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- A Geriatric Treatment Philosophy**
*Robert Chandler, Elizabeth Eslinger,
Margaret Mackler, and James Selkin* 79
- The New Community-Based Nonprofessional
Mental Health Aide**
Frank Riessman 87
- Treatment Goals For Patients
From Patients, Their Families,
And Staff.**
*Mary Lou Anderson, Paul Polak,
David Grace, and Aldora Lee* 101

A GERIATRIC TREATMENT PHILOSOPHY*

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Fort Logan's first geriatric unit opened in October of 1964. The staff, although familiar with the techniques and methods of the therapeutic community, had little or no experience in dealing with the geriatric patient. After many months of trial and error, a program evolved in which therapeutic techniques were adapted to the needs and capabilities of the older patient.

As presently constituted, the geriatric program differs from that of an adult psychiatric team in several significant dimensions. Alertness, memory, and orientation are emphasized with the geriatric patient, and certain programs are designed to strengthen the patient's awareness of his environment. Also, the geriatric patient requires a greater amount of medical care than the adult psychiatric patient. However, within his physical limitations, he is expected to participate in a variety of available activities.

Finally, the geriatric patient is more defensive about his disturbance and is less capable than younger patients to recognize his feelings or to search for insight. Although the staff consistently challenges patients' destructive defenses, this is done on a

*The authors wish to acknowledge the cooperative efforts of the many staff members who contributed to the formulation of the material presented.

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behavioral rather than on an intellectual level. Goals are directed toward changes in relatedness and appropriateness of behavior, rather than in thinking attitudes.

TREATMENT GOALS AND TECHNIQUES

The over-all treatment goals with the geriatric patient are to maximize his mental, physical, and social capacities. Remotivation techniques challenge the patient's desire to withdraw from life or to die. He is encouraged to establish new and re-establish old social relationships and to develop and redevelop former interests in church, recreation, games, household activities, and the like in close proximity with other people. He is encouraged to engage in mutual helping relations and to take an active interest in the lives of others. Staff efforts are utilized to combat patients' dependency upon bed rest, wheel chairs, canes, and laxatives. The treatment program is anti-regressive in nature.

Techniques of physical rehabilitation occupy an important place in the treatment program. Often aged patients consider a limited physical disability, such as hearing loss, to represent total incapacity. In addition to providing complete medical rehabilitation services, including physical therapy, correction of sensory deficit, ambulation, etc., the team makes an intensive effort to help a patient recognize the reality of his situation. At the same time it supports him to the point where he can become increasingly aware of the areas in which he functions at a competent level. For example, in occupational therapy special devices and fixtures have been built which enable visually handicapped patients to work effectively at projects.

One major treatment goal is for the team to help the patient develop attitudes of hope and satisfaction about future life. The treatment program includes the expectation that the patient will concern himself with interpersonal relationships, productive kinds of activities, and a place to live in the community.

Patients are expected to take an active role in coping with their problems whenever possible. As many decisions as possible

are left to the patients, and there is an implicit assumption within the treatment team that each individual is capable of directing his own life. In an effort to help a patient re-establish his self-esteem, he is involved in working out problems within a family group therapy situation and in relationships with other patients. Feelings of increased self-esteem are promoted through emphasis on productivity and on social roles that actually do exist for all people, despite their age. Thus the treatment program includes activities such as occupational therapy, industrial therapy, gardening, and recreational therapy which stress the individual patient's capacity to participate and to produce. Social roles, such as those of grandparents, parents, friends, and spouses, are emphasized wherever the patient's unique capacity to engage in these roles is realistic. Factors such as the increased experience and wisdom of age are identified as assets for the older person.

The individual's role as a patient in a mental hospital is seen as a transitional period in his life rather than as a label which marks him as a social deviant.

The physical structure of the hospital is important to the patient in terms of its "noninstitutional" setting. The absence of locked doors, the open corridors, individually designed sleeping quarters, and use of color and mirrors are all designed to promote the patients' conception of the hospital as a place which encourages individuality. The intake procedure is designed to preserve respect for the individual patient and his possessions. Standardized dehumanizing procedures, such as removal of personal articles and distribution of uniforms, characteristic of many institutions, are not employed.

THE TREATMENT PROGRAM

The entire treatment program is divided into four significant components, which are identified as (a) social therapies, (b) insight therapies, (c) activity therapies, and (d) medical therapies.

(a) Social therapies are designed to redevelop the social interests and promote interaction between patients and their peers,

and between patients and staff members. The newly admitted patient is met with a uniform expectancy, both verbal and nonverbal, that he will take an active part in the treatment program. Regressive tendencies are quickly countered. The "buddy" system has been developed as an initial pairing off between new and old patients, between relatively well and sicker patients. If a patient is physically handicapped, he is paired off with a healthier patient. This process promotes interaction and enables patients to utilize their capacities to help each other. It also promotes indoctrination and adjustment to life on the unit. In addition, through sharing help and ideas the patient's self-esteem is bolstered and his concern with the question, "How sick am I?" is relieved. His interest in other people and in his environment is stimulated. Small group formation begins with this initial pairing.

The experiences of daily living are organized to advance therapeutic goals. Patients are encouraged to ask for help when their needs are realistic and to operate as independently as possible in areas where they have demonstrated capability. A patient unable to tie his shoelaces, for example, may be expected to be independent in the lunchroom, where his gross coordination movements are adequate to eat appropriately.

Group meetings, such as patient government, industrial therapy meeting, and hospital dietary committee, are examples of programs designed to stimulate interest in the hospitalwide social environment. The varied opinions and attitudes about important issues in the hospital which emerge from these meetings develop the patient's sense of ego involvement and challenge his previously established patterns of social withdrawal.

The community meeting, which includes a patient report, starts each treatment day. Here the entire patient and staff group is led by one of the patients. Each individual is asked to report on his previous day's activities, visits, problems and gains. There is also time for planning new activities and for preparing for patients who will be joining the group, as well as for those who will be leaving. This meeting, besides helping to draw patients together, gives clues to the staff about those problem areas for various patients that need to be dealt with more extensively.

(b) Insight therapies begin with the social history. A review of the patient's past behavior with his family and his interested relatives provides knowledge of the stresses and conflicts which led up to hospitalization. Knowledge of the nature of the family constellation and of the social context in which the patient lived prior to hospitalization contributes to the development of patient-staff relationships, which are designed to counteract the sick attitudes prevalent in the patient's previous environment. A knowledge of the patient's home environment helps the staff interpret to the patient and aid him in facing realities which he may have been studiously avoiding.

Further insight is provided in family group meetings. These once-weekly meetings are held with groups of patients and their relatives for the purpose of discussing continuing family problems and helping patients and their families plan for the future. A group for patients and their spouses examines marital problems. A multi-family group is focused primarily on parent-child relationships. In these groups an atmosphere is created in which problems are freely discussed and accepted or resolved.

Small group therapies take place twice weekly on the unit. Patients meet with trained staff for the purpose of exploring their problems, their life situations, and their future plans. Although these groups frequently begin with patients for whom the primary goal of treatment is social interaction, not infrequently specific and complicated psychodynamics come under scrutiny in later sessions. Small groups are conducted by nurses and technicians and do not necessarily require the presence of doctors, although multidisciplinary consultation is provided.

Twice each week the hospital chaplain conducts values meetings with patients in which values and beliefs are discussed. Religious conflicts, life philosophies, and the interrelationships between these and feelings are shared. A nonsectarian atmosphere is maintained, and patients of all faiths have responded to the warmth and stimulation of these meetings.

(c) Activity therapies are coordinated with assessment in the treatment program. They are aimed at resocialization, remotivation, and the development of creative activity as a replacement for work.

Activity therapies encourage a sense of physical competence and develop new interests and a sense of adequacy in dealing with the environment. It is the intention that these skills will be of use after discharge.

In the home arts program a group of female patients gathers weekly to budget and prepare a meal, which is then served to invited guests. This program is designed to help patients redevelop interests and skills in activities at which they were once competent. Activities such as croquet, fishing, picnics, barbecues, and the like encourage the redevelopment of interests and abilities in bodily expression. Bingo and other quiet games, such as checkers, are representative of the constructive use of time and promote reconstitution of mental alertness and attention span.

Industrial and occupational therapies promote a sense of usefulness and productivity. The industrial therapy program features light factory work, for which patients are paid small sums. Even though these sums are small, they represent tokens of reward for participation in productive group experience. In both occupational therapy and industrial therapy, the feeling that accompanies being an actively participating member of a work group is seen as counteractive to the hopelessness which characterizes so many patients on admission. Again, both occupational therapy and industrial therapy involve active contact with younger people as members of a working group. Here, too, the older patient's sense of being an active participant in life is encouraged.

(d) The medical therapy of the psychiatric geriatric patient begins with the physical evaluation done at the time of admission. The medical history and physical examination, clinical laboratory determinations, chest X-ray, and dental survey are obtained routinely. These, plus whatever specialty consultations are needed (whether obtained at the center or from community facilities), provide staff with an early assessment of the patient's physical condition. The team leader's evaluation of the patient and the observations of the nursing staff are recorded in the patient's chart and also reported at daily staff meetings. Through these means, the need for drugs, special diet, treatments, or maintenance therapy for pre-existing physical illness is quickly determined and appropriate orders are

written. Drugs, whether of the tranquilizing or antidepressant variety, are selected and used as in other psychiatric settings, but with the awareness that their side effects are more frequent in older patients.

The staff makes note of the daily living experiences and activities engaged in by the patient, and this information helps differentiate the amount of psychological regression or true physical loss that exists. Aid in ambulation, dressing, or feeding is provided when it is felt to be absolutely necessary. Confinement to bed is considered inappropriate, regressive, and depressing for all patients, except for those with serious intercurrent or pre-existing illnesses. When this occurs, the patient will be transferred for care on the medical unit. The staff recognizes the necessity for avoidance of overdependency and excessive reassurance, and is cautious about tendencies to "mother" the patient. At the same time, the staff is encouraged to recognize periods of stress in the patient brought on by feelings of anger, resentment, or change which will lead to increasing problems with bowel and bladder control or various forms of behavioral symptoms.

Good nursing care depends upon a full knowledge and work-up of the patient. The patient with physical limitations requires a different type of care than that given to younger adults. Extra nourishment, rest, and a slower program of activities are provided. The need for physical medicine and rehabilitative efforts is necessarily greater in the geriatric patient. Older patients have more frequent occurrence of sensory loss. These must be dealt with whenever present, although such losses are frequently exaggerated by depression and the patient's need or desire to withdraw from outside stimuli.

PREPARATION FOR DISCHARGE

Discharge planning is a vital part of the treatment program and is designed to help the patient move into a situation which maximizes his living potential. Indeed, the results of discharge serve as a barometer of the success of each individual's treatment

program. Numerous variables influence discharge plans. The "when" and the "where" are themselves interrelated factors with individual patients.

Implicit in discharge timing is the attainment of maximum benefit from treatment in the hospital setting. Experience has shown that patients kept in the hospital past that point tend to regress to more primitive levels of adjustment. Time is critical with geriatric patients; staff must make a continuing effort to hurry. This is in accordance with the unit's philosophy that life is precious and needs to be lived.

The validation of assessments made about the patient at admission and of reassessments made during the treatment process occurs at the time of discharge. At this point, the team discovers how therapeutic and/or how realistic individual treatment goals have been. The treatment of the geriatric patient provides for many surprising and unpredictable results, and the staff can learn from each experience.

THE NEW COMMUNITY-BASED NONPROFESSIONAL MENTAL HEALTH AIDE*

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I would like to talk about the use of indigenous nonprofessionals, especially in the mental health fields, but also in a great variety of other fields. What I think has been discovered almost by accident in the anti-poverty movement is that we have here a new tool, a new type of manpower which carries with it the possibility of the use of new types of technology, new approaches to dealing with many problems. I think that in the course of this new affluence, or new possibilities of using this manpower, we can begin to plan very different strategies of intervention in a wide variety of areas, one of which is education and another, mental health.

Another area which I just would like to mention is family planning. A major international problem facing us today, other than war and famine, is obviously the population explosion and the fact that it has been difficult to persuade various populations to use various types of birth control measures. In the developing nation, the anthropologists and health educators have developed the use of the nonprofessional, or, as he is called, the auxiliary, in various small-scale experiments. For instance, two auxiliaries in Peru, twelve in India, etc., are being used in various studies. But it seems interesting that the world has not entirely caught up with the new possibilities of a massive use of nonprofessionals, training them and utilizing them on a large-scale basis to convince

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the populations involved to use some of the new birth control measures. It seems to me that new possibilities now exist because of the potential of the nonprofessional and the concept of being able to train and supervise them on a large-scale basis. This really arose out of the anti-poverty movement in the United States, and because of this it seems to be quite possible to consider vast changes in underdeveloped areas. There is no reason why we cannot think of deploying ten thousand such nonprofessionals in any nation where this is a major issue. As you probably know, Congressman Sheuer has suggested the use and employment of a million nonprofessionals in the United States. Before the escalation of the war in Viet Nam this was a distinct possibility, and I think it will again become a possibility.

Very briefly, what are some of the reasons why the use of this new technology — the nonprofessional — might be particularly significant? I always like to look for an action approach, or program, that has at least *four or five pluses* in it rather than just one. And I think that this particular area allows for these various pluses. For example, there are enormous manpower shortages in the various human services — mental health, social work, education, recreation, etc. We lack the professional personnel that are so badly needed in these fields, and consequently what has very often happened has been the watering down of professionals to do all kinds of things in these areas which could *easily be done by nonprofessionals supervised by professionals*. Aside from the fact that there is a manpower shortage which nonprofessionals could fill, there is the second possibility that professionals could be freed to do much more creative professional tasks, whether they be involved in program planning or providing more efficient use of advanced technology. If other services were being performed by nonprofessionals, the professional could be freed for the highest level of skill utilization, i.e., for program planning, for administration, and, perhaps the most important of all functions, training. The professional of the future, no matter what his field should be prepared very intensively for training, particularly for how to train low — income, noneducated populations, which requires a new training model.

Another function for the nonprofessional is for him to reach large sections of the population, particularly his own low-income populations, much more easily than previously and to establish rapport with them much more quickly. Another, and related, function has to do with much of the feeling of welfarism, or welfare colonialism, on the part of the poor, and this may be reduced as they see a member of their own group playing a major role in the service profession. The new concepts of the indigenous nonprofessional and the participation of the poor are all woven together. The poor participating can not anticipate in decisions with regard to the services that they are given, whether it be in welfare, housing, education, or whatever. In the same way, indigenous nonprofessionals want to have a voice in the decision-making of the service delivery system in which they are employed. They have been increasingly asking, and very intelligently, for participation with regard to making various decisions; and they frequently have a great deal to offer with regard to these decisions.

Now let me describe the Lincoln program a little bit and try to bring into this discussion some of the functions of the nonprofessional and some of the training involved in the program. We think training is extremely crucial, but it was not stressed in some of the earlier work with nonprofessionals in the United States, i.e., in the Chicago Area Project and in the use of nonprofessionals in welfare and youth work, etc. At those points, there was somewhat less concern for training. The Neighborhood Service Center project, which functions out of Lincoln Hospital Mental Health Services, its parent organization, includes psychiatrists, social workers, psychologists, psychiatric nurses, and mental health aides, or nonprofessionals. Four of these people are attached to the clinic base, and I will come back to them a little bit later in terms of things that they do that are quite specific. The Neighborhood Service Centers themselves, and there are three of them, are manned by some five-to-ten people who live in the neighborhood. They are residents of the neighborhood, do not have more than a high school education, typically have less, and in many cases have been poor and on welfare themselves, or at least have been working in service and manual positions. In other words, this new position as a mental

health aide represents a very different kind of work for them than they have been doing before. The Centers have been presented to the community, essentially by the aides, as places where people can take any type of problem that bothers them. I think this is particularly important, because in the planning of a mental health strategy in a low-income community, it is necessary to consider two related factors. One is that the communities of the poor have a remarkable tolerance for deviance. They are very accepting of mentally ill people, particularly so because they do not define them as mentally ill. The second point relates to this; that is, once they do define people as mentally ill, they are very rejecting of these people and thus exclude them from their community. This is a very important factor to keep in mind in programming such a community. If a powerful mental health kind of approach is used, only a small section of people in the community who define themselves as needing this assistance may respond, omitting large numbers of people who need this also but who do not define themselves that way and stay away. Furthermore, those who come may be further defined as negative and may be rejected by the community, which does not accept mental health concepts.

It is for this reason that we planned in Phase I at least to present to the community a neighborhood center which would provide any type or service whatsoever. By that I do not mean "provide" as such, but obtain for the individuals through relationships to all other agencies any type of service that they needed. This could vary from the problem of a broken leg to a problem with a child, to one of alcoholism, housing, or any other problems of living, and we have gotten all of them. The other day a couple of people came in to tell us they were having trouble with their labor union, and we asked them to bring some other people along. We got the president of the union to come to the meeting, and we got fifty-three people from that shop who came to talk about their problems with the labor leadership there. We feel that this approach allows people to receive help from us without having to define the problem in a way suitable to the care-giver, or caretaker, system. Rather, they are helped to define the problem as they experience it. We feel that this approach allows us to catch problems early as they

are embedded in other problems of living, to catch people at the point of crisis before battle fatigue builds up, and to provide assistance for them in all kinds of stresses, thereby reducing the stresses of their lives and enabling them to function better and not to break down.

The program is not directed toward simply dealing with stresses and problems and services, but it is also concerned with *changing the community life*. Attempts are made to build a more cohesive community, a community in which there is more closeness, more interest in other people, and more activities together. We do this with many different programs, varying from a good number of parties and socials, such as Christmas parties, childrens parties, or opening the Center with parties, to community meetings which are characterized by a good deal of guitar playing, singing, dancing, food, children being present, etc., but in which they have business. There have also been voting registration campaigns. In other words, *the program begins with the service needs of people and attempts to move them by a series of steps into various types of helper and group activities*. The Center tries to put the helpee into the helper role; it tries to help people get better by having them assist other people through volunteering, being on committees, groups, etc. The Centers are laid out in such a way that the moment one comes in, he sees pictures on the windows of the aides of the people with whom he is going to be working, and he sees them as they are—people like himself, who live in the neighborhood and, in most cases, are Spanish or Negro like the people in the community. There are also on the windows children's paintings, signs announcing employment openings, or new developments of significance, i.e., there are changing and lively windows. There is a little front part to the Center which might be called a waiting room. There is coffee and there are soft chairs, and there is no intervening person between the person entering and the mental health aide. In other words, he is immediately picked up by the nonprofessional who will work with him, talk to him and help him in various ways. There is no secretary to go through, form to fill out, or anything of this sort. The secretary and the director of the Center, the supervisor, sit in the back of the store where they can help out when the aides are completely

busy. They can come out to the front and ask people to wait. The director can see where there is need, and every store has at least one professional supervisor. If the store has ten aides, it has two professional people; it is approximately a ratio of five-or-six-to-one.

The aides provide a number of services. First of all, they provide basic assistance in terms of listening to people's problems, giving them support, helping them to talk about their problems, accepting them, etc. Secondly, they provide all kinds of simple, direct services, such as filling out forms, writing letters for people, etc. They also provide somewhat unusual services at times. They help people to find an apartment or to move. They have been involved in putting out fires in people's houses. They have gone to funerals and have said the services at the funeral if there was no one else to do it. They are engaged in a variety of activities that are not particularly economical or appropriate for professional personnel to be involved in. I am not saying professionals couldn't do these things, but I do not think it is the best use of their time. It is an excellent use of nonprofessional time.

Another function which the aides perform, and it is probably a major one, is the expediting of service in all other types of agencies. The aides accept all problems, and therefore they have to have some ability to negotiate assistance in all areas. This, it is very important to point out, is not simply giving information and making referrals in the classic sense. Traditionally all we could give to people was information and sources for referral because we did not have the manpower to give anything else. I will not review the limitations of the traditional agencies that gave information and referral services. But typically most people did not get to their destinations with a referral only. They didn't utilize the service as a result of this. So the expeditor or intervenor concept stresses that the aide should help the person in every way possible through action and the use of his legitimacy as an agent sponsored by the anti-poverty program, etc. He may do this by escorting the client to the other service. He may do it by speaking for him, by being his advocate, by being his translator, both literally and figuratively,

by being his baby-sitter, by following up to see that the service was received, by preparing him on how to use the service, explaining it to him, etc. In other words, it's a strong effort to provide the cement to get the service to the person. It's also interesting to observe the connection which is built up with all the agencies and to which aides must return all kinds of favors, because we accept the favors from all of them. We screen for all these agencies. We provide manpower assistance for them.

Use of this new manpower allows for the beginning of integration, defragmentation, and the coordination of services without loss of autonomy for the various agencies who fear very much the centralized control from above. Agencies are left intact, but a cementing source, the expediter, the nonprofessional, the new manpower to pull these agencies together for the client is provided. I think this is an extremely important role which is being played by the Neighborhood Service Center and the aide which allows for their positive reception by these agencies. Many people have asked, "Aren't these agencies annoyed with you? Aren't you causing them lots of trouble?" It is true that we cause them some trouble. I am not suggesting that there are not any difficulties; but our basic posture and stance is that *we have two clients*, the man that comes in from the street and the agency. We try in every way possible to assist the agencies with all of our resources, supplies, manpower, screening, acceptance of agency referrals, and providing agencies with new techniques.

In addition, the aides have been involved in running the community meetings, in setting up groups, committees, registration campaigns, etc., so that the program is not, as I tried to indicate before, simply a program of individual service.

Let me cite a couple of examples of some things that they have done that might make it a little clearer. In one case, for example, a woman who was eight months pregnant came into the Center. She had been to the Welfare Department and they had refused any help for her. The aide calmed her down, tried to listen to her carefully and gather the information from her, while trying not to rush

her. He finally found out that she had been living with a man for about ten or eleven years, and that he had recently left her. She had been working up until two weeks ago, but had left her job and had moved in with her brother and his family. (It is quite typical in such neighborhoods, by the way, to find this cooperative, everyday acceptance of people by their families, even though these families are very poor.) She had applied for public assistance from the Welfare Department, and the investigator had said to her that he could not believe that she did not know where her husband, or her common-law husband, was, and that she was simply faking in order to get assistance. The aide talked to her further, calmed her down some more, implied very much that we could help, and then asked her what her husband did for a living. It turned out that he drove a taxi cab. Finally the aide went with the lady to the police station to see if they could track down this man. They called up the taxi bureau and found out that he was actually employed by them and had lived at the address that was described, i.e., this woman's address, but he was involved now in criminal proceedings and had run away. They didn't know where he was. The police made up an affidavit to this effect, which the aide took to the Department of Welfare. The investigator said, "Well, this looks pretty good. Let me take it up further and I think you may be able to get some assistance for this lady." I would like to say that is the end to this story, but it is not. The investigator said we would hear from him within the next two days, but we did not hear from him. The woman called the aide again, and they called the investigator, who said that he had taken it up with his supervisor, but the supervisor still had doubts about this case. The aide thereupon called his own supervisor. He did not know what to do in this case. This is interesting because it shows that he really did need to get further assistance.

His supervisor surprised him with an illustrative model of behavior of what might be done. The supervisor got on the phone and said to the investigator, "I want to talk to your supervisor, and right away. I don't like what's going on here. This case is open and shut. We've investigated thoroughly, and I don't know what you're doing here. We got you the affidavit." He got the welfare supervisor on the phone and there ensued a further, rather sharp,

strong discussion, and this did lead to results. The aide has since learned that under certain circumstances it is appropriate to get angry in situations, and though it is not the way to begin a relationship, it may be ended that way. The woman got the assistance and, in the course of making the arrangements, the aide also got to know the investigator in this case; the aide sent a letter to the investigator and to the Department of Welfare thanking them for the assistance that was obtained and for the woman's obtaining welfare assistance. He got a letter back in about three days stating that this was greatly appreciated and that the Welfare Department would now have to open a new file, because they never received such a letter before! A good, joking relationship developed between them as a result of it. In the meantime the aide did something else. After this lady went on public assistance, he helped her find an apartment and move out of her brother's apartment. After her child was born, he also involved her in coming to a meeting at the Neighborhood Service Center and tried to involve her to some degree in other helping activities. Many different dimensions are apparent here — the relationship to different agencies, the police, welfare, etc., and the use of different levels and layers of the organization. We believe that this kind of case very much represents the warding off of serious damage to this woman and is an instance of primary prevention.

Let me now turn to the question of selection and training of these mental health aides. Incidentally, they do many other different types of things. They have been involved in a number of cases with people who have attempted suicide, and they have played a very striking and positive role in assisting these people with their various problems. There are cases in which services are not the main agenda. There are others in which clinical issues are very clearly involved, and in these cases there is immediate availability of the backup service of the Lincoln Hospital Mental Health Services, which has a full professional staff to assist.

We have had three rounds of recruitment for a total of thirty-two aides. In the first round of recruitment we attempted to use all formal and informal sources in the neighborhood to inform the people

of the kinds of people we needed. After the first round the information that has been brought to the neighborhood has come largely from the aides themselves. Not only do they tell the neighborhood about these jobs, but they show the neighborhood, and many people therefore want a similar job. They see this model and are interested in applying, so we have received large numbers of applications. In the first round, however, we got some sixty applications for the job, which was described essentially as one which did not require previous experience or training or special education. Less than a high school education was acceptable, and they were told that they would be given lots of training on the job. The pay was to be between four-and-five-thousand dollars a year, and the job consisted of working with people in the neighborhood and helping people. We wanted people who lived in the neighborhood. In the second round, because we did not get enough men applying in the first round, we simply suggested in our "advertisement" and word-of-mouth comments by the aides that we preferred males. The aides passed the message around the neighborhood. From that very simple information we had a great many more males applying. From the general description of the job, females had self-selected themselves. By emphasizing that we preferred males, we got many more men.

In the first recruiting session we had approximately sixty applicants. We divided the applicants into groups of ten, and we interviewed these in groups with two interviewers. The whole process was done in a room in which there was a one-way mirror, and behind the mirror sat four judges: a psychiatrist, social worker, nurse, and psychologist. The aides that were being interviewed were informed that they were being observed. In later rounds we have added a nonprofessional aide to the judges' group, and we have also added the supervisor of the Center where the aides are going to work, so that he picks people whom he really wants. This is an important element in the selection. The groups were oriented toward discussing all kinds of problems in the neighborhood. The group leaders, that is, the professionals who led this discussion with the candidates, set an atmosphere of an easy, slow pace with coffee, sitting around a table, and not rushing into any great amount of discussion. Then slowly over a period of an hour and a half, they

built up the discussion around such questions as: What do you think this neighborhood needs? What are the problems of the people? What do you think of the agencies, the schools, education, etc., around here? How can people be helped? What do you do when you help people? What would you do if a person had such and such problem? They started discussing some of the problems people might bring in and how they would handle them. The people behind the screen judged the candidates in terms of a number of criteria—flexibility, frustration tolerance (whether they could stand this difficult stress situation), ability to listen to each other sensitively, to lead each other, and finally, whether they could talk to two populations, ourselves, the professionals, and the people in the neighborhood. We want to reach people who can communicate to both types of population. After the six groups of ten met, we further narrowed it down to two groups of ten and intensified the group interviews even further, confronting individuals, disagreeing with them, and dwelling further on their attitudes towards various questions. In a few instances we did individual interviews to check certain things that we were not sure about. But essentially, this population was selected on the basis of group interviews.

After the selection process, we moved toward the training. The training really begins in the selection process, because the training staff is involved in looking at the candidates through the one-way mirror and builds up a lot of information about them before they get into the training sessions. So to some extent the pattern of training can be tailored to some particular needs. The training sessions are designed in three phases. The first phase is a prejob phase, which lasts three weeks. Our notion here is to prevent creating anxiety in the candidates, which builds up in a long training period, and to get them into the field as rapidly as possible. Also, as the training is short, the design of the job is made very simple. Essentially the training is based at the Clinic, and it is to our interest to prepare individuals to perform essentially two simple functions: (a) interviewing in order to get some simple information on a piece of paper, and (b) being able to utilize agency resources to deal with the person's problem. That is really not too small a job,

but these are essentially the things that are involved in the training. So the training is largely directed towards simulated exercises, such as actual role plays, pretending to interview clients and talk to people in agencies with a fake telephone system. They visited the agencies, did various field exercises, made home visits under supervision, etc.

At the end of three weeks, the second phase of the program began. We opened the Center for one-half of the day, and the aides went into the store and actually met clients under very careful supervision — not only the supervision of the director of the Center, but also the trainers who backed them up. They closed the store for one-half of the day and talked about their new problems. Some interesting shifts occurred between the pretending and the real life. The aides feel some very real differences there. They feel they cannot make mistakes in real life, but in the other they can. In this real life situation they discussed the problems very completely and got needed assistance.

Much of the training is group designed and all the aides and the supervisor meet together. In the afternoon they also carry on some of the work in seeing agencies and dealing with some of the places they have started to work with in the morning period. At the end of six weeks, the Centers are open full time, and then the training consists of various types of inservice training, both systematic and informal. First of all the supervisor meets with the aides once or twice a week as a group. He also meets with individual aides at any time at either their request or his. The aides also receive systematic inservice training in such things as letter-writing, in which we found them to be very deficient, and improving their interviewing and expediting skills; but they also begin to acquire new skills, such as working with groups, organizing campaigns, running meetings, developing committees, etc. This inservice program is coordinated with the actual on-the-job requirements, because the program starts to involve not only the individual clients but we plan community meetings at this point, and we use the meeting and the planning of the meeting as a training exercise situation.

We cover such questions as how to get people to come to the meetings, how to run them effectively, how to develop committees, how to not run ahead of oneself, etc. We also help the aides to examine the mistakes that they make. An early meeting, for example, produced too many committees, more than we could handle, and the aides ran ahead of themselves because the enthusiasm of the community was great. The committees had to be pulled back and reorganized. How do we go about this? Do we trick the community people and manipulate them, or do we go honestly to them and say, "We did make this kind of mistake, what can we do? We have some suggestions, maybe you have some, etc."

This is now the end of one year of the program, and we approximate that the inservice training takes one-fifth of the aides' time. The training is a powerful element built into the entire program. One of the major things we attempt to do with the aides is to teach them to be aware of their limitations and to ask for supervision. As in the example cited previously, when the aide could not deal with the welfare supervisor, he did turn this problem over to his supervisor. In the case of a patient who had been involved in a suicide attempt and had been seen back at the hospital, the aide again involved his supervisor in planning an approach to the problem. With anything that looks like serious pathology to them, they are encouraged not to tackle it alone. They have done some things that are not always the best, but I do not think their tendency has been to take on clients with serious psychological problems and attempt to decide things for them. The population itself, as well as the aides, are somewhat anti-psychological. That is something to keep in mind. They do not like the idea of psychological disturbances. They are not so convinced about the value of psychological intervention for these forms of illness, so they do not rush into being amateur psychologists, and we are not encouraging them to be.

However, there are all kinds of examples in which they do suggest psychological intervention. One woman who had just received a welfare assistance check for 350 dollars walked out of the Center

and on her way home saw a wig which she bought for the 350 dollars. Next day she came back to the Center with her daughter and started to tell several stories about where she had lost the money. But the aide, who was very good at digging out these things, finally obtained the truth. At this point the aide looked at her and said, "Mrs. so-and-so, I think you should go up to the Mental Health Clinic." This was not any great diagnosis, but he assumed that this behavior was a little too much and that maybe she needed some assistance that the aide wasn't able to give in this case.

There is no set limit to the number of clients with whom aides may work. Six aides in one Center actually help about 6500 families per year, or 25,000 people. This does not include those reached in campaigns, groups, committees, meetings or socials, which extends that number considerably further. Everyone comes as often as he wants to, and the orientation is immediate help for the presenting problem. The situation may be likened to that of treatment for cold. The cold is treated, but not the entire respiratory system. The emphasis is on dealing with the specific problem involved. Long-range "treatment" is indirect—based on changing the community life, cohesion, and pride.

TREATMENT GOALS FOR PATIENTS FROM PATIENTS, THEIR FAMILIES, AND STAFF

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INTRODUCTION

The development of a new basis for identifying therapeutic failures at the Fort Logan Mental Health Center is the primary objective of the Failure Criterion Project, of which this study is a part. Certain objective measures, such as readmission or length of time in the community, can be used as crude indices of therapeutic success or failure, but the fact that a patient is readmitted for further treatment does not necessarily mean that previous treatment was totally unsuccessful. Similarly, the fact that a patient does not return to the hospital does not always mean that his treatment was highly successful. The Criterion Project hopes to generate more definitive ways of identifying patients who do not profit from the treatment program and, eventually, to generate ideas about treatment methods which might help these same patients.

The judgments of individuals who are in a position to have opinions regarding a patient's treatment provide one way to measure the degree of success or failure of the treatment. At least three positions or perspectives may be considered: (a) that of the patient, (b) that of his family, and (c) that of the staff. To acknowledge that each of these is an important position from which to judge treatment outcome is also to recognize that there is not just one authoritative

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“correct” view. It would not be expected that these positions necessarily would be in agreement with each other.

Perspectives described by the patient, a member of his family, or a staff member reflect the *bases* upon which these individuals judge treatment outcome. One basis would be each one’s expectations or goals of treatment. It is assumed that final judgments would rest upon whether or not treatment goals had been realized. It is hypothesized that agreement regarding goals facilitates treatment and produces final agreement that treatment is successful.

Focusing on the goals of treatment and the judgment of treatment outcome, we undertook (a) to examine the kinds of treatment goals expressed by patients, family, and staff, (b) to determine the extent of agreement about goals among these three groups, and (c) to ascertain whether the three groups concur on the degree of treatment success or failure. The findings reported here, which are preliminary to the final objective of identifying therapeutic failures, reveal two general conclusions of importance in their own right: (a) for individual patients there is very little agreement about their treatment goals, and (b) the three groups demonstrate different perspectives by focusing on different types of goals. In essence, agreement on treatment goals is very limited.

METHOD

Eleven patients newly admitted to Fort Logan were interviewed regarding the help they wanted, the problems they thought they had, and their goals of treatment. Within one month after the patients were admitted, their families and Fort Logan staff members were interviewed to obtain their viewpoints on treatment goals for the patient. The subjects interviewed included 11 patients, 16 members of their families, and 25 staff members from the patients’ treatment teams. To date, only seven patients have been discharged.

The patient group included six women and five men, ranging in age from 19 to 68, with a variety of diagnoses, lengths of stay, etc. Eight were living with spouses, two were divorced, and one was single. Spouses were always interviewed if possible; when

appropriate, parents were interviewed. In one case, an aunt with whom the patient lived was interviewed. In three cases, grown children of the patient also were interviewed.

The staff members interviewed were the social worker, or the person who recorded the social history, and, as they were available, either the psychiatrist, psychologist, head nurse, staff nurses, or psychiatric technicians.

The number of specific goals stated in the interviews ranged from 5 to 17 (1). Thus, for each patient several different lists of treatment goals were derived: from the patient himself, from one or two close relatives, and from two or more staff members. These lists were compared to answer certain questions: Did the patient, his family, and his therapists agree on what the treatment goals should be, or did patients tend to see their goals differently from their families—from the staff? Did staff and family agree?

It was found that patients often listed similar goals, as did families and staff persons. Therefore, the lists of goals of each of the three groups were compared to determine any similarities or differences in perspective among the groups.

The kinds of goals focused upon by the respondents, including comparisons of goals for individual patients and the group lists, were analyzed. Again, these comparisons are preliminary to determining the effect of agreement or disagreement upon the participants' final judgments of treatment success or failure.

TREATMENT GOALS FOR INDIVIDUAL PATIENTS: THEIR OWN, THEIR FAMILIES' AND THE STAFF'S

The amount of overlap was small among the treatment goals in relation to individual patients as stated by family and staff and those provided by the patient himself. The lists of goals given here for one patient illustrate the kind of information obtained and the differences in the respondents' perspectives. The goals listed were for a 53-year-old male patient transferred from a city-county general hospital with a diagnosis of paranoid schizophrenia. Upon entering that hospital, he had exhibited extreme psychotic symptom-

atology, but by the time he was admitted to Fort Logan his symptoms were in partial remission. He had recently separated from his wife and stated he wanted a divorce. He had been working part time at radio and television repair, and also was receiving *Aid to the Needy Disabled* because of a heart condition. The patient was treated in Day Care for approximately one month and then as an outpatient for two months before discharge. At the time of the final research interview which followed discharge, the patient and his wife had been reunited. Both reported that his psychotic symptoms had disappeared, and he was less nervous, although still unable to work. He and his wife each rated treatment success more positively than the staff.

Below are the goal lists obtained for this patient:

Patient:

1. I won't be hearing voices.
2. I'll get help for my heart trouble.
3. I'll be able to go back to part-time work.
4. I'll learn to handle my nerves.
5. It will be possible to leave the hospital soon.
6. I will not have to come back to the hospital again.
7. I'll be able to take care of the apartment.
8. I want to be able to mix with people.
9. I want to get along better with my neighbors.
10. I want to settle the problem of separation from my wife.

Wife:

1. I want him not to imagine things.
2. I don't want him to be nervous.
3. I don't want us to be separated.
4. I want him not to be depressed.
5. He needs to sleep and eat better.
6. I want him to get over his talking constantly.
7. I want him not to try to do more than he can.
8. I want him not to turn against people closest to him.
9. I want him not to be displeased with everything.
10. I want him to get back to normal.

Social Worker:

1. He won't hallucinate.
2. We want to prevent a separation between him and his wife and to improve their marital relationship.

3. We want to get him to sleep and eat well.
4. He won't be psychotic.
5. He won't feel people are stealing from him.
6. He won't feel people are talking about him.
7. He won't be so quiet and withdrawn.

Psychologist:

1. We want him to stop hallucinating.
2. We want to be able to help him with physical problems.
3. We want to help him in his relationship with his wife.
4. We want to help him so he will not be depressed.
5. We want to help him so he won't be delusional.

Mutual items for this particular patient referred to psychotic symptoms and the marital situation. As can be seen, the patient named many goals which no other respondent mentioned: numbers 3, 5, 6, 7, 8, and 9. Yet the goals not mentioned by the others were neither unusual for respondents to mention nor inappropriate to this patient's situation. The patient's wife also listed items not mentioned by anyone else. These goals indicated her particular view of the patient: He talked too much, overdid, was displeased, was depressed, and had turned against her. These, too, are characteristics which one might expect the patient or staff to have noted. The responses of the staff focused on his intrapsychic symptoms, with reference to the marital relationship, eating and sleeping, and other physical problems. Staff members' expectations for this patient were limited.

We have presented the goals for one patient to illustrate the general finding that the items named by family and staff usually did not duplicate the treatment goals provided by the patient himself, nor did family members and staff usually agree. That some family members mentioned goals which reflected their own point of view is not surprising; but it was not anticipated that the staff who had seen the patients for evaluation, for the social history, and for at least two weeks in treatment would *not* include the goals mentioned by the patients in addition to those which followed from their professional orientation.

Analysis of similar data on all eleven patients indicated that there was little convergence of opinion among patients, their

families, and staff regarding treatment goals.

The mean number of goals mentioned by each respondent was 10.3. The average number of mutually shared goals between patients and all other persons was only 3.3, with a range of 0 to 7.

There were fewer mutual items between family members and staff than between patient and family or patient and staff. Family members and staff members, when interviewed about the same patient, mentioned an average of only 2.6 mutual items with a range of 0 to 8. Staff members among themselves averaged 3.5 mutual items per patient with a range of 2 to 6. In every instance staff members agreed upon at least two common goals when discussing a particular patient.

The findings reported here will be used to determine the relationship between the degree of consensus on goals for a particular patient and the final judgments of successful or unsuccessful treatment. Other methods of measuring agreement, as well as the material herein, indicate very limited agreement among the viewpoints of patients, family, and staff. However, the amount of consensus does vary among the cases studied, and the relationship will be investigated.

DIFFERENCES OF PERSPECTIVE AMONG THE THREE GROUPS OF RESPONDENTS

In the previous discussion the differing points of view of the patient, his family, and the staff were exemplified by the paucity of mutual goals for each patient. Frequently, identical goals were mentioned by several respondents but not in relation to the same patient. The analysis in this section was undertaken to determine the amount of contrast among the three groupings of subjects as they responded to questions about treatment goals. To examine the goals seen to be relevant by each of these groups, the treatment goals were categorized according to their content. The following categories were employed:

A. Leaving the Hospital

B. Instrumental Role Performance

- C. Physical Symptoms*
- D. Social-Interpersonal Adjustment*
- E. Suicide and Depression*
- F. Intrapsychic Symptoms*
- G. Behavioral Symptoms*
- H. Family*

Two methods were used in analyzing this material. One method involved the content of the items within the category with the material presented representing the topics mentioned most often by subjects within the three groups. The second method was to count the number of respondents who mentioned any item within a category, as well as proportions of items falling within each category.

CONTENT OF CATEGORIES

The following material describes the content of goals within categories for the three groups of respondents. The topics for patient, families, and staff frequently differed within goal categories. The items described below are those mentioned most frequently by different respondents within the group.

A. Leaving the Hospital

Patients mentioned leaving soon, not having to be institutionalized for the rest of their lives, and having other people realize they do not need psychiatric hospitalization. Family members hoped that the treatment would not take long. Staff were concerned about the possibility of readmission.

B. Instrumental Role

The content within this category was quite similar for all groups: for the patient, to find jobs and hold them or to complete schooling; for males, to support their families; and for females, to

take care of the home.

C. Physical Symptoms

Patients wished for relief from particular physical complaints; families wanted the patient to regain physical strength, or to gain or lose weight; staff emphasized the patient's adjusting to physical limitations.

D. Social and Interpersonal Adjustment

Patients most often mentioned being able to mingle with people socially and being more pleasant companions for others. Families most often mentioned socializing and getting along with people, adding that they wished the patient would not hide from personal relationships. Some staff mentioned interpersonal relationships and socializing, but less often; they more frequently referred to problems with persons in authority, improved relations with the opposite sex, and ability to talk about feelings with other people. Because of Fort Logan's emphasis on socialization, it seemed inexplicable that staff mentioned socializing so much less frequently than did patients and families. Perhaps it is an implicit goal for all patients. However, it is apparent that families and patients saw socializing as an important goal.

E. Suicide and Depression

The content of this category was similar for all three groups. It was inserted as a separate category because of the frequency and specificity with which these items were mentioned.

F. Intrapsychic Symptoms

The category of intrapsychic symptoms was constructed to reflect the patient's inner feelings and experiences which others might not be able to observe, in contrast to the more overt behavioral symptoms and social-interpersonal adjustment. The patients'

items concerned feelings of confusion, panic, and worthlessness. Families mentioned avoidance of responsibility, nervousness, worrying, and emotional problems. Staff mentioned lack of self-confidence, guilt, absence of insight, feelings of failure, and psychotic symptoms. The patients, as will be discussed later, did not always mention items in this category, nor did they express this type of item as frequently or in as many different ways as did family and staff.

G. Behavioral Symptoms

Patients mentioned the need for controlling their tempers, sleeping and eating better, being more active, and expressing themselves better. Families mentioned pride in appearance, sleeping and eating better, not talking so much, being active, and being happy. Staff were very often concerned with the patients' expressing anger appropriately, and also included their not crying or withdrawing and their being active.

H. Family Problems

Patients were mostly concerned about the possibility of separation or divorce from their spouses, having their families understand them better, being able to consider their families more, and raising children properly. Families wanted to have a good family life, to have patient and spouse present a united front, and to have children be less of a worry. Many staff stated generally that the marital relationship should be improved, in some cases specifically mentioning goals of avoiding separation, or improvement in parental roles. The staff perspective, in contrast to that of the patients and families, viewed the family as a unit whose problems of interrelationships needed to be corrected.

FREQUENCY OF USE OF CATEGORIES BY RESPONDENT GROUPS

The treatment goal items were classified by the categories already explained to determine the distribution of items mentioned by the three respondent groups. Table 1 indicates the number of respondents who mentioned any item within a category.

TABLE 1

THE NUMBER OF RESPONDENTS IN THE GROUPS OF PATIENTS,
FAMILY, AND STAFF MENTIONING ITEMS BY CATEGORY
WITH PERCENTAGES OF PERSONS IN THAT GROUP

	Patients N=11		Family Respondents N=16		Staff Respondents N=25	
	No.	Percent	No.	Percent	No.	Percent
A. Leave Hospital	6	54.55%	2	12.50%	4	16.00%
B. Instrumental Role	10	90.91	8	50.00	17	68.00
C. Physical Symptoms	3	27.27	3	18.75	4	16.00
D. Social-Inter- personal	8	72.73	12	75.00	13	52.00
E. Suicide & Depression	9	81.82	11	68.75	16	64.00
F. Intrapsychic	9	81.82	15	93.75	24	96.00
G. Behavioral	8	72.73	13	81.25	20	80.00
H. Family	10	90.91	9	56.25	25	100.00

It should be explained that although a category may have been mentioned by all three groups, it did not necessarily refer to the same patients. For example, patients 1 through 6 mentioned leaving the hospital, while two family members mentioned this category in reference to patients 1 and 8, and four staff members gave items in this category in reference to patients 1, 2, and 9. Therefore, overlap in category does not necessarily indicate agreement about individual patients.

Table 2 shows the percentage of items mentioned within each category by each of the three groups. The table is to be read *across* groups for each category to compare the emphasis given by each. Each of the percentages represents the number of goals in that category divided by the total number of goals provided by all members of that respondent group.

TABLE 2

PERCENTAGE DISTRIBUTION OF GOAL ITEMS FOR PATIENTS,
FAMILIES, AND STAFF

CONTENT CATEGORY	PATIENTS	FAMILIES	STAFF
A. Leave Hospital	8.47%	1.53%	1.49%
B. Instrumental Role	12.51	9.57	6.97
C. Physical Symptoms	2.62	3.71	2.02
D. Social Interpersonal	12.54	12.22	8.30
E. Suicide and Depression	9.73	10.18	8.15
F. Intrapsychic	19.20	27.64	31.09
G. Behavioral Symptoms	16.17	22.07	15.44
H. Family	18.66	13.08	26.53
TOTAL	100.00%	100.00%	100.00%

Both tables yield essentially the same information on the use of the various categories:

A. Leaving Hospital

Proportionately more patients than family or staff mentioned items relating to leaving the hospital as can be seen by Table 1. Likewise, Table 2 indicated patients focused 8½ per cent of their total items within this category, compared to about 1½ per cent for family and staff. The question arises as to why patients were more explicit and interested in this issue than others. Perhaps the

families were not more concerned (at two to three weeks after the patients' admission) because their relief in having the patient cared for still overshadowed their hopes of having him leave the hospital. The staff, interviewed a month after admission, was also not concerned about patients leaving. We learned through the content analysis that staff emphasized the problem of readmission rather than leaving the hospital on this admission.

B. Instrumental Role

Again, both tables demonstrate that patients were more concerned than family or staff. There was almost universal concern among the patients, who apparently felt the loss of their instrumental functioning most keenly. Family and staff changed positions on the two tables with a greater proportion of staff persons mentioning at least one role item. Only half of the family members mentioned this category, but those who were concerned mentioned a number of items or different aspects of the category.

C. Physical Symptoms

Physical symptoms seemed to be relatively unimportant as treatment goals for any group and there was little contrast in emphasis.

D. Social and Interpersonal Adjustment

Patients and family groups were almost identical in proportionate emphasis on this category, and both focused upon this area more often than staff. We have already discussed the peculiar fact that staff, even with Fort Logan's emphasis upon social relationships as a part of treatment, did not mention these items as often when considering the problems and goals of individual patients.

E. Suicide and Depression

The groups did not vary much in their emphasis upon these

problems. Some patients did mention suicide when neither their staff, nor especially their families, were concerned about this possibility. Patients and families were concerned more often with items relating to depression than staff.

F. Intrapsychic Symptoms

In terms of the proportion of respondents referring to items in this category, and the relative emphasis placed upon it by each group, staff and family were more concerned than patients. Since this category consists of items such as feelings of guilt, worthlessness, fears, failure, and other such internalized feelings, it is interesting that the patients refer to it less often than the other two groups. Patients' willingness to discuss suicide and depression would indicate that they are not reluctant to speak of personal feelings, but they do not mention these intrapsychic items as goals of treatment as often as the other two groups. If staff alone had emphasized this category, the responses might be considered due to professional orientation. However, families also emphasized it.

The results might be interpreted as lack of insight on the part of patients. It seems just as likely that family and staff have over-emphasized this area and were focusing upon the illness as internal to the patient.

G. Behavioral Symptoms

Again, the groups were not too diverse in the amount of emphasis they placed on overt behavior. A large majority in all three groups mentioned at least one item in this category. Looking at Table 2, it is apparent that family members mentioned more items within this category than did patients or staff. This finding might be expected, since family members are exposed to the patient's behavior over a longer period than staff and are more alert to the patient's behavior than either staff or the patient himself.

H. Family Problems

The information from both Table 1 and Table 2 that families were the least concerned with this category was a rather dramatic, unexpected finding. This is one instance in which this hospital's philosophy of treatment is evidenced in the staff's unanimity about the family's involvement in the patient's illness. The staff see the family as a unit, with the patient's problems not very separate or distinct from the family.

The patient group also was concerned about relationships with and within their families. As mentioned, patients' content usually emphasized fear of marital separation, hopes of becoming better spouses and parents, and gaining understanding within the family.

Family members, however, did not see the family as a part of the problem, or if so, they did not express their involvement in terms of goals. At the time these interviews took place, early in treatment, family members were not as concerned about their involvement and relationship with the patient and his treatment. Perhaps the attitude of the family members does change toward more involvement at a later stage of treatment as they are drawn into the hospital program through family group therapies and staff attention.

SUMMARY

As explained in the introduction, these findings are preliminary to the final objective of identifying therapeutic failures and relating agreement on treatment goals for individual patients to final ratings of the degree of success or failure. The findings presented are believed to be of interest in their own right. They demonstrate a general paucity of agreement among the varying points of view of the patient, his spouse and family, and his treatment staff in relation to goals of his treatment. This lack of agreement regarding individual patients is elaborated by grouping the data and determining that there are three different perspectives among these groups at the time of the patients' admission to the hospital. Further

evidence from the Project's investigation not reported herein indicates a growing agreement between patients and family over the time of hospitalization without a corresponding growth of agreement between patients and staff. Under the assumption that therapy would advance most successfully when the goals are explicit and congruent to the greatest possible degree among the persons involved, therapists should be concerned about this lack of mutuality.

REFERENCES

1. Fort Logan Mental Health Center Research Report, "Failure Study-- Criterion Project," Unpublished Report, October, 1964.

The Fort Logan Mental Health Center is Colorado's second state hospital. Currently serving almost half the population of the state, its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with emphasis on expansion of professional roles and the involvement of the patient's family and his community in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. Approximately one-half of its patients are admitted directly to day care, and evening care is offered. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient from the time of admission through all phases of treatment.

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