THE SUSTAINING CLINIC:

OUTPATIENT SERVICES FOR THE LONG-TERM MENTALLY ILL

A Case Review of Low Potential Rehabilitation Patients in the Sustaining Clinic and the Social Club; Mental Health Centre, Burnaby, B. C., 1957 - 1960

by

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ABSTRACT

The Sustaining Clinic is a recently-added service provided by the Mental Health Centre in British Columbia for a selected group of patients who are unable, for a variety of reasons, to benefit from more intensive therapy than a monthly interview. This study reviews the contribution of the therapeutic team at the Sustaining Clinic (of which the social worker is a part), toward the rehabilitation of a difficult group of mentally-ill patients, most of whom require long-term follow-up care.

To emphasize the focus on the appropriate type of patients, the method is to review (1) the problems of a sample group of these patients, and (2) the treatment services given to them; thus, establishing how far this meets their needs. Treatment is evaluated with the aid of three rating scales assessing the patient's functioning at the time of referral and at the time of discharge.

The evidence is that (1) The enormous disability associated with these patients is to a large extent imposed, preventable, and treatable. Disability originates particularly from parental rejection, and is later magnified by the rejection mechanisms stemming from cultural attitudes. (2) The treatment provided by the Sustaining Clinic is effective because it is related to the needs of the patient and to the specific conditions surrounding his illness. Therapeutic contributions include regulation of medication, support in cases of stress, limit-setting, information-giving, manipulation of the environment, and providing a figure for identification. (3) More resources than the Clinic can provide will be needed, because of the deep-seated personal and social handicaps of these patients. This study itself can be helpful only if coordinated with others which examine other "halfway house" programs, and the social worker's participation in them.

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CHAPTER I

THE REHABILITATION SPECTRUM OF THE MENTALLY ILL

The nature of disability produced by mental illness varies widely because of the complexities of personality development, marked individual differences in adaptation to stress, and great variations in ethnic and cultural milieu. However, it is currently assumed by many psychiatrists, psychologists and social workers, that mental illness derives from difficulties in interpersonal relations that result in the frustration of instinctive needs and strivings whose satisfaction is essential for normal growth and happiness. The blocking of thwarting of these drives leads to various unpleasant tension states, but their specific expressions vary over a wide spectrum.

In some patients the tension is manifested by anxiety or apprehension; in others, it is transformed into obsessions or compulsions. Some patients fix their attention upon actual or fancied somatic complaints and become "psychic invalids"; others have major disturbances in autonomic balance that result in malfunctioning of visceral organs (psychosomatic illness).

The behaviour of the Sustaining Clinic group is characterized by withdrawal, by preoccupation with primitive fantasies and attempts at the resolution of psychic tensions either by inappropriate aggressive action, or by specialized psychic trends such as delusions and hallucinations. From another point of view, the Sustaining Clinic persons may be understood as suffering from deep-seated feelings of unworthiness that frequently break

out in antagonism to authority or "rivalry figures" or potential objects of affection, and seriously impair their ability for work, play, or love.

Behaviour pathology is to a considerable degree the product of serious defects in the techniques of sharing the perspectives common to one's society. The difficulty in a specific case may stem from a failure to acquire adequate social skill in "role-taking" during early personality development, or it may represent the loss or distortion of role-taking in a person who had once acquired sufficient skill. Sharing attitudes and taking roles are matters of the utmost significance both in forming a diagnosis of and in planning a therapy for the Sustaining Clinic patient. One of the most difficult tasks in the treatment of behaviour disorders is that of learning to see a patient's problems from his own highly individual, personal perspective; yet at the same time leading the patient toward sharing some of the therapist's impersonal detached attitudes about symptoms and their origins. This is the basis of "rapport", and one of the factors in "transference".

The patients attending the Sustaining Clinic are maintained in the community on tranquilizing drugs, and are unable, for a variety of reasons, to benefit from intensive therapy. For many of these patients any contact beyond a brief monthly interview is so frightening they will terminate treatment. Though they crave a close relationship with someone who will understand and accept them, their fear of rejection and loss of power through lowering their defences is great. Thus, the therapist, because of the very nature of his patient's personality, is forced to deal with everyday reality problems.

Areas of Rehabilitation

The rehabilitation of the psychiatric patient presents a special

problem: How can the mentally ill patient be helped to live in the community, both socially and vocationally, in spite of any residual symptoms or personality disorder he may still have? Therefore, part of the rehabilitation process is not only to reduce or eliminate the psycho-pathology, but also to re-educate the individual in social and vocational skills to enable him to face situations that he will encounter in his community.

The principal areas in which rehabilitative effort should be applied in assisting the mentally-ill patient are: (1) psychological rehabilitation, (2) vocational, (3) family, (4) social-recreational, (5) community and (6) educational rehabilitation. Such a concept of rehabilitation of the mentally ill approaches that of total treatment.

Psychological rehabilitation comes first in the hierarchy of concern. Here interest is primarily focused in reduction or removal of clinical symptoms, resolution of disruptive anxieties and tensions, neutralization of intrapsychic conflicts, and so on. This is primarily a psychodynamic therapeutic problem and is best managed by intensive individual or group therapy, together with all other measures available in the hospital and out-patient setting. It is worth stressing that, for many patients, there exists a "psycho-pathological ceiling", which limits adaptational growth very sharply. For these patients, the critical psychological problems must be dealt with and resolved first before further rehabilitation effort can pay off. However, for other patients, although psychological problems may be sharply limiting, marked rehabilitative gains can be made through the employment of methods which are further discussed.

Second, vocational rehabilitation involves careful assessment or

survey of patients' occupational or vocational interests and capacities, testing of his fitness through occupational assignment, developing old or new skills via occupational therapy or work therapy, increasing work tolerance, training outside the hospital setting where indicated, assistance in job placement, and follow-up of vocational adjustment through contacts with the patient and, where possible and helpful, with the employer.

Third, family rehabilitation: The family and its assets and liabilities, it seems clear, will be of increasing concern to social work of the future. Child guidance clinics point the way by extending treatment to both child and parent. The patient's breakdown is often part of a major struggle going on in the family, the patient being the victim of character disturbances of other family members, long-standing feuds, or basic incompatibilities. The beneficial effects of hospitalization and the total plan of treatment may be vitiated by the family, unless considerable support and understanding is given them. Major changes within the family may occur as the result of a patient's hospitalization, and in turn may affect him: mental or physical stress in one or more family members, stigmatization by friends or community, movement of residence to another vicinity, or closing of ranks against him, especially if his illness assumes a chronic course. Thus, the family must be brought within the therapeutic orbit if the patient's rehabilitation potential is to be realized fully.

Fourth and fifth are social-recreational and community rehabilitation. Experience indicates that this is one of the weakest areas of patient adaptation and one toward which relatively little treatment effort is directed. Yet it is generally felt that those patients who develop deep roots

in the community have the fewest relapses. The ex-patient may go through the motions of holding a job, indeed be quite productive, yet be unable to tolerate social contacts, dependent as they are upon ease and naturalness of association and confidence in oneself. Part of the difficulty is the unavailability of suitable socio-recreational groups - "halfway" groups, so to speak - that have tolerance for the ex-patient appropriate to each stage in his reintegration.

Sixth is educational rehabilitation. The experience of being ill and of recovering, plus all the self-understanding that it can imply, especially in the successful case, may make a profound contribution to one's psychological education. Additional efforts are often worthwhile to attempt to develop more fully the person's skills, talents, curiosities, and special interests. Thus, mental hospitals should include programs of art, music appreciation, language instruction, photography, carpentry and cabinet-making, the dance, and lectures by teachers of local institutions as part of the rehabilitative procedure. Many patients have discovered that totally new areas of curiosity, competence, or striving, could be developed through the stimulation and support provided by a rich rehabilitative program.

Phases of Illness and their Implications

There are three phases of the patient's illness during which rehabilitation efforts must be applied: (1) during his hospitalization, (2) during transition to the community, and (3) during his community life.

During hospitalization, rehabilitation emphasis is on achieving a "therapeutic climate," that is, an interpersonal atmosphere calculated to undo the pathogenic relations of the patient's earlier life. Hospital staff,

therefore, in the aggregate should be accepting, sympathetic, uncritical, interested, and understanding. Within such a climate, three general patterns of treatment may be stressed. First, is intensive, individual psychotherapeutic work with a trained, professional therapist. A steadfast, reliable relationship that explores thoroughly a patient's thinking and feeling can be a remarkable catalyst for growth. The second aspect is "milieu" therapy; here is implied not only the "therapeutic climate" mentioned above, but also a program that makes available to the patient many activities, diversions, and socializing possibilities. An active occupational therapy, recreation, work, and sports program is essential. Also crucial are the relationships developed with other persons - with staff or patients - in these activities. Often the milieu program can be successfully supplemented by additional group experience such as formal group therapy or patient government. The third area of emphasis is somatic therapy. Here are included all efforts directed toward removal of physical or physiological handicaps, and in addition, specific somatic treatments including electric shock, insulin, surgery, and pharmacotherapeutic agents. All these efforts to help the patient, it must be noted, put major stress upon communication and coordination functions of the hospital; these are primary concerns of management or administration and are delegated essentially to the clinical team headed by the psychiatrist.

Insufficient attention has been paid to the <u>transitional phases</u> of the patient's experience. A severe cultural discontinuity exists between the hospital and the outer community that most patients, upon discharge, experience as more or less threatening. Much effort will be needed in the future to develop carefully graded steps for the movement of the patient

from the hospital to the outside world. In the case of deep-seated, chronic illness (e.g., the Sustaining Clinic patients), weeks or months of arrest in various transitional phases may be expected before the patient is secure enough to resettle himself independently in the community. It is not necessary to give more than a few illustrations of the types of facilities that may be offered.

1. The day or night hospital. The day hospital has been developed to allow early discharge of patients from hospital residency; however, they may continue their association with the hospital in whatever capacity is needed by returning during the day. This is especially suitable where the home environment is too difficult to endure for the full day, when patients are as yet unable to work on their own, and where long-term contact with the therapeutic climate is necessary. Night hospital patients work during the day but return to the hospital overnight.

2. The "sheltered workshop". This has been found helpful in the rehabilitation of many patients. It best follows a well-developed work program within the hospital. Additional work training and work "hardening" can occur within a sheltered workshop situation where progressively conditions of industry can be approached.

3. The "halfway house". This refers to a residency situation, usually under the guidance of a supervising person, for patients who might profit by group or dormitory living and can earn and help pay for their maintenance. Patients who have no home to go to, or cannot anticipate comfortable acceptance in a home, may do very well in a halfway house as a transitional measure.

4. "Family care". Especially for chronic patients, family care programs may be very successful. The patient is placed within a selected family where he becomes a member who may work or contribute up to his capacity. Either the provincial government or a philanthropic agency foots the bill, and the hospital usually maintains a watchful, supervising function through a social worker.

5. The ex-patient club. Patients and ex-patients are able to band together successfully in their own interests. Inpatient self-government is a gratifying actuality in some hospitals, and ex-patient clubs are increasing in number and variety throughout this country. In ex-patient clubs, former patients have an opportunity to participate in many group activities and thus gain assurance and confidence in social situations. Club membership may be a stepping stone to developing more secure community roots, and thus may play an important role in prevention of relapse.

6. Outpatient therapy. This is a growing service that proves invaluable to many ex-patients who need long-term supportive or analytic therapy, group work, or who require a course of pharmacotherapy or electric shock treatments. Outpatient clinics such as the Sustaining Service constitute a major bulwark of support and a line of defense against re-hospitalization.

Community adjustment under the conditions indicated above becomes a natural and easy consequence of graded transitional steps back to society. The patient will need considerable support against the stresses and slights felt in interaction with other citizens. Job finding often presents a problem because of the stigma of mental illness, and acceptance within the family or social group may be achieved at times only through an up-hill fight. Here

the continued interest and support of a social agency is essential, and in some instances counselling and home visits by a trained social worker can be helpful. Often family members may be encouraged to seek psychiatric or social work help themselves, for a patient's breakdown in many instances can be assumed to be part of a psycho-pathological family atmosphere. Finally, the hospital and social agencies working with discharged mental patients have a responsibility to educate citizens, in problems of mental health and to cultivate good will toward both inpatients and ex-patients.

Problems Faced by Discharged Mental Patients

For the person who has been hospitalized for mental illness, the period of readjustment to community life can be an extremely difficult and traumatic one. Long-term hospitalization in any setting often reactivates a person's dormant dependency needs. When he is mentally ill this problem can be particularly severe. Frequently, the mental-hospital patient who returns to the community suffers from intensified feelings of insecurity and extreme lack of confidence. Once again he must face problems and conflicts, perhaps the very ones from which his mental illness afforded an escape.

The rehabilitation of the Sustaining Clinic person is further complicated because, in all instances, there is still a residue of the mental illness. Unlike other people who have experienced emotional problems but whose defences have remained intact, this type of patient, returning to the community from the mental hospital, is likely to be disabled in most areas of social functioning. Often, his disintegration is so complete that he needs help in all the vital areas of day-to-day living - job placement, living arrangements, social contacts, and so on.

Since rehabilitation of the mentally ill is a social problem, in the most encompassing sense, it is the social worker who is best fitted to assume the role of the helping person. The social worker works with a mentally ill individual within the context of that person's social environment and, therefore, has the most appropriate skills to aid him in his environment.

What seems to happen in the vast majority of cases is that the patient returns to an environment which, far from being favorable, is not even neutral; it is more likely to be hostile or in some other way destructive. Frequently, the patient who returns home has little or no money, no job, and poor prospects either of obtaining a job in the near future or of being able to hold a job if one is offered to him. If his family is living on a minimal income, his release will mean that there is one more mouth to feed. It is obvious that these and similar factors can create or exacerbate certain psychological as well as financial problems.

Many families or spouses get used to having the patient in the hospital; in many instances they are actually better off without the patient. Is it any wonder that their behaviour toward him may range from passive rejection to overt control, humiliation, or even threats to send him back to the hospital?

One should not forget that the family is a constellation of interacting personalities. In the absence of one member of the family for a long period of time, the constellation re-forms, and the place formerly occupied by the absent one is eliminated. It follows, therefore, that the social worker may be faced with the added task of helping to realign the family con-

stellation in such a way that the returned patient is again a part of it.

There are many basic social and psychological dependency needs which must be met before these patients are re-established in the community; income, clothing, shelter, employment, and a meaningful relationship with one or more people who will understand their deep basic needs. The return to the community for a person who has been hospitalized for a mental disorder is often a threatening experience. To lack adequate resources in finances, home, relatives or interested friends increases the patient's insecurity and, therefore, feelings of anxiety. The possibility of a relapse and return to hospital becomes very real. There are patients, as already mentioned, who leave the mental hospital with a residuum of the mental disorder which led to their hospitalization. The inner psychological problems of these patients may be of such severity that they cannot be resolved by known methods of psychiatric therapy. The stresses of these patients can be eased, although not resolved, in making an adjustment to life, by manipulation of environment to help them feel more comfortable in their adaptation, and by the warm support, encouragement, and active interest of a social worker. The discharged mental patient who is inwardly weakened or handicapped in his ability to meet the exigencies of his situation, needs - and usually looks for - help in meeting the inner and outer stresses involved in maintaining himself, such as in securing accommodation, or obtaining financial assistance, until he can become self-supporting and able to live independently in the present complex society.

The Community Side of the Picture

The return of these patients to the community is setting up a new stress situation both for society and social agencies: One which will

require a significant change on the part of the staffs of social agencies and, equally, on the part of citizens.

What does the return of the person with a chronic defect of personality functioning mean to his family? What will he mean to his fellow workers on the job, to rail-warmers in the neighbourhood bar, to members of the bowling team, to the general practitioner who prescribes for his belly-ache, to the surgeon who removes his appendix, to the nurse who looks after him in the general hospital? What does he represent to the policeman on the corner, to the traffic engineer? How will he appear to the booking sergeant, the police reporter, the judge and the jury?

Because of his defects, the discharged patient will be a recurring burden to his family, his friends, his work mates, the social agencies and their professional staff. If these and other units of his society refuse to accept him, and adapt themselves to his peculiarities and weaknesses, then he will not be able to get well. He will probably be forced to return to the hospital. Hence any mental health rehabilitation program must complement efforts which deal with the patient's own response patterns with those designed to change the patient's environment in such a way as to meet him halfway. This two-way process of rehabilitation, that of modifying the patient and modifying the environment, has been adopted by the Sustaining Clinic at the Mental Health Centre.

The Mental Health Centre

Admissions rates to Crease Clinic and the Provincial Mental Hospital climbed steadily during the 1950's. Voluntary admissions now total one-third of all admissions. Treatment services have been strained to keep pace with

public demand, yet more and more patients are being returned to the community. The mentally-ill person is expected back in his place in the family and community in a relatively short period. At the same time the lot of the person who is sick a long time has changed. He enjoys more freedom on open wards, provision is made for a more rounded life with work assignments balanced with social activities, and community interest is shown by volunteer workers of the Canadian Mental Health Association. Thus, by 1956, the time was ripe to develop a service totally at the voluntary level which could offer treatment without interruption of family life, sometimes without interruption of work.

The Mental Health Centre opened January 2, 1957.[1] It consists of an Adult Clinic and a Children's Clinic (formerly the Child Guidance Clinic). The service offered by the Adult Clinic is a new one, aimed at treating emotionally disturbed adults in the early stage of their illness, and thereby preventing their admission to a mental hospital for complete twenty-four hour care. Another function is the after-care of certain patients under treatment in other Mental Health Service settings.

The Mental Health Centre serves two main functions - namely, consultation, and treatment. Two treatment services are offered - a day hospital service with a capacity of thirty patients with current staff, and an outpatient treatment service for a capacity of 140 - 160 patients. The consultative service is valuable both as a method of assessing patients for treatment and as a general service to the community, where many agencies

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[1] The Mental Health Centre is located at the corner of Willingdon Avenue and the Grandview-Douglas Highway in Burnaby.

look for consultation and collaboration with respect to the management of sick people who do not come within the scope of the Centre. The overall aim of treatment offered to the patients at the Mental Health Centre is the relief of anxiety and increase in self-understanding. Since patients come voluntarily to the Centre by referral of a physician, they are usually motivated to want and accept help. During their care they are encouraged to participate in planning for their own treatment and to take increasing responsibility for carrying it out.

The foremost categories of patient service may be defined as follows:

1. Intensive service - two hours or more of staff time each week.
2. Brief regular service - one hour a week for a period not longer than two months.
3. Prolonged regular service - one to three hours a month for a period in excess of two months.
4. Minimal service - brief contact of once monthly with addition of first aid in times of crisis.

The therapies offered to the patient are fourfold.

1. Psychotherapy - This includes individual and group psychotherapy and social casework.
2. Milieu therapy - This is the most important feature of the day hospital.
3. Physical therapies - These include oral medication, intravenous largactil drip therapy, somnolent insulin, and electro-convulsive therapy.
4. The acceptance and friendly contacts of other patients, volunteers and staff are an invaluable contribution to the patient's rehabilitation.

The Adult Clinic day hospital is located on the main floor and

includes a large occupational therapy room (weaving, pottery, sewing, carpentry, leathercraft, basket-weaving, etc.), adjoined to a recreational therapy room (piano, record player, shuffleboard, ping-pong, and table games). The recreational therapy room may be subdivided to provide for patient meetings, or a quiet place for patients. In summer, croquet, volley ball, and badminton are available. The program is planned by both staff and patients and includes organized games, play reading, dancing, parties and movies.

The day hospital staff include two occupation-recreational therapists, plus a physiotherapist (who is also trained in both occupational and recreational therapy), one registered nurse who is in charge of the day hospital, and five psychiatric nurses. All nursing staff participate each morning in physical treatments which are given in the treatment block. Day hospital patients attend everyday, Monday to Friday, from 8:30 a.m. to 4:30 p.m. The average length of stay is five weeks, and the patients are usually transferred to the Outpatient Department.

Outpatients have interviews with a social worker or a psychiatrist on a weekly, bi-weekly, or monthly basis depending on their needs. If they require medication, it is purchased by the patient, or supplied by the Centre if the patient cannot afford it. Physical treatments for outpatients are given with day hospital treatments. Outpatients receive treatment as long as they are able to use it constructively, usually six months to two years; often a spouse or other family member receives casework at the same time.

A Social Club, run by patients and ex-patients as well as two staff members, and five volunteers from the Canadian Mental Health Association, is

held every second Tuesday evening with attendance averaging from forty to sixty. Due to the lack of a professionally trained group worker, the Social Club now consists of only "drop-in" activities.

Referral to the Mental Health Centre is made via the patient's family physician or a psychiatrist. Following the initial interviews and a diagnostic conference, a decision is made about the applicant's suitability for treatment, and the applicant is either referred to a more suitable agency, (e.g., Family Service Agency), or accepted for treatment. The plan for treatment is made at this time.

There is no charge for treatment; however, patients may be required to purchase medication, hire a housekeeper and other incidental expenses. If a patient is in financial straits, a social worker may arrange for social assistance or for a housekeeper while a mother is in day hospital.

Within six months after the opening of the Mental Health Centre, the Director realized that a special form of service needed to be developed to provide a sustaining form of psychiatric care for those patients who were being maintained in the community on medication, and who did not have the ego strength to develop further insight, and improve adaptation through psychotherapeutic or intensive casework services. At this time, about one-half of the patients attending the Adult Clinic had been discharged within the year from either the Provincial Mental Hospital or Crease Clinic. The majority of these patients had been returned to the community as a result of successful chemotherapy.

Thus in August, 1957, a sustaining service clinic, known as the Largactil Clinic, was organized to meet one evening during the month, staffed

by one psychiatrist, one social worker, and one public health nurse. The plan was to have each patient seen once a month by either a psychiatrist or a social worker for a brief re-assessment, reassurance, and regulation of medication. A Social Club was organized in April, 1957, through the initiative of other patients attending the Adult Clinic and the participation of the staff and volunteer members of the C. M. H. A. The Social Club and Largactil Clinic (later changed to the Sustaining Clinic) were soon scheduled on the same evening, in an effort to give the Sustaining Service patients more opportunity for social participation, with the hope that they could be maintained on a social rather than a medicinal basis. It was agreed that although any patient attending the Clinic might attend the Social Club, patients attending for regular interview therapy would not attend the Sustaining Clinic at the same time. A year after its establishment, the Sustaining Clinic was duplicated by the participation of a psychiatrist and a social worker from the mental hospital. Accordingly, two groups of approximately twenty-five patients each were seen one evening a month on alternate Tuesdays between 6:00 p.m. and 9:00 p.m.

The Sustaining Clinic is backed up by regular outpatient clinic services if they become necessary, such as aptitude testing for job placement, assistance in finding work or accommodation, emotional first-aid (e.g. support, reassurance, information-giving, etc.) in times of crisis, and day hospital service for psychotic relapse.

Method of Study

The Adult Clinic offers service to two types of individual: (1) the person living in the community who is saved from going to a mental

hospital by intensive and rapid treatment; (2) the person who, on leaving the mental hospital, has not recovered sufficiently to live a normal life, but who has received as much help as the hospital can give. The present study is concerned with the Sustaining Clinic, a service designed to aid in the rehabilitation of this latter group.

In recent years in British Columbia a series of theses have been completed on social services directed to the rehabilitation of mentally-ill persons. A number of these are particularly concerned with the patient's transition from the hospital to the community. For example, "Vista", as a rehabilitation resource for women without families to return to, was surveyed by Sophie Birch. Currently, Mrs. Helen Jones is completing a study of the C. M. H. A. Social Centre as a social-recreational resource for the discharged patient, and Mrs. Beatrice Booth is examining foster home care for the mentally ill. These studies are relevant to the present one in that they illustrate how different programs attempt to meet the needs of different types of discharged mental patients.

At the date of writing, the Sustaining Clinic has been in operation for three years, and it is reasonable to believe that this can be considered a period sufficiently long to determine its contribution toward the re-establishment of the patients. In consultation with the appropriate staff, forty cases were selected for close examination, this being about the maximum number of cases that could be examined with the intensiveness that was required. The problems presented by these persons and the treatment offered to them, it can be assured, are representative of the Sustaining Service group as a whole.

The purpose of the study is to evaluate the contribution of the therapeutic team (of which the social worker is a part) toward the rehabilitation of this difficult group of patients, most of whom require long-term follow-up care. To emphasize the focus on the appropriate type of patients, the method is (1) examining the problems of the sample group of patients, and (2) reconstructing the treatment services given to them; thus, establishing how far this meets their needs. The treatment is evaluated by comparing the patient's functioning at the time of referral with his present functioning or his functioning at the time of discharge. In an effort to describe the patient's adjustment in meaningful terms, a number of points are summed up under the headings of degree of (a) impairment, (b) emotional distress, and (c) social tension, and three rating scales for these are compiled.

The unit files at the Mental Health Centre are unusually comprehensive. Unlike the files of many multi-disciplinary agencies, all entries made by the psychiatrists, social workers, nurses, and psychologists appear on the same narrative sheet, and are arranged in chronological order. Such a record gives an integrated picture of the total treatment services offered to the patient, and the contribution made by each discipline. The psychiatrist's contribution to the narrative sheet generally includes the findings of the physical examination, a social history obtained from the patient, the psychiatrist's comments concerning the patient's general appearance and behaviour, his pre-occupations, complaints, and insight, as well as a diagnosis and prognosis. The nurse records the type and amount of medication given to the patient. The social worker contributes social history

information on the patient as obtained from relatives and other interested persons, and a summarized account of subsequent contacts with the patient, members of the family, and other members of the hospital treatment team. The psychologist's contribution includes the results of psychometric tests, including the patient's intelligence rating, aptitudes, degree of mental deterioration and a personality evaluation. The "principle therapist" summarizes all contacts with the patient and members of the family, and records the results of Progress Conferences. Results of X-rays, basal metabolism tests and other laboratory tests are included in the reports of the various technicians. On the inside cover of the patient's file are two basic data sheets: one giving the medical and social information on admission, and another giving the same data at discharge. All correspondence relating to the patient is attached to his file.

All this material was examined for the sample cases; and where information was lacking or ambiguous, it was discussed with the appropriate staff.

CHAPTER II

THE PATIENTS AND THEIR PROBLEMS: AN ILLUSTRATIVE REVIEW

The Sustaining Clinic could hardly be expected to deal readily with the myriad array of situations that confront these patients in their everyday living. All the patients have had a long history of mental illness dating back many years prior to their first hospitalization. They have suffered from states of anxiety and vulnerability, whose roots are to be found in early childhood. They have exploited archaic mechanisms which are dormant in every human being, in the hope of decreasing anxiety and maintaining their own individuality, but mostly they have failed. They have struggled between the world of reality and the world of symptoms. Paleologic thinking[1] as one writer has termed it, and what can be called "de-socialization" have characterized their behaviour. They have regressed, but have not re-integrated at a lower level. They have accepted their illness, but their illness has not accepted them.

They have been placed in a mental hospital, and gradually their anxiety has subsided as the result of the protected environment and the few demands placed on them. Electrotherapy and medication have repressed their symptoms. At this point they succeed in making a tenuous adjustment to reality by decreasing their needs - sometimes to an almost unbelievable

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[1] Arieti, Silvano, Interpretation of Schizophrenia, Robert Brunner, New York, 1955, p. 186.

extent. They are discharged from the mental hospital and are referred to the Sustaining Clinic, but they are not well.

They do things haphazardly and half-heartedly, and cannot exploit their full potentialities. The reduction of spontaneous activity confers on them a certain awkwardness and inappropriateness. Their lack of experience in dealing with people increase their fears. When they succeed in evading their "schizoid" attitudes and in doing a few active things, the old sensitivity tends to come back, and tremendous anxiety is experienced. The early uncanny experiences[1] add a particular coloring to their present experiences. The persons they have to deal with are, symbolically speaking, other parents, and they have never learned to deal adequately with parents. The world appears to them to be populated by millions of authorities, ready to criticize them. Symbolically, every interpersonal situation is a reproduction of the old parent-child relationship; a compulsive attitude quite often compels them to make this reproduction more similar to the original situation than is actually required. Furthermore, in spite of their detachment, they maintain the image of themselves as the "bad child";[2] but to be a bad child now means to be incapable, inadequate, worthless. Their awkwardness seems to prove to them that they are really inadequate. The competitive spirit of contemporary society, where everybody is supposed to assert himself or to show how good he is, makes their predicament worse. Handicapped as they are, it is no wonder that they fail. Any additional

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[1] Sullivan, Harry Stack, The Interpersonal Theory of Psychiatry, W. W. Norton, New York, 1953.

[2] Arieti, op. cit., pp. 47 - 50.

failure increases their feelings of inadequacy and predisposes them to subsequent failures. To avoid disappointment they withdraw into a stronger armour, with more defensive mechanisms. Fantasies replace their need for action. Often when they are confronted with a situation which does require some action, they convince themselves that it is not necessary or worth while to act.

A Sample Group of Patients

Of the forty patients selected for assessment in this study, twenty-four were referred directly from the mental hospital to the Mental Health Centre. Of these twenty-four, sixteen were transferred directly to the Sustaining Clinic. The other sixteen patients were referred to the Mental Health Centre by their doctors. Five had never been hospitalized in a mental institution; eight had not been hospitalized within the year prior to their referral; and three had been hospitalized within the year. Out of this group of sixteen, only two were referred directly to the Sustaining Clinic.

Of the forty cases studied, twenty-seven are females and thirteen, male. By marital status, twenty-four are married or had been married. The majority of the patients, twenty, are between the ages of thirty and forty; ten are between the ages of forty and fifty; nine are over fifty and one is under thirty.

Thirty-three of the forty Sustaining Service patients live in primary family relationships; seventeen live with a spouse; ten live with parents; and six with a sibling or a son or daughter. Six live alone. The one woman who is employed as a domestic and living in, lives in a kind of

substitute family constellation.

In regard to education, twenty-seven have completed up to grade ten or grade twelve. Ten have an education between grade seven and grade nine. Only three have an education below grade seven, and of these, two are men aged thirty-three and thirty-eight, and the other a woman aged sixty. Five have extra training: two women have completed business courses, one has a B. A., and one has taken part of a course at an Art Academy. The only man who has training beyond grade twelve is a third year university student who, because of his illness, is unable to pursue his education any further.

Of the twenty-seven female cases examined, nine are married and occupied as housewives. Three are widows: one is receiving a Disabled Veteran's Allowance, one is employed as a saleslady and doing exceptionally well, and one is receiving free accommodation from her mother and supporting herself from her savings. Three are separated: one receives $125 a month from her estranged husband and is working, usually as a saleslady; one is employed as a clerk; and one is living on Social Assistance, working only occasionally and always at unskilled jobs. The one divorced woman is employed in a photo studio.

Six of the eleven unmarried women rely on Social Assistance for economic support. Two, however, were able to support themselves for a short period before going on Social Assistance, and one continues to work part-time occasionally. One of the single women is supported by her parents, but works occasionally at unskilled jobs. Of the four self-supporting single women, three have relatively stable work. One is employed as a domestic and receives the low salary of $25 a month plus room and board; one is employed as a sewer

in a clothing factory, is frequently being laid off, and receives the low salary of $96 a month. Two receive satisfactory salaries; one as a stenographer and one as a skilled worker in a school supply factory. However, as a result of their paranoid ideas, one changes her jobs constantly while the other fights continually with her co-workers. In summary, nine of the twenty-seven female patients are housewives; eight are employed; seven are unemployed and in receipt of Social Assistance; two are unemployed and supported or partially supported by their parents; and one is in receipt of a pension.

Of the eight married men, five are employed; none of their jobs have a high income or carry high prestige. One is retired and in receipt of an old age pension. Two are unemployed and supported or partially supported by their working wives. Of the five single men, one is employed as a truck driver, one is in receipt of a Disabled Person's Allowance, and one works occasionally at manual jobs, living the rest of the time on Unemployment Insurance and his savings. The other two single men are unemployed and supported by their parents. Of the six unemployed men, only one is unconcerned by his unemployment.

The sources of economic support of the forty patients are summed up as follows: fifteen are employed and self-supporting, fourteen are unemployed, nine are housewives and are supported by their husbands, and two are in receipt of pensions. Of the fourteen who are unemployed, eight are on Social Assistance, and six are supported or partially supported by their wives or parents.

The Transition Problems

The analysis of the diagnoses of the patients studied reveals

that twenty-nine are schizophrenic, six have depressive reactions (one in a schizoid personality); three have anxiety reactions (two in schizoid personalities and one in an inadequate personality); and two are manic-depressives. Excluding the five who have never been hospitalized in a mental institution, the thirty-five who had, spent an average of three years there. These patients are far from "normal" if efficient day-to-day living is the practical test.

In the community, a person is responsible for the scheduling of his activities, he must awaken himself, get to his meals, arrange for transportation to work, and be there on time. After work he provides for the use of leisure time and must judge the amount of rest he will have. In treatment as a patient, he is called in the morning, conducted to meals, scheduled for activities or work, checked on attendance and on the use of his leisure time. He has little responsibility for decision making, planning, and implementation of his ideas. He is assigned to groups. Participation is voluntary only within narrow limits; he is expected to participate because it is a part of treatment, not because he feels it is his right or social obligation. When he goes and where he goes is noted and reported by nurses and aides. Even his presence in bed is checked at regular intervals. The longer the patient remains in a mental hospital the more indoctrined he becomes with these institutional habits, and the more imbued he becomes with following a simple regime instead of thinking for himself. However, this constant supervision cannot be carried on into the community life of the patient.

A long period of hospitalization thus presents many problems to the

patient upon discharge. He must not only perfect skills that have fallen into disuse, but he must learn new ones. He must also discontinue practicing many of the habits and way of thinking acquired while in the hospital.

Personal Behaviour

The problems faced, though they are not necessarily verbalized or even realized by the Sustaining Service patients, fall into three areas:

1. Relationships with others - Co-operation and sharing with authority figures; co-operation and sharing with peers; acceptance by others; and ability to take responsibility.
2. Attitudes toward self - Self confidence; insight; and health attitudes.
3. Personal behaviour - Speech and conversation; eating habits; personal cleanliness; dress and personal appearance; money or budgeting; work habits; and use of leisure time.

The area of personal behaviour looms large as a problem because it is here that the person's incompetence arouses the strongest feelings of anger and frustration in other people. Much of these patients' personal behaviour follows no set pattern, thus interfering with the routine established by family or social structure.

For example, Catharine's mother reports that:

> Catharine does not get up until some time between 10:00 a.m. and 1:00 p.m. She is still uncommunicative with her mother and cannot be depended on to carry out routine household duties. However, when she feels like it she will do a bit of work. Catharine's stepfather has said either he or she will have to leave if her present behaviour continues.

Many of the patients present an appearance which the layman would

dub "feebleminded", and which is a clear, outward sign of mental illness. The vacant stare, the silly grin, the slow movements, characterize these people. In a society where physical attractiveness is highly esteemed, careless, untidy persons are at a disadvantage. They are seldom sought out as friends, and are eliminated as a potential means of gaining prestige and popularity. Because casualness or downright sloppiness is perhaps more acceptable in men, it is the untidy, carelessly groomed woman who most suffers the pangs of unpopularity and ridicule. Accordingly personal appearance is one of the means by which the patient's adjustment can be measured. Time and time again the therapist will note either, that the patient is neatly groomed and appropriately dressed - a sign of improvement - or else unkempt, disheveled and peculiarly attired, a sign that he or she is "slipping". For example, when Miss O'Connor[1], a fifty-year old single lady, began attending the Sustaining Clinic,

> she would usually arrive with no make-up on, her hair uncombed, and wearing a grubby cotton housedress. Granted this lady had little money; yet eighteen months after the initial contact, her appearance had improved immensely. She began to wear a bit of lipstick which brightened her pale, drawn face, her hair was neatly done, and her clothes though not expensive were clean and more appropriate to the occasion than the cotton housedress. Unfortunately, Miss O'Connor still retains many residual schizophrenic symptoms and her twelve years of hospitalization show in her vacant stare, in her slow deliberate movements, and in her lack of spontaneity in action and expression.

Miss Lake, a thirty-year old woman, is a similar example. She has an

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[1] This name and all others that appear in this study are fictitious.

income sufficient to permit her to buy attractive clothes. However, her combinations are most unflattering. Miss Lake:

> tends to be indifferent in her personal grooming - tousled hair, dirty nails, dirty clothes. She is prone to ruffles, bows, pleated skirts, and costume jewellery, and it is a bit overpowering when one of her outfits has all of these attributes. Her standard footwear is a pair of high heeled shoes worn with white ankle socks. Added to this she has a silly grin and a withdrawn "nothingless" manner which is immediately associated with mental illness, and which discourages people from trying to make social contact with her.

The leisure time pursuits of these patients are stereotyped and demand little emotional involvement. Because of their feelings of inferiority and fear of failure, the patients tend to be spectators of, rather than participants in, social activities. Because of the poverty of their relationships, their spare-time activities are generally solitary ones. Sarah Stone's use of her leisure time typifies the restricted nature of these patients' activities:

> Sarah Stone is quiet and restrained in her verbalizations. She still remains inappropriate in her affect, a residual schizophrenic feature which she will no doubt always have. She lives a very restricted existence with her mother, going out to shop for food about three times a week, and the odd time going to $1.49 Day. In the evenings she spends her time watching television. About once a month she goes to a movie.

Many of the problems of these patients are manifested in their work habits: problems with authority figures, relationships with peers, lack of vocational skills, passive-aggressive tendencies, and lack of confidence. None of the forty patients hold high-paying jobs. None are professional people; and only one is self-employed. All hold jobs that carry

relatively low prestige. Their income is low or barely subsistent. The social status and standard of living of the married female patient is dependent on her husband's occupation, and is, therefore, usually higher than the single female patient or the male patient. But even here the income and standard of living fall below the average. One might speculate on the effect of the wife's illness on the husband's occupation and income, as it could quite conceivably adversely affect the husband's work.

Because of the patient's narcissism, lack of satisfactory personal relations and low frustration tolerance, he is generally disturbed in relation to his work situation. He lacks the powers of concentration required for sustained effort, is over-sensitive to criticism and unable to accept rules and routine, expects praise and recognition out of all proportion, and blocks on learning new skills. In relation to the learning process, the patient fails to judge what is relevant, fails to identify due to his poor development of object relations and is unable (because he is unwilling) to foresee the consequences of his behaviour. As a result, he relies heavily upon denial and an avoidance of involvement, and feels insecure, sensitive, anxious, and full of grievances.

Mr. Rogers is an example of the type of patient who is unable to stick to his job because of his low frustration tolerance level and his inability to accept rules and routine. This case also illustrates the reversal or roles that takes place within the family, with the patient assuming the expressive role, and his wife, the instrumental role.

> Mr. Rogers is a fifty-two year old married man with a diagnosis of chronic schizophrenia and post-lobotomy syndrome. He is a former executive

> of a large business concern. Since his first hospitalization in 195- the family's standard of living has dropped considerably. His wife and two teen-age children have adapted to the unfortunate change in circumstances rather gracefully. Mrs. Rogers has obtained a job as a receptionist and enjoys her work. Mr. Rogers works only occasionally and has gradually assumed responsibility for the housework.
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> One evening at the Centre, Mr. Rogers informed the social worker that he had quit his job as a nigh watchman at an appliance warehouse, a position he had held for exactly one month. He rationalized his termination of employment by saying that he could not sleep during the day, that he was becoming anxious and irritable, that he was upsetting the family routine by the awkward hours he worked, and that he found the long nights exceedingly boring and lonely. Mr. Rogers is concerned about his employment, but has shown himself to be incapable of holding down the types of jobs he can get. At the same time he is aware of the fact that he will never be able to maintain a managerial type of job such as he had before his first hospitalization.

These patients' seriously impaired ability for work, play, and love is often the result of inferiority feelings. The isolation and suffering caused by the sense of inferiority is based (usually) upon fancied defects, or upon the emotional reactions to defects which of themselves are not isolating. This is one of the most important, most frequent and most serious of all factors in the personality make-up of these patients.

The Feelings of Inferiority

From the time when the first person shivered in fear before the threatening forces of nature and compared his puniness with the incalculable power of the universe, man has been subject to disagreeable sensations dependent upon his awareness of the discrepancy between his fantasy of power and his relative helplessness in the hands of natural forces. Having

reconciled himself to this with the aid of various devices - religions, philosophies, inventions, regional conquests over nature, and the like - he encounters the same discomfort in comparing himself with other men, stronger, quicker, or more astute than himself. This is especially true of the tiny infant and the growing child, who perceive parents as omnipotent gods, toward whom inferiority feelings first develop. Later this may be assuaged by compensations of dependency and by the growth process itself, and, depending on the family security, it may be the brothers and sisters who then excite envy by comparison. Or he may grow up to be mature and reasonably self-confident.

Ideally the results of such comparisons with one's fellow-beings are an intellectual adjustment of one's given powers to one's given tasks in the most productive way possible with a minimum of dissatisfaction. But in actuality, the occasional surrender to painful fantasies of relative incompetence and weakness probably replace productiveness to a lesser or greater extent in everyone. It is easy to see how these arise from envy, and from the omnipotent ambitions of infancy; but realizing these things does not make anyone totally immune from them. The expressions "inferiority feelings" coined by psychiatrists, social workers and psychologists during the past few decades are seized upon as technical designations dignifying any unworthy and disquieting emotion they are supposed to describe, and indicating it as a unique phenomenon in the self-diagnosed individual (and perhaps a few others). The fact is everyone is inferior in some sense. The mature or sensible person is aware of this, without pain or handicap. He has developed "positives" in his own individuality.

It is, therefore, no distinction and no credit to one to recognize one's inferiority feelings. To pity oneself because one lacks something that someone else has is an unflattering way of viewing the situation. The clinical fact is that whether they proclaim it proudly or deny it vigorously, the patients attending the Sustaining Clinic do suffer constantly and sometimes acutely with feelings of inadequacy, diffidence, self-dissatisfaction, so-called hypersensitiveness, and a pervading discouragement because of such feelings. To call these merely "a sense of inferiority" is not enough. They should be called an illusion or an alibi of inferiority; they may disguise envy, hate, guilt feelings, and other emotions which in turn arise from fundamental misconceptions and self-mismanagement.

Their feelings of inferiority consciously center on comparisons of themselves with other individuals. Usually these comparisons are originally of tangible, visible things - that is, physique, intelligence, and popularity. As a child, the typical patient probably compared himself, his little body, his physical equipment, with that of his omnipresent and omnipotent parents; later, also, with siblings and playmates. Necessarily he is constantly aware of discrepancies in size, in height and weight, in strength. His obvious inferiorities are associated with his obvious dependency and subservience. Since what Father and Mother say "goes", he is early taught without words that "might makes right".

These primary feelings of inferiority are ordinarily submerged in oblivion in the majority of persons. They usually become completely unconscious. But in these patients the childish anxieties are revived, and add to their intensity a few years later by unfavourable comparisons made by

someone in authority: "John is not so bright as his sister", remarks his mother to a visitor. "George is unusually awkward and clumsy for his age." "Daughter, it's a good thing you're smart in school, because you certainly are the homeliest child on earth." Such comments are deadly. They often crush the child's hopes, efforts and self-respect completely. They rarely stimulate, because the authority of their source makes them incontrovertible. Peter Owens' reaction to his parents' unfavorable comparisons of himself with other individuals is typical:

> Mr. Owens, a thirty-one year old single man, was referred to the Mental Health Centre by his physician in 195-. He had been hospitalized twice in Crease Clinic for a total period of seven months. His last hospitalization was three years prior to his referral. At the time of referral, Mr. Owens' chief complaints were those of inner depression, a general feeling of uselessness, and physical complaints such as weight loss, poor appetite and insomnia. He was in a highly dependent yet pressured position in his family as the hand maid of an aged and dominant grandfather.

Three years later the social worker reported that Mr. Owens' situation was virtually unchanged.

> Peter Owen continues to live at home with his parents, and while apparently needing this dependent relationship feels very sensitive about it. Each day he goes downtown and wanders about, primarily as a means of being able to feel that he is doing something. He has overcompensated for his homely appearance by always being immaculately dressed and well-groomed. Tonight he revealed in some detail the sense of helplessness he feels at being unemployed, being supported by his family and so on. His maternal grandfather was a very successful business tycoon and his mother continually reminds him of this with statements like, "Your grandfather never had anything to begin with, he really had to work to get what he got. And he made lots of money and was a big success ... Peter,

> you have been given every opportunity to get ahead, and look at you, you're no place." It is little wonder Peter feels inferior. He is coming much closer to being able to bring out many of his own feelings and concerns, especially in the sense of wanting to receive support and reassurance around them. He is very hostile toward his parents and deceased grandfather, but learned at an early age to control the expression of these aggressive feelings.

This man's problems revolve around emancipation and employment. His inferiority feelings stem from the unfavorable comparisons made between his grandfather's and his father's intellectual and professional attainments and his own rather average endowments. He has such tremendous feelings of inferiority that he is afraid of gaining employment for fear he will not succeed. He is very shakey in the masculine role. A failure in the job situation would reinforce Mr. Owens' conception of himself as an inadequate person.

There are other, less obvious ways in which the parents have built up inferiority feelings in these patients. One is by constantly exhibiting their own inferiority feelings. Some parents are incessantly complaining of their misfortunes, comparing their acquisitions and opportunities with those of their neighbours, voicing their enviousness and unhappiness and disappointments. They may go further and berate themselves, or they may scowl and sneer at their envied friends. More frequently they complain that their neighbours dislike them, that their friends have lost interest in them, do not return their social overtures, do not appreciate their efforts.

Still other parents of these patients excite inferiority in their

children by delinquencies. The child feels much more keenly than his parents the social disapprobation which they incur. An alcoholic father or a divorced mother may serve as a burden of bitterness to the children throughout their lives. "I have always felt as if I must apologize for my father," remarked one female patient.

Finally there are certain physical conditions of which no one needs to speak - nor can the organic inferiority remain unknown to the patient. He knows because he can see himself in the eyes of strangers; he knows because the cruel taunts of the little animals about him - glad to find someone their inferior and someone to torture - will not let him forget. This group includes speech defects, birth-marks on the face, dental deformities, crippled limbs, deformed bodies, cleft palate and hare-lip. So obvious are these things and so disfiguring that they permit of little real protection from exceedingly great mental pain. Miss Tanya Beriosova, a striking looking thirty-five year old woman is an example of this:

> She is a shy person with something of a Slavic accent. She suffered from cleft palate all her childhood and teen years and had it corrected only at eighteen. Her inferiority feelings originated from this defect. She was intensely sensitive about her speech, and about the laughing and teasing of other children. She talks of similar sorts of feelings at work, the cruel jokes of fellow employees and so on. She feels treatment has helped her overcome some of this sensitivity, although she is timorous about the future.

The Dynamic History

The history of these patients reveals that in childhood their anxiety was of such tremendous intensity that no sufficient self-esteem and sense of self-identity could be built and that certain trends of

psychological development prevailed over others. Although it was the mother who contributed most in producing their maladjusted condition, usually both parents failed them, often for different reasons. Frequently the combination was as follows: A domineering, nagging and hostile mother, who gave the patient no chance to assert himself, was married to a dependent, weak man, too weak to help the child. A father who did not dare protect the child because of the fear of losing his wife's sexual favors, or simply because he was not able to oppose her strong personality, was just as crippling to the patient as the mother was. Occurring less frequently was the opposite combination: A tyrannical father was married to a weak mother, who had solved her problems by unconditionally accepting her husband's rules. These rules did not allow her to give enough love to the child. At times, one parent died or was away because of divorce, separation, war, etc., and the child was completely at the mercy of the destructive parent, generally the mother. The history of Mr. McLeod illustrates the type of home situation to which many of these patients were exposed:

> William McLeod was born in Glasgow, Scotland in 192-, and was brought up under very poor family circumstances. He was the third of seven boys. The father was an irresponsible alcoholic who did not show much concern for his wife or his sons. The mother was an overprotective, controlling woman who wallowed in self-pity, forever complaining of her plight. She only loved the patient when he was better than the other children in the neighbourhood. She imbued him with ambition and a fear of failure by constantly telling him that when he grew up he would have to be successful and rescue his "poor mother". She early instilled in him a feeling that the family was deprived and inferior. She taught him to compare himself unfavourably with others.
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> William went to school until he was fourteen

> and was apparently the best in his class. He has many mental conflicts about being brought up in the slum district. Whenever he looked out the window he would see drunks and bums on the street. Consequently, he has always been afraid of gangs and fights. Due to his mother's nagging and complaining, William early decided that he wanted to make something of himself. However, at the age of fourteen, he and an older brother beat up their father, who was attacking their mother, and threw him out of the house. The father was not seen after this, and William had to quit school and go to work to support the family. He worked at various unskilled jobs, and joined the Navy when he was eighteen.

As can be seen, in these very unhealthy home atmospheres, a state of intense relatedness exists between the pre-psychotic patient and his parents, especially the mother. The child is actually overwhelmed with feelings, but this relatedness, these feelings, are extremely anxiety-provoking and destructive.

Although it is true that the disturbance originates on account of the patient's personality, it soon becomes more complicated or a two-way stream. The patient, who at this period (from the end of the first to the end of the fifth year of life) is intensely emotional and often overactive in his behaviour, causes out-of-proportion anxiety to the already over-anxious parent. The parent expresses her anxiety in the form of hostility toward the child, who will then be more adversely affected. He will respond with behaviour which will be even more objectionable to the parent. Furthermore, the mother often feels guilty for her hostility and this guilt-feeling increases her anxiety. A circular process of ominously vast proportions thus originates.

Because of the intensity of these experiences, the pre-psychotic

patient finds difficulty in organizing effective defenses. It is his awkwardness in developing these defenses which is often a prelude to the later psychotic disorder. The patient growing in an atmosphere of exposure to anxiety tries nevertheless to preserve the good image of the parent.[1]

In the majority of cases the good image of the parent cannot be preserved. In such instances, the patient remains to an extent conscious of the bad qualities of his parents. Even he, however, represses in large measure their worst characteristics. In the majority of cases the child represses the fact that he was hated, falsely accused or the innocent target of hostility. He remains, nevertheless, with the feeling that the parents are bad, and he harbours hostile thoughts of them. At the same time he thinks he should love them and therefore he feels guilty. Often he alternates in believing in his own values and in those of his parents. When he prefers his own he feels guilty; if, on the other hand, he follows the orders and values of his parents he feels crushed, victimized, compelled to surrender. Mr. McLeod's constant conflict about whether to remain the "good" child and do as his mother wished, or to assert himself and risk losing her love, is an illustration of this.

> After the war William McLeod left the Navy, and at his mother's insistence returned home to live with her. From the age of twenty-one to twenty-seven he worked during the day and went to night school. He found it very difficult to study because of the poor home environment. The mother, on the one hand, encouraged him to study, and, on the other, berated him for the poor wage he was earning.

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[1] Arieti, op. cit., pp. 48 - 56.

> At the age of twenty-seven, William broke away from his mother and emigrated to Canada. However, two years later she joined him, and urged him to obtain his senior matriculation and enter university. He did this, only to realize that, after having spent years struggling to better himself, he had no goals of his own.

Often the child is afraid that people can read his thoughts, see his hostility for his parents and will punish him. Even normal young children have the feeling that adults know their thoughts or "steal their thoughts". In pre-psychotic children, this impression is enhanced by their fear that the parents may know the feelings of hostility they harbour for them.

Since the child is in constant expectancy of disapproval, and tries desperately to anticipate possibilities of disapproval in the futile attempt to avoid them, he becomes very sensitive to the slightest sign of the oncoming reproach. This sensitivity to disapproval persists until it is covered by other defenses. The patient is never able to tolerate even minor frustrations, because frustrations mean disapproval from other human beings.

Like other children, the pre-psychotic patient, too, attempts to find ways of relating to others which will decrease his anxiety. Often he learns that complying, as the person with the compliant, dependent character does, or that being aggressive and hostile, like the hostile person pays. His parents may not accept either compliance or hostility. Then only by detaching himself emotionally can he avoid further attacks on his self-esteem. Furthermore, by detaching himself emotionally, it is easier for him to tolerate his own image of the bad child and to accept the partially conscious bad images of the parents. Moreover, the hostility for them

produces less guilt feeling. Thus, very often, but not in all cases, the patient develops the character changes which are found in a person with a schizoid personality. He becomes aloof, cold, inactive.

Lack of warm social contacts induces in these children a rich fantasy life, and excessive brooding about certain subjects, one of them being their own sex identity. The most common cause of this uncertainty is the fact that the child who is rejected by both parents tends also to reject both parents and, therefore, has difficulties in identifying himself with either one of them. Mr. McLeod's blurred masculine identification can be explained in this way:

> Mr. McLeod hated his father with whom he refused to identify; at the same time his conception of a masculine person is a "rough and tough type" like his father. Mr. McLeod is very ambivalent about gratifying his intense dependency needs because he feels that to be dependent is to be feminine. His dependency needs have never been satisfied because of the early responsibilities forced upon him. He has problems with authority figures. His inadequacy in the masculine role and his lack of success have reinforced his early inferiority feelings.
>
> While in the Navy, he was greatly threatened by homosexual tendencies. His first heterosexual experience was sodomy to preserve the girl's virginity. He had previously practised sodomy and mutual masturbation with an older brother.
>
> In 195-, Mr. McLeod married a nurse who supported him through his year at college. She is a cold, mothering person, five years older than himself. The marriage focuses many of the difficulties he has on sexual identification. He is very hostile toward his mother and his wife, both of whom are cold, controlling women. However, his hostility has never been openly expressed except in his phobia that he will choke his wife.

In addition to this confusion and uncertainty about his own sex,

the pre-psychotic patient has, to an exaggerated degree, that feeling of omnipotence common even in normal children. The normal child has feelings of ominpotence and lives in a world which he thinks exists for him only; but whereas a child who has normal relations with his parents is gradually "corrected" by them with their approach to reality, because he wants to accept their reality, the pre-psychotic child cannot depend on his parents for this correction. The reality which they show him, the reality of the world, is their unpleasant reality. The patient is reluctant to give up these feelings of omnipotence; when he succeeds in losing them, to a more or less conscious degree he still has the desire to go back to them. Together with this tendency toward the feeling of omnipotence, there is the tendency toward a unique, or very subjective outlook. The child has tendencies to use his own language, with expressions he has coined. All these tendencies, which are called autistic, are more or less suppressed and repressed but become conscious again during the psychosis. Mr. McLeod's thinking illustrates this feeling of omnipotence and the tendency toward a subjective outlook:

> Mr. McLeod has a fantasy life as rich as Walter Mitty's. In childhood, he spent hours daydreaming that he was a prince and that people vied with each other to cater to his wants. In his late teens he became concerned with magical thinking and was very anxious about the possible effects of magic in card tricks. Prior to his hospitalization, William felt that the teachers and students were looking at him unduly in classes. He began to think he might be exerting some sinister influence over them.
>
> Mr. McLeod is very pre-occupied with his mental conflicts and elaborates upon them extensively. He feels he is an actor on the stage of life but he is not really aware of the part he is playing, whereas everyone else knows what role he is playing and fits

> into the situation ideally. At times he has felt he was the centre of the universe. At other times, he does not clearly understand where reality fits into life. He becomes pre-occupied with fantasies of life, and tries to explain these thoughts on what he calls a pleasure pain and experiment principle.

Some of these tendencies could have been corrected at least partially if the child had been exposed to some healthy influences, like close relations with friends and distant relatives. Unfortunately, in many cases the personalities of the parents of pre-psychotic patients are such as not to encourage extra-family social intercourse, so that the "ingrown family" is constituted. Compensatory interpersonal contacts are lacking, and the children are dependent for psychological development on their unfit parents, even more than children usually are dependent on parents.

Poverty in Relationships

It is thus understandable why so many of the people attending the Sustaining Clinic appear aloof, detached, less emotional than the average person, less concerned and less involved. Actually, at an unconscious level many are very sensitive, but they have learned to avoid anxiety in two ways: first, by physical distance from situations which are apt to arouse anxiety and, second, by repressing emotions. This physical distance is maintained by avoiding interpersonal relations or avoiding doing things which will evoke an unpleasant reaction from other people. Often, they would like to do things, but they still remember from early childhood that action does not pay because it provokes a storm of intense and threatening emotional responses in the surrounding adults. Anticipation of actions means anticipation of a repetition of these emotional storms. They, therefore, become

underactive. In some cases the parents have actually encouraged them not to do things; doing nothing meant being a good child, "because" what the child did was "always bad". As a result, many patients have a deeply-rooted pessimism about the outcome of their actions.

There appear to be exceptions as some seem to be relatively active. On close observation they reveal, however, that they do things because they cannot resist the pressure of somebody who pushes them. This occurs not only in childhood and adolescence but even later on, when the patient has to select a profession, clothes, marital partners, apartment, furniture, etc. More often than not, this pressure is exerted not directly, but in a subtle way. The patients protect themselves from this invasion with further detachment.

These patients tend to comply in a perfunctory way. They go through the motions of the imposed act, but without being emotionally involved. They prefer to do this because they have learned that this is the best way to avoid anxiety. If they succeed in being emotionally uninvolved, their resentment and hostility remains deeply repressed. When they become psychotic, the resentment and the hostility may be displaced toward non-parental figures who may become the persecutors.

Undue suspiciousness is one of the commonest and most serious barriers to the establishment of satisfying relationships. Paranoid is a technical word, so apt, however, that it has been taken over into popular speech. No other word so well describes, with implications of their mental unsoundness, such patients as the man who eternally suspects and accuses an innocent wife of infidelity, the student who is sure the teachers

discriminate against him, the merchant who suspects a plot among his competitors. In contrast to the healthy person, the paranoid individual is forever tortured by suspicions, doubts, fears, constructions, and resolutions of self-defence. His delusions burn into his soul, and he becomes obsessed with his bitterness and plans for defence and revenge. He tries in innumerable ways to prove them or to disprove them and accumulates masses of useless data as evidence of the persecutor's intentions. Miss Tanya Beriosova, who has already been mentioned in connection with inferiority feelings, is a good example of a paranoid individual. Her undue suspiciousness aroused the hostility of co-workers and interfered with her work performance.

> Miss Beriosova's employer, Mr. Keller, contacted the Sustaining Clinic because she was creating a disturbance at work. She felt that the other girls in the factory were making "snide remarks" concerning her appearance, her spinsterhood and her mental illness. At first, there was no basis for her thinking this. However, she became so hostile and accusative toward her co-workers that they did begin to talk about her. This served to reinforce Tanya's paranoid thinking and she retaliated by verbal and physical combat. Mr. Keller declared her behaviour kept the place in a state of constant turmoil. The Clinic gained the impression that Mr. Keller wanted to fire Tanya but felt guilty about doing so because she is a capable worker and because he realizes she is sick.
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> When the social worker arrived at Tanya's flat, Tanya was lying in her unmade bed wearing a filthy duster. The room was dirty and reeked of her body odor. Tanya expressed hostility toward her co-workers because of their derogatory remarks about her. She had delusions that they were going to attack her, and that she should kill herself. The worker encouraged Tanya to admit herself to the Day Hospital. After receiving some support and reassurance that she would be well cared for, Tanya docilely allowed herself to be taken to the Mental Health Centre.

Frequently the paranoid symptoms appear not in actual delusions but in what are called "ideas of reference"; everything that happens is interpreted by the victim as having special reference to him; an article in the newspaper, the chance words of a passer-by, the peculiar sound of an automobile horn, all of these have some special meaning related to him alone.

In spite of the frequency of illness it is also true that some of the patients acquire a certain insight into their personality. From time to time they perceive the validity of their paranoid ideas. They recognize that their detachment is a very unsatisfactory solution and indeed they are justified in feeling that way. Some reach a pseudo-solution by denying a great part of their life, but by doing so they may make that part of their life which they continue to live more awkward and unstable. Frequently their unconscious hostility and resentment increase; their emotional and social isolation are never complete enough to protect them entirely from anxiety; on the other hand, they harbour secret desires to reconnect themselves with that emotional and social life from which they have tried to detach themselves.

Their lack of emotion is not due to simple repression of feelings; it is also a reaction-formation to too much sensitivity, not only to the sensitivity of the preceding intense relatedness to the parents, but also to the sensitivity which still exists at an unconscious or preconscious level. Frequently the dreams and fantasies of these patients transport them into an adventurous life, and often storms of affect. With their actions, on the other hand, these patients try to be as static as possible.

Often, if they act, they will be very impersonal and will try to avoid communication by direct contact. As already mentioned, they succeed without apparent difficulty in decreasing their needs to an almost unbelievable extent.

In summary, the Sustaining Clinic patients are people who have never acquired the degree of social skill they need for shifting their perspectives through taking successive culturally determined roles when they are under stress. In other words, they have not succeeded in establishing themselves firmly in their culture. They do not share their anxieties, conflicts, suspicions or loneliness with others because they lack the techniques for doing so. They may be overtrained in dependence and made reaction-sensitive in the process to the approval and censure of other persons; but they have been kept so consistently on the receiving end of this relationship that they are incapable of checking on the validity of their own interpretations by taking the roles of persons whose conduct frightens or puzzles them.

Such patients are left in a personal crises with only the relatively inept techniques of private fantasy, furtive observation and unwarrantable inference at their disposal. The initial disorganization which develops render these socially unskilled and immature persons still more inadequate and isolated, while their increasing isolation tends in its turn to reduce yet further their opportunities for the effective personal interaction upon which social adequacy must depend. Thus the patients' behaviour may describe a descending spiral from comparative inadquacy to complete ineffectuality, and sometimes to complete inaction.

Reduced to its simplest terms, the common tendency of the members of this Clinic is an inability to get along well with other people. This is almost too much simplified, because it might be applied to all of us at times, and to many criminals and "insane" all of the time. But this lack of social adaptability is of a special kind. These people sometimes appear to want to mix with the herd. Other times they obviously do not want to and they never do - successfully, at any rate. They may make gestures, go through the motions, even become extremists in social manoeuvres, but "the pane of glass is always there".

How does this make them appear? Well, variously, according to the combination of traits and reactions. Some of them are more or less seclusive, quiet, reserved, serious-minded, unsociable, and eccentric; others are timid, shy, very fine-grained, sensitive. Still others are dull, apparently stupid, indifferent, often quite pliable; while some are stubborn, morose and grouchy, and all too frequently suspicious and envious.

These are the problems of the Sustaining Clinic patients. After gaining an understanding of the patient's difficulty and its etiology, the treatment team formulates a plan of service. The mode of treatment depends upon the extent and degree to which the patient is impaired in his adaptation to reality, his ability to deal with people, arrange his affairs, and take consistent responsible action.

The social worker as part of the professional team, brings to the solutions of the problems created by the stress and strain of mental illness and readjustment into community life, the same techniques and skills that characterize social work in general. In essence the social worker's

contribution is based upon an understanding of the dynamics of human behaviour, upon an ability to translate this understanding as it applies to the individual patient, upon a thorough knowledge of the community resources which can be brought to bear on the patient, and upon special competence in guiding him toward maximal adjustment to his illness in the light of the limitations it imposes. The social worker's focus is on preserving and increasing the strengths of the patient(and family members) during this transitional phase from the hospital to the community.

Unlike the psychiatrist whose function imposes upon him the obligation to exercise authority, the social worker can remain free from the need to prescribe to any line of action and from emotional entanglement. The social worker's approach is governed by an attempt to see the patient as a human being, to move at his own pace, and to make his own decisions toward a goal that he is helped to set for himself. Such an approach can only be carried out when it is rooted in a genuine appreciation of the intrinsic worth and dignity of the human being regardless of the stage of his illness or the degree of incapacity it produces. For the patient such an approach assumes particular significance in the light of an illness that tends to undermine his feelings of usefulness and status. This approach, removing as it does the threat of control, compulsion, or censure, tends to minimize the patient's feeling of helplessness produced by the illness. It enables him to view his problem more realistically and to feel free to ask for help in its solution, convinced that he wants and needs such help and that he will not be forced into a line of action contrary to his needs and desires.

Like the patient, members of his family frequently need help; help in coping with the uncertainties, deprivations, and anxieties evoked by the patient's behaviour. A realistic recognition of the difficulties and strains imposed by these patients, coupled with an awareness of the importance of satisfactory family relationships for the patient's well-being, place on the social worker an obligation to render such help as may be necessary to maintain the "normal" functioning of the family as a unit and the provision of a healthful milieu for the patient.

CHAPTER III

TREATMENT SERVICES OFFERED BY THE SUSTAINING CLINIC

A person referred to the Mental Health Centre begins with an introductory interview, usually with a psychiatrist but sometimes with a social worker. The purpose of the interview is to obtain a history of the person, determine the present complaints and symptoms and assess the person's functioning and degree of impairment. Following this there is an intake conference. On the basis of an assessment, the person is assigned to a service which the treatment team thinks will be most beneficial for the patient. Treatment services at the Mental Health Centre include a day hospital, therapeutic interviews conducted on a weekly or bi-monthly basis, and a Sustaining Service. There are frequent progress conferences when the treatment team reviews each case and formulates future treatment plans including transfer to another service if this is thought necessary.

Accompanying most of the referrals from the Provincial Mental Hospital and Crease Clinic is a complete assessment of the patient, including a social history, a description of the patient's illness and symptoms, a summary of the treatment given, and a prognosis which helps determine the type of service which will be most useful to the patient.

Invariably the patient referred to the Sustaining Service is a severely damaged individual who is fearful of involving himself in a more

intensive type of treatment. He is assigned to a treatment team consisting of a psychiatrist, a social worker, and a Public Health nurse. The patient visits the Mental Health Centre on a specified Tuesday each month. He is met at the desk by the Public Health nurse, who introduces him to the other patients and to the occupational therapists and the volunteers who are in charge of the Social Club. Later the patient is seen by a psychiatrist or social worker for brief re-assessment, reassurance, and regulation of medication. This interview usually lasts about twenty or thirty minutes. At its conclusion the patient receives his medication, and is free to leave or remain and participate in the Social Club.

The Sustaining Clinic applies the concept of the "principal therapist". Each patient is assigned to a team. However, he is seen on a regular basis by one of the members of the team, (e.g., a psychiatrist or a social worker). If the patient is being seen by a social worker and problems arise concerning medication, he is referred to the psychiatrist. On the other hand, if the patient seen regularly by the psychiatrist complains of tension in the home or some other social problem, he is referred to the social worker.

The Two Forms of Casework Treatment

The social worker as part of the professional team, brings to the solutions of the problems created by the stress and strain of mental illness and readjustment into community life, the same techniques and skills that characterize social work in general. According to Florence Hollis,[1] there

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[1] Hollis, Florence, "Personality Diagnosis in Casework," Ego Psychology and Dynamic Casework, Parad, Howard, editor, Family Service Association of America, New York, 1958, p. 84.

are only two major forms of casework treatment: supportive treatment and the development of self-awareness. Her definition of the former is "treatment that aims to improve the ego's functioning of the person without substantial increase in the ego's understanding of previously hidden aspects of the self." She defines the development of self-awareness as "treatment that holds as a major aim the improvement of the individual's functioning by seeking to better the ego's direction of behaviour through enabling the ego to gain more accurate and more complete understanding of previously hidden aspects of the individual's own feelings and behaviour."

Florence Hollis[1] believes that both these forms of treatment have the aim of improving the individual's functioning. She thinks social workers have confused themselves quite unnecessarily in the past by pretending that supportive treatment did not have the aim of improving adaptive patterns, but rather was concerned only with maintaining current adaptive patterns. She is convinced that considerably improvement in adaptive patterns occurs as the result of using purely supportive measures. It might be added that social workers tend to confuse themselves by trying to define certain types of casework, particularly "insight development", as those that bring about so-called "basic changes" in the personality. It would be more fruitful to describe the nature of the change the social worker is seeking and the means by which he seeks to obtain it.

In supportive treatment the change sought is one that may occur either without the client's awareness of change in functioning, as such, or with his better evaluation of the reality situation but without substantial increase in his knowledge of himself. The improved functioning is brought

about by environmental changes, by the effects of catharsis, by the influence of an encouraging, anxiety-relieving relationship with a caseworker, and by better perception of external reality.

At the Sustaining Clinic, the joint aim of the social worker and the psychiatrist is to help the patient develop by dealing with everyday realities, by being a steady available support in cases of stress. Insight serves mainly as a means of emotional contact. It should be added that insight, by removing some areas of resistance, can aid in the forward movement of these patients, but in general it serves mainly as a means of relationship rather than a tool of understanding for the patient. In some cases, it must be realized, insight could have an adverse effect on the patient by undermining some of the defensive aspects of his symptoms. Because of their immaturity and narcissism, these patients are reluctant to accept responsibility for their acts. In many cases, they are poorly motivated in their wish to change. Acting on the pleasure principle, and employing concepts of omnipotence and denial, some are not pushed to adapt to reality.

The point about motivation which should be stressed is that a person, to benefit successfully from treatment, should have an appreciable ability to see that in a fundamental sense his problem is of his own making. If the defense of externalizing (projecting) is too strongly entrenched, the patient may be inaccessible to insight about his needs and attendant conflicts. In other words, the therapist must keep in mind the psychoanalytic principle that emotional problems arise from an inner struggle and not because of an environmental situation, though the latter may have a precipitating effect. Motivation, therefore, has to do both with the patient's

willingness to accept help and with his ability to see the forces that operate within himself as the cause of his anxieties and difficulties in relationships.

One of the most salient features in the treatment of these patients is concerned with the re-education of the patient, in the sense of helping him adopt patterns of behaviour that will improve his social functioning. With the chronic semi-psychotic, readjustment appears to be best achieved through his deliberate application of way and means of behaving that have been given to him by a constructive, accepting person, rather than the individual arriving at a more mature level of functioning in response to emotional growth from within himself. This readjustment in itself promotes further growth. A comparison may be made between the treatment of the neurotic patient and the psychotic: With the former, the therapist reaches the patient through open recognition and acceptance of his feelings, while with the psychotic, a deliberately educative approach is seen as being effective once a good relationship has been established.

The relationship between the worker and the patient is the main method of developing and strengthening the impaired capacity for feelings for others. Through identification with the worker, dealing with the "meat and potatoes" of everyday living, the patient can develop new identifications. He can gradually accept controls and attitudes more appropriate to reality. The patient's aptitudes and potentialities must be carefully assessed so that realistic goals may be reached. A major requirement of these patients is their need for a steady, constant relationship over a long period of time. Ego growth and integration requires time, as it does in

normal development.

Many of these patients, because of their difficulty in forming relationships, are not ideally suited for insight therapy. However, insight can often be given to the patient by confronting him with a particular reality situation; the therapist may point out how the patient failed to cope with it adequately - whether the failure was a result of conflict of needs or inability to understand reality. In short, confrontation may serve the purpose of clarification and of showing how emotional difficulties occur.

Most of these patients require what might be called "developmental therapy" - a therapy of relationship. It is in this area, where the need is great and other resources for help are meager, that the social worker with a psychoanalytic orientation has a great deal to contribute in a decisive fashion. But in the end, the therapist's best tool for successful treatment of these patients is persistence.

The Process of Treatment: A Case Illustration

Though no one single form of treatment is espoused by the Sustaining Clinic teams, an examination of the records reveals the pattern of treatment that is being developed. This has been reconstructed from the sample group experience; and is illustrated by a typical case.

The first stage of treatment is the establishment of a strong relationship. This stage takes considerably longer with these patients than with other people, because the patient, rather than having had satisfactory relationships, has had experience of a negative nature. He expects

rejection and misunderstanding and tends to cast the social worker[1] in the negative role. For this reason during the initial period, establishing a contact with the patient is more important than gathering specific historical data. Always the aim is to prevent the patient from relapsing into a psychosis.

In the following case, it took the social worker fifteen months to form a working relationship with the patient, Mrs. Foster. Mrs. Foster was referred to the Mental Health Centre by her private physician in August, 1957. She has been hospitalized twice for a total period of six months, her last hospitalization was three years ago. She has a diagnosis of schizophrenia and lacks self-reliance. Mrs. Foster was born in 192-. She is a tall, slim, plain-looking woman with greying hair. Her appearance and manner are inconspicuous. At the time of her referral, she was separated from her husband, fifteen years her senior, and an alcoholic. She was lonely, uneasy in her social relationships, discontented with her job, and anxious over the responsibility of supporting herself and her son. On the recommendation of a psychiatrist and a social worker, Mrs. Foster was assigned to the Sustaining Service where she is seen on a monthly basis. The tone of the early interviews was as follows:

> For the first fifteen months, Mrs. Foster was pleasant but superficial during the interviews. Most of them were spent complaining about her job and her many responsibilities. She worried about everything: the quality and quantity of her work, the care she was giving her son, the thought of becoming unemployed or sick. She had

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[1] In this section, the term 'social worker' will be used instead of 'therapist'.

> no insight into the fact that her anxiety arose from her need to feel secure. She was hostile to the world in general because of her fear that something unfortunate would befall her.
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> At one point, when anticipating a job promotion (she is employed as a clerk) she became very anxious and sought reassurance from the social worker that she could assume this new, more diversified job involving more responsibility. Allowing her to ventilate her anxiety and reassuring her that she could do the job relieved her and bolstered her confidence.

The social worker must avoid being case in the role of the "bad" parent (i.e., being either too restricting or too indulgent). This is particularly difficult with this type of patient because he continually attempts to recreate in all interpersonal relationships suitable structures by which to maintain his defensive behaviour. Therapy has to break into this pattern through the use of a constructive relationship that does not repeat the client's past experiences. Mrs. Foster's overwhelming need to feel secure was partly met by regular, monthly contacts with one therapist who listened sympathetically to her complaints and gave her gifts (i.e., medication). It is often difficult for the worker to respond positively to the personality of these patients, which have many unattractive assets. The social worker's great difficulty with Mrs. Foster was in accepting her, in spite of her great dependency needs (she could do nothing on her own), and her many illegitimate complaints. The volley of feeling which the patient levels at the worker may touch off the latter's own anxieties, and make it difficult to maintain objectivity. The indifferent or destructive treatment accorded to the patient's family often adds to the worker's problem of remaining objective. To help combat the onslaught on his own personality,

the worker needs to have a high degree of self-awareness so that he knows what is operating in the relationship.

Typically, the patients are particularly sensitive to the attitudes of others. Because they expect rejection, the social worker needs to continually communicate consideration and concern. He may need to take active steps in reaching out to the patient, such as following up missed appointments as in the case of Mrs. Foster, or making a home visit to the patient if he is ill. Some facility in using the patient's "lingo" is usually helpful. In the main, the social worker's activity takes the form of demonstrating attitudes rather than verbalizing that the patient has a problem within himself which the worker wants to help him with. To such a patient any focussing on personal problems at this point may be interpreted by him as rejection. Discussion is in the main centered on tangible, everyday crises. This is well illustrated by the Foster case.

> In January, 1958, Mrs. Foster was very upset because, as the result of her husband's unemployment, she had to assume support of her son without his aid. Thus, the interview was spent discussing budgeting and cheaper rent. In March, 1958, Mrs. Foster reported that the sister who was looking after her daughter was sick, and that she might have to begin caring for her daughter, also. Foster home care for the daughter was discussed as Mrs. Foster was unable at that point to assume any more responsibility. She was encouraged to contact the Centre if any crisis arose.

One phase of the social worker's activity deals with the patient's fears of revealing himself. His expressions of guilt about inadequacy need to be met, not by denial that it exists but by recognition that these feelings are hard on the patient. The patient may test the social worker

during this period by apparent digressions about someone else's problem. Once he is sure of the worker's attitude, he may feel secure enough to reveal himself. If he is still too fearful to trust his way of relating to the worker, it will be characteristic of his manner of relating generally, and will in itself provide significant diagnostic material. By November, 1958, Mrs. Foster had sufficient trust in the social worker that when an emotional crisis arose in her personal life, she sought his aid.

> Mrs. Foster requested this special interview because she felt depressed, lonely, and had lost control of her emotions because her "boyfriend" of three years had jilted her. At the beginning of the interview she poured out her feelings of loss and loneliness. Later, she related this present episode to incidents in her childhood when she had been rejected or abandoned. At this point she recognized that the present rejection only partly explained her anxiety and loneliness: she realized the problem was an internal one and she requested help with it.

The second stage is seen as the period of <u>imitation and identification</u>. It is at this stage particularly that the worker assumes the parent role and may need to continue reaching out to the patient in a variety of ways. In some cases including the Foster one, the patient is able gradually to move from complaining about his situation to permitting the worker to know more fully his feelings, attitudes and behaviour. In March, 1959, a special interview was precipitated by the fact that Mrs. Foster's boss criticized her in front of her co-workers:

> Mrs. Foster complained bitterly about her boss and asked for a letter stating that for medical reasons she should be transferred to another department. The social worker refused to do this, but encouraged her to express her feelings about being criticized. Mrs. Foster poured forth her feelings, and it became

> apparent that she had a need to be constantly praised in order to maintain her confidence, that she associated criticism with rejection, and that she was unable to defend herself against criticism for fear of precipitating greater retaliation.

Another incident a few months later illustrates Mrs. Foster's progress:

> Mrs. Foster reported that her sister wanted to adopt her daughter who was to start school in September. Mrs. Foster was ambivalent about the adoption, but after several discussions, concluded that she was unable to assume responsibility for her daughter, and that it would be in the daughter's best interests if she was formally adopted by her sister. Thus, she proceeded with the adoption.

It is at this stage that reality may be held up to the patient by pointing out that certain patterns of behaviour are not helping him achieve his goal. It is necessary, therefore, for the social worker to exert great care in making demands for more realistic behaviour. If these demands are made too frequently or at inappropriate times, the patient may be unable to tolerate them and resort to his usual withdrawn or destructive patterns. An assessment of the patient's life situation as to whether he can obtain sufficient gratification of healthy needs to give up his old pattern is very important. During this period when demands are being placed on the patient, he will need considerable support and approval from the social worker. For example, from November 1958 to March 1959, Mrs. Foster was under great stress: her "boyfriend" jilted her, her boss criticized her, and her son refused to accept her discipline. She also had financial difficulties, and was very lonely.

> During this period the social worker concentrated on those roles which Mrs. Foster was performing

> satisfactorily. She was commended on the quality of her work, and on her participation in the Social Club. She was congratulated on the way in which she managed her responsibilities and on her ability to budget. She was encouraged to develop friendships with co-workers, and when she was invited by a co-worker to go to Seattle for a holiday, the worker, as the "good" parent, gave his consent. She was also urged to take a firm, consistent stand with her son.

The techniques used during this period may be prohibition of acting out, exploration of inadequacy feelings, encouragement of social and occupational activities, and granting of valid dependency gratification. The emphasis is always on specific reality problems. In April, 1960, the social worker, who was now consistently perceived as the good parent, discouraged Mrs. Foster from sharing a suite with another patient, Mrs. Neal.

> The worker recognized Mrs. Foster's feelings of loneliness and her dependency needs, but pointed out the reality of the situation. Mrs. Foster admitted that Mrs. Neal's bellicose, domineering manner would be exasperating after a long day's work, and gave up the idea.

A useful technique when appropriate is the giving of rewards in the form of praise. Direct advice may be given but is usually couched as a suggestion and the ultimate decision is generally left up to the patient. During this period the patient may be able to imitate the social worker's method of mastering, even when his psychic structure is such that he cannot internalize a mature way of functioning. The more mature patient may be able to incorporate to some extent the social worker's attitudes.

This period is of considerable duration, and it may last from one to several years, depending on the degree of disturbance the patient manifests. With Mrs. Foster, the second stage of treatment lasted eighteen

months, from November 1958 to May 1960. Certain environmental factors may interfere with the treatment of these patients such as inability to obtain employment, family rejection, low income, and family neurotic interaction. Changes of therapists interfere with the treatment of these patients because of their need for a consistent parent figure.

The third stage occurs when the patient discovers there is real gain for himself in controlling his behaviour, when he experiences how much he likes himself, and when he obtains positive responses from others. This experience encourages him to practice his new ways of relating while the worker stands by, giving him support and approval long enough for the patient to feel comfortable in the use of his new patterns of behaviour. A distressing episode in May 1960, proved to Mrs. Foster that she had the inner strengths to withstand major crises without relapsing into a psychosis. Her ability to cope with this situation was primarily the result of confidence gained through successfully dealing with other traumatic incidents, such as adopting out her daughter and divorcing her husband.

> In May, 1960, Mrs. Foster's son, Randy, ran away from home with another boy, broke into a house and stole $140. She managed the courtroom visits very well. When her son was placed on probation, she moved to a new neighbourhood where he could make new friends. With the help of the social worker she began to set limits on him which she actually enforced. During this period the social worker supported her in her courtroom visits and in her periods of helplessness; and he praised her in her efforts to prevent her son from further delinquencies.

The patient is motivated by successes rather than needing to rely so heavily on the social worker's support and direction. The patient must be prepared

for ups and downs that are bound to occur, but he can take comfort for the future in the fact that he is experiencing fewer downs.

At the end, when termination is discussed, the patient may regress temporarily to his old behaviour pattern, to illustrate to the social worker that he is not ready to terminate. This may be a valid indication of unreadiness, or may be an attempt to test the worker's confidence in his ability to manage his own life. Widely spaced appointments, reassurance of the worker's interest and continued availability in times of stress are helpful mechanisms to deal with this problem. If the patient is actually ready to terminate, his general adjustment will be the best indicator once he has tried to function on his own. By December, 1960, all was going well at the Foster home:

> Randy, the son, was doing well in school, was active in sports, and well-behaved and obedient at home. Mrs. Foster was off medication, and had obtained a new job with a higher salary and more prestige. Three months later, Mrs. Foster reported that she was happier and more relaxed than she had ever been. In fact, she even talked about being well enough to be discharged.

The main treatment considerations for the therapeutic handling of this type of patient is well summarized by Melitta Schmideberg:[1]

> As the aim in treating the borderline patient is to strengthen the ego and its control over the id, we must be careful not to weaken the existing defences by interpretations, by encouraging the unconscious material to emerge indiscriminately as in free associations and uncontrolled fantasying, or

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[1] Schmideberg, Melitta, "The Borderline Patient," American Handbook of Psychiatry, Arieti, editor, Basic Books, New York, 1959, vol. 1, p. 413.

> by being unduly tolerant of pathological manifestations and impulsive behaviour. Moreover, we should develop the existing defences. In particular, setting limits, developing volition, forethought, responsibility, and consideration for others, stressing consequences, socializing the patient, and giving him values force him to develop defences. Values and standards are of positive emotional significance; they are as important for normal development as the fulfilment of material or sensual needs. They fashion the personality and form an important part of it. Values, ideals, and standards act as levers that check primitive impulses, and thus further repressions and other defence mechanisms, but they also give positive satisfaction that compensates the instinctual frustration.

This type of treatment is successful in rehabilitating the patient, especially when it is combined with social work services to the family. The aim of the social worker in working with the family is to help them accept the patient and his limitations. This is done by clarifying the nature of the patient's illness to the family, by helping the family lower their expectations regarding the patient's performance, and by giving advice as to how to behave toward the patient. At the same time the social worker accepts the family's negative feelings concerning the patient's irresponsible and detached behaviour, and supports the family in its attempts to re-integrate the patient into the family.

Some of the patients, after one or two years contact with the Sustaining Clinic, are able to assume responsibility for their behaviour. During this time, many are able to develop a number of sufficiently close relationships that they no longer feel isolated in the community. The confidence gained through having "weathered this stormy transitional" period gives them the courage to seek out new interests and activities.

An Evaluation of the Treatment

It is difficult to measure the kinds of results achieved by the Sustaining Clinic.[1] In essence, "no progress" is progress. Because the patients are so severely damaged and so vulnerable to further illness, the first aim of the Sustaining Clinic is to prevent the patient from regressing to the point where he has to be hospitalized. At the same time, attempts are made to improve the patient's functioning so that he can obtain greater enjoyment from his emotions, achieve more satisfying social relationships, and assume greater responsibility for his behaviour.

One of the simplest ways of evaluating the effectiveness of the Sustaining Clinic is by determining the number of patients who have been readmitted to Crease Clinic or the Provincial Mental Hospital. On this basis, the Clinic has been successful. Only six of the forty patients were hospitalized while attending the Sustaining Service, and the longest period of hospitalization was four months. Nine patients relapsed and were admitted to the Day Hospital; one was admitted on three different occasions and three were admitted on two different occasions.

Another way of evaluating treatment is by comparing the patient's functioning at the time of referral with his present functioning or his functioning at the time of discharge. Three rating scales have been used in an effort to describe the results of treatment in meaningful terms, instead of the traditional terms "recovered, improved, and unimproved".

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[1] In the present study no attempt is made to evaluate the specific contribution made by the social worker in the rehabilitation of the patient. Rather, this account is concerned with the total treatment service, including the social worker's contribution, to the particular kind of patient for whom it is designed.

The three ratings may be summed up as follows:[1]

1. Impairment - a performance scale.

2. Emotional Distress - a scale of subjective discomfort.

3. Social Tension - a scale of relationship.

Schedule A. Criteria Used for Rating Degree of Illness or Improvement

Degree	IMPAIRMENT (Performance)	EMOTIONAL DISTRESS (Subjective Discomfort)	SOCIAL TENSION (Relationships)
1. None	effective	emotions enjoyed	single and social satisfactions
2. Minimal	pre-illness functioning	symptoms appear only under pressure	structured relationships
3. Mild	impaired under pressure	symptoms present - mild	constricted relationships
4. Moderate	maintains self at lower level	symptoms present - marked	unsatisfying relationships
5. Severe	supervised	loss of control	marked social conflict

[1] The first rating is a simple adaptation from the American Psychiatric Association Manual, Rating scales 2 and 3 were devised by Dr. McNair, Director of the Mental Health Centre.

Table 1. Comparative Ratings of Sample Group, at Referral and at Discharge

Degree	Impairment		Emotional Distress		Social Tension	
	At Referral	At Discharge	At Referral	At Discharge	At Referral	At Discharge
Males						
1 None	-	-	-	-	-	-
2 Minimal	1	3	-	2	-	1
3 Mild	2	5	1	7	2	6
4 Moderate	5	3	8	1	9	4
5 Severe	5	2	4	3	2	2
Females						
1 None	-	1	-	-	-	-
2 Minimal	1	8	-	2	-	1
3 Mild	6	10	6	15	6	17
4 Moderate	10	4	10	10	11	8
5 Severe	10	4	11	-	10	1

Judging by the ratings, the patients' condition, grouped in terms of impairment, emotional distress, and social tension alike, was moderate to severe at the time of referral. At the time of discharge (or at the date of this study) their functioning had improved to the point where it was mild or minimal. The degree of improvement was about equal for men and women. On the whole, equal progress was achieved in all three areas.

In summary, this type of treatment, removing as it does, the threat of control, compulsion, or censure, tends to minimize the patient's feelings of helplessness and inferiority. A positive reality relationship between the worker and the patient is the main method of developing and strengthening the latter's impaired capacity for feelings for others. Through identification with the worker, the patient can gradually accept controls and attitudes more appropriate to reality. The treatment provides emotional and practical support aimed at strengthening the patient's necessary defences and filling some of his basic needs, so that his feelings of isolation and inferiority are diluted. It is a type of treatment that is appropriate to the Sustaining Clinic patient in view of his low rehabilitation potential.

CHAPTER IV

THE SUSTAINING CLINIC AS A BRIDGE TO THE COMMUNITY

The focus of this study has been the contribution made by the Sustaining Clinic for its appropriate class of patients. This has been done by (1) examining the problems of a sample group of these patients, and by (2) reconstructing the treatment services given to them; thus establishing how far this meets their needs.

Therapeutic effort, to be valid and effective, must be related to the needs of the patient and to the specific conditions surrounding his illness. But, as this material illustrates, it is often difficult to separate the part of the problem which belongs to the patient and the part that is related to his being a member of a family unit. The influences that push him toward illness and the influences that lead him toward health are intertwined. While these factors are known to be psychological, social, economic, and medical, in actuality it is difficult to make clear-cut distinctions between them and other elements which contribute to stress and breakdown in mental health.

The review of the cases under study demonstrates that each patient has many difficulties and concerns which are contributing elements in his illness. Treatment in hospital may have improved his psychiatric syndrome, but a period of hospitalization can create further difficulties for him in his social environment outside the hospital. For most patients, the

transition from the hospital to the community is a long one, fraught with many threatening real and fantasied problems.

Many patients may improve in hospital only to return to - what is for them - a sick environment. Not all environmental situations are correctable or amenable to modification, and it may be destructive to have the patient return to the environment where he first became ill.

The patients, because of the residual aspects of their illness, are unable to face all the complications and responsibilities that healthy people take in their stride. Confronted with distressing situations, they tend to relapse into illness, which, in a sense, offers them escape from unbearable stresses.

There is evidence, recognized by the staff at the Mental Health Centre, that the patients attending the Sustaining Clinic are unable, for a variety of reasons, to benefit from more intensive therapy. For many of these patients any contact beyond a brief monthly interview is so frightening they will terminate treatment. Though they crave a close relationship with someone who will understand and accept them, their fear of rejection and loss of power through lowering their defences is great. Thus, the therapist, because of the very nature of his patient's personality, is forced to deal with everyday reality problems. He helps the patient maintain a kind of equilibrium through being a constant support in cases of stress, through setting limits, through information-giving, through manipulation of the environment, and through being a figure for identification. No hope is held out, of making changes in the basic personality structure of the patient.

Readmission rates indicate that the Sustaining Clinic has been, on the whole, successful in its aim of maintaining the patient at his pre-referral level of functioning; six (or fifteen per cent) of the patients studied returned to the mental hospital during the three years the Clinic has been in operation. This corresponds with results recorded in studies done by Donald Carmichael[1] and Elsie Kris[2]. Carmichael found the relapse rate of patients attending four Aftercare Clinics in New York City to be fifteen to twenty per cent during a three year period. Kris, studying one of the New York Aftercare Clinics, found the relapse rate (of 250 patients over a two year period) to be ten per cent.

However, in view of the Sustaining Clinic patient's severe impairment, intense emotional distress, and unsatisfying social relationships, mere maintenance through medication and brief monthly contacts is not enough. This is not to negate the importance of tranquilizing drugs because without them the Sustaining Clinic patients would probably still be in a mental hospital. However, sustaining the patient is but one step in the total rehabilitation of the mentally-ill person. The staff of the Sustaining Clinic are aware of this, and have evolved a pattern of treatment that has helped improve the functioning of the majority of the patients. The rating scales reveal that the patient' condition, grouped in terms of impairment, emotional distress, and social tension, was on the average

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[1] Carmichael, Donald, "Community Aftercare Clinics and Fountain House," Rehabilitation of the Mentally Ill, Greenblatt and Simon, editors, Washington, D. C., American Association for the Advancement of Science, 1959, pp. 157 - 173.

[2] Kris, Elsie, "Patients Maintained in the Community on Tranquilizing Drugs, Rehabilitation of the Mentally Ill, pp. 191 - 199.

moderate to severe at the time of referral. At the time of discharge (or at the date of the present study) their functioning had improved to the point where it was in general mild or minimal. The degree of improvement was about equal for men and women. On the whole, equal progress was achieved in all three areas.

However, the patients after demonstrating their ability to use more intense treatment services, are seldom transferred to it. This is primarily due to staff shortages, not reluctance on the part of staff. It would cost the provincial government very little to increase the staff at the Adult Clinic to the point where these patients could receive bi-monthly or weekly interviews, for some of whom this might be beneficial. The benefits of the Sustaining Service would be extended if the Social Club, associated with the Clinic, offered a variety of special interest and problem-centered groups. However, a professionally trained group worker would be required to organize these services.

The Sustaining Clinic in the Network of Social Agencies

The goal in the development of social welfare resources is to ensure in the community a network of facilities for meeting the needs which individuals are unable to meet themselves. The process of social action is the mobilization of group efforts in the interests of social welfare. Some of the needs of the patients at the Sustaining Clinic are distinctive and require specialized facilities; some of these needs are the common needs of other sick or disturbed persons.

There are a wide range of community resources significant for mental health. Certain of them are primarily directed to the population as

a whole or to large segments of it, with a view to helping people develop and maintain maximum capacity to cope with the ordinary problems of life. Examples of such agencies are the Vancouver City Social Service Department, the Outpatient Department at the Vancouver General Hospital, and Gordon and Alexandra Neighbourhood Houses. The clientele of these agencies is not confined to people with emotional or behavioural problems, though such people are included. The Vancouver City Social Service Department offers financial assistance to those applicants who pass a "means" test. The Outpatient Department at the Vancouver General Hospital provides medical services for low-income groups. The Neighbourhood Houses provide social, educational, and recreational programs for people from many segments of the community.

Then, there are agencies designed primarily for people with emotional or behavioural problems such as the Family Service Agency and the Mental Health Centre. The Family Service Agency is not designed to provide service for people with a low rehabilitation potential (e.g., the Sustaining Clinic patients).

The Adult Clinic of the Mental Health Centre is the one agency in metropolitan Vancouver offering a comprehensive rehabilitative program for the mentally-ill patient.

Its Day Hospital has four goals: (1) The Day Hospital makes possible early discharge from the hospital of patients who can establish living arrangements outside. (2) Patients may maintain therapeutic contact with a hospital setting for a longer time without tying up a much needed hospital bed. (3) The Day Hospital is helpful in preventing the hospitalization of relapsing patients. (4) It is helpful in preventing

the hospitalization of new acute cases.

The Outpatient Department offers therapeutic interviews on a weekly, bi-weekly, or monthly basis depending on the needs of the patient. Treatment usually lasts from six months to over two years: often a spouse or other family member receives casework at the same time. The Psychiatric Outpatient Department at the Vancouver General Hospital offers a similar service.

The Social Club at the Adult Clinic is organized only for drop-in activities two evenings a month. Unfortunately, the Social Club is not open every day, nor are there any special interest or problem-centered groups as there are at the C. M. H. A. Social Centre.

Finally, there are facilities designed exclusively for discharged mental patients. These facilities have already been mentioned in the first chapter, and include follow-up care by a social worker from the mental hospital, foster home care, Venture, Vista, the C. M. H. A. Social Centre, and the Sustaining Clinic. Each attempts to meet a particular need of the discharged patient or provides a service for a particular type of discharged patient.

Patients referred for follow-up care from the mental hospital usually have a high rehabilitation potential but are returning to unsatisfactory home situations. Follow-up care rarely extends beyond six months after discharge. Venture and Vista offer a temporary protected environment to employable patients who lack family and friends. Foster home care is designed primarily for the chronic, non-recoverable patient who requires little supervision and who can live in the community in controlled

conditions. The C. M. H. A. Social Centre offers organized and "free" social activities for discharged patients whose central problem is difficulty in establishing social contacts.

As can be seen, the crux of rehabilitation of the mentally ill is the array of services which must be integrated to do the job. Disablement of a human being is a complex thing; the person is himself complex; and the society in which he finds himself is complex, too. To achieve rehabilitation of mental handicaps, to "reable" the individual takes the combined efforts of a number of disciplines in a number of different social agencies. The Sustaining Clinic alone does not suffice.

As more and more patients leave the hospitals, many of them after a hospitalization of at least several years' duration, questions related to modern drug therapy assume progressively greater importance. One of the main purposes in establishing the Sustaining Clinic, formerly known as the Largactil Clinic, was to regulate the medication of discharged mental patients.

The ultimate benefit to humanity from tranquilizing drugs will depend on how social workers and psychiatrists solve the social problems and meet the social needs of the patients discharged on medication. The results of this study suggest that no drug can alter the social and economic pressures which proved to be the underlying causes of illness in these patients. Such therapy can help insulate the discharged patient from the stresses caused by rejection, ignorance and prejudice, but the stresses are still there. Only the community itself can remove them. Social workers can help in the process by interpreting to the community the problems,

needs, and capacities of the discharged mental patient.

Interpretation to the Community

In the past, the attitude of society toward patients suffering from mental illness was one of hopelessness, an attitude that is reflected even today in the type of provisions made for their care. If the advances of psychiatry and social work are to benefit such patients in the future, it is essential that steps be taken to modify this attitude.

Social workers in mental health settings have ample opportunity to observe the close relationship existing between substandard social conditions and the incidence of mental illness. Cognizant of the impact of social pressures upon health, the hardships imposed by lack of suitable facilities for care of the mentally ill, and the end results in human misery they create, the social worker must assume greater responsibility for calling these situations to the attention of the community and for suggesting, whenever possible, ways and means of providing remedies. In fact, such activity is in line with, and cannot be separated from, the social worker's total effort to marshal all the forces in the patient's environment to serve his best interests.

In these efforts toward providing adequately for human needs, the professional team in the mental health setting can be of vital influence. Working together, the team can influence community attitudes through interpretation of the individual patient, the problems confronting him, and the measures necessary for his maximal rehabilitation. Although it is true that many patients returning to the community after mental illness may have residual handicaps, these handicaps do not preclude the existence of real

potentialities which should be recognized and utilized as fully as possible.

Social work has a responsibility to re-orientate the community so that it will accept the mental patient and react more tolerantly to his behaviour. The public must learn to respond to the patient's disordered functioning without depriving him of all positive social roles and must take the trouble to help him maintain a sense of personal destiny and self-control in the presence of illness. Rehabilitation is achieved only when the patient is accepted by the citizens of the community.

Ability or disability is a characteristic of the relationships which a person establishes with his environment; they either fit each other well or they do not. It is no more nearly correct to say that the round peg does not fit the square hole, than it is to say that the square hole does not fit the round peg - neither, of course, fits the other. Fortunately, the futile argument is ending as to whether the environment of the chronic psychotic is unsuited to the needs of the patient or the patient is unsuited to his environment. There are signs of recognition that periods of decompensation signify that each has become unsuited to the other. Thus, at the same time that techniques are being perfected to help the patient keep himself adapted to his environment, programs should be developed to create an environment in which the patient can live without undue stress. The Sustaining Clinic with its two-way process of rehabilitation - that of modifying the patient in some degree, and modifying the environment, such as home and work circumstances, as far as possible - has as its goal the increase in the patient's capacity to pursue life.

The Sustaining Clinic is an essential aspect of the patient's

transition from the hospital to the community and the coordination of his overall post-hospital career. There is evidence that it reduces relapse rates and helps patients remain in the community longer at higher levels of adjustment. This is done by regulation of medication and regular therapeutic contacts. The Sustaining Clinic is appropriate for its type of patients: the severely damaged patient with a low rehabilitation potential who is maintained in the community on medication. The service would not be particularly beneficial to all types of discharged patients. It does not, nor is it intended to, meet the needs of the chronic patient requiring boarding or foster home care, the discharged patient without accommodation, or the patient whose primary problem is a financial or a vocational one or in the realm of social relationships. The Sustaining Clinic is one of the bridges between the patient's illness and his community.

Appendix A

Schedule B - Statistical Data on the Male Sample Group

Name	Age on Admission	Marital Status	Formal Education	Economic Status	Length of Hospitalization
Mr. A.	69	married	Grade 9	unemployed, O.A.S.*	6 years
Mr. B.	54	married	Grade 10	employed	1/4 year
Mr. Rogers	51	married	Grade 12	unemployed	5 years
Mr. C.	50	married	Grade 10	employed	1/3 year
Mr. D.	43	married	Grade 9	employed	1/4 year
Mr. E.	41	married	Grade 10	employed	1/4 year
Mr. McLeod	33	married	3rd yr.un.	unemployed	1/2 year
Mr. F.	30	married	Grade 10	employed	nil
Mr. G.	36	single	Grade 5	unemployed	2 and 1/4 years
Mr. H.	35	single	Grade 10	unemployed, D.P.A.**	6 years
Mr. I.	30	single	Grade 6	unemployed	nil
Mr. Owens	30	single	Grade 10	unemployed	2/3 year
Mr. J.	28	single	Grade 9	employed	nil

* Old Age Security

** Disabled Persons Allowance

Appendix B

Schedule C - Statistical Data on the Female Sample Group

Name	Age on Admission	Marital Status	Formal Education	Economic Status	Length of Hospitalization
Mrs. A.	54	Married	Grade 8	Housewife	1 and 3/4 years
Mrs. B.	50	Married	Grade 10	Housewife	2/3 year
Mrs. C.	45	Married	Grade 9	Housewife	1/2 year
Mrs. D.	45	Married	Grade 8	Housewife	nil
Mrs. E.	43	Married	Grade 12	Housewife	1 year
Mrs. F.	40	Married	Grade 9	Housewife	1 year
Mrs. G.	34	Married	Grade 12	Housewife	3/4 year
Mrs. H.	31	Married	Grade 11	Housewife	2 years
Mrs. I.	31	Married	Grade 11	Housewife	1 and 1/2 years
Mrs. J.	57	Widowed	Grade 6	D.V.A. pension	nil
Mrs. K.	54	Widowed	Grade 10	employed	2 years
Mrs. L.	46	Widowed	Grade 9	unemployed	1 and 1/2 years
Mrs. M.	35	Separated	Grade 10	unemployed, S.A.	4 and 1/2 years
Mrs. Foster	35	Separated	Grade 12	employed	1/2 year
Miss N.	34	Divorced	Grade 12	employed	5 years
Mrs. O.	33	Separated	Grade 11	employed	1 year
Miss A.	54	Single	Grade 8	employed	7 years
Miss B.	47	Single	Grade 12	unemployed, S.A.	4 years
Miss O'Connor	47	Single	Grade 12	unemployed, S.A.	12 years
Miss C.	47	Single	B. A.	employed	14 years
Miss D.	38	Single	Grade 11	employed	1 year
Miss Beriosova	35	Single	Grade 8	employed	1 year
Miss Stone	34	Single	Grade 12	unemployed, S.A.	13 years
Miss E.	31	Single	Grade 8	unemployed, S.A.	3 and 1/2 years
Miss Lake	30	Single	Grade 10	unemployed	9 years
Miss F.	29	Single	Grade 12	unemployed, S.A.	2 and 1/2 years
Miss Catherine G.	29	Single	Grade 12	unemployed, S.A.	1 and 1/2 years

Appendix C.

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