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A Study of Male Neuropsychiatric Patients Who Went Out on Trial Visit between July 1st and December 31st, 1953, From Downey Veteran's Administration Hospital and Were Later Discharged

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A STUDY OF MALE NEUROPSYCHIATRIC PATIENTS WHO WENT OUT ON TRIAL VISIT BETWEEN JULY 1ST AND DECEMBER 31ST, 1953, FROM DOWNEY VETERANS' ADMINISTRATION HOSPITAL AND WERE LATER DISCHARGED

by

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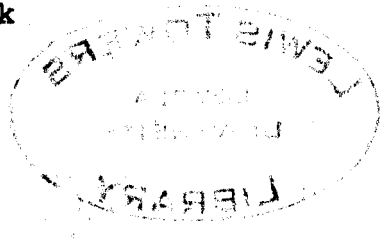

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INTRODUCTION

The treatment goal of hospitalization for the mentally ill patient is his return to the community and his satisfactory readjustment to community living within his limitations. In relation to this basic concept, the trial visit program in Veteran Administration Neuropsychiatric Hospitals plays an important and meaningful part in the mentally ill patient's total hospital experience. "Many psychiatric patients could live outside the hospital, but they may have personal problems that make them entirely unable to manage by themselves. Sending improved patients out of the hospital without provision for further professional concern for their community readjustment problems too often results in their rehospitalization in worse condition. Social Service is Charged with providing this continuity of concern for the patient, and encouragement and prudent counsel to him and his family in meeting situations that might otherwise compel him to return to the hospital. For those patients who have homes to which they can go, the trial visit program, as a preliminary to outright discharge, is being used more and more each year." [1] Trial visit offers the psychotic patient the opportunity to move out into community living under conditions that will allow for a continuation of the reinforcement of such strengths and abilities as he may possess.

The casework services rendered to patients who are being prepared for trial visit are based on a concept which regards trial visit experience as a

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1 Administrator of Veterans Affairs, Annual Report, 1952, United States Government Printing Office, Washington, 1952, p.47

treatment process. Hospitalization represents a medical, psychiatric, treatment experience and the ability of the patient to view his investment in the hospital in that light, to some extent, determines the effectiveness of his personal experiment in healthy living within the hospital community. Casework efforts to enable the patient to give up hospitalization must have their rationale rooted in awareness of the unique reactions of the individual patient to treatment received in the hospital and his relationship to all professional persons significant to him. The approach of the social worker to the patient as he anticipates trial visit encompasses the belief that every psychotic person has within him some positive capacities which may be mobilized and utilized to the end of a healthier relationship in his society.

The social worker, with this concept in mind, enters into a casework treatment relationship with the patient, the purpose of which is to enable the patient to leave the hospital under as favorable circumstances as possible. It is the responsibility of the social worker to conduct his casework services within the framework of a reciprocal, thoughtful, regular consultation with the ward physician, so that the casework treatment is in harmony with psychiatric objectives.[2]

Request and recommendations for trial visit may be made by the medical staff, a relative of the patient, or other interested person (such as guardian) or the patient himself. Such request and recommendations must be approved by the medical staff, after which the patient is released in the custody of the person assuming responsibility for his care. On some occasions the patient

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2 Robert T. Dacy, et al. Responsibility of Social Service in Trial Visit. Downey, Illinois, 1953, p.5.

may be released in his own custody, if there is no one to assume responsibility for his care. Under the trial visit program, the patient is released initially for a period of ninety days. Depending on the continued satisfactory adjustment of the patient, the ninety-day periods may be renewed up until one year, at which time the patient is then discharged. Occasionally, if the adjustment is satisfactory, and it seems therapeutically advisable, the patient may be discharged before the expiration of one year. Also, where it is deemed therapeutically advisable, the trial visit period may be extended beyond a year.

During the trial visit period, supervision is offered the patient by the Veterans Administration Regional Office in the city in which the patient is living. The hospital works in close collaboration with the Regional Office. The Case Supervisor from the Regional Office, who has responsibility for trial visit supervision, visits Downey and interviews patients who are about to leave the hospital on trial visit. The services of the Regional Office are discussed and the patient is encouraged to make use of these services. The purpose of these interviews is to further assure the patient of the possibility of a continuous, meaningful, helpful service from Veterans Administration. The hospital social worker sends a referral to Regional Office requesting supervision. This referral contains social background information, an evaluation and assessment of the patient's strengths and weaknesses, as well as information concerning his illness and hospital adjustment. Attention is called to specific problems which the patient may have and with which he may desire and need help.

The social worker in the Regional Office attempts to assist the patient and his family with problems around patient's readjustment to the community, through the skillful use of casework of all types (supportive, clarification, etc.). The Regional Office submits periodic evaluations to the hospital concerning the patient's adjustment. It is on the basis of these reports that the patient's trial visit is either terminated and the patient returned to the hospital if the adjustment has been unsatisfactory, or, if the adjustment is satisfactory, the trial visit period may be extended and eventuate in final discharge. The experiences of an individual on trial visit are used to determine his capacity to handle and administer his funds. This aspect of the program was not studied in the thesis.

The purpose of this study is to explore various factors present in cases of patients who went out on trial visit from Veterans Administration Hospital, Downey, Illinois between July 1st and December 31st, 1953 and were later discharged, with a view toward ascertaining what factors in these cases tended to make for a successful trial visit experience. The term "successful trial visit" as used in this thesis merely denotes that the patient was granted a final discharge from the hospital upon termination of his trial visit. "Successful" as used here has no connotation of the more subjective considerations that enter into an evaluation of success, but rather, the determination as to successful or unsuccessful was made on the basis of the adjective fact that the patient was discharged from the hospital or returned to the hospital upon termination of his trial visit. Simultaneously, and in conjunction with this study, a closely related study was made which sought to isolate factors which

might have influenced the mentally ill patient's return to the hospital from trial visit. These two studies represent a joint project undertaken by two students from Loyola University School of Social Work. In the last chapter of this thesis, the writer will attempt to draw a comparison between the two study groups by presenting a critical analysis of the significant factors in the life situation of the members of each of the study groups in an effort to ascertain if there were any outstanding differences in the two groups which might account for the discharge of the one group and the return to the hospital of the other group.

The year 1953 seemed appropriate for the study as the most current year in which the trial visit program could be evaluated, since the usual period of trial visit is one year and ordinarily in all cases some disposition would have been made(i.e., the patient returned to the hospital or discharged) by the time the study was undertaken. Also, it was during the year 1953 that the Social Service Section at Downey issued a formal statement, ("Responsibility of Social Service in Trial Visit," Robert T. Dacy, et al) defining this section's responsibility in trial visit. The statement provided that trial visit data would be recorded in the case records in a formal report, the trial visit preparation summary. The preparation of these summaries by the Social Workers began in October, 1953. These summaries in the case records facilitated the collection of information for this study regarding trial visit preparation of those patients who went out on trial visit during October through December, 1953.

It was decided to study only male patients since the male and female population of the hospital was so disproportionate (approximately 143 females

to 2,037 males during 1953), that it would be difficult to obtain an equal number of cases of each sex that would meet the criteria of the study. After gathering these facts, it was finally decided to limit the study to the male, neuropsychiatric patients who went on trial visit during the last six months of 1953. Female veteran population in VA and non-VA hospitals on 1-31-53 totaled approximately 1,600. It was found that a total of 122 male patients went out on trial visit during the year 1953. Initially, it appeared that 56 patients went out on trial visit to their own home or the home of relatives during the six-month period studied. However, a careful investigation of the 56 cases revealed that actually only forty-four fell within the limitations of the study; of these, twenty-six were discharged from trial visit and eighteen returned from trial visit. The twelve other cases that fell within the time period of the study were eliminated for the following reasons: three patients were discharged to another hospital, one because the patient was not actually a trial visit case, one because the patient was not a neuropsychiatric patient, and in two cases there was a mistake in date of the patients' release from hospital. One patient went out on trial visit under the home care program. (This program provides for patients' release to homes other than their own or those of relatives. This study is concerned only with patients who were released to their own homes or homes of relatives and were subsequently discharged.) Four patients were still on extended trial visit.

A schedule (See Appendix) was devised so that partinent and uniform data could be recorded on each of the cases included in the study. The schedule covered five broad categories of information regarding the patients; each cate-

gory had appropriate sub-items. The five categories were: 1. Identifying information, 2. Medical information, 3. Social information, 4. Pre-trial visit information, and 5. Trial visit information. The two students undertaking the project assumed equal responsibility for isolating the cases that would fall within the limitations of the study from the total number of patients on trial visit during the period, for constructing a schedule, for the gathering of data, and for completing the schedules on the cases selected for study. After the completion of these initial steps in the research project, each student worked independently in presenting, analyzing, and interpreting the material pertaining to the particular study group on which each was focusing.

CHAPTER I

THE VETERANS ADMINISTRATION HOSPITAL AT DOWNEY, ILLINOIS

The Veterans Administration Hospital at Downey, Illinois is one of the 172 hospitals operated (as of January, 1955) by the Veteran's Administration. These hospitals are maintained by the federal government and are the direct responsibility of the Department of Medicine and Surgery. The Administrator of Veterans' Affairs, in his Annual Report of the Fiscal Year, 1953, stated that it is the mission of the Department of Medicine and Surgery to provide the highest level of in-patient and out-patient medical treatment and domiciliary care to eligible veterans within the monetary limitations set by Congress.[3]

Of the 172 hospitals operating in 1955, 21 hospitals are designated as serving the tubercular patient, 39 as neuropsychiatric, and 112 as general medical and surgical. The designation given the hospital is based on the medical type of the majority of patients under care there. In January 1955, there were 117,762 beds available for use in all VA hospitals. The neuropsychiatric hospitals averaged 94 per cent of operating capacity. The VA will, when the situation warrants, pay for the care of veterans in non-VA hospitals. As of December, 1954, there were 3,831 beds being occupied for care of VA patients in various non-VA hospitals; 2,246 of these beds were occupied by psychiatric and neurological patients. As of January 31, 1954, there were approximately

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3 Administrator of Veterans' Affairs, Annual Report 1953. United States Government Printing Office, Washington: 1954. p.8.

46,030 VA patients hospitalized in VA and non-VA hospitals with a diagnosis of psychoses. In addition, there were approximately 1,632 hospitalized with a diagnosis of psychoneurotic disorder.

The Veterans Hospital at Downey, Illinois was opened in 1926. At that time, the hospital had a bed capacity of 325 and there were five hospital buildings. Through the years, the hospital has continuously expanded its program until today it has approximately 165 buildings, covering 590 acres, and a bed capacity of 2,415. In 1954, the tuberculosis unit was closed so that the hospital is, at this time, devoted primarily to the care of veterans with neuropsychiatric disorders. There is, however, one building designated exclusively for the care of veterans with both tuberculosis and mental illnesses. A new center for treatment of psychiatric patients with tuberculosis was opened in 1953 at Downey, Illinois in accordance with plans to centralize the treatment of such patients in 13 centers throughout the country.[3]

While it is the admission policy of the hospital to give preference to veterans with service-connected illnesses, veterans with non-service-connected illnesses are admitted when space will permit; and when in need of hospital treatment. Veterans entering the hospital are generally from the Chicago area; however, they may come from such neighboring states as Wisconsin and Indiana. The veteran may come to the hospital as a transfer from other Veterans Administration hospitals, a state hospital or army hospital, or direct admission from their homes by commitment or on a voluntary basis.

The responsibility for treatment and care of the patient rests with the medical staff. The medical staff prescribes treatment which may consist of insulin shock therapy, electro-shock therapy or psychotherapy. Physical

Medicine and Rehabilitation services are also available. This service consists of occupational therapy, manual arts, education, physical and corrective therapies. The staff consists of specialists in the field of psychiatry, psychology, nursing, and social work.

The Social Service Section of the hospital plays a major role during the patients' hospitalization. The social worker, in collaboration with the psychiatrist and other members of the ward team, contributes the skills and knowledge of her profession toward helping to make the patient's hospital experience a profitable one.

The chief responsibility of social service is to assist hospital patients to establish life situations favorable to good health and to gain the peace of mind that hastens recovery.[4]

This responsibility is assumed, when full staff is available, by the social worker at Downey at the time of the patient's admission to the hospital and is continued on a selective basis throughout hospitalization up until the patient's discharge from the hospital. When the patient is first admitted to the hospital, he is seen by a social worker in a reception interview. The purpose of this interview is to explore with the patient his feelings and attitudes around his present situation in order to ascertain the areas in which the social worker may be of help to him. Many times the necessity for hospitalization may engender in the patient feelings of resentment, guilt and hostility. The fear of loss of status in the family and community may over-

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4 Administrator of Veterans' Affairs, Annual Report 1952, United States Government Printing Office, Washington: 1952. p.47.

whelm him. All of these feelings can serve to hinder the patient's adjustment to hospitalization in such a way as to make recovery on any level a more difficult process. When the patient is able, in some measure, to work through these feelings he is freer to adjust to hospitalization. In addition to working with patients at time of admission, the social worker may, after collaboration with other medical staff members, work with the patient on a casework treatment basis. The services of the social worker are made known and available to all patients on an "as needed" basis around any particular problem at any point during hospitalization.

It is the responsibility of the social worker to obtain psychiatric social history information when necessary from family members. This information is used by the social worker in his evaluation and treatment of the patient and is used by the medical staff for diagnostic and treatment purposes. In interviewing responsible relatives, the social worker may find that the relative has feelings and attitudes that he may want and need help with concerning the patient's illness. In these situations, the social worker may see the relatives frequently in accordance with the policy of the Social Service Department to the effect that "At every phase of the patient's hospital course, our communication with the family should be vigorous, and directed toward the concept that the family has continuing, responsive investment in the hospital treatment program for (their) patient."[5] The role of Social Service in preparing the patient and his family for the trial visit period will be explained in detail in Chapter VI, Trial Visit Preparation.

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5 Robert T. Dacy, et al. Responsibility of Social Service in Trial Visit

CHAPTER II

SOCIAL CHARACTERISTICS AND PRE-HOSPITAL ADJUSTMENT OF THE STUDY GROUP

In this chapter consideration will be given to the social characteristics and adjustment of the Study Group in order to ascertain if there were any factors in these areas common to the majority of the members of the Study Group. An effort will be made to ascertain whether there were any common factors present in the situation of the members of this group either prior to or at the onset of hospitalization that may have accounted for or facilitated a successful trial visit experience toward the end of their hospitalization.

Identifying Information and Military Information

Table I shows the age distribution of the members of the study group at the time of trial visit.

TABLE I

AGE DISTRIBUTION OF PATIENTS
DISCHARGED FROM TRIAL VISIT

AGE	NUMBER
20 to 25	6
25 to 30	7
30 to 35	7
35 to 40	2
40 to 45	0
45 to 50	1
50 to 55	0
55 to 60	1
60 to 65	1
65 to 70	1
Total	26

As can be observed from the table, the majority of the patients were young men between the ages of 20 and 40. The median age of World War I veterans is 61 years, while the median age of World War II veterans is 35 years. There are two major classes of VA hospitalized patients: those over fifty years of age, who are veterans of World War I and prior wars; and those under fifty years of age, comprising in the main, World War II veterans.[6] An analysis of the study group according to wars participated in revealed that 5 of the 6 patients in the age group of 20 to 25 were veterans of the Korean conflict. Eighteen patients in the age group from 20 to 50 were veterans of World War II. The remaining 3 patients, (ages 56, 64, and 67 respectively) were veterans of World War I. It is interesting in this connection to note the following information: "Because of age differences, the principal diagnoses of the World War II veterans differed greatly from those veterans of earlier periods of service. As was the case during the calendar year 1950, psychoneurotic disorders constituted the leading diability category treated among World War II veterans discharged from VA and non-VA hospitals (14,732)."[7] An investigation of the marital status of the group revealed that 18 were single, 5 were married, and 1 was separated from his wife. This patient separated over twenty years ago, after only a few months of marriage. Two of the patients were divorced; one of them remarried while on trial visit. Thus, of the 26 patients, only 8 had experienced a marital relationship. The following table gives the marital status of the group according to age.

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6 Administrator of Veterans' Affairs, Annual Report 1952, United States States Government Printing Office, Washington: 1952. p. 21

7 Ibid., p.20

TABLE II

AGE AND MARITAL STATUS OF THE STUDY GROUP

Age	Single	Married	Separated	Divorced	Remarried	Total
20 to 25	6					6
25 to 30	4	1		1	1	7
30 to 35	5	2				7
35 to 40	1	1				2
40 to 45						0
45 to 50	1					1
50 to 55		1				1
55 to 60						0
60 to 65	1					1
65 to 70			1			1
Total	18	5	1	1	1	26

These statistics are in keeping with the findings of a similar study, conducted in 1950, of veterans who left Downey on trial visit.[8] This study revealed that of a total of 63 veterans, 63.5 per cent, or 40 veterans were single; 80 per cent of that group were under thirty-eight years of age, and had spent time in military service during early adult life when, under more normal conditions, they would have had more opportunity to make better social adjustments. The high percentage of single men in the group may be partially explained by the fact that mental illness is by its very nature detrimental to emotional growth and maturity and thus inhibits the establishment of satisfying adult relationships. In this study it is noted that 88.8 per cent of the total of single men are under thirty-eight years of age.

Religion seems to have played a role in the lives of all 26 men as all claim some religious affiliation. Two men were of the Hebrew faith; 11 were Protestant and 13 were Catholics. No attempt is made to evaluate what significance religion has in this situation. It is not possible to determine from the case material the degree of importance which religion played in their lives.

A breakdown according to race revealed that 23 men were Caucasians; 3 were Negroes. The total number of Negro male neuropsychiatric patients in the hospital during 1953 was 139.

It seemed pertinent to investigate the factor of education as a means of further gauging the pre-hospital adjustment of the men in community life. The following table will point up educational achievements in relation to age.

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8 Katherine Heerey, An Analysis of the Case Histories of 63 Veterans Under Trial Visit Supervision, Unpublished Master's Thesis, Loyola University, Chicago, Illinois, 1950, p. 16.

TABLE III

EDUCATION AND AGE OF STUDY GROUP

Age	Years of Education			
	0 through 8 years	9 to 12 years	13 years & over	Total
20 to 25		3	3	6
25 to 30	2	4	1	7
30 to 35	1	5	1	7
35 to 40	1		1	2
40 to 45				0
45 to 50		1		1
50 to 55		1		1
55 to 60				0
60 to 65	1			1
65 to 70	1			1
Total	6*	14	6	26

* This includes one patient who had no formal education.

It is interesting to note that as an indicator of the type of pre-hospital adjustment these men were able to make, a significant number (14) of the men, actually 53.8 per cent, were able to complete at least a portion of high school training. Six men completed some part of the four year college educational requirement. None of the men had any special training.

Consideration of the family background of the men in the study group seemed important in attempting to evaluate their pre-hospital adjustment. In this regard, the factor of the marital status of the patients' parents was considered. In the cases of 14 patients, the parents were married and living together; parents of 3 patients were divorced. In the cases of 7 patients, either one or the other parent had died. In the case of one patient, there was no statement in the record regarding the marital status of the parents. One patient's mother was an unmarried mother and the whereabouts of the putative father had been unknown since the patient's birth. Two of the divorced parents remarried and two of the widowed parents remarried.

Although the items "birthplace" and "Occupation" of the parents of the patients appear on the schedule, the number of cases in which this information was reported in the case records was too small to merit statistical attention.

An attempt was made to ascertain whether there was any known mental illness other than the patient's, in the family. It was discovered that three patients had fathers who had suffered a mental illness. One of these fathers had been a patient some years ago at Downey. One patient's mother was known to be mentally ill and had been ill in the home since patient was 13 years old. At the time of this study, this patient was twenty-one years old. Eight

patients had "other " relatives (siblings or near kin) who had been known to be mentally ill at one time or another. Thus almost one half of the study group had some relative who had suffered mental illness. However, there were no statements around this point in the records of the remaining fourteen patients. It is, therefore, impossible to make any significant generalizations regarding the possible correlation between the relatives' mental illness and that of the members of the study group.

An effort was made to gauge the type of relationship each patient's parents had with each other. It was thought that perhaps through this method some idea could be gained of the emotional "tone" or atmosphere as it existed in the home. This is not easy for the caseworker to determine in the interview. The difficulties involved in attempting to determine such a factor through material contained in case records are such that one questions realistically the scientific value of such inferences. In order to avoid as fully as possible the dangers of subjectivity, the writers devised items "d" to "f" (page two, Category C, Social Information) as shown on the schedule. These items were completed only when the information sought was definitely stated in the case records. Because of the lack of information in the records concerning these items, no relevant statements were available in 21 cases. In one case, the patient opined that his parents "appeared to get along well together." In three cases the parents' relationship was described negatively. One of these statements was the expression of the caseworker, and two statements were the patient's expressions. In the case of the patient whose mother was unmarried, there was no interparent relationship involved. The whereabouts of the father was unknown since shortly after the patient's conception.

Items "g" to "i" on the schedule (page two, Category C, Social Information) were devised as a method to gauge the relationship of parent with patient. Here again similar difficulties as just described above were encountered. The breakdown in these items was as follows: In 13 cases, this information was not available in the record or the statements were too vague to be interpreted accurately or with any degree of certitude; five positive statements were obtained. Of these statements, two were expressions of the caseworker, two of the patients and one parent stated that patient and parents got along well together. In eight cases there were definite negative descriptions of the parent patient relationship. In seven of these cases the statements were made by the caseworker. In 2 of these seven cases, the patients also expressed an opinion that they and their parents did not get along well together. It is interesting to note that the patient with the unmarried mother was one of these patients. On the basis of information obtained from the patient, the caseworker in this situation conlcuded that the mother was most rejecting of the patient. Patient felt that neither he and his mother nor maternal grandmother, with whom he resided for a number of years, got along well together.

An effort was made to gauge the relationship of married patients with their wives and children. (See Pages 3 and 4, items "d" to "h" of schedule.) In evaluating the patients' relationships with wife, an attempt was made to obtain a definite statement by the caseworker, wife and patient. In regard to patient's relationship with children, an attempt was made to determine this from statements made by wife and patient. Table IV shows the breakdown regarding relationships of patients to wives and children according to definite statements made in the case records.

TABLE IV

RELATIONSHIP OF PATIENTS TO WIFE AND CHILDREN

Marital Status	Relationship to wife: According to Caseworker			According to Wife			According to Patient			Relationship to Children: According to Caseworker			According to Wife			According to Patient		
Married 5	P	N	NS	P	N	NS	P	N	NS	P	N	NS	P	N	NS	P	N	NS
Pt. A			x		x			x		No Children								
Pt. B	x			x			x						x			x		
Pt. C	x			x				x					x					x
Pt. D		x			x			x		No Children								
Pt. E	x			x			x			x			x			x		
Separated:1 Pt. F			x			x			x	No Children								
Divorced 2																		
Pt. G		x				x		x							x	x		
Pt. H.			x			x			x						x			x
Remarr. Pt. H			x			x			x	No Children in second marriage								
Total	3	2	4	3	2	4	2	4	3				3	0	2	3	0	2

P....Positive opinion
N....Negative opinion
NS....No statement

It is noted that in only three cases, patients B, C and E, did all three sources report positive opinions regarding relationships of patients to wives and children. In regard to patient D, all three sources reported negative opinions of the relationship. Out of a total of twenty-seven possible responses, either positive or negative, concerning the factor or relationship between patient and wife for all cases, eight responses were positive, eight negative and in eleven cases no statement regarding this was made. In the relationship factor regarding children there are ten responses; six are positi and four show no statement.

Employment was taken into consideration as a factor in the pre-hospital adjustment of the study group. Table V shows the pre-service and post-service employment adjustment of the group. Jobs described as "unskilled" refer to such employment as janitor or waiter. The "semi-skilled" jobs are such employment as retail merchant. Jobs described as "skilled" refer to such employment as carpenter and machinist.

TABLE V

PRE-SERVICE AND POST-SERVICE EMPLOYMENT OF THE STUDY GROUP

Pre-service	Age 20-25	25-30	30-35	35-40	40 plus	Total
Skilled			2		2	4
Semi-skilled	1		2	1	1	5
Unskilled	3	3	2	1	1	10
Student	1					1
Unemployed	1	2	1			4
No statement		2				2
Total: 26	6	7	7	2	4	

Post-service	20-25	25-30	30-35	35-40	40 plus	Total
Skilled			2		2	4
Semi-skilled	1				1	2
Unskilled		5	3			8
Unemployed		1		1		2
No statement			1		1	2
In hospital	5	1	1	1		8
Total: 26	6	7	7	2	4	

As seen in the foregoing table, 19 of the twenty-six men were employed before service. One person was a student with no employment. However, two others in this age group were both employed and going to school. Four patients were unemployed. In two cases there were no statements recorded regarding pre-service employment. It was found that 14 of the group were employed in the community after service. Only two were unemployed. There were no statements in records regarding post-service employment of two patients. It is of note that eight of the group were hospitalized directly after discharge from service so they would have had no opportunity for employment. These men went directly from service into an Army or Veterans Administration Hospital for treatment of a neuropsychiatric disorder.

The factor of personality was considered in terms of pre-service and post-service personality traits. The information is based in all cases, except one, on statements made by the relatives who were interviewed by the medical staff at Downey or other hospitals. In the one exception, the information given by the patient was listed because no such information was available from a relative. The purpose of drawing a comparison between pre-service and post-service personality traits of the individuals in the group was to attempt to ascertain if any noticeable changes occurred in the personality as a result of the military experiences. The primary consideration here is an attempt to ascertain whether the individual's breakdown occurred as a result of the military experience, or whether the person was predisposed to mental illness and such illness might have occurred merely under the stress and strain of every day life and responsibility. Authorities in the field of psychiatry are at variance in their opinion as to the extent to which factors in the personality that

predispose the individual to mental illness contribute to war neuroses and breakdowns that occur while the individual is in service? The information gathered in this study does not lend itself to any conclusions as to what degree the factor of personality traits influenced the mental breakdown of the individuals.

In obtaining data about personality, ten descriptive terms were used on the schedule. In some instances, these exact terms were not used in the relatives' description of the personality; at those times, such terms as were used were listed on the schedule. To facilitate statistical analysis, this material was later grouped under two headings; personality description of a predominantly positive nature and personality description of a predominantly negative nature. It was determined that the person's personality description was made up of predominantly positive or negative traits on the basis of terms used in the description. For example, one relative described the patient as being "friendly, popular, sociable and well-adjusted" prior to entry in the service. Such a description would be placed under the predominantly positive heading. Another relative described the patient as being "shy, backwards, moody." This description would be placed under the heading of predominantly negative. In all cases except one, the statements were sufficiently definitive so as to permit classification in one of the two categories mentioned above. In the one case the parents gave conflicting information on different occasions concerning the personality of their son prior to service. It was the impression of the

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9 Edward A. Strecker and Kenneth E. Appel. Psychiatry in Modern Warfare, New York: 1945. pp. 12 to 17.

caseworker that the family's statement was influenced by their concern lest the information be used to the detriment of the patient in adjudicating his eligibility for service-connected compensation. Table VI explains the breakdown regarding the personality factor.

As shown in Table VI, there was not a great deal of change in the patients' pre-service and post-service personality according to the relatives. It is to be taken into account however, that eight of the patients were hospitalized immediately subsequent to discharge from service. The relatives' evaluation of the pre-service personality of three of these patients was predominantly negative. Three others had predominantly positive evaluations. The patient whose relatives gave conflicting information concerning his personality was in this group. In the remaining case, there was no statement made by relatives concerning the patient's pre-service personality.

TABLE VI

PERSONALITY OF PATIENTS ACCORDING TO RELATIVES' DESCRIPTION

Pre-service Personality	Age groups 20-25	25-30	30-35	35-40	40 plus	Total
Pred. positive		4	5		2	11
Pred. negative	3	3	1	1		8
Conflicting inf.	1					1
Not stated	2		1	1	2	6
Total: 26	6	7	7	2	4	

Post-service Personality	Age groups 20-25	25-30	30-35	35-40	40 plus	Total
Pred. positive		2	2		2	6
Pred. negative	1	3	3	1	1	9
Conflicting inf.						0
Not stated		1		1	1	3
In hospital	5	1	2			8
Total: 26	6	7	7	2	4	

CHAPTER III

THE HOSPITAL EXPERIENCE OF THE STUDY GROUP

In this chapter, emphasis will be placed on the period of hospitalization that immediately preceded the period of trial visit on which this study is focused. An attempt will be made to ascertain what factors relating to the patient's hospital experience are common to the majority of the study group. Consideration will also be given to method of admission to the hospital, symptomatology at time of admission, as well as the number of previous hospitalizations each member of the group had experienced.

In attempting to arrive at some tentative prognosis as to whether the mentally ill patient will recover sufficiently from his illness to adjust, in some measure, to community life, it would seem important to consider the chronicity of the illness. In this study it was felt that some investigation into previous hospitalization experience would give some clue as to the chronicity of the mental illness of the men in the study group. It was found that among the members of the study group, twenty had experienced periods of hospitalization for mental illness prior to this present period of hospitalization. Downey VA Hospital is set up primarily to provide care and treatment for the chronically ill neuropsychiatric veteran. If the number of previous hospitalizations and length of time spent in these hospitals can be used as one measurement of determining chronicity of illness, it would appear that the study group members are, on the whole, representative of this policy. Fourteen of these

men received a Certificate of Disability Discharge from the Armed Forces. Eleven of the fourteen received their discharges from service while still in a military hospital. The following Table (Table VII) will show by age groups, type of discharge received by the men, number of previous hospitalizations and total length of time spent in all hospitals (excluding the present period of hospitalization under study).

TABLE VII

TYPES OF DISCHARGE FROM SERVICE, PREVIOUS HOSPITALIZATIONS AND TOTAL LENGTH OF HOSPITALIZATION OF STUDY GROUP BY AGE

Type of Discharges (by age groups)	Number previous Hospitalizations	Total months In hospitals
Number		
Age 20-25 6		
CDD	1	5
CDD	1	Not stated
CDD	5	3
CDD	1	3½
Honorable	None	None
CDD	1	2
Age 25-30 7		
Honorable	1	10
CDD	None	None
Not stated	1	6
Honorable	1	2
Honorable	None	None
Honorable	2	15
CDD	1	Not stated
Age 30-35 7		
Not stated	1	1
Honorable	None	None
CDD	1	2
CDD	2	14
CDD	3	13
CDD	6	55
CDD	2	6
Age 35-40 2		
CDD	Not stated	10
Not stated	5	11
Age 40-45 0	0	0
Age 45-50 1(Honorable)	0	0
Age 50-55 0	0	0
Age 55-60 1(Honorable)	8	55
Age 60-65 1(CDD)	7	Not stated
Age 65-70 1(Honorable)	1	Not stated

As stated in the first chapter, the majority of patients admitted to Downey are those veterans whose illness is considered to be service-connected, i.e., determined to have been incurred in or aggravated by service in the United States Armed Forces. This statement holds true for the majority of the study group, as the investigation revealed that eighteen of the men suffered illness which was considered to be service-connected. The remaining number (eight) were considered to be suffering from a non-service-connected illness.

The determination of whether a veteran's illness is service-connected or not rests with the adjudication board whose office is in the Veterans Administration Regional Offices. The adjudication board also has the responsibility for determining to what extent the veteran's disability prevents him from maintaining employment and otherwise adjusting adequately to life in the community. When the extent of disability is determined the veteran may receive monthly financial compensation or pension. In regard to the eighteen men in the study group whose illness was adjudged to be service-connected, fifteen received compensation, one received pension pending decision regarding a service-connected compensation; in one case no decision had been reached regarding compensation or pension, and in one case no statement could be found in the record regarding adjudication data. Of the eight men whose illness was considered non-service-connected, four received monthly pensions and four received no financial aid other than hospitalization for this particular illness.

As previously stated, a veteran may be admitted to the hospital on a voluntary basis or by commitment. According to the law of the State of Illinois commitment may be under one of two categories. The person may be committed either as being in need of mental treatment or as being mentally ill. When a

person is committed as mentally ill, he loses his civil rights. These rights may be restored after a determination is made by the court that the person is mentally competent. The person who is committed as being in need of mental treatment does not lose his civil rights. The court decides under which category a person should be committed. In the study group it was found that ten of the men entered the hospital on a voluntary basis. The remaining number (sixteen) were committed. Of the committed patients, four were committed as in need of mental treatment, and one patient was committed under neither category—this patient was committed by a court in Indiana and therefore does not fall under the law of having to be placed in either one category or the other.

It was further noted that six of the group were transferred to Downey from military hospitals. Six of the group were transferred from other hospitals (Veterans Administration or State Hospitals). A total of thirteen men were admitted to the hospital from their homes. In one case it was not clear in the record whether the man was admitted to the hospital from his home or from another hospital.

In considering the admission diagnosis of the men in the study group at the time they entered the hospital, it was seen that twenty-three had a diagnosis of schizophrenia. There are four sub-classifications for schizophrenia; namely, catatonia, hebephrenia, manic depression and paranoia. The patients' illness of schizophrenia is classified under one of these headings, according to the primary symptoms manifested in the illness. In the twenty-three cases, all classifications of schizophrenia were present in varying degrees. In the remaining three cases, one was diagnosed as "anxiety reaction," another, age 64, was diagnosed as "chronic alcoholism, without psychosis, cerebral arterio-

sclerosis, anxiety neurosis." In the third case it was not possible to determine the admission diagnosis from information in the case records.

The writers attempted to gather information as to presenting symptomatology of the study group at time of their admission to the hospital, at time of their release on trial visit, and at time of discharge from or return to hospital. Presenting symptomatology provides an index for determining if the patient's condition has improved or is in remission. The symptoms of the illness, as manifested by the patient's behavior, is described in the case records by the medical staff. The medical staff's description of the patient's symptoms were entered on the schedules. To facilitate the categorizing of this information the writers then indexed the cases, according to symptomatology under two headings, those cases in which presenting symptoms seem to be predominantly severe and those whose presenting symptoms seem to be less severe or predominantly mild. An example of presenting symptomatology at time of admission to the hospital, which, according to the criteria decided upon for this study, would be considered as "severe" would be that of a patient described as "actively hallucinating, over-active, confused, assaultive and desctructive, irrational, oriented to person and place but not to time. Patient's thinking and behavior was said to be disorganized." Whereas another patient described as having "no psychotic manifestations of thinking or interpersonal relationships, in good contact, well-oriented and having spontaneous emotional reactions," would be placed in the category of those whose presenting symptoms seem to be "predominantly mild." In regard to admission symptomatology, six patients in the study were placed in the category of "predominantly mild" and twenty in the category "predominantly severe."

As to be expected, the treatment received by the patients whose presenting symptomatology was severe and those whose presenting symptomatology appeared to be mild differed as to type. For example, Table VIII illustrates the type of treatment received in relation to degree of illness. Information as to whether psychological tests were given or not appears on the table. In some cases, a variety of psychological tests are given by the Psychology Department at the request of the medical staff. Usually a series of tests, combining projective techniques and intelligence quotient tests are administered.

TABLE VIII

TREATMENT AND TESTS GIVEN STUDY GROUP
IN RELATION TO DEGREE OF ILLNESS

Degree of Illness	Number	Electro-shock	Insulin	Both Elec.Shock and Insulin	Indiv. Psycho-Therapy	Group Psycho-Therapy	Intensive Casework	Psychol. Tests Given Yes	Psychol. Tests Given No
Severe	20	12	1	6*	5	2	1	9	11
Mild	6	0	0	2	1	2	1	4	2

Total: 26

*One patient had a lobotomy operation in addition to electric shock and insulin

It can be noted that those receiving treatment of all types total twenty-seven in the "severe" group. This is true because some members had more than one or two types of treatment. For example, three members in this group had electro-shock, insulin, and psychotherapy treatments. Ward routine as a type of treatment does not appear on Table VIII; however, all men participated in this type of therapy. Ward routine consists of daily patient activities such as meals, recreation and use of services in the Physical Medicine and Rehabilitation Dept.

In the age groupings between twenty and forty, 18 of the twenty-two patients were classified as having severe symptoms of illness, as were the patients in age groups forty-five to fifty and sixty-five to seventy. The patients in age groups fifty-five to sixty and sixty to sixty-five were in the group whose degree of illness was considered mild.

CHAPTER IV

TRIAL VISIT PREPARATION

It is established practice in Veterans Administration Psychiatric Hospitals that the medical staff does not await the request by families or other persons interested in the psychiatric patients to initiate the release of the patient on trial visit. Rather, the medical staff actively surveys the ward population continuously to seek out those patients whose response to treatment and total life situation indicates trial visit for them.[10] The referral of a patient for trial visit may thus come from the medical staff, the patient, a relative, or other interested person. The patient's situation is reviewed by the medical staff at a meeting of members of the ward team. In cases where trial visit seems to be a good plan for the patient, a formal request for trial visit preparation is sent to Social Service. The social worker undertakes to explore with patient and relatives feelings and attitudes around patient's return to home and community. An attempt is made to help individuals concerned handle such negative feelings as they might have so that the best interest of the patient is served. The patient's strengths and weaknesses are assessed and the patient is supported in his move into the community. Interviews with the patient who is about to leave the hospital on trial visit

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10 Dacy, Robt. T., et al. "Responsibility of Social Service in Trial Visit"

include a review of reality factors in his life situation affecting trial visit. The patient is helped to formulate definite plans for community living. Such factors as living arrangements and employment are discussed. The patient is helped to anticipate how he will handle problems he is likely to encounter as he endeavors to find employment, attempts to establish interpersonal relationships and the like. It is hoped that the experience of the positive relationship established with the hospital social worker during the trial visit preparation will be carried over into the relationship between the patient and the Regional Office social worker.

Unquestionably, the mentally ill patient who returns to a family whose members understand his illness and are positive in their attitude and behavior toward him is more likely to continue to make improvements in his health than if the reverse were true. The family's participation in trial visit preparation is very important. The social worker, in trial visit preparation, enters into a casework relationship with family members in an attempt to help relatives understand and appreciate the patient's illness and his role in relation to this illness.

Here consideration will be given to the factors involved in preparation of the members of the study group for triad visit. Attempt will be made to show what factors were common to the members of the study group and which of these factors might seem to facilitate successful trial visit.

Leave of absences and weekend passes from the hospital before release on trial visit are seen as one way of helping the patient to gradually become once more adjusted to home and community living. In length of time, the leave

periods may be from a few days to two or three weeks. By discussing with patient and relatives the patient's adjustment while in the home for these short spans of time, it is possible to obtain some idea as to whether the patient is ready to move out into the community for a more extended period. Also where the patient is on leave, it is possible to obtain some impression of the family's readiness and receptiveness to the possibility of the patient's return to the home. Thus, leaves of absence are utilized as an integral part of the trial visit preparation.

An analysis of the case records revealed that fifteen of the twenty-six patients in the study group went home on at least one leave of absence before their trial visit. Ten men did not leave the hospital on leaves of absence. In one case there was no statement as to whether the patient had a leave of absence before trial visit. In 12 of the fifteen cases of men who went out of the hospital on leave of absence and/or week-end passes, it was seen that both patient and relative expressed the opinion that the LOA. period was satisfactory; that is to say, the patient seemed to have adjusted well while in the community. In one of these fifteen cases, there was no statement as to whether patient or relative thought the leave of absence was satisfactory or not. In the remaining two of the fifteen cases, relatives expressed the opinion that the patient's home adjustment was satisfactory, but no statement was recorded regarding patient's attitude toward his leave of absence visit.

An investigation of the family constellation of the homes into which patients went on leaves revealed that 4 of the fifteen patients returned to family groups consisting of mother, father, and siblings. Three lived with

mother and father only, one with mother only, and two with adult siblings. Two patients resided with mother and other relatives. One patient resided with friends. The remaining two patients were on leave to homes consisting of their wives and children. All of the fifteen patients who went on LOA to the homes of relatives or friends also went on trial visit to these same homes, with the exception of one patient, who had lived while on leave from the hospital with his sister and brother. He was later released on trial visit in his own custody and took a room, alone, in the city to which he went to live.

Nine of the patients were referred for trial visit by the ward physician. Seven patients referred themselves for trial visit. Ten were referred by relatives. There were four main reasons for referral of the patient in the study group for trial visit: Eleven patients had reached maximum hospital benefits; nine had a satisfactory adjustment while on leave from the hospital; four requested release for economic reasons; and two had made a good hospital adjustment.

As can be seen from the listing of reasons, the economic factor did not play a major role in request for referral for trial visit. Only four patients referred themselves for trial visit, for this reason. Two of these men received compensation for service-connected illness, had no dependents, but felt they wanted to leave the hospital to secure employment. Another of this group also had no dependents, received non-service connected pension and wanted to leave the hospital to obtain employment. The remaining member of this group was one of the divorced patients whose illness was considered to be non-service connected and who received no pension or compensation. This patient

had three children for whose care he had been ordered by the court to pay twenty-seven dollars per week. In considering the economic factor as it relates to the total group, it was seen that sixteen members had no dependents whatsoever. Five had relatives who were fully dependent on them and five had relatives who were partially dependent on them.

All of the patients in the study group had contacts with social service in preparation for trial visit. It was not possible to determine from the case records the number of social service contacts. In 23 of the twenty-six cases, the patient expressed a desire to leave the hospital. Two patients were ambivalent on this point and there was no statement recorded regarding one patient's attitude in this matter. Nineteen men participated actively in trial visit planning, four were passive, two did not participate at all, and in one case there was no expression of attitude toward the plan.

In eighteen of the cases, social service had more than one contact with a family member. In six cases there was no social service contact and in two dases there was no statement in the record regarding social service participation in trial visit. In twenty-one cases the family expressed desire and interest in having the patient return to the home. In three cases, the family definitely indicated that they did not want the patient in the home. One family was ambivalent and there was no statement in two of the case records about the family's attitude toward having the patient return home. The following Table will show the relationships between patient and family at time of trial visit according to caseworker, family, and patient. The family constellation is also shown. Only when definite statements clearly indicated a relationship to be good or poor was the information categorized and recorded.

TABLE IX

CONSTELLATION OF TRIAL VISIT HOME AND RELATIONSHIP BETWEEN PATIENTS AND TRIAL VISIT FAMILIES

Constellation of Trial Visit Home	Relationship according to impression of Caseworker		Family		Patient	
	Good	Poor	Good	Poor	Good	Poor
1.Mother & Others	x		x		x	
2.Mother	*NS		NS		NS	
3.Self	x		NS		NS	
4.Mother&Father	x		x			
5.Mother		x	NS		NS	
6.Mother&Father		x	NS		NS	
7.Siblings	x		x		NS	
8.Mother&Others	x		NS		x	
9.Mother&Others	x		x		x	
10.Mother&Father		x		x		x
11.Self		x		x		x
12.Mother&Father	x		x		NS	
13.Self		x	NS	x		x
14.Self		x		x	NS	
15.Wife	x		x		x	
16.Wife,children	x		x		x	
17.Mother&Father	x		x		NS	
18.Mother&Others	NS		NS		NS	
19.Siblings	x		x		x	
20.Siblings	x		x		x	
21.Self	NS		NS		Ambivalent	
22.Mother&Father	NS		x		x	
23.Mother		x	NS		NS	
24.Father&Step-mother	x		x		x	
25.Mother&Others	NS		NS		NS	
26.Father&Mother	NS		x		x	
Total: 26						

*NS: Not stated

At the time of release on trial visit all patients, with three exceptions, showed an improvement in symptoms as manifested at time of admission. In the three situations the symptomatology appeared to be the same as at the time of admission.

Investigation revealed that nine of the patients had experienced previous trial visits at this or other hospitals. Five of these patients had one previous trial visit and two had experienced two prior to this present one. One patient had three previous trial visits and one patient had experienced five.

Length of stay in the hospital is that period spent in the hospital from time of admission up to discharge but excluding days spent on hospital leave or trial visit. This period, however, includes time spent on passes of three days or less. The median length of stay for a group of hospital admissions is the duration of hospital care required by the median patient.[11]

During the calendar year of 1952, the median length of stay for the psychotic and tuberculosis veteran was almost four months. Veterans with other types of illnesses stayed in the hospital less than one month (median length). Table X will show the length of stay in months of patients in the study group in relation to their age group.

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11 Administrator of Veterans Affairs, Annual Report, 1952, Washington, D.C. Page 22.

TABLE X

LENGTH OF STAY IN HOSPITAL
IN RELATION TO AGE GROUP

Age	Months of Hospitalization							
	0-10	10-20	20-30	30-40	40-50	50-60	over 60	Total
20-25	5						1 (107)	6
25-30	3		1	1			2(94-97)	7
30-35	4			1	1		1 (69)	7
35-40						1	1 (61)	2
40-45								0
45-50	1							1
50-55								0
55-60			1					1
60-65	1							1
65-70							1 (214)	1
Totals	14	0	2	2	1	1	6	26

CHAPTER V

THE TRIAL VISIT ADJUSTMENT

As mentioned previously, trial visit supervision in most instances is provided the patient by the Veteran's Administration Regional Office nearest his home. Supervision by Regional Office is a condition of release from the hospital under the trial visit program and is a responsibility of the VA Regional Office. The Regional Office social worker is interested in and has the responsibility for, establishing and maintaining a relationship with the patient throughout the trial visit period for the purpose of helping the individual in his adjustment to community living.

This readjustment means that the patient, as a member of the community, must set himself about the tasks of obtaining employment, availing himself of recreational facilities and re-establishing interpersonal relations with family and friends. The patient has also to cope with the misconceptions of and prejudices against mental illness as it exists today in society and often within the patient's own family. So it is that the mentally ill patient, whose illness is in remission and who has become accustomed to institutional living, must somehow find a new way of living. In this he needs the help of the social worker who is acquainted with his situation and understanding of some of his problems.

It is with this adjustment period of the members of the study group that this chapter concerns itself. An attempt will be made to show what factors were common to the majority of members of the group in this area.

Investigation revealed that seventeen of the patients were referred to the Chicago Regional Office for trial visit supervision. Nine were referred to other VA offices. All patients were contacted and all, with the exception of three, availed themselves of the agency's services. Of these three, one patient was unable to respond in a relationship with the caseworker. However, the patient's mother received casework services during the trial visit period, through a supportive relationship with the worker. Two of these patients, both with non-service connected illnesses, were placed on trial visit so that they could avail themselves of the services of the Mental Hygiene Clinic. However, these patients never followed through on the plan and contacts with social worker consisted of unsuccessful attempts to help them accept the clinic as a resource.

It is difficult to know the exact number of interviews or contacts each of the twenty-three patients had with the social worker. In most cases the interviews appeared to have been scheduled on a fairly regular basis. The contacts ranged from one, in two cases, to as high as thirty in one case. In thirteen cases the interviews ranged from at least two to twenty and in seven cases it was not possible to determine the exact number. Eleven patients' families had contacts with the social worker. Here again exact figures as to number of contacts were not available. This information was taken from Regional Office evaluations sent to the hospital and exact number of contacts are not always given in the summarized evaluations. Services extended to patients included helping patient to make realistic future plans and supporting them in their efforts toward adjustment. Sometimes the worker assisted

the patients in their efforts to clarify financial status. Families were assisted and supported in their efforts to adjust to patient's presence in the home.

In regard to the employment adjustment, it was seen that sixteen of the patients were able to obtain employment while still on trial visit. Ten were unemployed. Eleven obtained employment as unskilled workers, four as skilled and one semi-skilled. Seven worked less than six months, six from six months to a year, and three for an undetermined length of time. Fourteen of these men found their own jobs while two obtained work through the help of another person. Eight of the sixteen were employed on a regular basis, while eight worked irregularly. Nine of the men expressed job satisfaction, six expressed dissatisfaction and there was no statement in one case regarding the man's attitude toward his job. In the Regional Office worker's evaluation, five men were said to have made a good job adjustment and nine were said to have made a poor job adjustment. In two cases, the worker's evaluation of the men's job adjustment was not mentioned.

It was seen that twenty patients were able to participate in some recreational activities. The activities included sports, spectator and participation, movies and visiting and renewing acquaintances with friends. One patient did not take part in recreational activities. There was no statement regarding this in five cases.

Personality traits as described by the family and the Regional Office worker were considered as a factor in the adjustment period. This was seen by the writers as being important insofar as it might possibly be an indication of how well the patient was adjusting and whether improvement or

regression was occurring in his illness. In nine cases, the family described patient personality traits as being predominantly negative; in seven cases there were no statements in records regarding this factor, and in six cases there was no contact with any family members. The worker in sixteen cases described the patient as having predominantly positive personality traits; in six cases, negative traits and in four cases no statements were recorded.

The factor of the relationship of the patient with family members while on trial visit was considered. This information was gathered according to statements made by three sources; the relative, the patient and the Regional Office worker. In eleven cases all sources reported the patient and family members got along well together. In one case all sources agreed patient was not getting along well with family members. In four situations there was no report from any of the sources concerning this factor. In four cases there was no record of a statement being made by family but patient and caseworker felt relationship was good. In three cases the family and caseworker felt the relationship was good, but the patients' impression of the relationship was not recorded. Two families felt relationship was good, patient made no statement and worker thought relationship poor. In one case the family felt relationship between family and patient was good and there was no statement from patient and worker regarding this.

Trial visits were extended the usual length of time (three months at a time up to one year) in fourteen cases. In two cases the period was extended over one year for administrative reasons. In nine cases the trial visit terminated in discharge before the year's period had elapsed. In one case there

were no extensions. This patient, a non-service connected patient, was released on trial visit so that he could attend the Mental Hygiene Clinic. When it became apparent that he did not plan to attend the clinic, he was discharged from trial visit.

At the time of termination of hospitalization by discharge, fourteen of the patients showed marked improvement in manifest symptoms of their illness in comparison to symptomatology at time of trial visit. Twelve patients showed slight or no improvement and were making only a marginal adjustment at time of discharge.

CHAPTER VI

SUMMARY, COMPARISONS BETWEEN THE RETURNED GROUP AND THE DISCHARGED GROUP AND CONCLUSIONS

Investigation of case material revealed that certain common factors appear in the majority of the cases of the members of the discharged study group. The majority (twenty-two) of the patients were young men between the ages of twenty and forty. Nineteen of the patients were veterans of World War II. The majority (eighteen) of the men in the discharged group were single. All men claimed some religious affiliation.

A significant number of these men seem to have made some adequate adjustment to community life prior to entry into the Armed Forces as manifested in their educational pursuits and employment. Twenty of the men completed over nine years of formal education. Nineteen of the men were gainfully employed prior to service.

In regard to family background, it was observed that fourteen patients came from homes where the parents were married and living together. Almost one-half (twelve) of the members had relatives who had been known to be mentally ill at one time or another.

Twenty of the men in the discharged group had experienced periods of hospitalization for mental illness prior to this present period of hospitalization. Fourteen of the men received Certificate of Disability Discharge from service. Eighteen of the group had illness which was adjudged to be service

connected. Twenty patients had symptomatology, at time of admission to the hospital, which was considered severe.

Trial visit preparation seems to have played an important part in the total trial visit adjustment. All men in the group, with the exception of two, participated in preparation planning; Social Service had contact with eighteen patients' families prior to trial visit; eight families were seen several times. In thirteen cases, according to the social worker, the discharged patients' relatives appeared to have had a good understanding of the patient's illness. Twenty-three of the members of this group expressed a desire to leave the hospital. Fifteen of these patients went out of the hospital on Leave of Absences prior to trial visit.

Twenty-three of the discharged patients availed themselves of the services of the Regional Office, with eleven families having some contact with this office. In eleven cases, the patient, his relatives, and Regional Office social worker evaluated the relationship between the patient and his relatives during the trial visit period as good. Sixteen of the patients were able to obtain employment while on trial visit. The Regional Office social worker in sixteen cases described the patient as having predominantly positive personality traits while on trial visit.

In drawing a comparison between the discharged group and the returned group, similarities were observed in regard to age, marital status, and education and employment. The majority of the returned group were young men between the ages of twenty and forty. Thirteen of the eighteen members were single. Fourteen of the members of this group were gainfully employed prior to entry into service. Twelve of these men completed over nine years of formal education.

Thirteen of the patients in the returned group had experienced hospitalization for mental illness previous to this one as compared with the twenty men with this experience in the discharged group. As with the discharged group the majority (fourteen) of these men presented symptomatology at time of admission to the hospital which was considered severe.

In considering the trial visit preparation of the two study groups it was noted that relatives of thirteen (72 per cent) of the returned group had contact with Social Service. Eighteen (69 per cent) patients' relatives in the discharged group had contact with Social Service. The number and frequency of the contacts were greater, however, with the discharged group. Fifteen patients, or 83 per cent, of the returned group participated in trial visit preparation, compared with twenty-four, or 92 per cent, of the discharged group who participated in trial visit preparation. Less than fifty per cent of the returned group went out of the hospital on Leave of Absence prior to trial visit, while over fifty per cent (fifteen) of the men in the discharged group had Leave of Absence periods prior to trial visit. All patients in the returned group with one exception(94 per cent of the patients in the returned group) expressed a desire to leave the hospital as compared with twenty-three or 88 per cent of the discharged group.

Twenty-three, or 88 per cent, of the discharged patients availed themselves of the services of the Regional Office with eleven families having some contact with this office. Thirteen, or 72 per cent, of the men in the returned group had contact with Regional Office. Ten of these patients' families had some contact with Regional Office.

The stability of the members of the discharged group as compared with that of the members of the returned group is, of course, seen in the actual trial visit adjustment. All of the members in the discharged group were able to make a sufficiently satisfactory adjustment to stay out of the hospital, at least long enough to be discharged from trial visit. Seven of the patients in the returned group were returned within the first month of trial visit and five more were returned before the expiration of six months of trial visit. Only five of the returned group attempted employment in contrast to the sixteen members of the discharged group who were able to obtain employment. Only one member in the returned group was thought to have established good relationships with relatives by social worker, patient and relatives, while eleven of the discharged group was so described. Only one member in the returned group was described as having predominantly positive personality traits, while sixteen patients in the discharged group were so described.

Actually it appears that it is not possible to ascertain from the study exactly what factors made for a successful trial visit (one terminating in discharge) as against what factors made for an unsuccessful trial visit. It appears that to some extent both patients and relatives in the discharged group were more adequately prepared for the trial visit experience. One might conjecture that the stresses and strains encountered by the discharged group were not such as to make return to the hospital necessary. Perhaps family relationships were such as to sustain this group, rather than hinder them in trying periods of adjustment although actually the information in the case records concerning relationships is not sufficiently comprehensive and definite

to permit of such a conclusion with any degree of certitude. In regard to the returned group, it is possible that a combination of factors in the environment and illness tended to make continuation outside the hospital impossible.

The positive factors that appear in the cases in the study do not seem to be outstanding or unique with the discharged study group. Definitude in recorded information concerning such factors as interpersonal relationships of the patients and family, which might give clue to the question of what makes for a successful trial visit, is deficient to the extent of making it impossible to arrive at any valid conclusions as to the actual significance of this factor. It is recognized of course, that such an assessment may have been made by the social workers but not fully recorded in the case records.

The findings of the study do not permit of any definite conclusions as to what factors tend to make for a successful trial visit experience. Certainly all of the positive factors such as Social Service contact with patient and relatives in trial visit preparation, patients' willingness to return to the hospital and Leave of Absence from the hospital before trial visit, enhance the possibility of a favorable outcome of the trial visit. It is not known, however, to what extent this is so, nor to what extent other unknown factors played a part in the patient's successful trial visit.

The writer is of the opinion that the study would have reflected general trends in relation to the trial visit program had the number of cases in the study group been larger.IIn regard to the collection of data, the lack of information in the Social Service case records concerning certain factors has already been commented upon. Generally, however, the records were most adequate for the purposes of the study. This was especially true of Regional Office reports,

BIBLIOGRAPHY

A. BOOKS

Administrator of Veterans Affairs, Annual Report, 1952. Washington, D.C., 1952.

Administrator of Veterans Affairs, Annual Report, 1953. Washington, D.C., 1953.

Appell, Kenneth E. and Strecker, Edward A. Psychiatry in Modern Warfare. New York, 1945.

National Conference of Social Work, Proceedings of the National Conference of Social Work, 1946. New York, 1947.

National Conference of Social Work, The Social Welfare Forum, 1953. New York, 1953.

Stern, Edith M., Mental Illness: A Guide For the Family. New York, 1942.

B. ARTICLES

Ashton, E.T., "Friendship and Mental Illness," Mental Health, (Autumn 1953), 5-8.

Faris, Mildred T., "Casework with Mentally Ill Patients and Their Relatives," Journal of Psychiatric Social Work, (January 1955), 108-112.

Freeman, Henry, "Casework with Families of Mental Hospital Patients," Journal of Social Casework, (March 1947), 107-113.

Kahn, Shirley W. and Prestwood, A. Rodney, "Group Therapy of Parents as an Adjunct to the Treatment of Schizophrenic Patients," Psychiatry, (May 1954), 177-185.

Krisley, Sally, "Authority: A Factor in the Casework Relationship with Trial Visit Patients," Journal of Psychiatric Social Work, (October 1954), 36-42.

Shea, Margene M., "Planning for Psychotic Patients at Home," Journal of Social Casework, (December 1950) 420-423.

Stephens, Elsie, "The Schizophrenic in Remission. Diagnostic and Treatment Considerations," Journal of Psychiatric Social Work, (January 1954), 57-66.

C. UNPUBLISHED MATERIAL

Dacy, Robert T., et al, "Responsibility of Social Service in Trial Visit," Downey, Illinois, 1953.

Heerey, Katherine, "An Analysis of the Case Histories of Sixty-three Veterans Under Trial Visit Supervision," Unpublished Master's Thesis, Loyola University, Chicago, 1950.

ode #
egistration #

Identifying Information:

1. Admission date _____
2. Age _____
3. Marital Status: S M S D R W
4. Adjudication data:
   a. Service connected _____
   b. Non-service connected _____
   c. Compension _____
   d. Pension _____
   e. Amount _____
5. Service date:
   a. Entry _____
   b. Discharge _____
6. Type of discharge _____
7. Branch of service _____
8. Rank in service _____
9. Religion: _____
   a. Protestant _____
   b. Catholic _____
   c. Other _____
10. Legal Status:
   a. Committed _____
   b. Voluntary _____
      1. Mentally ill _____
      2. In need of mental treatment _____
11. Education:
   a. Year Last completed _____
   b. Special training _____
12. Race:
   a. White _____
   b. Negro _____
   c. Other _____

. Medical Information:

1. Previous Hospitalization:
   a. Number _____
   b. Dates
      1. _____
      2. _____
      3. _____
      4. _____
   c. Place
      1. _____
      2. _____
      3. _____
      4. _____
   d. Admission Diagnosis
      1. _____
      2. _____
      3. _____
      4. _____
   e. Discharge Diagnosis
      1. _____
      2. _____
      3. _____
      4. _____
   f. Treatment
      1. _____
      2. _____
      3. _____
   g. Reason for hospitalization
      1. _____
      2. _____
      3. _____

h. Adjustment

1. good _____ poor _____ fair _____
2. good _____ poor _____ fair _____
3. good _____ poor _____ fair _____
4. good _____ poor _____ fair _____

2. Present Hospitalization:

a. Admission diagnosis _____
b. Discharge diagnosis _____
c. Reason for admission _____
d. Treatment _____
1. ECT _____
2. Insulin _____
3. Casewk. Therapy _____
4. Group Therapy _____
5. Psy. Ward Routine _____
6. Other Ind. Therapy (psychology) _____
e. Psychological Test Given _____
1. Stanford Benet _____
2. Wechler-Bellvue _____
3. Rocharch _____
4. _____

C. Social Information

I. General Background

1. Parents

a. Marital status S M S D R W
b. Birthplace
1. father _____
2. mother _____
c. Occupation
1. father _____
2. wife _____
3. mother _____
d. Relationships of parents to each other-According to caseworkers impression
1. Parents appeared to get along well with each other _____
2. There appeared to be marital discord _____
e. Relationships according to patient
1. Did parents appear to get along well with each other _____
2. Did there appear to be marital discord _____
f. Relationship as stated by parents (if interviewed)
1. Did both parents feel marriage satisfactory _____
2. Did both parents feel marriage unsatisfactory _____
3. Did one parent express marital discord _____
g. Relationship of parents to patient according to caseworker's impression
1. Parents appeared to get along well with patient _____
2. One or both parent appeared not to get along well with pt. _____
h. Relationship of parents to patient according to patient
1. Patient felt he & parents got along well together _____
2. Patient felt he and one or both parents did not get along well togethe
_____
i. Relationship of parents to pt. according to parents
1. Parents felt they got along well with pt. _____
2. One or both parent felt they did not get along well with pt. _____

2. Siblings

a. number _____
b. pts. position in family _____
c. significant sibling relationship _____

3. Known mental illness in family
   a. father_____
   b. mother_____
   c. other_____
4. Patient's adjustment
   a. Personality-pre-service
      relatives (mo. or parents)
      describe patient as
      1. shy _____
      2. moody_____
      3. withdrawn_____
      4. friendly_____
      5. outgoing_____
      6. passive_____
      7. agressive_____
      8. ambivalent_____
      9. dependent_____
      10. independent_____

   Personality-post-service
   relatives describe patient as
      1. shy _____
      2. moody_____
      3. withdrawn_____
      4. friendly_____
      5. outgoing_____
      6. passive_____
      7. agressive_____
      8. ambivalent_____
      9. dependent_____
      10. independent_____

   b. Employment - pre-service
      1. Type
         Skilled_____
         Semi-skilled_____
         Unskilled_____
         Professional_____
      2. Length of employment
         Less than 6 mos._____
         6 mos. to one yr._____
         one to three yrs._____
         Over 3 yrs. - state length._____
   c. Employment - after service
      1. Type
         Skilled _____
         Semi-skilled_____
         Unskilled_____
         Professional_____
      2. Length of employment
         Less than 6 mos._____
         6 mos. to one yr._____
         One to 3 yrs._____
         over 3 yrs. - state length_____
   d. Relationship of patient to wife according to wks. impression
      1. Did patient and spouse appear to get along well together_____
      2. Did there appear to be marital discord _____
   e. Relationship according to wife
      1. Wife expressed marriage satisfactory_____
      2. Wife expressed marriage unsatisfactory_____
      3. Wife expressed ambivalence re: relationship_____
   f. Relationship according to patient
      1. Patient expressed marriage satisfactory_____
      2. Patient expressed marriage unsatisfactory_____
      3. Patient expressed ambivalence re: marriage relationship_____
   g. Relationship of patient to children according to wife
      Patient was said to
      1. get along well with children _____
      2. get along poorly with children_____
      3. Participates in activities with children_____

h. Relationship of patient to children according to patient
Did patient express
1. That he got along well with children _____
2. That he got along poorly with children _____
3. Participated in activities with children _____
4. Did not participate in activities with children _____

i. Recreation
1. none _____
2. family only _____
3. spectator sports _____
4. participation sports _____
5. others (specify) _____
6. alone _____
7. friends _____
8. church _____

j. Patients' home
1. Patient resided
a. with wife _____
b. with children _____
c. with father _____
d. with mother _____
e. alone _____
f. others _____
2. Number in home _____
3. Number of rooms _____
4. Housing adequate _____
5. Housing substandard _____

k. Family management
1. Family dependent on patient for support
a. Full _____
b. Partial _____
2. Family not dependent on patient for support
a. Full _____
b. Partial _____
3. Family managed adequately without outside assistance _____
4. Family received financial assistance from welfare agency _____
5. Family received help from relatives _____
6. Dominant member Wife _____ Patient _____
Mother _____ Father _____

e-Trial Visit:
. 1. Did patient leave hospital on LOA before T.V. - yes _____ no _____
2. Has he placed on T.V. status from LOA without returning to hospital - yes _____
3. Number of LOA's _____
4. Length of LOA's _____
#1 _____
#2 _____
#3 _____
#4 _____

2. Patient resided on LOA
a. with wife _____
b. children _____
c. father _____
d. mother _____
e. alone _____
f. others _____

3. a. Patient expressed LOA period satisfactory _____
b. Patient expressed LOA period unsatisfactory _____

B. 1. Did patient leave hospital on weekend visit before T.V.
yes _____ no _____ number _____

2. Patient resided on weekends
a. with wife _____
b. children _____
c. father _____
d. mother _____
e. alone _____
f. others _____

3. Patient expressed weekend period satisfactory _____
Patient expressed weekend period unsatisfactory _____

4. Person with whom patient lived on weekend expressed weekend period satisfacto
Person with whom patient lived on weekend expressed weekend period unsatisfac

E. Trial Visit:

1. Date of initial request by referral source _____
2. Date of T.V. preparation staffing _____
a. Regular staffing _____
b. preliminary staffing _____
3. Date patient left on T.V. _____
4. Referral source:

a. source
Physician _____
Father _____
Mother _____
Wife _____
Patient _____
Other _____

b. reason
1. Remission _____
2. Absence of symptoms _____
3. Better behavior _____
4. Felt pressure by hospital _____
5. Economic factors _____
a. Support family _____
b. Secure or hold job. _____
6. Felt guilt around hospitalization
(worker's impression) _____

5. Preparation
a. Constellation of T.V. Home:
1. mother _____
2. father _____
3. brother _____
4. sister _____
5. wife _____
6. children _____
7. other _____
8. self (only) _____

b. Family
1. Number of social service contacts _____
2. Understanding of patients illness (wker's impression)
good _____
poor _____
3. Family expressed wanted patient home _____
4. Family expressed did not want pt. home _____
5. Ambivalent in desire to have patient home _____

b.2 Relationships:
1. Relationships at time of T.V. according to wk's impression _____
Relationship between pt. & T.V. family appeared to be good _____ poor ___
2. Relationship at time of T.V. according to T.V. family
T.V. family expressed relationship between pt. & family good _____ poor ___
3. Relationship at time of T.V. according to patient
Patient expressed relationship between himself and family good ___ poor ___

c. Patient:

1. Number of Social Service contacts_____
2. Pt. expressed desire to leave hospital_____
3. Pt. expressed did not desire to leave hospital_____
4. Nature of So. Service contact
   a. Supportive_____
   b. clarification_____
   c. insight _____
   d. environmental manipulation _____
5. Did pt. have contact with R.O. worker - yes_____ no _____
6. Patient participation in planning - active_____ passive _____
7. Vocational counseling - yes _____ no _____

c.1 Trial Visit Employment

a. Type: 1. skilled_____ 2. unskilled_____
   3. semi skilled _____ 4. professional_____
b. Length of employment:
   1. Less than 6 mos._____
   2. 6 Mos. to one yr._____
c. Number of jobs _____
d. Did patient find job - yes_____ no _____
e. Was job obtained by another person for pt. - yes_____ no _____
f. Was work regular_____ irregular _____
g. Length of time after release from hospital before
h. Employment _____
i. Did patient express satisfaction with job - yes_____ no _____
j. Did patient express dissatisfaction with job -yes_____ no _____
k. Did patient attend vocational rehabilitation _____
l. Regional office worker's evaluation of employment situation
   Was employment adjustment said to be good_____ poor_____

m. Patient returned to former employment _____

d. Social adjustment:

1. Information provided by T.V. family
   a. Relationships
      1. Did family feel patient got along well with family_____
      2. Did family feel patient did not get along well with family_____
2. Information provided by patient
      1. Did patient feel he got along well_____
      2. Did patient feel he did not get along_____
3. RO worker feel patient adjusted to family members - yes _____ no _____
4. Physical aspects of T.V. home adequate_____substandard_____
5. Did patient have own room - yes_____ no_____
6. Recreational activities
   a. none_____
   b. family only_____
   c. alone_____
   d. friends_____
   e. other activities_____
   f. church_____
   g. sports: spectator_____
   h. participation_____

7. Personality-source

	Family	Caseworker
a. Shy		
b. Moody		
c. Withdrawn		
d. Friendly		
e. Outgoing		
f. passive		
g. Agressive		
h. Ambivalent		
i. Dependent		
J. Independent		

8. Number of T.V. extensions_____
9. Reason for extension according to
   a. VARO Report
      1. Facilitate return to hospital if need indicated_____
      2. Give patient security_____
      3. Administrative Reason_____
      4. Others_____
10. Services to patient during T.V.
    a. Agency

	VARO	Locale	Public	Private
b. Type casewk.				
Supportive				
clarification				
Environmental manipulation				
Insight				
c. Casewk focus				
Family				
employment				
social				
d. Number of contacts				
e. Length of service				
f. Referral to another agency				
g. Remarks				

11. Services to family
    a. Agency

	VARO	Public	Private
b. Type casework			
Supportive			
Clarif.			
Envir. manip.			
Insight			
c. Casework focus			
Family			
Job			
Social			
d. Number of contacts			
e. Length of service			
f. Referral to another agency			
g. Remark			

12. Disposition for T.V.
    Discharged_____ Date_____
    Returned_____ Date_____

13. Reason for return from this T.V.
a. Patient _____ b. Family _____

14. a. Number of previous T.V. _____ c. Disposition _____
b. Dates of previous T.V. _____
_____ _____
_____ _____
_____ _____

d. Reason for return previous T.V.
Source Source
1. Patient 2. Family

15. Symptomatology at time of admission to hospital _____

16. Symptomatology at time of T.V. _____

17. Symptomatology at time of termination of hospitalization _____