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FANTASIES, FABLES AND FACTS ABOUT GROUPS*

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INTRODUCTION

The title of this paper was chosen not because it is alliterative, but rather to ascertain whether it is possible to separate the fibers that make up the yarns of group life. The fantasies are two: (a) that work with groups is a newly discovered phenomenon which has burst upon the social work scene and, (b) that the most important, meaningful, and satisfying experience for both the patient and the worker is the "therapy group." The fable about work with groups is that a model exists which, if grasped, opens the door to understanding group life in all its forms. The facts will speak for themselves.

FANTASIES

The Group as a New Phenomenon

The re-discovery of the use of groups in helping people achieve satisfactory solutions to life's problems often reads like a fairy tale. It is as if we had stumbled upon a new existence with a most bright present and a rosy future. Yet, this fantasy of the novelty of groups fades into the background as one peruses social work literature. For example, Grace Coyle (2) reports that in 1915 Zilpha Smith, then director of the Boston School of Social Work, commented, "The kinds of social work which do not

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in the long run require both the family and group work methods are few." Mary Richmond (12) prophesied in 1920, "This brings me to the only point upon which I can attempt to dwell at all, a tendency in modern casework which I seem to have noted, and noted with great pleasure. It is one which is full of promise, I believe, for the future of social treatment. I refer to the tendency to view our clients from the angle of what might be termed small group psychology." Grace Coyle (2) noted that Miss Richmond's prophecy was a long time in being fulfilled. However, prior to and during the twenties, the Settlement House movement experimented with small group psychology and its meaning for social work. In the late thirties, the use of group methods was beginning to be accepted in medical and psychiatric settings. By the mid-forties, many articles were appearing in professional journals, and the National Conferences of Social Welfare contributed to the further development of group modalities.

In a reader comment in *Social Casework,* Hans Falck (3) more recently noted what appears to be a defect in our vision; that is, the ability to see what is before us but increasing difficulty in looking backwards. He stated, "I am concerned about the total absence of recognition that for more than thirty years social workers, such as Coyle, Wilson, Ryland, Konopka, Vinter and Klein have been publishing articles and books, evidently in vain so far as your authors are concerned. I suggest that this omission points up a major problem in the profession. The problem is that we do not build on what others have thought before us."

It would be equally dangerous to imply or reinforce the myth that all things are the same and nothing is new. Certainly the explosion of knowledge of all facets of life has left its mark upon what we know about groups. The abounding literature from the social and clinical sciences attests to this fact. However, Dr. Falck's admonition to build upon the past is a sound one. Although one may question, and legitimately so, some of the previous knowledge and its present applicability, our savants of the past have much to offer.

Meeting Varied Needs Through Many Group Forms

The second fantasy is that there is a hierarchical structure in work with groups. Those who sit sedately at the top of this framework are the workers who are involved at the deepest therapeutic level with their

clients, practicing some form of group therapy. Wallowing at the base are the practitioners who work with short-term groups or with activity groups. Those of you who are somewhere in between may take succor from the fact that you are not at the bottom of the pyramid.

Caseworkers have learned that individual therapy alone is not always satisfactory and have used conjoint, family and group therapies, as diagnostic assessment dictates and as patient needs emerge. It may be equally true in the use of groups that at any particular time, a variety of group experiences may be offered together with individual and group therapy, or separate from it. The choice may be based on a diagnostic assessment, or the determinant may arise from understanding that not all patients are verbal and articulate; some need bridges to span the gap between their inarticulate behavior and communication. Those familiar with the work of Mrs. Evelyn Heimlich* of New York may be aware of the remarkable results she achieves using music as a channel of communication with children.

Martha Steinmetz (15), in an article on role playing in a maternity home, commented, "We believe that this technique is particularly valuable for helping girls who have difficulty in expressing their feelings, and also for helping those who learn best from seeing and being. Girls who already had enough self-assurance to handle difficult situations are encouraged to participate in the role playing in order to demonstrate their ability."

One may assume in working with currently or recently hospitalized psychiatric patients that the more concrete the situation and the more structured the task, the less anxious the patient is and the better able he is to respond to the demands made of him. This may provide some direction as to the kinds of group which may prove beneficial. Dr. Jerome Frank (6) writes apropos this point, "The more poorly a situation is defined, that is, the more ambiguous it is, the greater the anxiety it produces. Hence, if it is desired to increase tension, the definition of the task is ambiguous; if it is desired to diminish tension, a task is chosen which is within the patient's grasp and it is clearly defined. Thus it is

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that classical psychoanalysis and non-directive therapy in which the task set for the patient is only vaguely defined, seem most useful for patients who are not too sick, while therapeutic social clubs and psychodrama, which structure the task for the patient quite elaborately, have found chief applicability in the treatment of psychotics."

In my experience at one hospital, role playing, music, poetry reading and art were used at times as means of reaching patients who were inarticulate, withholding or silent for a variety of reasons. In our work with these patients, we tried to structure the situation and to keep the material reality-oriented rather than to indulge in free association techniques. For example, we would not usually say to patients listening to music, "As you listen to this music, will you say something that comes to mind?" We were more likely to ask, "Of what does this remind you about the ward or home?" This was in keeping with the general mode of operation of the hospital which emphasized suppression and reinforcement of repression of overwhelming impulses for these patients, who reside at the hospital for a brief period of time.

I should like to describe a group program used for patients who had been hospitalized but who were currently in remission. Some of these patients were recent dischargees, while others had been functioning minimally in the community. All the patients shared one thing in common--a deep sense of alienation, isolation, loneliness, and boredom. Many of them lived alone in the community; others, although with their families, were not adequately fulfilling their function as mothers, wives, husbands or fathers. Several years before, a program called "The Social Hour" had been devised to provide a socializing experience for these patients. The program's potential was limited by a lack of knowledge of effective use of the time and some confusion as to roles of staff in an informal setting. Few demands were made upon patients for involvement, the sick rather than the healthy aspects of the patients' personalities were emphasized, and operation of the program was dependent upon volunteers without adequate guidance from staff. The professional staff--a psychiatrist, a social worker, and a psychologist--found the program increasingly burdensome and felt that they could use their time to greater advantage elsewhere. Because they saw the social hour as an onerous task, they welcomed us (the writer and two students) expansively and literally turned over the program to us. Early this year, goals were established in which

socialization was seen as more than people sitting together in the same room. Emphasis was placed on the healthy aspects of the ego, insisting that demands be made of the patients consistent with their health, and recognizing that some patients can do more than others and should have opportunities to flex their atrophied social muscles. Among other tasks set was direction for volunteers based on the purposes of the social hour and designed to better integrate them into the program. As the program developed, staff had to reevaluate their roles to move from the fringe of this informal setting, wherein they tended to attach themselves to an individual patient, to more intensive involvement in activities related to socialization. Some staff members found it difficult to change from the role of therapist in a formalized situation to a role more akin to that of a group worker.

For the patients, it meant strengthening the roles of their executive committee members and delegating more responsibility to them. It meant greater involvement of the membership in decisions which affected them, e.g., the number and variety of activities in which to engage, in which committees they wished to participate, and their degree of participation compared to staff's. It also meant planning programs that met differential needs of patients and placed new demands on them.

Our goals were modest and our successes limited, but all of us had an opportunity to find another way of breaking into the circle of isolation which engulfs so many of the emotionally disturbed. None of us saw the social hour as *the* method of treatment for all the mentally ill. For some, this was the only modality; for others, the social hour served to test what had been learned in individual casework and/or group therapy, or to feed back into the other treatment methods.

Let me cite briefly other kinds of group within the hospital setting, so well described by Joseph D. Jacobs (9). He writes of the promotion of units within the hospital to provide a higher level of participation for those ready for more sophisticated activity. These groups were patient-government bodies whose efforts to cope with numerous ward and hospital issues were directed toward enhancing cooperation, providing resocialization and self-actualization, and reinforcing feelings of mastery and achievement. These ego-strengthening efforts served to counterbalance those forces in hospital life which chip away at one's independence, resourcefulness, and sense of responsibility.

I hope I have conveyed to you that there are a number of group forms which might be used jointly and singly to meet the needs of patients. Further, that each of the modalities may be valid at any given time, each contributing in like measure to the eventual rehabilitation of the patient.

FABLE

A Single Frame of Reference

That there is a single frame of reference for understanding groups is the fable I wish to address--the fable that if this frame of reference is mastered, one can work with equal skill with groups in the settlement house, in the child guidance clinic, in the mental hospital, and with families, children and adults. If this were so, work with groups would be eased considerably.

However, I don't believe that our present state of knowledge permits us to entertain what I contend to be a myth about group life. Louise Frey and Ralph Kolodny (7), in an illuminating article on illusions and realities in work with groups, point out the conflicts within the fields of group therapy with respect to methodology, which has its roots in different perceptions of group life. Slavson (14), for example, sees group psychotherapy as a modification of individual therapy and uses himself in the group as he would in the dyadic relationship. In the past, he has raised the question of whether there are group dynamics in therapy groups. Foulkes (5), also deeply tied to the psychoanalytic school, argues that phenomena occur in group life which cannot be totally explained by understanding the group via the framework of individual psychopathology. He writes of mirror reaction, communication systems, and content as related to the present rather than to genetic history. Whitaker and Lieberman (16), also group-focused and psychologically-oriented, have as their central frame of reference what they call the "disturbing motive," "reactive motive," and "group solution." There is no question that how one perceives the group has a direct bearing on how one uses himself, on the content encouraged or discouraged, on developing or aborting some group phenomena and on the demands made upon the group. For example, Slavson has taken a point of view that cohesion is antitherapeutic, in that it lowers the anxiety level, and does not permit easy access to intro-

psychic difficulties. He maintains that the diminished tension and the degree of comfort engendered is not helpful. Contrast this with Dr. Lawrence Frank (6), who comments that "Members' sense of belongingness to a group, more simply termed group cohesiveness, plays an analogous role in therapy groups to the relation between therapist and patient in individual treatment. That is, it supports the self-esteem of the members and so increases their tolerance for unpleasant emotions and their ability to function as free and responsible persons. The intensity of emotional interplay which members can stand without excessive anxiety is largely a function of the cohesiveness of the group. Since emotions supply the motive power to change of attitudes, fostering of group cohesiveness is a major goal in group therapy." Part of the confusion may rest in the fact that Slavson and Frank are making rather global statements about group cohesion in two different populations. I believe Slavson addresses himself more to the out-patient group, whose ego functions may be more intact, while Frank appeals for the development of a sense of belonging among groups in the mental hospital, where most patients are psychotic, with fragmented ego structures, and in need of lowered anxiety levels.

There are differences, too, in the developmental phases of group life. Slavson (14), because of his orientation toward individual psychopathology, recognizes that initial sessions are characterized by some commonly induced group anxieties, but questions whether one can arbitrarily divide group treatment into distinct beginning, middle, and ending phases. He is supported somewhat by Whitaker and Lieberman (16), who state that phases are never clear-cut, that "mixed and transitional phases occur and that behavior assumed to be primarily characteristic of one phase appears in another." They remark that "consequently any definite statement about phase must be heavily qualified." They appear to be more in accord with a developmental task approach worked out by Coffey (1) which indicates that groups generally are confronted with certain basic issues. These include attempts to maintain one's individuality while accomplishing the group's work, attempts to handle problems of authority as group members come to grips with feelings toward the therapist, efforts directed toward handling conflictual situations, and coping with problems in the development of emotional support. These problems are ubiquitous in the life of the group and do not develop in an assigned sequence.

These points of view differ somewhat from that of Johnson (10), who writes about three specific stages in the life of the treatment group, each lasting approximately six months. Stage One is characterized as the period of time in which a working relationship is fostered between the therapist and the group. Stage Two is defined as a transitional state delineated by the recognition and ventilation of hostile feelings toward the therapist and the development of a group identity. Stage Three is marked by mutual analysis and mutual cooperation.

More recently Garland, Jones and Kolodny (8), writing from their experiences with groups in social work settings, came to a tentative formulation of group developmental phases which may be of interest. They postulated that there are five stages of group development: Stage One is that of approach-avoidance; Stage Two is characterized by struggles over power and control; Stage Three is delineated by the growth of intimacy in relationships; Stage Four, by differentiation; and the final phase is noted as one of separation.

Despite differences in perceiving group life—whether one looks at the group as a whole or simply as an extension of the dyadic relationship, whether one sees developmental stages or one's perceptions preclude this, some phenomena appear to be ever present. One might say that in the treatment situation, and possibly in other group situations, there is evidence to adduce that people generally struggle with problems of independence versus dependence, maintenance of one's individuality versus submission to authority (group's or worker's), conflicts around handling of emotions (control versus loss of control), problems with maintenance of equilibrium versus pressures to change, and distance versus intimacy in relationships.

There also appears to be a difference of opinion, depending on one's frame of reference and one's goals, about who can benefit from group therapy. Rosenbaum and Hartley (13), in reviewing current practices of psychotherapists, commented that "while it may be gratifying to note the variety of classes of patients for whom it is believed group therapy is indicated, it is disturbing to note the overlapping responses in the lists of those for whom it is recommended and those for whom it is not." They suggested the need for further study of the problem.

Although there are many commonalities in the matter of group composition, there are also differing opinions. The differences are often

due to the purpose and goals of the group, e.g., the reconstruction of personality may be a more attainable goal with those who fall within the range of neurotic behavior. If one accepts socialization, better reality testing, and greater psychological-mindedness, then the range of diagnostic categories may be increased. However, the lack of clarity as to what kinds of groups authors write about and what their purposes and goals are, confuses guidelines for group composition.

There are other points of contention such as alternate sessions without the worker, the group dynamics about which the worker should be knowledgeable, and the use of co-therapists. My intent is to select a few notes of discord, rather than discuss the entire array of differences.

We in social group work also have our problems. For many years we thought that our knowledge of group processes and the role of the worker in stimulating interaction would be immeasureably helpful in working with families. In truth, the family is a natural group which appears to have many of the attributes of other natural groups with which we are accustomed to work. Yet, the Family Study Project (4) of the Alleghany General Hospital notes that, "In summary, from the results obtained in a variety of role discrepancy measures, and the communication pattern in counseling, it appears that some of the assumptions of group work concepts are not easily confirmed." The wide age ranges of family members, the deep emotional ties that bind them, and the freezing of roles present new tasks to the worker.

FACTS

The title of the paper, you may recall, is "Fantasies, Fables and Facts About Groups." Fantasies and fables have been discussed. I am fully cognizant that what I may describe as facts may be thought otherwise by some. I am also aware that these facts may not be applicable to all situations, but let us look at some guidelines which may be helpful to you.

1. All of us bring our past experiences with individuals and groups into new interpersonal situations. If our relationships have been good and our experiences pleasant, we tend to approach the new multipersonal activity with somewhat less anxiety and resistance. If, like many of our patients, participation in the past has been marred by rejection, retaliation,

failure or a host of other trauma, one might well expect that initial meetings will reveal these various fears about group involvement. Whitaker and Lieberman (16) list some of these fears as (a) fear of retaliation or disapproval from the therapist; (b) fear of abandonment and therapist's angry reaction; (c) fear of guilt about tattling; (d) fear of loss of control over sexual feelings; (e) fear of looking foolish; (f) fear that destructive impulses will get out of hand.

2. The group situation often appears to be fraught with danger for many individuals simply because the stimulation by other group members in what they say or do arouses all kinds of feelings, often uncomfortable ones. The spontaneity in verbal exchanges that take place may sometimes be pleasurable and satisfying, and at other times generates feelings of discomfort, particularly if the individual finds it difficult to control his impulses or the productions of others which may be threatening.

Regarding the spontaneous therapy group versus the everyday groups in our culture, Johnson (10) remarks that in our normal group situations, structuring tends to control the range of emotional stimulation and response of group members. "In this way members can relax and engage in group behavior while impulses that are unacceptable or discomforting to them can be held in abeyance. In groups, where a great deal of security from this danger is desired, behavior may be almost completely ritualized. Ritualizing eliminates surprise and the danger of spontaneous activity."

3. I have indicated that past group experiences and internal pressures created by the productions of other group members generate tension and strain. To alleviate the pain caused by these interactions, people usually bring into action their habitual modes of behavior. Some lapse into silence; others become over-talkative or press toward development of a structure. It is fascinating to observe how quickly emergency defensive maneuvers are brought into play.

4. Not only does the individual quickly use old patterns of behavior to ameliorate his situation, but each group appears to develop a style of coping with the stress of the moment. These styles vary, depending upon the composition of the group; for example,

(a) the teacher-pupil or doctor-patient relationship, in which group members attempt to involve the worker in questions-and-answer sessions with the admonition that "You're the expert, you know what's wrong, you tell us!"

(b) the group solution that allows one patient to dominate the sessions and siphon off the energies of the worker toward him;

(c) the group solution that seems to avoid involvement and intimacy by seeking to make the group into a social gathering discussing trivia;

(d) the group solution that is dependent on the "change agent" syndrome. The words "change agent" have generally been used synonymously with "worker." However, my use refers to the persons who always change the subject which produces pain, conflict or discomfort. This is a style known not only to therapy groups, but to all of us at one time or another.

You may be aware of other coping devices of groups. The danger is not in the expression of these defensive maneuvers, but rather that any such style may become frozen through repetition.

5. A group does not magically evolve into a work group with a focus on mutual analysis of problems; it must be helped to do so by the worker. It is the worker's acceptance of a wide variety of behavior and thoughts, his support through understanding, reassurance and encouragement, his involving the group in initially observing what is going on, and increasingly assessing and evaluating group and individual behavior that guides the group in becoming a helping instrument.

6. There is an associative quality in the verbal production of each member which permits identification of what may be called group themes; that is, from what is being said, the worker attempts to sift the underlying concerns of the group members. At times, group members may be preoccupied with hostile feelings, at others with dependency feelings, and on some occasions may be grappling with conflicts regarding authority figures.

For example, when several weeks before the end of the group sessions, Mrs. D. comments about some friends of hers who wonder where they could get help, and Mr. H. says he won't miss the group because he has found a doctor he can confide in, and Mrs. J. indicates that things have not gotten any better for her, we can be sure that the group members are dealing with all sorts of feelings around termination—anger, ambivalence about leaving, or feeling up in the air. At other times, putting together the content would reveal other disquieting conflictual material

with which the group is grappling. Group members often disguise their concern about what is going on in the group. For example, at beginning meetings, it is not unusual for people to talk about persons outside the group who did not seem to understand group members' feelings and how nice it is to be in a group where people have the same problems. It is undoubtedly true that it is comforting to know that others share the same concerns, but it is equally sound to wonder with the group if they are questioning whether this experience will be the same as others.

Much of the group content discussed at a meeting will have a strong relationship to the "here and now"--to what is going on at the moment. It is the worker's role to bring these concerns to the awareness of the group so that they may come to grips with them. For elaboration, I would refer you to Elsa Leichter's article (11) which focuses on the interrelationship of content and process.

7. As the group members share with one another, as an atmosphere of permissiveness and trust develops, as a sense of belonging is nurtured, old fears and anxieties show some signs of dissolution. Individual members and the group as an entity tend to give up habitual response and seek expansive rather than restrictive solutions to life's complexities and problems.

These are but a few facts of group life. Many other facets of group living have not been mentioned, such as manifestations of resistance in groups (absences and lateness), group contagion, effect on groups of additions and losses of group members, and the role of the worker and his problems in facing groups.

In this paper I have described what appear to be fantasies, fables and facts pertinent to groups. An effort was made also to balance the role of iconoclast with that of a provider of guidelines which might better explain group life.

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FORT LOGAN PATIENTS TWO YEARS LATER: A PILOT STUDY*

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Follow-up studies are a part of the research aimed at understanding mental disease. The complex processes underlying the behavioral disorganization which characterizes psychiatric conditions are not well known, and the relative weight of each of the myriad biological, psychological, and social factors in the course of mental illness has not been established.

Both premorbid adjustment information and intensive follow-up observation are necessary in longitudinal studies to determine which common characteristics may constitute the natural history of a disease. In the absence of such information, it cannot even be asserted that the processes studied are mental or can be called diseases. Therapeutic procedures in psychiatry are concerned not only with immediate, temporary changes in the patient's behavior, but also are expected to have delayed or prolonged effects upon his adjustment. Post-treatment observation is indispensable in evaluating long-term changes and in establishing which effects can be attributed to treatment. Equally important, the compilation of facts about the fate of the mental patient can provide a means to test

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*This article summarizes an unpublished, detailed report (Sept. 1967) of the survey information obtained and the methods and instruments used. A portion of the data used in the study was supplied by the Fort Logan Record System Project, Paul R. Binner, Ph.D., Director. The Record System is supported in part by Public Health Service Grant No. 5-R11 MH 00931-07 from the National Institute of Mental Health.

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hypotheses, to plan the therapeutic program in terms of past results, and to furnish some scientific support for the treatment methods utilized in everyday clinical practice. This is a benefit not to be underestimated in a field characterized by empirical application of treatment procedures and the proliferation of untested or untestable theories.

There has been little agreement among investigators on specific criteria or methods of measurement against which the results of psychiatric treatment can be evaluated. It is crucial to obtain exhaustive information on the life course of every patient, on the detection and measurement of changes in adjustment and functioning during and after illness and treatment, and on the meaning of such changes, but it is impossible for a single team of investigators to plan and carry out a follow-up inquiry comprehensive enough to cover all aspects. Each study has to define a specific purpose within a limited area of inquiry. A cursory review of the literature shows that investigators usually have had to devise their own instruments, criteria, and procedures, and that the applicability of other designs to new studies has been quite limited. Further, because there is no standard follow-up procedure, the particular goals of each study require different, specialized ways of collecting and interpreting information.

The evaluation of methods and results of psychiatric treatment has occupied a prominent place in the program of the Fort Logan Mental Health Center. The Research Department has a long-range plan in which three main areas have been delineated: (a) the establishment of a system of information collection, retrieval, and analysis, (b) the determination of criteria of therapeutic success, and (c) the follow-up of discharged patients.

The present report describes a pilot study in the third area. Its main purpose was to determine the feasibility of continuous assessments of post-hospital adjustment which might provide uninterrupted feedback for the hospital clinical and research operations. To determine the viability of such mechanism and to formulate recommendations toward its eventual implementation, a group of discharged patients was studied by means of individual interviews with them and their relatives. This limited trial was carried out to determine the adequacy and usefulness--as well as the cost and personnel requirements--of the instruments used and of the analysis procedures. The interviews also were expected to yield enough information to gauge the expatients' personal and social adjustment.

METHOD

Sample

The group selected for study were the patients discharged during the first year of the hospital's operation. This cohort consisted of 59 patients who had been admitted between July 1961 and June 1962. Since all had been discharged prior to July 1962, and the interviews were conducted between July 1964 and March 1965, the time elapsed since discharge ranged from two to three years.

Contacting Procedure

Letters were sent in June 1964 to all patients in the cohort requesting the patient's consent to be interviewed and his permission to interview one of his relatives or friends. The follow-up study was explained as an effort to evaluate and improve the services of the hospital. A second letter was sent if no response was obtained from the first.

A wide variety of methods was used to locate and communicate with patients who did not respond to the letters, but many of the procedures, such as checking city directories, the post office, other hospitals, and employers proved unproductive and expensive. Telephone contacts and unannounced visits to the patients' homes were effective ways to gain information and arrange for interviews.

Instruments

Three instruments were chosen for organization of the follow-up data:

1. An identification form. Designed to record information essentially similar to that obtained for all patients admitted to Fort Logan, this instrument was used to record demographic data and summarize dates, type, and extent of medical and psychiatric care. In addition, it provided space for recording time required, cost, and other circumstances of the interview.

2. Questionnaires. The post-hospitalization interview schedules devised by Freeman and Simmons (2) for their sociological study of

discharged patients and their families were used in the collection of data dealing with family characteristics, economic productivity, deviant behavior, adjustment problems, and circumstances of rehospitalization. In addition to the questionnaire originally intended for interviews of relatives, a parallel questionnaire was adapted for use with patients. The changes consisted only of modifications in the wording required for addressing questions about himself to the subject; neither content nor order was altered.

The questionnaires were used in structured interviews and did not contain the interviewer's evaluations. The questionnaires were originally designed to test specific hypotheses about social correlates of successful post-hospitalization performance, while the present study tested indices descriptive of general social adjustment. However, it seemed advantageous to use an instrument extensively field-tested, organized into areas of immediate practical interest to Fort Logan, and already used in several other studies (1,3). Other rating scales from the Freeman and Simmons study were not used in this project.

3. A mental status summary. This instrument, a form filled out on all Fort Logan patients during hospitalization, was used in the follow-up interviews to record the interviewer's evaluation of behavioral, intellectual, and emotional disturbances.

RESULTS

Response to Inquiry

The initial mailing produced 13 interviews (22 per cent) and a second mailing added two more. Including three refusals from each mailing, a total of 21 replies (36 per cent) were received. From the total cohort of 59, 47 patients (80 per cent) were located, but three refused to give any information. Of the remaining 44, two had died between discharge and follow-up, but information on them was provided by relatives. Information on these 44 patients was obtained by interviews with 37 patients and 33 relatives. For the most part, the patients who agreed to be seen had no objection to the interview of the relative, but problems were encountered with the intelligibility of the questionnaires, ethical issues regarding the propriety of obtaining information from relatives in the absence of the

patient's permission, finding privacy for the interview in the home setting, and in one case, a language barrier.

Characteristics of the Group Studied

A comparison of 18 demographic and clinical variables showed no differences between the group of patients in the sample on whom follow-up information (N=15) was not obtained and the patients studied (N=44). Comparisons with other admission cohorts did not show marked demographic differences. Nevertheless, the sample studied is probably not typical of later Fort Logan populations, because all admissions during the first six months were to the day program, and criteria for admission were more selective than those adopted later.

Psychiatric Care since Discharge

Information about amount and type of psychiatric attention was obtained for 48 of the 59 patients in the cohort (including rehospitalization data only from Fort Logan records for four patients). Of the 48 patients, 35 had received professional care at some time since their discharge; four patients had had only outpatient psychotherapy, twenty-seven had been rehospitalized, and four had had only occasional contacts with psychiatric professionals. Twenty (42 per cent) of the 48 patients were under psychiatric attention at the time of interview. Of these, seven were inpatients and two were day patients in psychiatric hospitals, two had regular psychotherapy appointments, and nine were maintaining contact with psychiatrists or institutions regularly or occasionally. There was some evidence that in addition to professional psychiatric care, a good deal of help was obtained from family physicians or other persons, but data was not collected systematically in that area.

The percentage of time since discharge during which patients had received regular care was computed for each patient. For the 44 patients on whom detailed information was obtained by interview, the percentage of time under treatment ranged from 0 to 100. Fifty per cent of all patients (22 cases) had been under care for less than twelve per cent of the time, while 25 per cent spent over half of their time under some type of psychiatric attention.

Rehospitalization, which is often used as a criterion of failure or success, was investigated for the 48 members of the cohort on whom any information was available. Twenty-seven patients were known to have been rehospitalized since their discharge. Thus, at least 45.6 per cent of the Center's first-year discharged patients have had a second hospitalization. Correcting for lack of information in 11 cases, and for the three patients who stayed in the community continuously for over two years, an estimated rehospitalization rate of 50 per cent can be set for the first two years after discharge. Seventeen of these patients were readmitted to Fort Logan, where the policy of short stay and simplified admission may have contributed to the high incidence of rehospitalization.

Readmissions showed a gradual decline during the first two years after discharge. Thus, by six months after release, 25 per cent of all patients had been rehospitalized and by the end of the first year 42 per cent, but only an additional 8 percent were rehospitalized during the second year. Of the patients followed up, nine had more than one rehospitalization, five had three readmissions, and two had four or more readmissions in two years.

In order to study the possible correlates of rehospitalization, a number of demographic, clinical and prognostic characteristics of the patients were reviewed. None of the demographic factors (sex, age, marital status, employment, education, income) appeared to influence the rate. When family settings and attitudes were examined, there was a tendency toward more readmissions and a significantly shorter stay in the community after discharge ($p<.01$) among patients going to live with the spouse than those going to parental homes. Other studies have shown opposite results. A negative attitude toward the patient by his family at the time of admission (as recorded in the Psychiatric Social History form), together with the patient's feeling of having been discharged too soon, were associated with a high incidence of rehospitalization ($p<.03$). Financial performance of the patient, breadwinner position in the family, and expectations or demands from the family bore no relationship to readmission.

Previous psychiatric care was associated with the incidence of rehospitalization ($p<.01$). Of the 40 patients with a history of inpatient care in other psychiatric hospitals before admission to Fort Logan, 22 were readmitted, while only five of the 19 who had not been previously

admitted to a psychiatric hospital were rehospitalized within 2 years after discharge.

No relationship was found between length of stay at Fort Logan and readmission incidence, but in 19 out of 24 cases rehospitalization tended to be considerably longer than the first admission. This finding may be an artifact, in part, of the limitation of length of stay imposed by the selection of the cohort, but comparisons with admission cohorts (e.g., 1962-63) showed very similar lengths of stay for the different groups.

Of the clinical judgments made in the course of hospitalization, only response to treatment was clearly associated with readmission ($p<.05$). Eighteen of 22 unimproved or slightly improved were rehospitalized, while only six of 16 rated moderately or markedly improved were readmitted. Diagnosed severity of illness showed some tendency to parallel incidence of rehospitalization but ratings of improvement (short-term prognosis) and danger to self or others did not seem to be good predictors of readmission. The distribution of diagnoses for the first readmission was similar to that of the entire cohort, but there were six schizophrenic diagnoses among the nine patients with a third admission. By contrast, the majority of patients who received no psychiatric care after discharge had a diagnosis of psychoneurotic reaction.

Psychiatric Symptomatology

Presence and frequency of certain abnormal behaviors--aggressive, depressive, hallucinatory-delusional, irresponsible, and antisocial--were evaluated. The most common symptoms encountered were nervousness, worry and complaint, hopelessness, and social withdrawal, while reports of antisocial behavior were rare.

There was low agreement between patients and relatives when reporting individual symptoms, but agreement increased when combinations of symptoms were ranked. A significant association ($p<.05$) was found between symptom ratings and amount or type of psychiatric care and between symptom rating and rehospitalization ($p<.01$). There were also indications that rated response at discharge was associated with symptomatology reported.

An attempt to compare symptom ratings at the time of the patient's hospitalization and at the time of follow-up was unsuccessful.

At least three fourths of the sample studied had been taking medication, mostly tranquillizers, at some time since discharge. No objective assessment of the effects of drugs was possible, but a high proportion (over two-thirds) of patients and relatives felt the medication was definitely beneficial.

Economic performance

The economic performance of patients in the cohort was evaluated and summarized using a variety of measures. The measure used most extensively was the "employment index," which was essentially the prorated percentage of time worked since discharge. Other measures were patient's income, family income, change of family income since admission, employment at the time of interview, and household chores performed by housewives.

Most of the patients (74 per cent) spent some time in full employment. When our cohort was matched as closely as possible to the U.S. labor force (i.e., excluding full-time housewives and full-time college students), they were found to be working considerably less than the labor force of 1959 (44 per cent vs. 77 per cent). This is not to say, however, that the patients were generally poverty stricken. The median family income for the cohort was about $6,000 per year. Where patients were the breadwinners, the median family income was $5,600. The number of patients whose family incomes increased after hospitalization was significantly larger than the number whose family incomes stayed the same or decreased. These changes may have been the result of the patients' hospital experience; investigation showed that the changes could not be ascribed to inflationary economic trends or to the acquisition of additional wage earners in the family. Patients who were full-time housewives appeared to be functioning as well as the average housewife.

Analyses were made of 57 possible relationships between economic performance and (a) variables collected during the patients' hospital stay, (b) family characteristics, and (c) psychiatric experiences since discharge. In all, six statistically significant relationships were found. Three of these findings were somewhat surprising and three were expected. Probably most interesting was the finding that patients whose discharge diagnosis was "psychosis" tended to have higher employment indices

than patients in other diagnostic categories. The finding seems contrary to many accepted ideas about psychosis, but it must be remembered that a high proportion of these patients had been only on day-care and possibly not sick enough to require inpatient care status.

Where family incomes rose between the time of hospitalization and the time of follow-up, patients tended to perceive less insistence from their families and performed better than those who reported more insistence that their social and economic activities conform to levels seen as "normal" in the community. This finding does not indicate whether the change in family income was a result of patients' efforts or of the efforts of other family members. It may mean, however, that patients perform better when they perceive less pressure from their families. A third finding of interest was that breadwinners received more psychiatric care after discharge than supplementary breadwinners received. This may reflect that the breadwinner role is seen as more important than the supplementary breadwinner role and, therefore, more deserving of the expenditure of family funds, or it may be that the breadwinner role subjects the patient to more stress.

Three of the significant relationships seemed to be almost self-explanatory. It was not surprising to find that patients with financial obligations, either for themselves or for others, tended to work more than those without such obligations. Furthermore, this finding perhaps explains in more detail why patients living in a conjugal setting performed better than those living in a parental family setting. The third significant finding was that when relatives expected patients to be working full time, the patients tended to have a higher work index. This may have been a post hoc report by informants, i.e., informants may have tended to report that they expected patients to be working full time if they knew that, in fact, they had been working full time.

Sometimes the absence of a significant relationship is surprising in itself. For example, none of the indices of economic functioning were found to be related to rehospitalization or with community tenure. Such in-hospital variables as length of stay, diagnosis, and response to treatment were unrelated to the patients' later economic performance. Also, there were few significant relationships between family attitudes and economic functioning.

Having been unable to find much empirical evidence for direct

association between work performance and psychiatric characteristics does not mean that economic aspects are irrelevant to the work of a community mental health center. However, it may mean that we should reevaluate the extent to which vocational problems are related to such things as rehospitalization and community tenure. It may be more fruitful to utilize indicators of subjective discomfort and of behavior disturbing to others. It would seem that too many factors enter into the financial or social activities of a patient, thereby minimizing their usefulness as indicators of the course of psychiatric abnormality.

Family and Social Adjustment

Several related areas of social functioning were examined. The information requested was designed to elucidate the characteristics of the homes and families of the patients after they left the hospital and the quality of patients' functioning after discharge.

The post-discharge living arrangements of Fort Logan patients, with a high proportion of individuals living away from their families (15 per cent at discharge, 36 per cent at follow-up), seem to differ from those of other studies (Freeman and Simmons), where a larger group of patients went to live with siblings. In addition, the longer Fort Logan patients remained in the community, the more they tended to move from parental homes to solitary quarters. Furthermore, Fort Logan patients were more mobile than those of Freeman and Simmons, but mobility was not related to rehospitalization. Despite results of other studies (Freeman and Simmons (2) found conjugal homes more favorable than parental homes or solitary quarters; Pasamanick (3) found no differences between the three environments), Fort Logan patients who lived with their spouses were rehospitalized more often than those who lived with their parents. However, in spite of similarities in the method of study, the groups were too dissimilar to draw conclusions directly referable to a difference in the treatment received or in the hospital program.

It did not appear that the families of Fort Logan patients exerted much pressure upon patients to perform at a very high level of social interaction, but when severe symptoms of psychopathology appeared, relatives did tend to contact the hospital or other agencies rather than deal with behaviors such as suicide threats, antisocial acts, or confusional and hallucinatory episodes.

Relatives did expect patients to function in an organized manner in regard to self-care, getting along with family members, and helping with household chores. Much less often their expectations extended to full time work or to participation in social activities and family financial decisions.

Most relatives reported few management problems in taking care of the patient; 14 of 39 relatives had no complaint. A relatively common problem was an increased need for supervision. The fact that most patients seemed to move into a rather permissive atmosphere may have fostered what many families considered to be a good adjustment. This is further supported by the fact that patients who saw their families as insisting on a high level of performance were under psychiatric care longer or more often than those who sensed fewer demands.

None of the indices of social participation were related to indices of psychiatric functioning such as rehospitalization, amount of psychiatric care since discharge, or community tenure. The social participation indices included friendships, social activities at home and on the job, participation in clubs, religious and other organizations, and hobbies. Involvement in hobbies was reported as frequent, but there was little activity in clubs and organizations. It was also found that patients whose hobbies were classified as solitary were rehospitalized less often and remained in the community longer. Rather suprisingly, patients with higher social participation scores tended to have discharge diagnoses of psychosis rather than neurosis, and these patients came from the "worker" group rather than the "housewife" group.

Some of these findings seem contrary to usual expectations based on family relationships and social activities, but they emphasize the need for developing more consistent criteria of adjustment.

DISCUSSION

Our study was mainly aimed at exploring problems of method. That aspect, as noted above, is described elsewhere. Also, it did not include specific measures of treatment effectiveness. Such measures would not have been possible given the small size of the group, the heterogeneity of its members, and the variety of therapeutic procedures.

If changes in hospital programs are eventually to be guided by the results obtained from follow-up, these measures, of course, are crucial.

In spite of their absence, the present study did obtain enough information about the condition of patients after discharge from Fort Logan to gain a first impression of their post-hospital adjustment and to point to areas worthy of future studies.

A large majority of the patients studied were able to remain in the community, not on brief stays, but for most of the period since discharge. Rehospitalization rates were high, but the length of admissions--although longer than first admissions--did not usually exceed three months, and their rate decreased sharply after one year. Successive readmission tended to be much longer, but multiple rehospitalizations were not common. These, together with short stays in the community, appeared to be limited to a small group of chronically ill patients with multiple manifestations of deviant behavior. These findings deserve further examination, because they suggest that, for a large proportion of patients, hospitalization does lead to an increased ability to cope with community demands. They also suggest that increased readmission rates need not necessarily be considered evidence of therapeutic failure or regarded as part of a revolving door system in which the patient is tossed back and forth between hospital and community while the needs of neither one are met effectively.

Symptoms seemed to be the strongest determinant of whether the patient received further care, but they did not appear to influence economic or social performance. Conversely, the quality of economic or social functioning did not seem to be a major criterion of psychopathology unless it was accompanied by obviously unconventional behavior.

The reports of the patients' usual behavior ranged from normal to consistently disturbing. In the reports of symptoms the lack of agreement on the seriousness of abnormality--against a fairly good agreement as to its presence--points up the need to study the systems of values and expectations on which patients' and relatives' reports are based.

Information from different sources consistently indicated that patients and relatives saw an increase in productivity and improvements in economic adjustment after release. A better capacity to hold jobs, to maintain or increase earning power, and to meet economic demands was reported far more frequently than not. Expectations associated with a role such as breadwinner seem to have influenced economic performance. To what extent the hospital might utilize family and community expectations in its therapeutic program bears investigation, since there also were

indications that excessive pressure by his family could be detrimental to the patient's performance.

Association of economic factors with prehospitalization demographic variables or with clinical variables during hospitalization was not immediately apparent. This may be due in part to the lack of uniform, pertinent information about prehospitalization adjustment but, again, it may reflect largely independent criteria for pathologic behavior and for occupational and financial performance. As a group, the patients studied fell below the norm of the community in income and productivity, but excluding a relatively small number of failing patients, the adaptation of many does not depart seriously from usual community expectations.

A similar lowering of overall functioning was found in family and social relations. As a group, patients were withdrawn, dependent, and not highly active. Nevertheless, in many cases their behavior was not too different from that of their families, and frequently patients who could be considered sicker in terms of symptoms and diagnosis reported more active and appropriate social interactions.

Successful readjustment required a certain amount of accommodation and permissiveness by the family. Relatives seemed to be willing to handle an increased amount of dependency and accepted deviant behavior of moderate severity. However, self-destructive, antisocial, or hallucinatory-delusional symptoms almost always led the families to seek help and usually to request rehospitalization.

The study indicated that most patients and informants saw a definite improvement in the condition of the patient after discharge compared with his situation at admission. Although in some cases such reports were inconsistent with other available information, a few relatively objective indices supported this opinion. At the same time, nothing in the patients' backgrounds or hospitalizations can be pinpointed as an unambiguous factor or predictor of a patient's course after release. Most patients and relatives ascribed improvement to the treatment received, either in terms of hospital procedures, or simply the medication taken, rather than to a natural process of recovery.

The study did not throw much light on how improvement was accomplished, nor did it contribute information usable in refining or modifying treatment practices. It is doubtful what value group findings have in the planning of an individual patient's treatment, but even though

more questions were raised than answered, the study helped to clarify certain issues and suggested more definite ways to approach them.

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IS THERE PATIENT CHRONICITY IN A "PROGRESSIVE" STATE MENTAL HOSPITAL?*

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Five years after the final report of President Kennedy's Joint Commission on Mental Illness and Health (1), one may note the existence of two schools of thought regarding the function of state mental hospitals. One group, composed primarily of clinicians engaged in service activities, is still enthusiastic about the new, "progressive," approach to mental illness. They believe that the earlier optimism for the increased treatment effectiveness offered by community mental health centers is quite justified, and that predictions about obsolescence of the state mental hospital (4, 5, 7) have been borne out in fact. The other, "tough-minded," school holds that the success of such an approach has not been scientifically established. Gorwitz (3) and the Cummings (2), among many others, urge a more realistic appraisal of what mental health services actually accomplish, especially in terms of reducing the numbers of chronic, unresponsive patients who so frequently come to glut outpatient clinics, aftercare facilities, state hospitals, nursing homes, and other agencies offering long-term treatment.

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The Fort Logan Mental Health Center, Colorado's second, and new, state hospital, was not only fortunate to have been planned along lines suggested by the Joint Commission, but also was blessed by not having inherited a core patient group merely transferred from the other state hospital in Pueblo. It was assumed that the Center would begin operating with an essentially new patient population, but it became apparent later that most of the Center's patients had had psychiatric experience prior to admission here.

This paper looks at one aspect of the age-old bugaboo of mental hospitals--chronic patients, or as Fort Logan terms them, "long-stayers." When the research discussed here was started, some crude projections were made of the impact long-stayers might have on the hospital several years hence. The data indicated that the average and median lengths of stay for nondischarged as well as discharged patients were increasing as the Center grew older. Was the hospital steadily accumulating a constant proportion of chronic patients out of each year's admission cohort as well? Without belaboring the ways in which such estimates were derived, indications were that by the end of fiscal 1967-68, the Center could well be confronted by more long-term than new patients. Otherwise stated, most patients would still be in treatment either continuously from their first admission or repetitively from several admissions. Treatment teams could be faced then with an increasing discrepancy between the stimulating challenges posed by patients at Fort Logan for the first time and the recurring, apparently insoluble problems of individuals who had, as our literate British colleagues (9) reported, "silted up" in the hospital.

Even more specifically, it was felt that treatment teams might be less disturbed by their growing backlog of chronic patients if they were less "visible"--if they could be shunted into Family Care, for example. However, if the pattern of long-stayers' utilization of this therapeutic modality continued, by 1967-68 the need for Family Care placements would be quadrupled! This last discovery confirmed our belief that the long-stayers were worthy subjects for research.

When the study began, in 1965, 82 patients met the basic criterion of having been in continuous treatment two years or more, and were thus, from the Center's point of view, chronic. From this group, a 50% sample was drawn, and each patient was matched with a control from the same admission year cohort who was similar in terms of age, sex, marital

status and admission diagnosis. From approximately 850 variables available, 356 items were selected and studied to see what characteristics differentiated the chronic from the nonchronic group. Included were data from the Admission Form, the MACC Behavioral Adjustment Scale (a ward behavior rating inventory), the Social History form, Mental Status Summary, Activity Therapy Evaluations, and Opinions About Mental Illness Scale.* These data are collected by different staff members at various times during the patient's treatment course. In addition, the Opinions About Mental Illness Scale contributes information from the standpoint of relevant community informants, usually friends or relatives, whom the patient designates may be contacted by the Center.

RESULTS

The controls and long-stayers were matched on admission diagnoses to partially equate the groups for initial severity of illness. However, examination of the diagnostic labels which were changed further on in treatment showed that, while the long-stayers did not appear to get worse, the controls frequently did tend to get better. Control subjects were more apt to have their diagnoses changed after admission to a prognostically more favorable label. Long-stayers were equally likely to be changed in a negative *or* a positive direction. Since many of these patients had psychotic labels to begin with, and negative change went toward organicity, those that were altered negatively showed a diagnostically poor picture indeed.

The fact was confirmed that the long-stayer is basically more psychotic, pale, autistic, and withdrawn (as many other studies have shown) than his control. The present study further revealed that initially the long-stayer is seen by clinicians as evidencing more hallucinatory behavior, more personality disorganization, and more obsessive thought content. He thinks more autistically, is more preoccupied and mute, and acts in what is deemed a more inappropriate fashion. However, he is not a difficult patient to manage. Long-stayers are no different from their controls with

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*Tables summarizing items from the data pool yielding statistically significant differences (largely chi square tests) are available from the Research Department, Fort Logan Mental Health Center.

respect to such variables as hostility, resistiveness, anxiety, anger, and depression, suggesting that they are more open to some forms of help, and do not obstruct staff's efforts to provide assistance. It was hypothesized that these individuals become liked because they are not troublesome. Other studies suggest that the generally helpless-appearing, resourceless long-stayer tends to attract attention, pity, and nurturance, all of which may serve to increase the probability that he will become more and more dependent upon the hospital. It was found that although long-stayers are apt to be termed "less friendly" than the controls, this does not reflect overt hostility so much as it probably demonstrates preoccupation with their own deluded inner reality. Long-stayer are, in truth, neither friendly nor unfriendly, because they cannot relate to other people in ways which warrant such affective characterizations.

Other authors have provided empirical evidence supporting the interpretations of the results. These writers have seen long-stayers as extremely stimulus-bound and in need of immediate, rather than delayed need gratification. "Impairment in abstracting abilities" found in this study can be construed to show that such individuals have few realistic expectations about their future life, chances for happiness, or success. The long-stayer's needs of the moment are of paramount importance. In the eyes of many theorists, chronic mental hospital patients' early lives have been so replete with traumatic events, especially during childhood, that their prognosis is poor. Indeed, in this research they were rated as having much poorer adjustment than the controls. The overall view of long-stayers' etiology (but purely from psychological grounds) is that their current emotional disturbances arise not so much from recent stress as from a process, probably schizophrenic and usually lifelong in duration.

As far as their social history was concerned, the findings indicated that long-stayers had experienced more trauma of all varieties during significant developmental periods. This fact certainly alludes to their being encouraged to depend upon their environment for support beginning at an early age. It is sometimes thought that therapeutic community programs such as Fort Logan's will curtail burgeoning dependency needs; however, Sanders (6) has pointed out that such treatment plans deal effectively with withdrawal behavior, but do not handle especially well the type of dependency behaviors found in these patients.

Many of the results, therefore, seemed to hinge on this particular

variable of dependency, although it is often confusingly defined--if it is defined at all--as a clinging, active kind of excessive reliance upon others. Long-stayers at Fort Logan actually do not move *toward* people; in fact, they tend to pull back from social contact very early in their hospital careers, and according to the MACC Scale ratings, take part less in "sensible back and forth conversation" than do the controls.

The study indicated that long-stayers adjust to the Center rather easily. One might hypothesize that as these individuals are exposed to our treatment, they not only do not react negatively, but even seem to settle in, becoming comfortable and contented with their role. Long-stayers are not angry, easily disliked, or obnoxious persons. They do not appear to be among the more disruptive patients. We could speculate, along with supportive evidence cited earlier, that long-stayers generally are liked, albeit in a lukewarm manner, by the staff. At worst, they could be team mascots with reference to the feelings they engender in staff members.

Fort Logan probably is viewed by the long-stayer as a place where he need not worry about food, shelter, or the basic hazards of living. He can depend upon the hospital to take care of him. The fact that he is likely to be admitted to 24-hour care may facilitate the development of this economic dependency; transfer to Family Care, when it is encountered, furthers his perception that he can rely upon the Center. This dependency upon the hospital is not, however, the type related to interpersonal relationship difficulties so much as a sociological variety related to economic and physical reliance upon an environmental situation which is both physically protective and satisfactory for primary need gratification. Sommer (8) has stressed that the longer a patient has been hospitalized, the more important physical needs such as eating and sleeping become, and the less important do social needs become.

In order to shed more light upon the composition of the hard-core portion of long-stayers studied, Dr. Wertheimer read the medical records of 67 long-stayers. Nineteen of these had been outpatients for at least a year and were considered not to present a true long-stay problem as far as extreme dependency upon the Center was concerned. Of the 48 remaining, 45 (95%) were schizophrenic. Hence, it seemed even more probable than the preceding results had suggested that our long-stay problem was the old, familiar one of chronic, likely process, schizophrenia.

Other results of the record-reading showed that core long-stayers had the following characteristics:

a. Chronic undifferentiated or hebephrenic diagnoses accounted for half of the long-stayers versus about one-third of the schizophrenics in non-long-staying groups.

b. Childhood onset predominated for males (41% of the male long-stayers, 12% of the other male schizophrenics). Schizophrenic males over 30 at onset were apt *not* to be long-stayers (6% of long-stayers versus 38% of the others). Age of onset did not differentiate female long-stayers except that onset in the teens was found to be relatively less frequent in long-stayers than in other schizophrenics (for both males and females). Thus, preadolescent onset for males and postadolescent onset for females tended to be typical of the long-stayers.

c. In accord with the above age-sex-prognosis relationship, long-stay males tended to be admitted before age 35, long-stay females after 35. And again, but as a secondary finding, long-stay males admitted to Fort Logan were typically admitted within two years of their first treatment by *any* mental hospital. Females usually had longer histories of mental hospital treatment.

d. Long-stayers were apt to be single (86% of the males, 43% of the females, versus 53% and 27%, respectively, of the other schizophrenics), suggesting the long-stayers' problems were severe, early, and continuous enough to prevent marriage in a large number of cases.

e. Schizophrenics who are going to be discharged from Fort Logan are typically discharged two to five months after admission. About half of those discharged after five months are known to be back in treatment here or elsewhere (compared to only one-quarter of the earlier discharges). Over half of the schizophrenics not discharged by nine months apparently go on to become long-stayers.

f. Essentially all long-stayers were treated with phenothiazine or its derivatives during their stay, compared to about two-thirds of the other schizophrenics. Of those so treated, two-thirds of the long-stayers required Parkinsonism control drugs, compared to one-third of the discharged schizophrenics. The difference can be attributed only partially to a higher phenothiazine dosage in the long-stayers.

SUMMARY

The answer to the question posed by the title of this paper now seems painfully obvious. Not only is it unhappily clear that "progressive" forms of treating mental illness have not eliminated chronic patients from at least one quite exemplary state hospital, but it is equally plain that these patients are not basically different from those encountered so frequently before in the literature and in practice. While it seems certain that they do not differ in *kind* from earlier-described chronic patients, it is quite uncertain how much similarity exists in the *degree* of illness. After all, the patients summarized here have only had a chance to settle in (or "silt up") for two years--how regressed will they look in another two, or eight, or even twenty-eight years?

Despite the pessimistic quality of the evidence presented here, clinicians at the Center fortunately have retained much of their optimism* regarding the efficacy of new treatment approaches. In a survey subsequent to these studies, a representative sample of our clinicians classified long-stayers as having shown some progress. They definitely did not believe long-stayers were abysmal failures, nor did they feel hopeless and defeated about the possibility of helping these patients more. In the true, tough-minded scientific tradition, however, we predict that unless some marked advances in treatment technology take place, time will demonstrate that the Center's chronic patients will show slow, but measurable, withdrawal from all social contacts, further diminution in general and specific functional capacities, and increasingly noticeable symptoms of probable organic impairment.

**Editor's Note:*

When it became apparent that the caseload of chronic patients at Fort Logan was increasing steadily, a group of administrative and clinical staff members began to look for new ways to meet this challenge. The optimism, noted by Dr. Dickey, among clinicians at the Center is reflected in the following programs which evolved from the intensive consideration of our long-stayer problem.

The Community-Oriented Remotivation Program. The COR plan embodies an adult remedial training and research program designed to help chronic, hospital-dependent psychiatric patients acquire the necessary skills, cognitive ability, interpersonal support, and self-confidence to

effect and sustain a permanent and independent community adjustment.

The major features of the program include (a) a didactic course of study of practical living skills, (b) simulations and rehearsals of extra-hospital living conditions, and (c) experiences geared for graduated changes and designed to maximize self-environmental and self-goal awareness.

The patients are placed into "intentional groups" and they proceed through much of the program as a group. The program is time-structured, and after four months of in-hospital training, the groups are moved into a Halfway House on the Center grounds. The latter phase is limited to three months. At the end of this period, the groups of patients move into the community where they will use both hospital and community resources. The program aims at decreasing the patients' dependence on the hospital and increasing their use of community and "intentional group" supports.

The Lodge Program. In an effort to meet the treatment needs of certain psychiatric patients for whom traditional methods have been ineffective, the Lodge program attempts to develop an autonomous group capable of handling its own work and social life on an independent basis. This innovative approach is based on the prototype designed and implemented by The Veterans Administration Hospital in Palo Alto, California. The program follows closely that of Palo Alto and, in effect, provides an extension of the existing treatment program for chronic patients.

The initial development of the patient group is a critical factor and is the responsibility of a highly qualified, professional group worker. Selection of Lodge members is based on (a) the patient's inability to live in the community without a socially-supportive situation, and (b) his inability to work in the competitive labor force. Physical and psychological separation from the hospital is essential to the maintenance of group autonomy, and group responsibility for problem-solving and for developing and maintaining discipline is encouraged strongly. However, a house manager is available evenings and on weekends for emergency situations.

The Lodge membership presently comprises 15 men who live in the community full-time. Work contracts in light janitorial services and yard work are obtained by a member of the Vocational Services staff, who is also responsible for the business management of the Lodge. Capable members assume leadership in the business operation and group management as soon as they are able to do so. Beginning costs for room, board, supplies, and equipment are provided by the Colorado Department of Rehabilitation. As the group earns money, its members will gradually assume the cost of operation. It is hoped that as time progresses the group will become self-sufficient and will require a gradually diminishing investment of staff time and financial support.

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BOOK REVIEW

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.