in helping them to adjust smoothly.

In the chapter following we see case situations and statements by patients which illustrate the patient's great emotional need for a helping person to see them through their early post-discharge adjustments.

CHAPTER VII

THE LONG-TIME NEED FOR A HELPING PERSON

We have seen in the preceding chapter that the psychiatric social worker must supervise the patient in the placement and must also offer psychiatric interpretation to the community so that the patient's adjustment is facilitated and the community's understanding is deepened. Responsibility for the placement and at least part of the work in adequate after-care are logically allotted to the psychiatric social worker. This does not presuppose that the psychiatrist drops his treatment of the patient upon the patient's discharge from the hospital. The doctor's treatment may stop at the point of discharge or may continue long after the patient has left the hospital. The length of the treatment given by the psychiatrist is, of course, determined by him according to the patient's needs. The psychiatric social worker attached to the hospital is in a somewhat different role. She works closely with the psychiatrist on the case. However, she also serves as a link between the hospital and the rest of the community.

Because she is on the staff of the hospital, the psychiatric social worker may be cognizant of the kinds and intensity of treatments the patient has received and of the way the patient has reacted to hospitalization. On the other hand, by her contacts with other agencies and through her own professional use of community resources, she can be well aware of facilities in the community which may be used to help the

patient after hospital discharge.

She owes it to the patient and to the community to be thoroughly aware of the patient's assets and liabilities. She cannot do this merely by reading someone else's report, by a short conference with the psychiatrist on the case, and by one or two interviews with the patient. In order for the worker to supply the help that she is equipped to give, she must have understanding of, and good rapport with, the patient concerned. She obtains some of her understanding of the case through her close work with the psychiatrist. She obtains her rapport with the patient gradually over a period of a number of interviews.

In order to help the patient after hospital discharge, it is of great importance that the social worker doing placement and after-care enter the case long before discharge is considered. It is not possible to prepare a patient emotionally for discharge within one or two interviews. The worker must enter the case and have her relationship with the patient well under way before the time comes for her to help the patient work through feelings about leaving the hospital. It may take some time to establish this relationship since these patients who have been affectionately deprived very often have difficulty in accepting the warm relationship they so badly need. If the worker does not have time to work on this relationship before discharge is discussed with the patient, she may find herself almost inextricably connected in the patient's mind with hospital "rejection". This can give her considerable

perhaps even unsurmountable, difficulty in establishing a warm, workable relationship with the patient for the after-care period.

In the study of the cases presented here, we can see many indications of the depth of the patients' need for a helping person who will see them through their adjustment period. Many patients have a particular need for a mother-figure who will be a stabilizing force and, therefore, a source of security to them.

By her training the psychiatric social worker can provide an adult object with whom the patient can identify. From this identification, the patient can learn to assume her adult responsibilities and to appreciate basic human values. The worker can meet the patient's affectional and disciplinary needs as the patient's mother should have done. However, as the worker controls her countertransference and maintains her own individuality, she does not become enmeshed in the patient's Oedipal difficulties. Although the patient may put her in a variety of roles, the worker is an "alter mater" against whom the patient may measure her unrealistic and neurotic criteria of human values. With the worker's help and by her example, the patient may see new, more acceptable ways of doing things.

Most of the patients in this study need such a helping person over a comparatively long period. This need arose because of unhealthy factors in their home situations. Those patients of our sample group who had homes at all came from

environments that had contributed to their illnesses to such an extent that placement had to be made. Other patients in this study had been virtually homeless. Because of the long-standing unsatisfactory conditions in which these patients had lived, their relationships with people were not on a satisfactory level of adjustment. Although some improvement in socialization is often made during hospitalization, we have no reason to believe further improvement in socialization can be made immediately and miraculously upon placement.

Conversely, it seems that often the patient returning to the community can be compared to a man going to Mars. She is making a complete change from an environment (the hospital) that has meant a lot to her. She now enters into an entirely new setting. She is leaving a place where her friends can understand and accept her aberrations from "normal" behavior because they, too, are ill. Now she comes into a setting where, possibly, she is the only sick person and often, also, the only psychiatrically oriented person. Often her difficulties in adjustment can be ameliorated a great deal if she has a person in the hospital to whom she can turn for emotional support.

It is very important that she feel "on her own" as much as it is possible for this patient to encompass independence. However, it is equally important that she should not actually be "on her own" in all respects. If she feels that all support has been withdrawn suddenly and that her problems

of adjustment are too great to meet without support, she may show regression and the recurrence of sick responses.

As a general rule, it seems, the patient's statements of this need do not come out unless she has an especially good relationship with the worker or an especially poor one. Under these conditions, the patient may express her need for the worker's help directly. Indirectly, she may show her need by saying how much she has depended on someone else in the environment or by saying how much she longs for a family. When the patient's relationship with the worker is neither positive nor negative enough for her to feel free to state her feelings, the affectional need shows up in case situations. Dividing the patients arbitrarily into age groups as we have done throughout this study, we find that each group of patients has made some statements which, in a few words, show the depth of their need. We have, also, a number of case situations which show us in a more detailed, but perhaps more clear way, some of the life factors which call for comparatively long-time help from the worker.

A. <u>The Teen-Agers' Needs</u>

One 17 year old patient (C) had stated that she wanted another mother and father and a chance for fun as she was "only 17, you know". She had had a long history of family rejection. She had become illegitimately pregnant before entering treatment and delivered her baby while under psychiatric care. Her affectional needs were brought out

further in her feelings about giving up this baby. At one time she stated that she could never go through another pregnancy and therefore wanted to keep this part of herself. Unable to look ahead hopefully, she said, "The baby is the only future I have." However, conversely, she thought that if the baby were placed she herself might have an opportunity to become someone's loved child. Her relationship with her mother had been very poor, but she was able to accept the worker as a good mother and wanted to give her baby to the worker.

At earlier periods, this patient had been placed in various foster homes where she had not been able to adjust. It seems this was partly because her need for love was so great that she had to deny her own family's rejection of her. Because of this, she could be hindered in accepting the people in her foster homes. We also feel that another large factor in her inability to adjust in these homes had been the lack of a good mother-figure with whom she could identify.

As partial proof of this last statement we point out her marked improvement in adjustment after entering the hospital. There she found a good mother-figure in the worker. She felt rejected, however, when her discharge became imminent and she tried to commit suicide. The worker, however, continued in the case and the patient was later able to find an out-of-town job for herself. In this her adjustment seemed to be good.

At this point the case was not continued. Therefore, we do not know the extent of social adjustment this patient

was able to make. Optimally this type of case would be continued to be carried at least throughout the patient's early attempts at socialization. This patient had strong feelings against working in the city where she felt everyone knew her. Coming back to the city at a future time may re-activate her difficulties. Also, as this patient's relationships, at the point of discharge, had not improved enough under therapy to let us make any statement about the solution of her sexual difficulties, it is possible that she may have future illegitimate pregnancies.

Another patient in this group (E) stated: "I know I will get along all right, because I have this place behind me. I can do things if I know I have somebody to back me up." This statement was borne out by the way the patient made contacts outside the hospital. She found a room in a girls' residence and was able to find employment for herself. Some degree of her dependency may be shown by the fact that she did not get the job until she was faced with the feeling that was held by the hospital staff and employment interviewers that she did not really want a job. She was slow to make general adjustments and she was resistive toward help until she was told that this help could be given for a limited time only. Therefore, it was necessary for her to work actively on her adjustments.

In this case, the social worker saw the patient three times a week and gave support and direction in a growing up experience. She also served as a mother-figure, implementing

and supplementing the psychiatrist's work. This patient particularly needed a responsible, warm woman to whom she could learn to relate. Her mother was a very neurotic woman who seemed to have neither understanding nor love for her daughter. Her older sister had virtually adopted her, but this was also a very neurotic relationship. Without being able to analyze why, the patient stated that she did not trust women. In her relationship with the worker she was able to act out her feelings toward women in general and toward her mother in particular.

One of the patients studied (F) had been helped by the social worker over a six year period. This length of time may seem very long; however, this was an unusual case calling for skilled help over a period of years. The patient came into the hospital when she was thirteen years old. Although she lived at home for several short periods after hospitalization, permanent placement away from home was definitely indicated for her. These placements had to be well supervised. The patient needed help in many areas in order to grow up emotionally. At one time the case was transferred to another treatment setting but the patient needed the security and affection she was getting from her social worker and insisted on returning. Earlier, when the patient had been discharged from the hospital and when social service contact, under some circumstances, might have ceased, the patient kept returning to the worker. She asked for considerable education and focused well on problems with which she wanted help.

This patient had never had a good mother-figure and she sought to find one in her relationship with the worker. She had had many rejections from her parents and from residences where she was placed. The continued acceptance that the social worker gave throughout the years helped to minimize the traumatic effect these rejections would have had. The worker also helped the patient set goals within her reach. Thus she was helped to accept limitations within herself and in her environment. The worker taught the patient gradually to set her own standards of behavior and helped her learn a way of earning.

When this patient became 18 years old she apparently felt that she should be old enough to solve her own problems. For a brief period she cut herself free from her mother-figure, in the person of the worker. The worker allowed her to do this without guilt. The patient was thus enabled to return easily when she had problems with which she wanted help. Her adjustments seem to have improved progressively throughout the contact. It would appear that her chances for a quite well adjusted adult life are very good.

One teen-ager (G) needed a good mother-figure very much and used a good deal of energy in searching for one. Social service was used in this case, not for direct help with the patient, but for interviews with the patient's adoptive mother and her two aunts to whom she turned successively in her search for love and care. The patient's use of her aunts,

however, was not constructive. Their acceptance of her in their homes made further family difficulties. Their inability to reach her intellectually or emotionally frustrated her and aggravated her problems.

In her search for further help, the patient, on one occasion, tried to force hospitalization. Failing this, she dropped treatment. She later appealed to the school nurse for help. It would appear that the patient might have identified with this woman previously because, during treatment, she had maintained that she wanted to be a nurse. The nurse was able to meet her needs to some extent. She contacted an agency which procured a job for the patient at a summer camp. This seemed to be a good temporary solution. The patient had enjoyed doing the work of a camp counselor previously. She needed the money and the discipline of working. She also needed a chance to be free from her family. Here is a case in which it seems that inclusion of a psychiatric social worker in therapy and in after-care could have provided the mother-figure which this patient seems to have needed so badly.

Another patient (D) who also needed a mother-figure in the person of a worker did not receive this kind of help. She was hostile toward authority, particularly when it came from women. A warm, stable relationship with a professional woman might have done much to help this girl.

Her worker made a good residence placement for her and tried to make school or employment plans as well. However, she did not meet the patient's needs for direction and support.

Through fairly violent behavior the patient tried to force direction even by punishment. Then she felt guilty. The worker did not allow her to feel guilty, nor did she change her own role with the patient to a more directive one. On one occasion the worker said that nobody liked to be told what to do as this made them feel like doing the opposite. The patient answered that she was not sure about that. Here again, she seems to have shown fairly clearly her need of and desire for direction.

The final patient in this age group (B) also needed the worker to serve as a mother-figure. Her own mother's drab and ineffectual life and the mother's wish that the patient had been a boy made the patient feel that womanhood was bleak. The patient had an unconscious, strong sexual attachment to her father who was a very dependent man. She resented her mother for not aiding her in the solution of this situation.

This patient had had a mother attachment toward the doctor until the social worker entered the picture. The use of two therapists, - a man and a woman, seemed particularly indicated for this patient because of her relationships with her parents. It seems that a doctor and a social worker working together with this type of patient can implement and supplement each other's work especially effectively.

B. <u>The Needs of Patients in Their Twenties</u>

Among the patients in this age group we find two whose

primary need for the worker was for help in interpreting their needs to their families. Both patients could fit well into an employment setting as domestics. Both would definitely need protective environments over a lengthy period.

One (H) was a 20 year old girl who was mentally deficient. Her father was very strict. Her mother was very protective and very rejecting of her. The parents were not adjusted to each other and quarrelled a great deal. The environment thus created was very upsetting to the patient. While she remained at home this patient's social contacts were very much limited. The parents apparently restricted her socialization primarily because they feared she would become sexually promiscuous. Interpretation of this patient's needs and close work with the mother on her problems with the patient were definitely indicated and were carefully given.

The other patient (L) had a very neurotic mother who used her own illness to keep the patient a virtual slave. The social worker was able to interpret the patient's needs to the father who, in turn, could give the patient support in leaving home.

Since both of these patients had poor relationships with their mothers, a good relationship with a stable mother person would do much to help them work through their feelings about women. This type of relationship was formed in the first of these two cases. The social worker in the second case was not asked to provide this type of contact. It seems that it might have been quite effective.

The other three patients who were in their twenties had need for a good deal of warmth and understanding. One of them (J) said she felt she had never had a mother as her mother was not affectionate. She had received some affection from her god-father's wife. She had tried to live with her aunt but was not wanted. This girl made considerable improvement in the hospital. Finding security and understanding, she wanted to remain even as a maid. Here is another case where it seems a patient could be helped to leave the hospital and to make a good outside adjustment by the assurance of continued acceptance in a program of after-care.

One patient (K) was able to adjust well toward others in a superficial manner. Actually, she stated that she felt "on her own" and that friends did not want to help her. Part of her motivation for this statement may have been a wish to assure herself of hospital care. If, prior to her need for hospitalization, her affectional needs had been met even partially, she would not have had so much fear of being friendless and on her own. This patient related very well with her worker. It would seem that because of her long history of emotional deprivation she would need a helping person over a lengthy period.

The last patient in this group (I) was ashamed of her own mother whom she could not remember but whom people had said was insane. This patient had been in institutions since she was two months old. She considered returning to one of these institutions to work. It had apparently been the near-

est thing to a home that she had ever known. In her contacts with her worker she brought out that she was seeking a home more than anything. She often said how lonely she was. Because of her emotional upsets, she was not able to function nearly up to her inherent mental ability. At one time, when she became desperate for a room, her neurotic symptoms increased and she was committed for a brief period.

This patient had become very much institutionalized and could probably adjust optimally only in institutions. A good residence placement, however, could not meet this patient's needs unless she were simultaneously given help by a warm, secure person. A social worker in the residence, when such is available, is not the person who can provide this relationship. If, for one or more reasons, the placement proves unsatisfactory, this relationship with a resident worker would have to terminate. The hospital psychiatric social worker who has known the patient during her hospitalization is the person whose services are very much needed in the after-care period. During this patient's treatment, her doctor was away for four months. Therefore, it seemed doubly important that her relationship with a social worker be particularly well developed.

C. The Needs of Patients in Their Thirties and Forties

This section includes seven patients who were in their thirties and one who was in her middle forties. Three of these patients needed the social worker primarily as a supportive

person to assist in making the placement and to help them in their socialization. All three would always need protective environments. One was a post-lobotomy case with limited ability to adjust. Two combined epilepsy with neurotic symptomatology. While all needed to use the worker as a helping person, none of the three needed her to assume a mother role. In none of these cases was such a relationship attempted.

The other four patients in this group, who were also the younger four and ranged in age from 31 to 34 years, all seemed to have particular need for the worker to assume a mother role. Two of the four (P and N) had suffered a great deal of rejection from their mothers. One mother could give very sparingly to her daughter. She was requested by a private agency to give her daughter financial help but did not. Later she gave the patient very small amounts. The patient felt unloved. She said that she had never had a home (i.e., love and security) and that she wanted one more than anything. She succinctly expressed her need for emotional support in her statement that after hospitalization she needed a home "before going into the world".

The other patient (N) who had experienced particularly severe rejection had a very over-protective mother whose neurotic needs seemed to be such that she could not be well unless the patient were sick. The patient made some hospital improvement but became very ill again when she had to live with relatives who did not know how to help her. She returned to her mother's home and to her very sick pattern.

This patient had resisted the plan for her to live with relatives. However, she had no choice as no other arrangement for placement was made. She was dependent upon her mother but was also very hostile toward her. It seems that her neurotic pattern could have been more easily broken up if she could have had another mother-figure in the person of a psychiatric social worker.

The two other patients (M and O) had not had such noticeable rejection from their mothers but had suffered instead from an insidious type of coldness. During and after hospitalization they gave considerable evidence of needing affectional support. One (M) was able to relate well toward her supervisor and her assistant supervisor; she related fairly well toward the social worker. She wanted all three to take the lead in all activities where she was concerned. For example, she would have liked to join the Y.W.C.A. but someone (apparently the social worker) "would have to drag me there". At times, during her hospital employment, both prior to and after her hospitalization, she refused to eat unless a staff member went to her room and brought her to the dining room. She wanted to talk with the psychiatrist but she t ried to force him to take the lead during the treatment hour. In all these ways, she seems to have tried to f orce the emotional support that she needed.

The last patient in this group (O) was emotionally tied to her family. However, her condition was extremely

aggravated at home as her father was seductive and her mother apparently was quite cold. In the hospital she could be concerned only with her own problems and anxieties. She said she longed to have friends and to go to parties. However, as she had had little experience in socialization, she found this adjustment very difficult. She rationalized her mother's failure to visit her during her hospitalization by saying her mother could not come. However, when a woman doctor for whom she had worked failed to re-employ her, she felt very much rejected and could bring out a great deal of her concern. Here again, a psychiatric social worker who could set up a patient-worker relationship with herself as a mother-figure might be able to offer this type of patient the assurance and support she seemed to need so badly.

In this chapter we have offered case material to illustrate that patients who need protective environments also have a long-time need for a helping person to give them impetus and support. When these needs are met, many of these patients may live quite well adjusted lives.

This study is closed in the next chapter by a brief summary of the findings which have been brought through the analyses of the group of sample cases.

CHAPTER VIII

SUMMARY AND FINDINGS

The use of protective environments for girls and women discharged from hospitals for the mental and nervous can be a therapeutic device. However, in order for it to fulfill this use both the patient in need of a protective environment and the community institutions which may class as protective environments must be carefully studied.

The writer has approached this problem by analyzing cases of nineteen girls and women between the ages of 17 and 45. Five cases were from the Illinois Neuropsychiatric Institute in Chicago; fourteen cases were from the Allan Memorial Institute of Psychiatry in Montreal.

The problem has been studied by considering first the reasons why the patients in our sample group would not be able to go home after their hospital discharge. In Chapter II we studied the cases from two angles: 1) the home backgrounds which made placement of these patients necessary, and 2) the possibility of success in placements for these patients, considering their ages, diagnoses, prognoses, and the ways in which they had reacted toward previous institutionalizations.

Analysis of the home backgrounds showed that some of these patients had no homes at all. Other patients had homes that were not suitable because the relatives could not provide suitable surroundings for the patient at the point of discharge. The great majority of the patients, however, came from homes that had contirbuted largely to the illnesses that had caused

the hospitalization. In none of these cases did the home situation improve noticeably during the patient's hospitalization. Therefore, it was considered unwise for these patients to return home. However, by the time the patient was hospitalized, the situation was never so simple that removal from the home alone could solve the problem. The difficult home situations had existed for such a long time that they had affected the patient's adjustment in all areas. This was an indication that these patients would need continued help after discharge if they were to learn how to get along in their new homes.

Of the nineteen patients studied, three had had no homes at all. Sixteen had had homes, but in all sixteen cases there was an element of rejection which was severe enough for the psychiatrists to feel that the patients could not return home. In several cases this rejection was disguised under an atmosphere of over-protection. In most cases there were several reasons why a patient could not return home. The most outstanding reasons are summarized here.

In fourteen cases patients were in homes where the Oedipal situations were particularly disturbing. In eight cases adolescent difficulties were considerably aggravated by parental rejection. This aroused increased hostility in the patients. They released their hostility directly in negative expressions or in acting out in various ways. Where such expression was inhibited, the patients turned their resentments inward and expressed them in psychosomatic complaints. Two of

these adolescents were in adoptive homes which were rejecting. These patients were further greatly influenced by sudden traumatic discoveries of not belonging to their "parents".

In six homes housekeeping conditions were particularly unsatisfactory. Three homes were repulsively dirty. One was excessively clean. One was maintained in a manner far above the parents' means and by dint of sacrificing more important needs. The final home in this group was a storeroom which, of course, provided very inadequate housing.

In five homes sibling rivalry was excessive. In only two of these five homes, however, was the hostility thus aroused severe enough to warrant placement on that basis alone.

In three cases homes fostered dependence to such a degree that psychosomatic symptoms were brought on and considerable hostility was expressed.

Among the four patients who had lobotomies during treatment, we found three whose homes would not or could not offer the re-training necessary to these patients. The fourth patient had never had a home.

One patient was mentally deficient. Here it seemed that much of the parental rejection was based on the patient's low intelligence.

In view of the fact that patients with epileptic conditions often meet rejection, it seemed surprising to find that among the four patients who had elipepsy plus mental or nervous difficulties, the incidence of epilepsy did not seem to cause or to influence the parental rejection. In two cases,

the families denied the epilepsy; in one case, the patient was very much rejected even though medication was given to control the seizures; in the fourth case, the patient's seizures were taken calmly. In this latter case the patient's hostility and childish demands were the prime causes of her not being accepted in her sister's home.

However, epilepsy does complicate the placement of these patients in "homes away from home". It seems that families may be able to accept seizures as they would another medical problem. With such, they may not feel the need to identify themselves. Behavior disorders, however, seem to be interpreted, consciously or unconsciously, as direct or symbolic manifestations of the patients' dissatisfactions with their parents or with their role in the home. This interpretation may stir up corresponding anxieties in the parents who may consequently find the patient intolerable.

After the reasons why these patients could not go home were considered, we examined our data for reasons why placements for our sample group might be satisfactory. It was found that seventeen of the nineteen cases had diagnoses which would classify in the neurotic group. Two cases had psychotic diagnoses. In the great majority of cases, prognoses had not been made. The relative lack of prognoses and the very small percentage of psychotic illnesses seemed very favorable signs. Patients with neuroses are easier to help toward normal adjustments than those with psychoses. The future of patients without prognoses depends to a great extent on the environ-

ments which they procure by themselves or with professional help.

The patients in the sample group were fairly young. Their arithmetic average age was 26 years. Seven of the nineteen were under twenty years of age. This seemed to be another factor in their favor. People in this age group are usually quite welcome in clubs and residences. In the process of their re-adjustments in the residence and in situations outside the residence they may be aided: their instability may be taken for normal adolescent instability and their hostilities for normal adolescent revolt. The people in the sample group (ages 17 to 45) were beyond the age where compulsory education and the use of children's institutions might enter their plans. Yet, they were not old enough for the age factor to affect training for new types of employment.

The onset of their illnesses could not be determined with any degree of precision. From our knowledge of psychopathology we would place the true onset within the first five years of life. Our patients did not receive help during that period, but some were hospitalized within a few days or weeks after their symptoms became recognized by their immediate families. The comparatively early treatment that some of the patients received was another factor that might prove favorable. However, so many other factors enter the total configuration that the early recognition of illnesses and the correspondingly early treatment cannot necessarily guarantee

successful adjustments.

The patients' reactions to previous institutionalizations was considered as these reactions can give the psychiatric social worker a key to the patients' probable ability to adjust to a placement in a club or residence. Although too much group living can be quite detrimental, particularly if it takes place during the patient's first five years, no experience in group living may mean that a patient may have difficulty in adjusting to group life.

The sample group included seven patients who had had no previous institutionalization. Of these, five could be considered for residence placement. The other two had had lobotomies. Their chief need was for a foster home where they could receive re-training.

Two patients had had some institutional contact which might influence their feelings about further group living. One was upset over the fact that she had been a foundling in a creche. The other had had a long, successful contact with a hospital as an out-patient.

A total of ten patients had had institutional experience. Three of these had spent most of their lives in institutions and would probably only be able to adjust in some form of group life. Two patients, unfortunately, had had extended institutional experience as in-patients in hospitals. This type of environment often seems to intensify the patient's feelings of dependence and her interest in her ill-

nesses. These two patients also were given lobotomies during their treatment. For the remaining five in this group of ten, group living would seem to offer many advantages.

It can be seen by the above three paragraphs that the lobotomy cases were the only ones of our sample group for whom placement in a residential club seemed contra-indicated. Foster homes seem usually to provide the protective environment best suited for these patients. One patient, who was not a lobotomy case, might have adjusted in an institution but was placed in a foster home since she had a physical ailment which required more care than most institutions would give.

In Chapter III, we compared and contrasted the behavior of the patients at home, in the treatment setting, and in the placements. The treatment used to alter the behavior was mentioned. We considered to some extent the ages and diagnoses of the patients to see how much we might realistically expect their behavior to be altered.

The study of behavior is important primarily in helping the professional worker to locate factors which brought on improvement of behavior upon hospitalization. These factors may aid the worker in her help of the patient after hospital discharge. We know that behavior is not a chance phenomenon but is an indication of how the patient feels. Behavior changes for the better are signposts toward general improvement.

One of the most beneficent elements in the hospitalization of these patients is the removal from the home and separa-

tion from the responsibilities of day-to-day living. It was not possible to weigh the factor of removal from the home at this point as in no case was treatment limited to removal from the home to the hospital. The difference removal makes can only be evaluated when it is isolated. For example, later in the treatment, the patient may be moved from an unsatisfactory environment to a comparatively satisfactory place.

The data at hand showed that the original attitude toward hospitalization had negligible effect on behavior in the hospital and on later adjustment. However, there seems to be considerable relation between ability to adjust in the hospital setting and ability to adjust in placement in a protective environment. The length of the hospitalization appeared to have no bearing on the hospital adjustment or on the attitude toward discharge. The patient who was well enough for discharge and emotionally ready for a placement did not find it difficult to leave the hospital when she could be assured that she was going to a reasonably good placement.

A brief review of the adjustments in the hospital, compared with those in the final placement is given here. The degrees of adjustment are the writer's evaluations and were determined through the analyses of the cases. They are shown in Table VI, on page 197.

As can be seen, of the 19 patients:

14 patients adjusted well in the hospital

11 of the 14 adjusted well in the <u>final</u> placement

2 of the 14 adjusted well in the hospital but not well in the placement. One of these patients seemed to be too sick to take responsibilities. In the case of the other patient the hospital required no responsibilities and gave no restrictions. The patient would not accept these in the placement.

2 patients adjusted in a fair manner in the hospital and in the placement.

3 patients adjusted in a poor manner in the hospital and in the placement.

TABLE VI - COMPARISON OF ADJUSTMENTS TO HOSPITALS AND ADJUSTMENTS TO PLACEMENTS

Adjustment to Hospital	Totals	Adjustment to Placements		
		Good	Fair	Poor
Totals	19	11		
Good	14	11		3
Fair	2		2	
Poor	3			3

It seems possible that further help in adjustments or removal to another placement might have improved the "fair" and "poor" adjustments seen here.

All of the patients studied received psychotherapy from a psychiatrist and either psychotherapy or case work from a psychiatric social worker. Occupational therapy was offered

most of the patients by persons especially trained in the field. Psychiatrists gave medication for physical ailments. They gave electric shock treatments, coma insulin and somnolent insulin to some patients and arranged for four lobotomies to be performed.

We summarize here briefly the behavior changes noticed in the patients as they came to the hospital and as they came to their placements. In those patients whose ages ranged from 35 to 45 years, we saw numerous changes for the better when they were hospitalized and relieved of their home situations. This behavior seemed to be a fairly good indication of how their behavior would be after a good placement was made. The study of the behavior of those in the teen-age group during hospitalization showed that patterns of adult conduct were still in the process of being formed. The worker was needed as an educator as well as a mother, companion, confidante, and therapist. Some of the behavior exhibited at home continued not only during the hospitalization but was evidenced again after placement. Any new home setting will reactivate some of the old behavior difficulties. When treatment continued after discharge, some of the sick behavior patterns showed progressive modification.

Generally speaking, patients who were in their twenties or early thirties, regardless of diagnosis, showed considerable change of behavior when they entered the hospital. They were apt to be friendly and co-operative. However, behavior in the

new environment or environments, for the most part, reflected again the behavior exhibited at home. This seems to show their continued need for the worker's further help after discharge.

In Chapter IV the placement itself was considered. This entailed discussion of the advantages and disadvantages found in the various protective environments that were used for the sample group. The importance of this knowledge to the psychiatric social worker is, chiefly, that she may consider which placements she may use for a patient and in which areas her help may be most needed after the placement is made. Also, in this chapter we considered the contacts with relatives and the timing of the preparation of the patient for placement.

Disadvantages found in residences were as follows. One residence had a standard of living which was too low. Two residences catered chiefly to girls who had been delinquent. This may make the patient feel that she, too, is delinquent. She may not be encouraged to socialize with the other residents. The others may require so much attention that she gets less than she needs. Some residences are managed by religious denominations. They may try to give religious direction to the patient. They may not be sufficiently discriminating but may take in all ages and classes and expect them to get along well together. Many residences do not have many single rooms. The discharged patient needs a single room or a good double. Dormitory life may be too complicated for easy adjustment.

Disadvantages found in convalescent homes seem to outweigh any advantages they can offer. The convalescent home repeats the hospital experience but on a less satisfactory level. The patient is treated as a sick person. There is a lack of sufficient recreational facilities. Therefore, the discharged patient is with sick people constantly and follows sedentary pursuits.

The disadvantages found in rooming houses were that they prefer to take patients as invalids, and they expect patients to be grateful for any kind of room. The landlady may pry into the patient's personal life. The psychiatric social worker has little control over this placement. She cannot expect the landlady to meet certain standards that an institution is required to meet. When the landlady causes difficulties to arise, the psychiatric social worker's only recourse may be to accept the landlady unofficially as a patient and to try to work through the difficulties with her.

This type of environment provides neither socialization nor recreation for the patient. Its only claim to being a protective environment is that it keeps the patient from her family.

There seem to be both advantages and disadvantages in placing domestic workers in a hospital setting. Among the advantages offered in this type of placement is that the patient does not have the trauma of separation from the hospital. She remains close to the treatment center, which is both convenient and emotionally satisfying. She has a job and a home in an

atmosphere where there is more than the usual acceptance of illness. She is in an environment where fairly good standards of living are maintained. The disadvantages are that this placement is limited to a certain number of domestics. In order for the patient so placed to advance, she must usually leave the setting entirely. In this way her separation is only postponed and may need to be worked through at a time when she is not under treatment. When she leaves her job, she also leaves her home in the hospital. This could make her leaving doubly difficult. Also, recreation is usually not planned for these workers, and socialization may lag.

The foster home has both advantages and disadvantages. Its advantages are that it can offer the patient a new mother and father who are interested in her. She may have a home she can call her own and she can expect to be included in a certain amount of family life. The disadvantages are that the patient must learn to adjust to new parents. She will bring to the new home many of her neurotic patterns that she used toward her own parents when she was at home. Her adjustment and the foster parents' adjustment to her may thus be made quite difficult. For a considerable period she may not be able to give the foster parents the emotional satisfaction they can expect from a person who is not ill. Furthermore, this type of placement may hinder the patient from growing up emotionally. However, it may be a good placement for the very young patient or for the older ones who will never be able to be on their own. In any event, this placement must be given

careful supervision.

The advantages that girls' clubs and residences may offer seem to outweigh considerably the disadvantages of some residences, and to outweigh the advantages that many other placements have. A good residence can provide a satisfactory room with some service, good meals well served, entertaining facilities, some group life, the security and protection of flexible house rules, and, often, a staff member who can help with little problems that arise. However, in order to make the best use of the placement and to make it a placement which can be used again and again, the patient in residence must be supervised by the hospital's psychiatric social worker.

An optimal placement, the writer believes, would be a residence maintained by hospitals particularly for the newly discharged patient. Residents in this home could be given considerable therapy and supervision while they made their first re-adjustments to the community.

The choice of placements for the patients studied depended to a great extent on the types of placements available in the communities. However, certain age groups and certain diagnoses seem to do better in particular types of environments than do other age groups and other diagnoses.

Six of the seven patients in the teen-age group were placed in some form of group living. One of the six, unfortunately, was in a convalescent home. Her job, however, provided a group setting for her. The one patient who was not

placed in some form of group living was with relatives. She might have done better in a girls' residence. Patients of this age can often do very well in group settings. One of the reasons is that they can often accept restrictions imposed on the group and by the group much more easily than they can accept restrictions imposed by a parent person. Also, in a residence there are none of the emotional demands that may be found in foster homes.

The ten patients in their twenties and early thirties had numerous kinds of placements. The kinds of protective environments used and the numbers of times they were used were as follows: Y.W.C.A. residences, twice; convalescent homes, five times; hospital employment, seven times; rooming houses, twice; and placement with relatives, once.

Patients of this age group are acceptable in residences. However, aberrations in their behavior are often more conspicuous than aberrations in teen-agers' behavior for people expect behavior of an older person to be better adjusted. While these patients do not always want group residences, those patients who can accept institutions seem to progress considerably better than those who take rooms in rooming houses. For this age group, hospital employment and residence seems also to have been satisfactory.

The two patients in the older group needed care as well as protective environments. Both made good adjustments in foster homes.

The patients' financial stiuations had considerable effect upon their placements. Not all patients can work immediately upon discharge from the hospital. A financial backlog can give them a great deal of support. If the finances are provided by a family who can also give some emotional support, the patient is doubly helped.

Adolescents can expect their parents' assistance from the legal and social points of view. Emotionally, however, they may have difficulty taking parental help even in the form of money with no "strings attached", or, they may unconsciously use money to resist treatment. Likewise, the parents of the patient who cannot go home are often the least able emotionally to give help in any form. The following brief summary shows the ways the patients managed financially upon hospital discharge.

Of the seven teen-agers in the sample group, one could work upon discharge. Two were helped by their families for short periods and another was constantly given financial help by her family. Three were helped by an agency. One of these three did not work at all during the contact. Another could have worked but it seemed better for her to continue in school. The third was soon employed.

The five patients who were in their twenties were all employed upon hospital discharge. However, three of the five particularly needed, and lacked, emotional support. Two of these three had serious recurrences of symptoms and could not continue their jobs and placements.

Of the seven patients who ranged from 31 to 45 years, three were employed upon hospital discharge. A fourth was employed soon after discharge. One could not work and received family help. Two had families who helped complainingly. Neither of these two latter patients did well.

Contacts by the psychiatric social worker with patients' families seem to be very important if the patient is to have success in placement away from home. All but four of the patients had relatives who were seen during the patient's contact with the hospital. None of these four patients made good adjustments to their placements. Of the remaining fifteen, only three patients had relatives who showed some positive interest in them. All three did well upon placement, although not necessarily upon their first placement. Three patients had relatives who were indifferent. Two of these patients made good adjustments. One made a fair adjustment. Nine patients had relatives whose attitudes were rejecting. Six of these nine patients were able to make good adjustments. It seemed that these patients felt degrees of interest in the negative attitudes that were sufficient to enable them to adjust well to placement. The family which is indifferent can make the patient feel not only unloved but unimportant.

A very important factor in the success of a placement is the careful timing of the patient's separation from the hospital. The patient's preparation for placement should be made

at a point in her treatment when it is evidenced that she no longer needs the benefit of full-time care at the hospital and when she may be expected, with help, to begin to relate herself once more to community life. The patient who is discharged from the hospital to a protective environment for more or less permanent residence will generally need, and generally has, fewer emotional resources than the patient who is discharged to herself. However, all of these patients may need protection against, and help with, relatives whose demands or whose well-meaning efforts in their behalf would hinder their adjustment. If the patient is helped to leave the hospital comfortably and to accept the idea of placement, she is given a good start toward her adjustment in the placement.

When the placement is either delayed or made too suddenly difficulties arise. The case material at hand showed that in the case of two teen-agers placements were delayed. Both patients exhibited much anxiety. One teen-ager's placement was made quite suddenly. She became suicidal. Three patients in their thirties also experienced difficulty at this point of their treatment. One patient whose discharge was delayed feared losing her hospital job and her living quarters because of the delay. Three felt that their placements were made suddenly or too early in treatment. One of these patients was suicidal; another complained considerably; the third showed a temporary exacerbation of symptoms.

When the patient made her own sudden discharge the situation was easier. She could be helped by the constant ac-

cepting attitude of the hospital staff and by the psychiatric social worker's continued supervision.

As the preparation for placement is being worked through the patients' feelings about placements in general emerge . With the younger patients, rosy ideas of placements seem to come out when the worker-patient relationship has been good, the hospital adjustment favorable, and when the worker has been able to get the patient to realize that separation from the hospital is not rejection but a "promotion" with the worker and the doctor continuing to offer support and therapy for a considerable length of time after discharge. Some of the unrealistic, perfectionistic ideas are verbalized and may be worked through, partially, at least. Other ideas are evidenced later in the patient's reaction to the reality situations in her placement. These can be handled at that time.

With older patients who have had many institutionalizations, we often find no reluctance to leave the hospital but also no positive feelings about any placements. Rather, we see apathy, dejection, and a real fear of community attitudes. Here again, the worker's continued help can do much to make the placement successful.

A good picture of how well a patient is after discharge can be gauged fairly adequately by how she acts in all settings. The patients' behavior outside the placement was studied in Chapter V.

In a protective environment, hopefully, the patient's adjustment is facilitated by factors in the environment. Her adjustment outside the placement, however, often shows the need for additional help from the psychiatrist and the psychiatric social worker. When the worker-patient relationship has been good, the worker is able to continue to help the patient through any vicissitudes that may, and will, arise. Also, and even more important, the patient who has been able to establish one warm relationship, such as her relationship with the worker, is better able to form other good relationships. These are necessary to her if she is to achieve a comparatively good emotional maturity.

During her first adjustments the patient needs the stabilizing influence of a very much interested friend or relative. In order for this interested person to be able to give the most constructive help, it is of great value if this person has had help from the hospital psychiatrist and the psychiatric social worker to understand why the patient may have difficulties in adjusting and to learn what help the patient may be able to use. As mentioned previously, relatives were contacted in all but four cases.

Other help that can also be utilized is that offered by recreational therapists and group workers in recreational centers or in settlement houses.

The difficulties these patients experienced in socialization and in employment are summarized briefly. Only one

patient had had recent favorable employment history prior to hospitalization and in this instance it was the employer who noticed strange off-the-job behavior. The patients all had varying degrees of difficulties in socialization. Of the seven adolescents, six had had marked socialization difficulty. The seventh got along well with contemporaries and with most adults. However, she was extremely negativistic toward all parent persons. Of the five patients in their twenties, one was a mental defective whom the parents did not want to socialize. The remaining four of this group were very much withdrawn prior to hospital contact. The six patients who were in their thirties and the one patient who was in her forties had all had quite poor socializations. Most of them actually had no friends and enjoyed no recreational activities.

After hospitalization, it seemed that fifteen particularly needed further help in socialization. Three seemed to be able to progress fairly well in this area when they were given help in other areas, as help in home-finding and in job-finding. The socialization of the one remaining patient was unknown.

After hospitalization, nine of the nineteen held jobs satisfactorily. One went to school. Another could not work. Five had a good deal of difficulty with jobs. One changed jobs often. Two others would not work. These latter eight could have used further help in the area of their employment adjustment.

In Chapter VI we saw that some of the patients' difficulties arose because of the existing community attitudes toward those with mental or nervous illnesses. Sometimes the patient's feelings about community attitudes were not due to existing reality factors as much as to the patient's inexperience and naivete. Sometimes the patient's feelings were part of the patient's neurotic pattern. Help can be given in the area of the patient's feelings toward community attitudes when the patient continues to receive psychotherapy and supervision which includes education and re-education. Community attitudes are improved when discharged patients are carefully supervised. The psychiatric worker must also give help to key members of the community by the general interpretation of mental and nervous illnesses.

The patients' feelings toward community attitudes are summarized briefly. Of the teen-agers, two were primarily naive. They were unco-operative, dramatized their illnesses, and manipulated their environments. Neither of these patients were well supervised. The patients' relatives reacted negatively toward them in both cases. Three teen-agers seemed to exhibit a mixture of naivete and fearfulness. Some of their behavior was sick enough to cause community question. Both of these patients were well supervised and seem to have ultimately adjusted well. Two patients in this age group were primarily fearful because of bad experiences they had had with community attitudes. One was summarily turned down by two

residences. The other was misunderstood by her school, by a residence director, and by a social agency.

The five patients in their twenties had a dominantly fearful attitude. The exceptions were a girl of low intelligency who was quite naive and a young woman whose only known attitude was fear of her mother's domination. The other three in this group definitely showed strain. All three had financial difficulties and lacked friends to help them re-orient themselves socially and occupationally.

Among the seven remaining patients we found that one found fault about community attitudes. This was based on reality factors. The second patient was very much protected but did well. Three were very fearful of community attitudes. They had had long difficulty in socializing and in meeting responsibilities themselves. The two remaining thought, at first, that they would find community attitudes accepting. However, they met much rejection and responded in sick ways. They were given additional help from the hospital staff and were enabled to adjust in much better ways.

A number of the patients reacted with exacerbation of symptoms on discharge. Where the psychiatric social worker gave supervision this initial difficult period was eased.

Two of the reasons why patients may have difficulty are that they may lack sufficient defenses against over-curious people in the community. They may also still be actively working on their conflicts and so use large amounts of projection and displacement.

People in the community may get an unusual amount of abnormal responses from discharged patients for two reasons. They may react abnormally toward the patients. Abnormal actions will usually bring an abnormal response. Others in the community try to be lay therapists. By this, they can do a great deal of damage.

One solution to this is for the worker or patient to tell these people only what they must know about the patient. Some who have shown that they cannot accept psychiatric orientation may not need to be given any information about the patient's illness or present needs. This type of situation is best handled when the patient is helped to make her own placement. In this way she need not mention her hospitalization.

Community attitudes encountered show us that some relatives and some residence directors feel helpless to help. Some residence directors have a negative feeling toward psychiatric illnesses. Others are accepting. In most cases, we feel that the objections of residence directors can be worked through by some interpretation and by the careful supervision of one patient.

The writer believes that it is too much to expect for the patient to do community interpretation. In the process of her psychotherapy she was not trained in psychiatry. It usually requires all her energies as well as a good deal of supervision and support in order for her to make satisfactory adjustments.

Chapter VII was devoted to illustrations of the patients' long-time need for a helping person. The patient makes a complete change from the hospital to an environment where she is often the only sick person and perhaps, also, the only person with any psychiatric orientation. It is found that she usually needs not only a good deal of emotional support but often, because of her long affectional deprivation, also needs the experience of a warm relationship over an extended period.

It was brought that the psychiatric social worker can often provide this warm relationship. However, in order to do this, the worker must have started in the case well before discharge was considered. Otherwise she would run a risk of being associated in the patient's mind with hospital "rejection".

Many of these patients had a particular need for a mother-figure who would be a stabilizing force and therefore a source of security to them. Among the teen-age group we found that all could use a mother-figure for support and direction in their growing-up experiences. They had great need for affection and discipline. Those in their twenties needed extended periods of warmth and understanding if they were to work through their poor relationships with their own mothers and outweigh their long emotional deprivation. Patients whose ages ranged from 31 to 34 years all needed mother-figures for the same reasons as those in their twenties.

The three older patients apparently did not need a mother-figure but they needed the worker as a supportive person to assist in the placement and to help them achieve satisfying socializations.

The writer has attempted to treat the consideration of the use of protective environments for the sample group of patients in the same order that a psychiatric social worker might consider placement for one patient. In order for the psychiatric social worker to give the services she is equipped to give, she must enter the case early in the patient's hospitalization. In this way she may know her patient's strengths and weaknesses and may be able to form the warm working relationship that is so necessary. The writer has tried to show that the use of the psychiatric social worker's skills and understanding may make the placement of discharged patients in protective environments and their after-care real parts of treatment.

BIBLIOGRAPHY

Bassett, Clara. Mental Hygiene in the Community. New York: MacMillan Co., 1936.

Bleuler, E. Textbook of Psychiatry. New York: MacMillan Co., 1924.

Catlin, Lucy. The Hospital as a Social Agent in the Community. Philadelphia: W. B. Saunders & Co., 1918.

Copenhaver, Roberta M. "Social Work with Patients on Parole from a Mental Hospital," Smith College Studies in Social Work Vol. XVI, p. 123.

Crutcher, Hester B. A Guide for Developing Psychiatric Social Work in State Hospitals. Utica: State Hospitals Press, 1933.

_____. Foster Home Care for Mental Patients. New York: The Commonwealth Fund, 1944.

_____. "The Role of the Social Worker in Family Care of Mental Patients," Smith College Studies in Social Work Vol. XIV, p. 118.

Davis, John Eisele and William Rush Dunton. Principles and Practice of Recreational Therapy for the Mentally Ill. New York: Barnes, 1936.

Deutsch, Helene. The Psychology of Women, Vol. I. New York: Grune and Stratton, 1944.

_____. The Psychology of Women, Vol. II. New York: Grune and Stratton, 1945.

Dula, John E. "The Child Away From Home," Journal of Social Casework Vol. XXIX, No. 4 (April, 1948) p. 130.

Dunbar, Flanders. Mind and Body: Psychosomatic Medicine. New York: Random House, 1947.

Fenichel, Otto. The Psychoanalytic Theory of Neurosis. New York: Norton, 1945.

French, Lois M. Psychiatric Social Work. New York: The Commonwealth Fund, 1940.

Friend, Jeannette C. "Work Adjustment in Relation to Family Background," Journal of Social Casework Vol. XXIX, No. 3 (March, 1948) p. 89.

Gartland, Ruth M. Psychiatric Social Service in a Children's Hospital. Chicago: University of Chicago Press, 1937.

Goldfarb, William. "Variations in Adolescent Adjustment of Institutionally-Reared Children," American Journal of Orthopsychiatry Vol. XVII, No. 3 (July, 1947) p. 449.

Hamilton, Gordon. Psychotherapy in Child Guidance. New York: Columbia University Press, 1947.

Hinzie, Leland E. The Person in the Body. New York: Norton, 1945.

Hotchkiss, Mary, Jane Duffee, Arpine Mardiguian, Christine Tarpinian and Mary Shirley. "Environmental Factors Relating to the Adjustment of Dementia Praecox Patients Paroled After Insulin Shock Therapy," Smith College Studies in Social Work Vol. XIII, p. 14.

Horney, Karen. Our Inner Conflicts. New York: Norton, 1945.

Hoskins, R. G. "Dementia Praecox, A Simplified Formulation," Journal of the American Medical Association, April, 1931.

Hutchinson, Dorothy. "Case Work Implications in the Use of Money in Child Placing," The Family Vol. XXI, No. 5 (July, 1940), p. 150.

_____. In Quest of Foster Parents. New York: Columbia University Press, 1943.

_____. "The Parent-Child Relationship as a Factor in Child Placement," The Family Vol. XXVII, No. 2 (April, 1946) p. 47.

MacEachern, Malcolm T. Hospital Organization and Management. Chicago: Physicians' Record Co., 1947.

Menninger, Karl A. The Human Mind. New York: Literary Guild, 1930.

_____. Love Against Hate. New York: Harcourt, 1942.

_____. Man Against Himself. New York: Harcourt, 1938.

Mitchell, E. and B. S. Mason. The Theory of Play. New York: 1934.

Rennie, Thomas. "National Planning for Psychiatric Rehabilitation," American Journal of Orthopsychiatry Vol. XIV, (March, 1944) p. 386.

Sayles, Mary Buell. Substitute Parents. New York: The Commonwealth Fund, 1936.

Shepherd, Helen. "Some Criteria for Choosing Effective Family Care Homes," Smith College Studies in Social Work Vol. XIV, p. 249.

Sitkin, Sarah H. "Influence of Environmental Factors on the Social Adjustment of Epileptics Paroled from a Mental Hospital," Smith College Studies in Social Work Vol. XV, p. 227.

Slavson, S. R. Recreation and the Total Personality. New York: New York Association Press, 1946.

Walkiewicz, Sophia Theresa. "Convalescent Patients as Mental Hospital Employees," Smith College Studies in Social Work Vol. XVI, p. 282.

Weston, Sylvia. "Traits of Successful Family Caretakers of Psychotic Patients," Smith College Studies in Social Work Vol. XIV, p. 250.

Wickes, Frances G. The Inner World of Childhood. New York: Appleton-Century Co., 1927.

Witmer Helen and Phebe Rich. "A Task for Social Work in Connection with Psychiatric Rehabilitation," Smith College Studies in Social Work Vol. XV, p. 101.

Woodward, Luther E. Rehabilitating the Psychiatrically Handicapped. New York: Division of Rehabilitation, National Committee for Mental Hygiene, 1944.