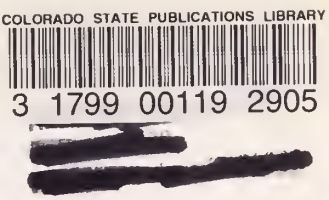

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SPRING - SUMMER 1968

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SPRING – SUMMER CONTENTS 1968

TREATMENT ETHICS: A FINE AND SOMETIMES ELUSIVE LINE

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In the early years of the mental health professions, care of the mentally disturbed was primarily custodial. There were few attempts to treat patients, and physical care was equally neglected. One has only to read Beers' (1) *The Mind That Found Itself* to recall the physical abuse existent in the asylums.

Over the years the emphasis on custodial care has been replaced by a desire to return mentally disturbed persons to the community as quickly as possible. Concurrent with this new direction have been more humane physical treatment of patients and greater efforts to treat their mental disorders. With these changes in treatment philosophy, professional groups such as the American Psychiatric Association and the American Psychological Association found it necessary to define basic ethical concerns in the form of a Code of Professional Ethics. Unfortunately, such broad, encompassing expressions do not answer the difficult questions every mental health professional wrestles with in applying professional ethics.

The ethical issues involved in treatment take varied forms. One group of positions appears to vary along a dimension in which the ancient philosophical question of means versus end is implicit. There are those who lean toward the position that any treatment form is justified if it is effective. Here, the ethical responsibility is seen as an obligation to the community to return the patient as a "fit" member of that community.

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The means for accomplishing the return are secondary. At the other extreme are those who refuse to consider a proven treatment approach simply because of the slightest ethical reservation. Between these two extremes, perhaps the most frequent position currently taken is ethical justification through an intricate process of weighing the value of the expected outcome of the treatment approach against the undesirability of the procedure. Cahoon (2) illustrated this nicely when he said, "Amputation to 'cure' a hangnail would be unethical, but amputation would scarcely be unethical if necessary to arrest a gangrenous process."

A second group of ethical positions is qualitatively different. Hobbs (3) posited that "the practice of psychotherapy requires adherence to exemplary conduct not solely to protect the client when he is in a vulnerable position but more importantly to provide the client with a concrete experience of an intrinsically moral relationship with another human being. It is commonplace to note that the character of the relationship between the therapist and his client is a major source of therapeutic gain; the relationship must be a living, immediate act of ethical discovery." Hence, rather than search for an intricate, often delicate, balance of clinical and ethical values, the second postion considers the two values inseparable.

Regardless of the ethical position one chooses, treatment always raises inherent issues of applied ethics. The clinical problem reported here illustrates some aspects of the complexity of the relationship between ethics and the treatment of the mentally disturbed.

THE APRIL INCIDENT

The focus of this study was a specific staff-patient interaction that occurred in April 1968 in an adult psychiatric treatment unit at a state mental health center. The incident occurred in an institution whose primary treatment philosophy is a therapeutic community approach. In this setting the authority to make treatment decisions is probably spread more horizontally than in traditional settings. Uniform agreement on the facts of the April Incident, as it came to be called, was difficult to obtain. However, the following account probably contains most of the significant details.

The April Incident centered around a young female patient who had posed long-standing management and treatment problems for the psychiatric team staff and patients. A verbally abusive patient, she frequently directed "foul and obscene language" at staff and patients in a way that disrupted treatment activities. On several occasions she threatened physical harm by brandishing broken pop bottles.

Following a morning nursing report, the patient attempted to enter the nurses' station, which is off-limits to patients. Staff members made several attempts to get her to leave, but their efforts met with the usual verbal abuse and threats. Finally, with the intent to seat the patient outside the nurses' station, the psychiatrist tugged down on the patient's hair, guiding her toward a chair. This approach yielded some compliance on the part of the patient. After a "huddle" on the procedure, the staff repeated the approach several times during the morning.

At 1:00 P.M. that day, the staff discussed the problems with this patient and decided to discontinue the hair pulling. In the hope of controlling the patient's foul language, the staff decided that one of the phenothiazine derivatives would be sprayed in her mouth whenever she resorted to that kind of verbal abuse. (Phenothiazine derivatives in liquid form are very bitter to the taste and, in this instance, the patient complained of burning of the oral mucosa.) One cc. of the medication was ordered, to be used as needed. The spray was applied 20 times in a period of 16 hours, after which time this procedure also was discontinued.

The division chief who supervised this team and four others was absent from the center when these events took place; he returned five days later. He inquired about the patient in question during a regular supervisory hour with the team leader (a social worker) and the team psychologist. The two team members reported nothing unusual about her. Two days later, however, after the team leader of a sister treatment team reported the events of the prior week to the division chief, he confronted the team with those events. He was especially concerned that the incident had not been reported in supervision, and it appeared to him that an attempt had been made to "cover up" the incident.

As a result, the team leader and the psychiatrist were immediately suspended from duty and subsequently dismissed. The team's head nurse was given a choice of resigning or accepting demotion and transfer on probation to another team. The team psychologist was given the choice of transferring on probation or resigning.

The entire chain of events in the April Incident profoundly affected the center as a whole. Centerwide meetings in which the director and other upper administrative personnel explained the reasons for their actions precipitated angry discussions. Staff members not only reacted strongly to the ethical question about the treatment of the patient; they accused administrative personnel of acting precipitously, of exceeding their bounds of power and authority, and of over-reacting to the incident with unnecessarily punitive action.

In an attempt to look objectively at the initial ethical questions raised by the incident, an "action research" study was undertaken. The project focused upon systematic observation of an *in vivo* problem, and rapid execution and feedback took precedence over sophistication of design.

DESIGN AND METHOD

The study addressed three questions:

(a) What degree of agreement exists among staff members about what is ethically acceptable or unacceptable treatment behavior?

(b) What are some of the important components of the judgment process?

(c) Do the internalized guidelines that influence such decisions differ at various administrative levels?

A series of ratings on a seven-point, Likert-type scale was designed to elicit from administrative personnel at various levels the degree of ethical acceptability or unacceptability seen in the actual treatment procedure of the April Incident and in the hypothetical treatment approaches of three dramatized incidents.

Ethical Acceptability Scale

Ethically	:	:	:	:	:	:		Ethically
Acceptable	1	2	3	4	5	6	7	Unacceptable

The staff subjects selected were asked first to rate all four incidents as noted and then to rate the three hypothetical incidents after considering certain qualifying circumstances.

A problem with all Likert rating scales is the ambiguity of the midpoint on the scale. The midpoint reflects either uncertainty or an attitude that falls in the midrange of the scale. Therefore, to free subjects to use the midpoint as a reflection of attitude rather than uncertainty, degree of certainty was recorded on a second scale, ranging from "Very Sure" to "Very Unsure."

Certainty Scale

Very	1	2	3	4	5	6	7	Very
Sure	:	:	:	:	:	:		Unsure

Subjects

Initally, random selection was planned to obtain a sample of subjects from each administrative level in the center, i.e., upper administration, division chiefs, team leaders, supervising nurses, and other team members. However, the necessity for rapid execution of the study made random selection impossible. Table 1 shows the administrative distribution selected and the numbers participating at each level.

(See Table 1 on page 6.)

TABLE 1

NUMBER OF SUBJECTS REPRESENTING CENTER ADMINISTRATIVE LEVELS

Administrative Level	Professional Group	Number
Upper Administration	Division Chiefs and Center Executive Committee	9
Senior Staff on Treatment Teams	Team Leaders	6
	Psychologists	10
	Social Workers	19
	Supervisory Nurses	7
Team Members at large	Nurses	7
	Psychiatric Technicians	8
Total		66

Procedure

The subjects first rated the April Incident on the Ethical Acceptability and the Certainty scales. Using the same scales, they then rated three hypothetical situations designed by the authors to be qualitatively different in ethical acceptability. The staff-patient interactions in these hypothetical situations, called "focal incidents," were dramatized on videotape.*

Focal Incident #1: "The Water Treatment." An adolescent is seen lying in bed in his room. Two staff members enter and begin chiding the patient about staying in bed all day, and they ask the patient to get up

*The authors wish to thank the University of Colorado "Spontaneity Theater" group and their director, Lann Meyers, for their skillful portrayals of the focal incidents.

and enter the team activities. The patient is verbally abusive and refuses to get up. Finally, one staff member says, "You've got exactly two minutes to get up before I give you the water treatment." The staff member leaves and returns with a large glass of water. The scene culminates in the water being thrown on the patient.

Focal Incident #2: "The Cold Shoulder." Several staff members are seen busily working in the nurses' station. A female patient comes to the door asking that someone speak to her. It is obvious that the staff members can hear the patient's repeated requests and are simply not attending to them. In fact, the staff members are talking among themselves, and it is necessary at times to speak above the patient. The scene ends as the patient is imploring the staff to "please talk to me," while the staff members are still chatting.

Focal Incident #3: "Coerced Participation." As the scene opens, two staff members are attempting to coax a patient to leave her room and become involved in the day's activities. The patient looks depressed and responds with an account of the many physical complications which prohibit her participation. Finally, the two staff members indicate that it will be necessary for the patient to join in with the other patients. As the scene ends, each staff member takes one arm of the patient to propel her down the hall. The limp, passive-resistant behavior of the patient makes it necessary to half carry and half drag her down the hall.

Following the initial rating of the hypothetical incidents, these qualifying statements were added, one at a time, to the information conveyed by the tapes:

(a) The patient had been warned that the action would be taken if he did not alter his behavior.

(b) The action was planned by the staff. Lengthy discussion in team staff meetings preceded the action, and the decision was recorded in the patient's chart.

(c) The patient's behavior had persisted over a considerable length of time. The team's numerous attempts to modify the patient's behavior had been frustrated and frustrating.

The subjects were asked to reassess the focal incidents in light of these statements. Thus, four ratings were made of each focal incident. The qualifying statements were counterbalanced across the focal incidents to control for order effects.

RESULTS AND DISCUSSION

Three questions evolved from the April Incident: (a) Do staff members at the center hold common attitudes regarding ethically acceptable patient treatment? (b) How do pieces of clinical information affect the judgment process in determining ethical treatment behaviors? (c) Do various administrative levels differ in attitudes concerning ethically acceptable treatment behavior?

These questions are discussed first in a general presentation of the data. Following this, the data are presented in a manner relevant to each of the three questions. Table 2 provides the mean ratings and standard deviations for the three focal incidents and the April Incident. Figure 1 provides similar data in graph form. (See page 10.)

TABLE 2

MEAN RATINGS AND STANDARD DEVIATION ON FOCAL INCIDENTS AND APRIL INCIDENT

	Incident			
	Water Treatment	Cold Shoulder	Coerced Participation	April Incident
Mean	5.40	6.00	3.55	5.79
Standard Deviation	1.62	1.59	1.70	1.30

These data show that, on the average, subjects rated the Water Treatment and the Cold Shoulder incidents as highly undesirable. The Cold Shoulder was perceived as slightly more unacceptable than the Water Treatment, but a t test indicated no statistical difference between means. Although Coerced Participation was seen as somewhat unethical, it was perceived by subjects as significantly more acceptable than either the Water Treatment ($p<.025$) or the Cold Shoulder ($p<.005$). On the

average, subjects perceived staff's behavior in the April Incident as unacceptable, with mean ratings falling between that of the Water Treatment and Cold Shoulder focal incidents but without statistical differences. The April Incident also was perceived to be significantly more unacceptable than the Coerced Participation incident ($p<.01$). The mean rating for the April Incident provides what might be called a "reality anchor" for understanding how subjects used the seven-point scale to represent the dimension between ethically acceptable and unacceptable extremes.

An atypical form was chosen to represent the variance of responses in Figure 1, in the hope that the meaning of variance would be more understandable. In Table 2, variance is represented by the standard deviation. In Figure 1, variance is portrayed by the shaded area, representing one standard deviation on either side of the mean ratings. The judgments of 68% of the subjects fell in the shaded area, while the ratings made by the remaining 32% of subjects fell outside the shaded area. The meaning of this variance in relation to the three initial questions is discussed further on.

Looking now at the question about uniformity of ethical norms, these data gave us no answers in an absolute sense because no uniformly accepted norms or expectations exist for comparison. Figure 1 provided an index of variation in the form of the standard deviation. But the question remained: Do these data indicate a critical amount of variation in making ethical judgments?

Figures 2, 3, 4, and 5 present the data in a form that is relevant to the first question. In these figures the total number of ratings for one specific focal incident are presented by quartile, and the mean rating for each quartile is shown in a histogram. For instance, the mean rating of the entire sample on the Water Treatment incident was 5.40, indicating that it was perceived as fairly undesirable. Looking at Figure 2, it can be seen that when the highest 25% of the ratings are broken out of the total, this quarter of subjects rated the incident as extremely undesirable. Also, ratings didn't change with the addition of qualifications. For the second quartile, the mean ratings indicated a less extreme attitude with the addition of legitimizing qualifications. In the fourth quartile, 25% of the subjects perceived the Water Treatment per se as moderately acceptable; as qualifications were added, this quartile saw the procedure as quite acceptable.

Figure 1. Mean Ratings and Standard Deviations on Focal Incidents and the April Incident by Entire Sample.

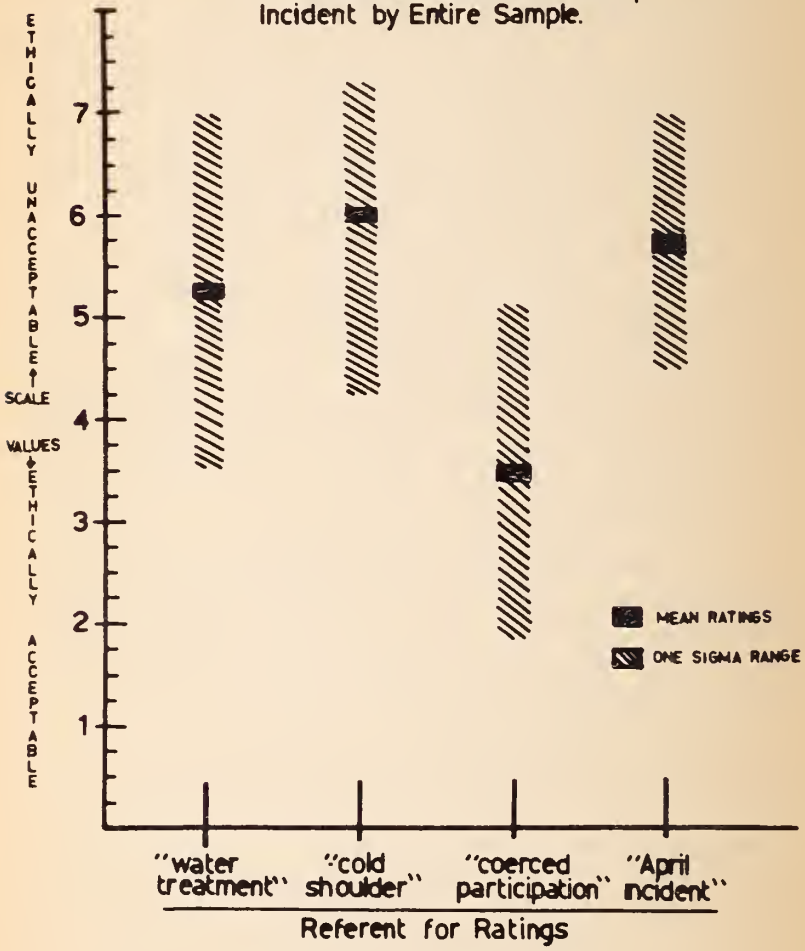


Figure 2. Mean Quartile Ratings for "Water Treatment" and Qualifying Statements for Entire Sample.

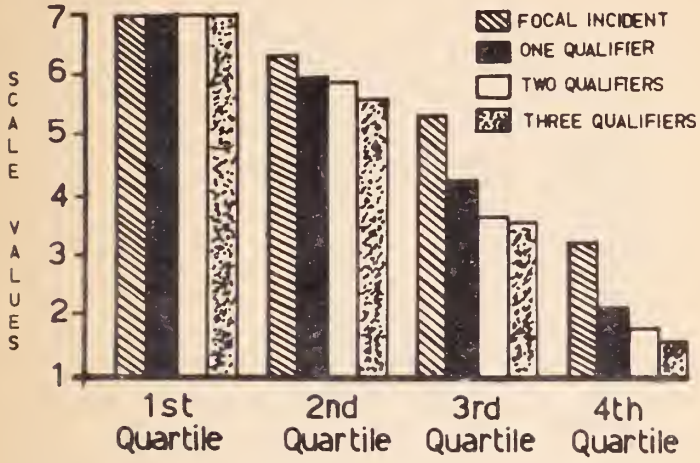


Figure 3. Mean Quartile Ratings for "Cold Shoulder" and Qualifying Statements for Entire Sample.

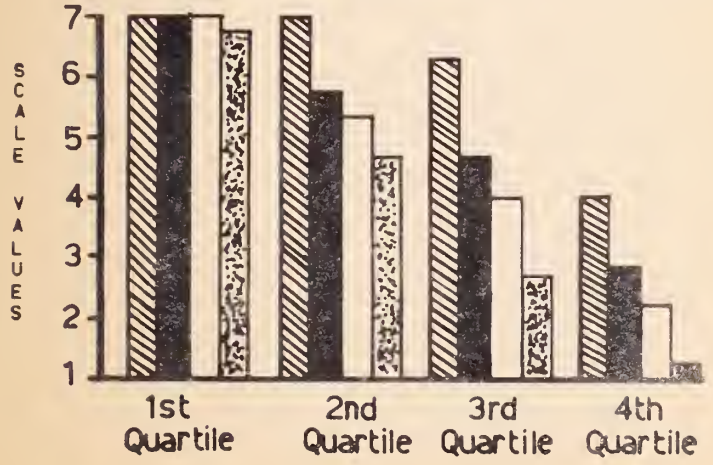


Figure 4. Mean Quartile Ratings for "Coercive Participation" and Qualifying Statements by Entire Sample.

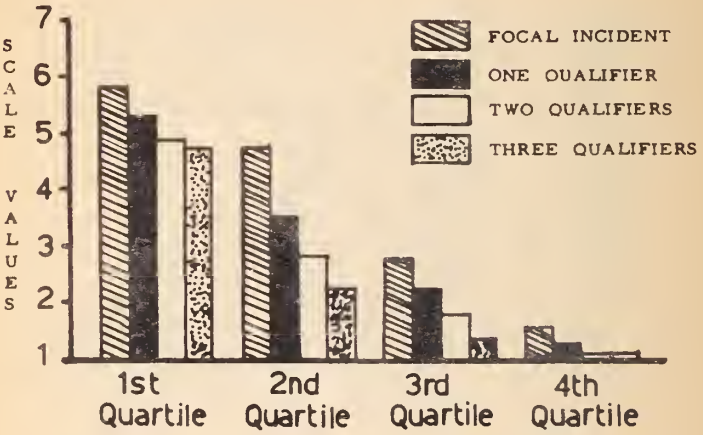
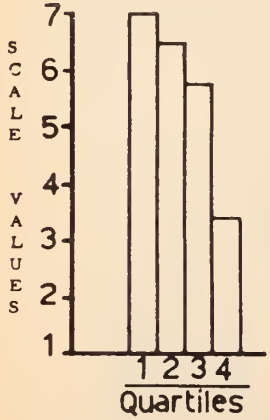


Figure 5. Mean Quartile Ratings for "April Incident" for Entire Sample. (no qualifying statements)



Still, there was no absolute "yardstick" against which to judge these data. Looking back at the April Incident, the ultimate authority for evaluating the staff's behavior was the director of the center, and, no doubt, the executive committee of the center served as a resource in reaching the decision. Perhaps this was an absolute of sorts, and perhaps it can be assumed that the mean ratings of the executive committee were a rough estimate of consensus among the members.

The mean rating of the Water Treatment by the executive committee was 5.88, indicating that members perceived it as fairly undesirable. Looking back at Figure 2, the ratings of those in the fourth quartile take on new meaning. Although the executive committee found the staff's behavior in the Water Treatment incident undesirable, the fourth quartile of subjects found it to be moderately desirable. In the case of the Cold Shoulder incident, the executive committee felt strongly that it involved unacceptable behavior; the mean rating was 6.11. Figure 3 indicates that in this case the fourth quartile was "on the fence" between acceptable and unacceptable. The executive committee saw Coerced Participation falling in the medium range of acceptability (mean = 4.33). Here the difference between the executive committee and any quartile was less striking.

In summarizing the data related to the first question, it must be reiterated that no answers were found. However, the data did show some variability in judging the ethical acceptability of staff-patient interactions. The critical question remained: Can an organization tolerate this level of variability or does it reach critical latitudes? If, in fact, this variability has reached a critical level, the second question would appear to be: How can more uniformly internalized guidelines be developed among staff members of the organization?

TABLE 3

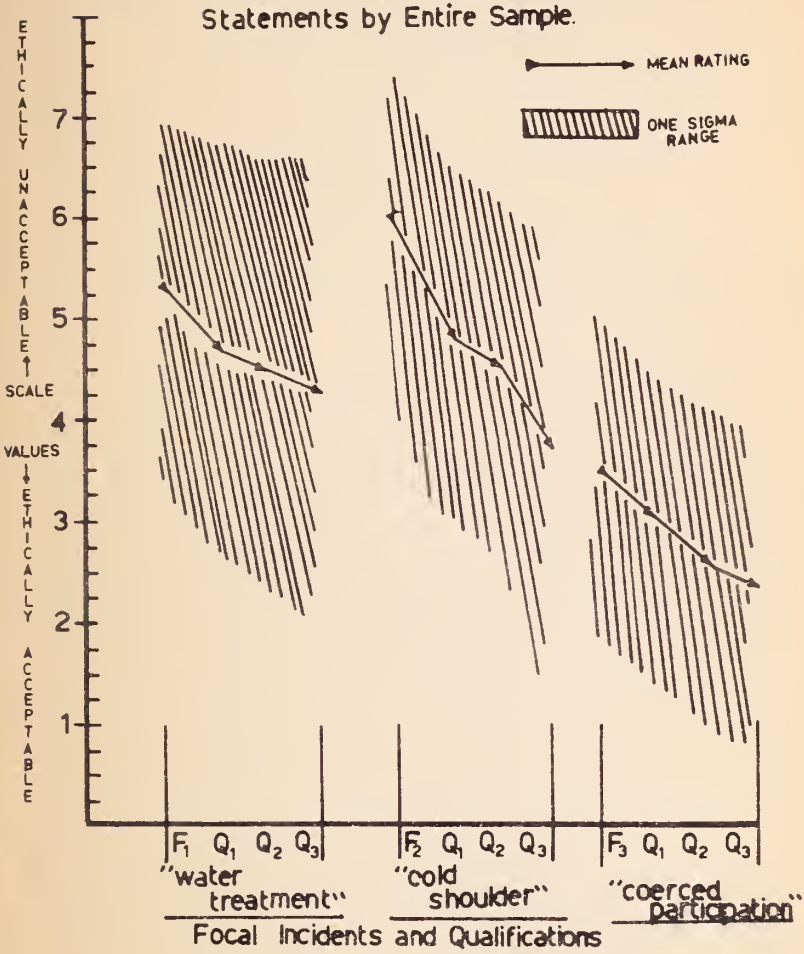
MEAN RATINGS AND STANDARD DEVIATION OF RATINGS FOR EACH FOCAL INCIDENT AND THE RELATED QUALIFYING STATEMENTS (N=65)

	Referent of Rating					
	Water Treatment		Cold Shoulder		Coerced Participation	
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	$\bar{X}$	S.D.
Focal Incident	5.40	1.62	6.00	1.58	3.55	1.70
One Qualification	4.78	1.94	4.90	1.86	3.09	1.71
Two Qualifications	4.55	2.15	4.63	1.91	2.60	1.62
Three Qualifications	4.44	2.24	3.86	2.11	2.41	1.67

Table 3 and Figure 6 show the data relevant to the second question posed at the outset of this study: What are some of the important components of the judgment process? The qualifications given to subjects reflected important dimensions in judging ethically acceptable staff-patient interactions in that judgments changed as qualifications were added. Adding clinical qualifications had a uniform effect of legitimizing the staff's behavior in the focal incidents, i.e., subjects saw staff members' behavior as ethically more acceptable as qualifications were added. A t test was used to measure the differences between initial mean ratings on the focal incidents and mean ratings after three qualifications were added. This difference in the Water Treatment incident moved in the expected direction but was not statistically significant ($p<.150$). In the case of the Cold Shoulder and the Coerced Participation incidents, the difference was statistically significant ($p<.025$ and $p<.05$, respectively).

As in Figure 1, the shaded area in Figure 6 represents one standard

Figure 6. Mean Ratings and Standard Deviation for Focal Incidents and Qualifying Statements by Entire Sample.



deviation on either side of the mean ratings. These data provided the basis for an additional observation on the effect of adding qualifying pieces of information. While some subjects stated during the experiment that more information was needed to adequately judge the focal incidents, variability of ratings increased as qualifying information was added. Figure 2 shows that as qualifying pieces of information were added to each focal incident, the shaded area increased in size, indicating that additional information increased rather than decreased disagreement among staff. Inspection of the data suggested two things that might have caused the increased variability: (a) for the majority of subjects, adding additional qualifications tended to legitimize the staff's behavior; (b) for a portion of the subjects, however, adding qualifications appeared to have the opposite effect.

Also pertinent to this discussion is the way subjects responded to the certainty scale. The average rating of certainty indicated uniformly high certainty (mean ratings ranged from 2.5 to 1.9) across all focal incidents and qualifications. It is interesting to note that although some subjects felt they needed more information to make the initial judgment, they did not consider their initial judgments tenuous. Also, certainty remained relatively stable and fairly high despite the fact that opinions became more divergent as qualifications were added. Such is the making of interpersonal conflict in evaluating treatment decisions.

The third question raised at the outset of this study was whether or not attitudes toward ethically acceptable behavior would vary among administrative levels in the center. There were two reasons for suspecting that individuals would be less accepting of ethically questionable treatment behavior at successive steps up the administrative ladder. First, there are some indications from the field of industrial psychology that an individual develops a more conservative attitude toward risk-taking as he moves up management lines. Second, direct staff-patient contact increases as one moves down the administrative ladder. The nurse and the psychiatric technician daily face questions of practical clinical ethics; hence, conservative ethical judgment is more threatening because it may enjoin self-criticism and may be seen as inhibiting individual freedom in handling problems.

Table 4 and Figure 7 present data on the three focal incidents at each administrative level. The samples shown here were selected only

on the basis of their relation to line authority. They do not include the psychologist and social worker samples, since these individuals do not always have line authority as a function of their professional identification. No significant differences or consistent trends appear in Figure 7 to support the notion that upper administration would be more stringent in their ratings.

TABLE 4

MEAN RATINGS AND STANDARD DEVIATIONS ON FOCAL INCIDENTS BY ADMINISTRATIVE LEVEL

Administrative Level	Focal Incidents					
	Water Treatment		Cold Shoulder		Coerced Participation	
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	$\bar{X}$	S.D.
Division Chiefs & Executive Committee	5.89	1.28	6.11	1.10	4.33	1.83
Team Leaders	5.66	1.80	5.66	2.21	3.33	1.70
Supervisory Nurses	6.71	0.45	5.43	2.40	4.43	1.18
Team Nurses	6.00	1.07	6.57	0.73	2.29	1.16
Psychiatric Technicians	5.75	1.20	6.38	0.69	3.75	1.98

SUMMARY AND CONCLUSIONS

This study was undertaken to examine and clarify the importance and complexity of the relationship between ethics and the treatment of the mentally disturbed. Interest in this area arose from a particular hospital

incident, referred to as the April Incident, in which several clinical staff members were dismissed for mistreating a patient. The study was designed to answer the following questions:

(a) What degree of agreement exists between staff members about what is ethically acceptable or unacceptable treatment?

(b) What are some of the important components of the judgment process?

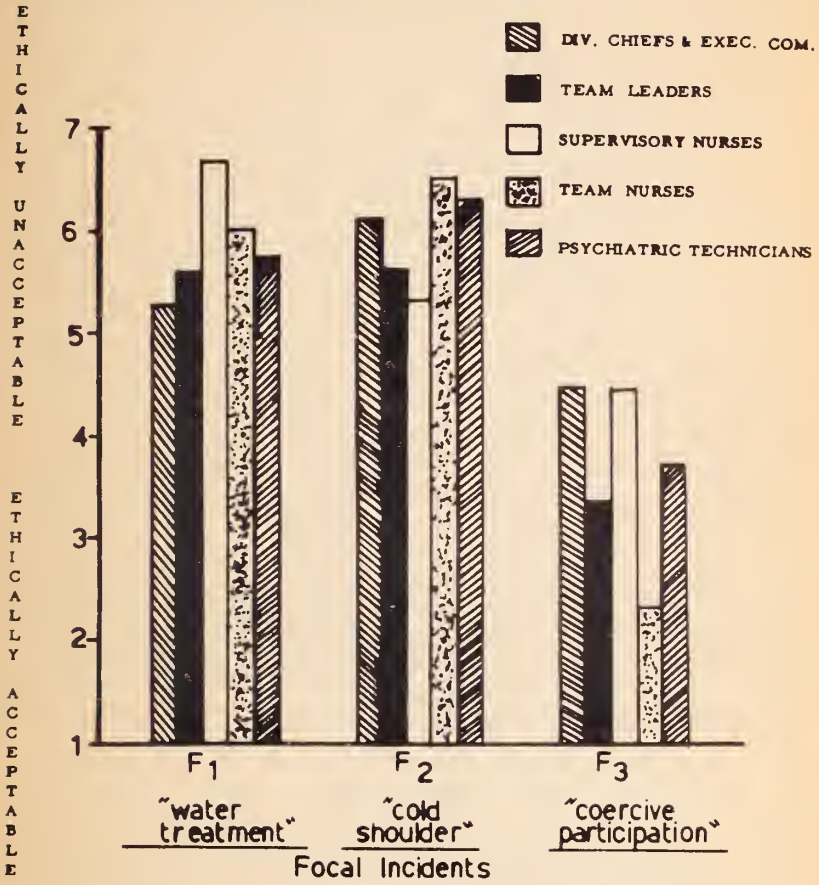
(c) Do the internalized guidelines that influence such decisions differ at various administrative levels?

A total of 66 subjects from various levels within the hospital were asked to rate the ethical acceptability or unacceptability of the April Incident and three videotaped portrayals of hypothetical patient-staff interactions. Each of the videotaped interactions also were rated following the introduction of each of three qualifying statements: (a) the patient was previously informed about the treatment, (b) the action was planned by the staff, and (c) the patient had been highly resistive to other approaches and persistent in his undesirable behavior. Estimates of certainty were obtained following each rating.

Since there is no absolute criterion by which to measure the ethical acceptability or unacceptability of treatment, the mean rating of the center's executive committee (the final decision-making body of the center) were used as "reality anchors" for comparison purposes. There was little incongruity between the executive committee's ratings and other subjects in the upper quartiles as to what behavior was acceptable or unacceptable, but some incongruity existed between the executive committee's ratings and the lower quartiles.

With the addition of qualifying statements the over-all ethical acceptability of the patient-staff interaction in each focal incident increased; however, variance increased also. The variance appeared to result from a refusal in the upper quartile ratings to see the incident as acceptable regardless of the qualifying statements, while the lower quartile ratings showed the incident to be more acceptable as qualifiers were added. All of the quartiles were certain of their ratings in all cases. While the qualifying statements appeared to be important components of the judgment process, they also appeared to be potential sources of conflict among staff members. The over-all variance in ratings increased while the certainty estimates remained consistently high.

Figure 7. Mean Ratings on Focal Incidents by Administrative Level



Comparison of the ratings from various administrative levels of the center indicated no reliable differences in the ethical acceptability or unacceptability of the focal incidents. It was noted that the variance for the mean rating of the April Incident was lower than the variance for any other focal incident. It appears that the entire staff sample agreed that the treatment employed in the April Incident was undesirable.

Of all the findings, perhaps the most interesting and far-reaching one concerns the agreement of staff about the ethical undesirability of the patient treatment which precipitated the April Incident. The heated debates that followed it apparently centered around the administration's dismissal of the staff involved rather than the ethics of the treatment. Yet, at the time there was a good deal of debate about treatment ethics as well. In our minds, these questions were raised: (a) Was the treatment defended, not because it was considered ethical, but because the staff was unable to amend the administration's counteraction? (b) What should be done when an ethical standard is violated? When should the offending hand be cut off and when should it be re-educated? What criteria should be used for such a decision and who should make the decision?

Editor's Note: The preceding article is in keeping with this journal's policy to encourage systematic exploration of issues that often are considered controversial. In continuing this policy, the video vignettes will be made available to any institution that wishes to replicate the study and provide comparative data.

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THE SOCIAL DYNAMICS OF THERAPEUTIC RECREATION*

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With the rise of the social therapies, the central authority figure who prescribes by fiat is rapidly giving way to a psychiatric team that includes various types of communication specialists. For example, the occupational therapist has skills in nonverbal tasks geared to express feelings through form, color, and texture. The music therapist, an expert in rhythm, sound, and movement, directs expression through music, dance, and song. The nurse sustains the social culture through daily living experiences. The psychodramatist creates an existential life scene under colored lights with speech, pantomime, music, and dance. The recreational therapist encourages communication through games, sports, parties, picnics, and other group projects geared toward social growth and development.

In recent years recreational therapy has been developing an autonomous role. It has, within a sociological framework, become an eclectic therapeutic process that focuses heavily on group processes, sociometry, role theory, and symbolic communication for both the verbally affluent upper and middle classes and the less verbal lower classes. Action-oriented therapy is perhaps most important for the last-named group, as the writings of Hollingshead and Redlich (2), Riessman and Goldfarb (4), and Swanson and Miller (5) indicate.

In order to clarify the function of recreational therapy at the Fort Logan Mental Health Center, we experimented with several techniques to integrate traditional treatment approaches into the dynamically oriented therapeutic-community milieu. One method we selected is a combination

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of psychodrama and recreation, using a modification of the psychodramatic "sharing process" developed by Moreno (3). All types of staff members take part with the patients in the activity. It begins with a pre-game "warm-up" in which the participants discuss the group's mood and decide which recreation activity would be most appropriate; then each member selects the role he will take during the game, whether in an aggressive forward position, in a backup spot, or on the sidelines as a rooter. When the game is over, players and spectators discuss their feelings and observations about how the whole group and the individuals behaved in the game and about the actions that took place.

Games and competitive sports lend themselves to a psychodrama approach because they parallel many aspects of the society from which the patients come and to which they will return. It is through group play that a child takes unto himself all the attitudes of the others involved in the game. Through internalizing those attitudes, he defines limits and freedoms. He synthesizes for himself the values of everyone else with whom he is playing, and that creates in him a consciousness of his own self as well as of others. The child plays many roles while interacting with his peers, and at the same time he becomes aware of the roles of the others and learns unconsciously what to expect of them and what they expect of him. As Goffman (1) says, "Games . . . are world-building activities."

Adults as well as children engage in recreation to develop and sustain their emotional and social balance and their interpersonal relations. In recreational therapy the activity can be conceived of as a miniature model of the patient's community life. Responses to the stresses, responsibilities, and expectations observed during a recreational activity, such as volleyball, softball, charades, or social dancing, often reflect reactions to family, work, or community. For example, a patient who has difficulty with impulse control and tends to test limits and authority figures will often test the rules and officials during a recreational activity. (See Table 1.)

Making use of the parallels between recreational therapy and society requires therapy staff members to engage in the activity along with the patients and to disclose their own needs as they exist at a given time in a given place. Some therapists are encumbered by the need to intellectualize and offer erudite interpretations about their interactions

TABLE 1
PARALLEL ASPECTS OF RECREATIONAL THERAPY AND SOCIETY

Recreational Therapy	Society
Rules of the game (acceptable and unacceptable behavior)	Norms, folkways, mores, and laws (freedoms and restrictions)
Penalties inherent in games	Social sanctions (jail, fines, social isolation)
Activity leaders (team captain, staff members, patient leaders)	Authority figures (minister, teacher, parent, supervisor)
Umpire and officials	Police
Game competition	Societal ideology of competition (e.g., capitalism)
Teamwork and appropriate relationships	Cooperation with peers, co-workers, reference group
Team position and responsibilities	Role expectation and role function
Team goals	Institutional goals

with patients, and thus remain safely aloof from them. I do not mean to negate the positive values of interpretation; however, we should remain aware that our interpretations result from our own past experiences. To offer interpretations dogmatically is to delude oneself. It is easier to understand the patient if we confine our responses to the action that takes place during an activity.

Recreational therapy is an instrument for diagnosis as well as for social therapy. Szasz (6) says the layman defines mental health as "the

ability to play whatever the game of social living might consist of and to play it well. Conversely, to refuse to play, or to play badly, means that the person is mentally ill." One should be cautious about labeling a person as mentally ill. Whenever we observe someone's deviant behavior, we should ask, "Does this reflect mental illness, or do I think he is mentally ill because of my attitudes toward his deviance?" It is a delicate endeavor to develop a model for analyzing pathological actions, because there are many explanations for unusual behavior. We can, however, observe repetitive patterns that can be clinically perceived in a therapeutic framework as consistent with defined mental illness.

A volleyball game offers examples of how actions that take place in a game can be used as a yardstick for gauging deviant behavior. In the game, player A serves the ball over the net on his first try, but fails in subsequent serves. If the faltering second serve is met by group reproach, player A may be seen not only as trying to change his role by hastening the rotation of servers but also as inviting the group to focus on him, even though with anger and discomfort. Had he helped to gain the point, he might have reaped the group's approval, but also their expectations of further success and increased pressures for independent action. We must observe how the player responds to success or failure: is his response congruous with or in opposition to the responses of the other players?

Also noticeable is player B's behavior. He is in the center of the front row, a position in which he is most vulnerable to failure. It is the pivot around which the other players operate and the key spot for getting the ball over the net. Player B's successes and failures are apparent to both teams. On occasion he drifts backward into the second row; at other times he consistently hits the ball into the net instead of spiking it successfully at the opposing team. His psychomotor coordination seems poor and, in contrast to when he had other positions in the game, he seems to suffer much discomfort.

As with player A, we can describe the apparent dynamics of player B's behavior by looking at it in terms of the individual, the activity, and the group. His drifting backward is by definition a retrogressive movement: he retreats from a very active area to one that is less demanding, thus abandoning the aggressive position he is committed to take by the rules of the game. His hitting the ball into the net, like player A's unsuccessful serve, acts to halt the play, hasten rotation, lose the point

or the possession of the ball, and hence lessen the group's expectations of him.

Player C, at the right side of the front row, tends to drift outside the court boundaries. In fact he has difficulty paying attention to the game no matter where he is located. He daydreams, talks to spectators, and shows little involvement in the game. When he moves out of the court, he withdraws literally from the game and figuratively from the microcosmic interaction it represents.

Although I have cited only a few examples, a game such as volleyball affords many observations pertinent to diagnostic criteria and social therapy approaches. It also offers a vantage point from which we can draw significant analogies to the legal sanctions of the social order. The interactions among patients during a volleyball game are located on a court. Dictionary definitions of the word "court" shed light on the multiplicity of its applications to this discussion. For example, the noun "court" signifies a place where justice is meted out and judgments are made; a sovereign and his retinue; and a quadrangle where games are played. The verb "court" means to woo, to seek something, whether favor or disapproval.

From these descriptions emerge the revelant actors: the judges, the rulers, the competitors, the wooers. On the volleyball court the wooers are the players, both the patients and their staff teammates; the rulers are the team leaders and officials of the game; the competitors are the two opposing teams; and both teammates and officials (peers and leaders) act as judges.

In the game, as in life, social order is preserved by rules that define the freedoms and the prohibitions and provide for penalties that theoretically are applicable to everyone. The roles that the player-members take are also susceptible to the less formal sanctions of peers. Deleterious behavior during a game may be censured by fellow patients so that the transgressor either conforms or provokes rejection. The volleyball court has physically delineated boundaries. To step beyond those limits, or their social counterparts, during a game results in redress by correction or assistance from teammates or the umpire-judge. The rule book itself, the final authority, usually is in the possession of the umpire.

To analyze the game's transactions, we focus on the group, the ongoing activity, and the individual. This triad has sociolegal counterparts

in the society, the formal and informal systems of social interaction, and the member, and we can see certain similarities between society's system of law and order and therapy's system of law and order. The manner in which a patient responds to the social system in the therapeutic milieu may, in fact, predict how he will respond in the greater society to which he may return.

We apply such sociological observations about how patients and staff interact during recreational therapy in our program at Fort Logan. As mentioned earlier, when we use the sharing technique developed in psychodrama, we follow the game with a discussion. Under the guidance of the recreational therapist, all patients and staff members who have taken part in the game, whether as players or spectators, discuss their feelings and observations about what has taken place in the game. Following are some examples of the material that is discussed:

Role mobility. "How did you feel when you were serving the ball as opposed to getting the ball up to the front line?" "Was it as comfortable in the first row as in the back?"

Reference group. "Were you comfortable with the team that chose you?" "Did you enjoy sitting with the spectators?"

Grief-success. "What feelings were generated by losing the game? Did this feeling seem familiar to you?" "How did it feel to defeat the the other team?"

Sociometric placement. "Were you comfortable playing next to Mrs. White (or Dr. Adams or Mr. Jones)?" "Did you feel you had enough people on your team?"

Limits-authority. "How did you feel when you were reminded to play your own position rather than moving all over the assigned area?"

Stress tolerance. "I noticed whenever Mr. Jones threw the ball to you, you moved out of bounds. You seem to leave your position whenever someone expects you to assume responsibility. Can you share your feelings with us?"

Group involvement. "You seemed to stay by yourself and remain quiet. Is there anything we can do to help you feel more a part of the team?"

Through the discussions, patients learn what in particular or in general recreational therapy contributes to their treatment. Often a patient expresses resistance to becoming involved in an activity that is

pleasurable and seems remote from the problem-centered discussions he experiences in group psychotherapy. He feels that recreation is a waste of treatment time and energies: "Why, I've got my neighbors sitting with my kids, and you expect me to come out here and play games!" The post-game sessions become progress discussions, feeding back the nature of improvements in behavior and other forms of changes that require exploration. Very often discussions originating here are continued in other areas of the treatment program where the issues can be explored more deeply.

One side effect is the value of the discussions for teaching new staff what therapeutic roles they should play during the recreational therapy activity. The usefulness of the recreational therapy program is contingent on the skillfulness of the treatment team, the nurses, social workers, psychiatrists, psychologists, psychiatric technicians, and occupational, vocational, and recreational therapists. All team members participate in the many therapies that are available. The postgame discussions afford a purview of the over-all group process plus a comparison for the other areas where group sociometry is applied. All in all, we have found that recreational therapy, through its spontaneity, existentialism, and interpersonal exposure, is useful in a therapeutic community.

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CONJOINT FAMILY THERAPY WITH GERIATRIC PATIENTS*

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Although current literature abounds in material supporting the use of conjoint family therapy, there are few reports of its application to the treatment of geriatric patients. In a survey of the psychiatric literature on aging, Moss (6) found several statements to the effect that "work with the family was important," but work goals were not defined nor were there any indications that conjoint family therapy was used. Post (7) briefly discussed some family unit treatment with geriatric patients. In describing the psychiatric social workers' therapeutic contribution, he stated that casework focused mainly on daughter or son and patient separately, but that sessions that involved patient, child (usually a daughter), psychiatrist, and social worker showed positive results in nine of 32 cases.

This paper describes the conjoint family therapy program used by the staff of one of the treatment teams in the Geriatric Division at the Fort Logan Mental Health Center. The terms "conjoint family therapy," and "family unit treatment" are used here interchangeably. They both reflect the idea that family members are seen together in varied combinations and that their basic tie is a familial one aimed toward joint action. The philosophical base of our approach was drawn from current findings in the fields of human behavior, the social sciences, and gerontology, and from our own experience in working with geriatric patients.

The treatment plan emphasized ego-support and the communication

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theory and techniques described and demonstrated by Satir (8,9). In developing treatment techniques, we explored Blenkner's (2) "filial maturity" formulation of assisting the child to complete his emancipation from his parents, thus freeing him to help them more effectively.

Goals of Family Unit Treatment

We think of aging in terms of developmental tasks, adaptive capacities, mastery and growth within the framework of the individual life cycle, individual development, and the interrelatedness of their various stages (4,10,11). Many of the major stresses of older people are related to certain basic anchorages that all people share throughout life. Cath (3) identifies these as (a) an intact body and body image, (b) an acceptable home, (c) a socioeconomic anchorage, and (d) a meaningful identity and purpose in life. For many older people these anchorages are loosened or torn away through loss of social and economic status; diminishing physical stamina and, often, severe illness or disability; physical, financial, or emotional dependence on others; or the necessity of leaving their own homes to accept care in an alien environment (5).

Often the family can be seen as not only the matrix of an individual's suffering and conflicts, but also the medium through which his stress can be relieved in a major way. The symptoms of the identified patient, viewed within the total family interaction, imply a relationship between the patient's illness and the status of the family. The family's potential health as a group and its capacity and motivation to work together must be primary considerations in the use of family unit treatment.

Ackermann (1) stated, "A central goal of the family approach is to find the locus of the most destructive conflict and fear, to reduce this within the matrix of interpersonal relationships, and heighten the level of complementation of interpersonal needs." This was our goal also in working with older persons in conjoint family therapy. We tried first to ascertain the strengths, weaknesses, and unmet needs in the family system and then to assist the family members in understanding each other's developmental tasks and stresses and in strengthening their coping abilities.

Treatment Techniques

In exploring ways to involve families of patients in treatment, the staff initiated a spouse group of several couples, but these families seemed unable to benefit from the experience. It took several sessions for the group to understand the purpose of the meetings; further, they wanted to talk about trivia rather than interpersonal relationships, and they became uncomfortable when conflicts were brought into the open. Their cultural orientation tended to be, "We don't wash dirty linen in public." We observed much the same attitude toward group therapy composed only of patients.

To help patients and their spouses use the group process in greater depth, the therapists began seeing each couple individually as a supplement to the spouse group. Through a progression of several stages, we concluded that conjoint family therapy, involving as much of the extended family as possible, might assist the geriatric patients and their families to achieve not only greater depth, but also greater carry-over into their living situations.

One or two hour-long therapy sessions per week over a period of three weeks to seven months constituted the usual schedule. A senior therapist (social worker, head nurse, physician, or psychologist) and one co-therapist (a psychiatric nurse or psychiatric technician) conducted the sessions. In our treatment unit, a specific nurse or technician was assigned to each patient. This staff member had more frequent contact with the patient than anyone else and was always involved in the family unit if this treatment modality was selected for the patient. His special knowledge of how the patient involved himself in daily living experiences at the hospital provided continuity between family unit therapy and individual treatment. We saw family unit treatment as problem and relationship oriented and not technique oriented, so techniques varied considerably in each family unit.

We involved the extended family as much as possible because we believed that working with as large a portion of the family system as possible would provide the maximum benefit for both the individual and his family. We believed also that family assistance in the psychosocial-economic situation tended to reduce or eliminate the anxiety, isolation, and loneliness of the older person.

Role-playing and psychodramatic techniques were especially helpful in making ideas, conflicts, and decision-making patterns more reality focused, in making "dry runs" of old and new situations facing the family, and in bringing feelings into the open. Within the "we don't talk about feelings" culture of many of our geriatrics patients, some found it easier to act out their feelings than to talk about them.

We found that the use of touch, especially with those who have difficulty seeing and hearing, was a meaningful method of communicating warmth and concern. Family members were encouraged to express themselves in this way also.

Other methods, such as reality-testing, descriptive discussion, ventilation, reflection on the present situation, alternative patterns of behavior, environmental manipulation, and sustaining and nurturing procedures, were used in accordance with the problem and the capacities of the family. At times the presence of chronic brain syndrome in one or more family members called for certain modifications, such as more concreteness, making allowances for a shortened attention span, or limit-setting.

One example of family unit therapy for patient and spouse involved Mrs. L., the 72-year-old identified patient, and her 69-year-old husband of ten years:

> Mrs. L. was a former public school teacher, later worked as fund-raiser for a college, and then managed an apartment building until her retirement ten years ago. She was an intelligent woman with an outgoing, sometimes overbearing, personality. She dominated her husband, who passively waited upon her every demand. She had been subject to periodic psychotic breaks since her retirement and had severe difficulty adjusting to living on a retirement income, worrying excessively about money. Although she had always had many friends, she now tended to be asocial, isolating herself in her home. Without the structure and motivation of her job, she felt lost. She never learned to enjoy housework or leisure activities.
>
> Mr. L. was a quiet, easy-going man. He worked six hours a day. His religion meant much to him, and he attended church regularly. He submitted to Mrs. L.'s demands at home to avoid arguments and met many of his emotional needs at work. While Mrs. L. insisted that her husband look after her, he seemed to enjoy having someone dependent on him.
>
> Mrs. L. was admitted to the hospital on 24-hour care as

a result of a psychotic condition. Family unit therapy was started within a week because there seemed to be a definite relationship between the patient's symptoms and the marital interaction. Previous treatment had been limited to electroshock therapy and spouse group. Treatment sessions were held for an hour twice a week, with a social worker and a psychiatric technician as co-therapists. Using role-playing and other psychodramatic techniques, descriptive discussion, and reality-testing, the patient and her spouse were able to look at some of their patterns of behavior, especially their decision-making, their interpersonal relationships, and interdependency needs. The genuine warmth in their relationship and the complementarity of their personalities were emphasized.

Gradually, Mr. L. became more confident and skilled in setting and maintaining limits on his wife's behavior. This raised his level of self-esteem and gave her the security of knowing that he would set limits on inappropriate behavior, not allowing her to embarrass herself. Mr. L. was able to handle the family finances effectively, whereas Mrs. L. had been prone to having spending sprees and then becoming depressed about paying the bills.

After 24-hour care for two months, Mrs. L. was placed on day care for two weeks and then was transferred to outpatient care. We continued family unit treatment for another two weeks (a total of three months). She then attended an outpatient group meeting in the community twice a month and was an active, appropriate member. She was encouraged to find some stimulating and challenging interests. On her own initiative she began boarding her husband's granddaughter, who was attending college. This gave her an incentive she had not found since her retirement.

This couple gained some insight and were able to alter their patterns of behavior to better meet their mutual dependency needs, although their basic personalities remained the same.

We found it necessary, often, to help the family look at, accept, or adjust to, the need for a different type of living situation for the geriatric patient. Sometimes it was a need felt by the identified patient alone, sometimes of the patient and his spouse, or a need first felt by the family when the presence of the identified patient was a disruptive factor. A family that appeared to need a change of living situation involved an 83-year-old matriarchal widow, five children and their spouses:

Mrs. R. came to the hospital for short-term, 24-hour care, primarily because her children, especially the child with whom she was living, could no longer accept her with-

drawn, passive-aggressive behavior. Family unit therapy was started immediately on a biweekly basis, with as many of the family members as possible attending each session. As many as nine persons at one time attended. The therapists were a social worker, a psychologist, and a psychiatric technician.

The goals of treatment were focused upon improving interpersonal relationships and behavioral reactions by helping each family member (a) to express his conflicts and frustrations with the others, (b) to look at how each one's behavior affected the others, (c) to work toward some modification of the most destructive behavior, (d) to use alternatives in responding to behavior that the patient could not modify, and (e) to encourage the family to consider nursing home placement for their mother if the other goals could not be attained.

Family unit therapy was conducted on an intensive basis for three weeks. The family unanimously reached a decision for the mother to return to the home of the son with whom she had lived because he and his wife had been able to achieve the earlier goals to a limited degree. The mother's going to a nursing home was accepted as a possibility for the future but was discarded for the present because each child felt he could do more to help his mother's life to be more meaningful. The culture of the family that "we look after our own" and the mother's rigid and domineering personality influenced this decision.

SUMMARY

This paper describes the use of conjoint family therapy as a treatment for geriatric patients. The techniques employed in the family approach are outlined and illustrated with case examples. The staff found that the use of conjoint therapy seemed to lessen the need for a continuing relationship with the Center after the initial crisis had been resolved. Also, the percentage of geriatric patients returned to their own homes or to their families was greater than for patients who did not receive family unit treatment.

The treatment sessions provided training opportunities for staff persons acting as co-therapists. However, the staff felt that much more study is needed to clarify goals and refine treatment methods.

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VOCATIONAL REHABILITATION GOALS AND PROCEDURES

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The Vocational Services Department of Fort Logan Mental Health Center was developed in the belief that work activity is an integral part of each patient's life and, therefore, ought to be an integral part of his treatment. All facets of its program are designed to help the patient establish or reestablish himself vocationally and prepare for productive activity after discharge. Each member of the department's counseling staff is also a member of the psychiatric treatment team to which his clients are assigned, and rehabilitation services are immediately and continuously available to each patient as part of his total treatment regime. Since its inception in 1963, the department has provided services to approximately 80 percent of the patients admitted to the Adult Psychiatry and Alcoholism Divisions.

The goals of the rehabilitation program are: (a) to enable the client to become employable in an occupation that is within his capacity and that will provide him reasonable satisfaction; and (b) to help him maintain that employment. To achieve these goals, we must engage the individual in activities that will promote his *recognition, acceptance, development,* and *utilization* of his vocational potential.

The program comprises five phases: assessment, remedial procedures, vocational planning, job placement, and follow-up. These steps are basically sequent, but not always separate.

The goals and phases of the program can be translated into a conceptual model that provides perspective to the total rehabilitation process and assists rehabilitation personnel in formulating ways to help the client understand the process in which he is engaged. The Industrial Relations Center at the University of Minnesota (2) has developed an applicable Model of Work Adjustment based upon the compatibility of *vocational*

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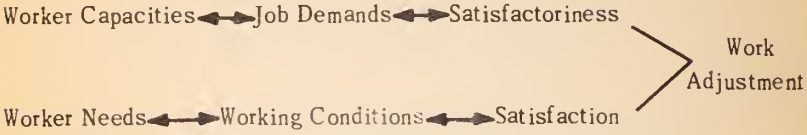
Journal of the Fort Logan Mental Health Center, Vol. 5, pp. 37-42.

capacities and *personal needs* with *job demands* and *working conditions:*



The model assumes that: (a) if vocational capacities are compatible with the demands of the job, work will be performed satisfactorily, (b) if working conditions meet personal needs, the worker will be satisfied, and (c) if the work is satisfactory and the worker satisfied, work adjustment has been achieved.

Within the framework of this work adjustment model, worker capacities and worker needs can be determined in the assessment and remedial phases of the program; job demands and working conditions are coordinated in the vocational planning and job placement phases; and satisfactoriness and satisfaction, in a sense functions of time, are fostered and evaluated through follow-up.

WORKER CAPACITIES AND WORKER NEEDS

Assessment

In this initial phase of the program, three areas of vocational capacity are considered: (a) the individual's job skills, i.e., his ability to perform a given job or jobs, (b) the individual's repertoire of "worker characteristics," and (c) his cognizance of, and reaction to, co-worker and authority relationships.

Job skills. Usually an individual's job skills are evaluated by standard procedures such as psychometric testing; reviewing education, work history, and avocational pursuits; and sampling task performance. For the psychiatric patient, however, this may not be sufficient. It is not unusual for the psychiatric patient to have adequate work ability, but it may be a delicate, difficult task to identify his usable skills. Many patients find work situations so threatening that they cannot fully mobilize their capacities; their skills sometimes are revealed only through job trials in actual work settings.

Worker characteristics. Work habits, grooming, maintenance of production, quality of job performance, decision-making ability, and stress tolerance are especially important to the psychiatric patient. He may never have learned what is normally expected of an employee, or he may have acquired inappropriate attitudes. The vocational counseling services and job-seeking training help to acquaint the patient with realistic work standards.

Interpersonal relationships. Inability to meet the social demands of a job is often a major factor in vocational failure (1,3,4). Many patients are insensitive to, or unable to respond to, the norms of co-workers; moreover, they are often unable to relate flexibly and appropriately to supervisors. The counselor's day-to-day observations of the patient's behavior on the treatment unit and in the workshop identify strengths as well as limitations in the individual's reactions to co-workers and authority figures.

Vocational aspirations and job expectancy usually include personal interests that satisfy the individual's desire for security, status, or structure and purpose in his life. There may also be a need to express basic impulses (e.g., aggression). The vocational counselor must obtain sufficient background information to ascertain *from the client's point of view* the client's basic needs in order of importance. Clues to these needs may be found in observations recorded by the treatment team in the psychiatric history, in the results of special tests, and in the response to personal interviews.

Remedial Procedures

The rehabilitation process initially focuses upon determining the client's vocational assets and finding ways to enhance those assets. If deficiencies or discrepancies are evident, various remedial measures are used to modify or eliminate them.

If the individual is deficient in job skills but has adequate worker characteristics and work relationships, he is given vocational training in a regular training institution or a sheltered training environment. More often our clients need help with grooming, work habits, and co-worker and supervisory relationships. In these cases, work adjustment training in the Work Therapy unit at Fort Logan or in one of the community workshops, a

therapeutic work experience, and concurrent individual or group counseling have been helpful. These techniques are used also to modify inappropriate and unrealistic job needs. When work that is compatible with the individual's capacities and tolerance does not meet all of the needs he hopes to satisfy, avocational pursuits are encouraged.

The relationship of work habits and attitudes to the fulfillment of personal needs often requires considerable discussion and "working through." Sheltered or part-time employment or volunteer work makes it possible to continue therapy during the transitional period.

JOB DEMANDS AND WORKING CONDITIONS

Vocational Planning

When the boundaries of the client's capacities and needs have been established, he is encouraged to explore sources of occupational information, to visit job locations, and perhaps, to engage in work trials either at Fort Logan or in a community agency.

Essentially vocational planning clarifies the relationship of *capacities* and *needs* to *job demands* and *working conditions*. Individual and group counseling on these factors and their interrelationships can be an effective tool. With some intransigent patients vocational planning is focused upon work situations that tolerate, or perhaps even capitalize upon, eccentric behavior.

Job Placement

The Placement Program provides information about local job availability and often appraises the demands of a particular job. When necessary, the rehabilitation counselor visits prospective job sites for more detailed assessment. An emotionally restored person often needs placement that is tailored to his needs and capacities. Therefore, it is incumbent upon rehabilitation personnel to furnish the placement officer a clear picture of the client as a prospective employee in one or more possible placements. In turn, the placement officer explains the specific requirements of a given job and particular circumstances that might affect

the client. It is essential to help the patient find work that is both satisfactory and satisfying and to avoid the temptation to "match" him with available jobs. Liaison between rehabilitation personnel and the placement officer must be strong since many of the problem areas are identified only through discussion and careful review of the job possibilities.

As he makes the transition to work, the client often needs extra therapeutic support to resolve his fears of returning to work. And he may need further assistance with job interviewing and application procedures, dress, employer expectations, and company rules. Individual counseling, vocational groups, the Patient Employment Committee, and the Job-Seeking Training program are resources for coping with these sorts of problems.

SATISFACTORINESS AND SATISFACTION

Follow-up

Follow-up is perhaps the most critical, but frequently the weakest, point in the continuum of vocational rehabilitation. Ideally, the counselor and his client maintain enough communication to allow periodic evaluation of the client's employment situation. This is the testing ground for the congruence between capacities and job demands and between needs and working conditions.

The counselor must be sensitive to incipient problems before they become crises. He must determine when it is necessary to intercede and when it is constructive for the client to work out his problems independently. During the follow-up phase, rehabilitation efforts are directed toward reinforcing the traits that maintain the client's job functioning and increasing his awareness and use of resources that can alleviate disrupting elements in his work environment.

Personal problems that interfere with the client's performance of his job may call for the counselor's assistance in developing social contacts, talking with the family, or changing living arrangements. If job-centered difficulties occur, the counselor may be able to assist by supporting the client's efforts on the job, discussing with his employer the client's progress as well as his problems, and suggesting possible modifications of the working environment.

If a client's behavior becomes seriously disruptive and a work crisis develops, more intensive intercession is initiated. The counselor may employ crisis intervention techniques: helping the client face and accept the reality of the situation, supporting him in expressing negative feelings; pointing out avenues for constructive effort; opening channels of communication with other helping figures; and encouraging the client to accept help.

Should it be necessary for the client to return to the hospital, the counselor tries to help him see this as a temporary setback to ultimate long-term gains, rather than as a failure experience.

SUMMARY

A work adjustment model has been used to bring into perspective the successive phases within the total process of vocational rehabilitation. To achieve the goal of effective work adjustment for each client, the rehabilitation program must be an integral concurrent part of the over-all treatment program. The coordinated process integrates the patient's therapeutic experience and gives him a sense of direction and purpose in his efforts.

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THE USE OF VIDEOTAPE TO TRAIN PATIENTS FOR JOB INTERVIEWS*

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The employment interview is a stressful event even for those who have escaped the ravages of emotional illness. The applicant encounters varying levels of threat to which he must respond within socially acceptable modes, using content which conveys job competence and personal skill to the interviewer. Indeed, it is a test of the applicant's interpersonal skills, stress tolerance, flexibility, and adaptability at a level at which many clients fail (1).

The program described here attempted to deal with the issue of training the emotionally disturbed to cope minimally with predictable job interview situations and demands. It was designed to be realistic about what is usually encountered, based on the assumption that unless the client can accommodate to the job interview the question of job stability is irrelevant. The organization and execution of the program is presented in the hope that Fort Logan Mental Health Center will develop ways to test the appropriateness and effectiveness of the program both within the center and in the community. Such a test would provide treatment personnel with a partial answer to the question: Does a program of enhancing job-getting capacity assist, in yet another way, that client who requires job stability as a concomitant to emotional stability?

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One might expect that hospital treatment programs which emphasize social activity and verbalness would teach patients social and interpersonal skills; however, research suggests that such programs may not

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equip patients with realistic "coping" behaviors (3). The learned in-hospital behaviors do not necessarily transfer to the community; there is not a one-to-one correlation between the two environments (2, 7, 9). Patients must be taught to deal with post-hospital situations by learning new behavioral responses to the "real world." One specific situation for which patients must be trained is the employment interview, the most difficult hurdle in vocational rehabilitation. In an effort to meet this need, the Mental Health and Manpower Project staff at Fort Logan Mental Health Center developed a specialized, directive training program utilizing closed circuit television as a training tool.

The use of television as a behavior modification technique has special relevance for the mental patient (5). The etiology of mental illness includes conditions which generate intrapersonal conflicts and prevent the development of good personal relations. Most especially, a patient's failure to understand his interpersonal behavior as others respond to it counts heavily in his continuing inability to profit from experience or expand his behavior repertory.

The value of videotape as a training tool and a therapeutic aid has been demonstrated in many in-hospital situations. Walz and Johnson (8) reported that counselor trainees, after seeing themselves in counseling via videotape, showed greater confidence in the interview situation and found their self-perceptions more in keeping with their supervisors' ratings. Other research has shown videotape to be effective in modifying patients' behavior (5, 6); however, little has been done to utilize it as an aid to their post-hospital adjustment. In the training program undertaken by the Project, television assessment of employment interview situations was found to be the most influential factor in helping patients to alter ineffective or undesirable job-seeking techniques.

THE TRAINING PROGRAM

The program sought first to instruct the trainee in the practical aspects of a successful interview, e.g., the accurate preparation of application forms, appropriate dress, acceptable behavior. In addition, attention was focused on reinforcing the patient's self-confidence and self-esteem, reducing his anxiety about job interviews, and maintaining a realistic vocational attitude.

The training staff consisted of instructors from the Fort Logan Placement Department. Interviews were conducted by potential employers from private industry and by Colorado Department of Employment personnel. Each interviewer also assisted in evaluating the videotape replays of the interviews he conducted.

Selection of Trainees

Patients chosen for the program were either currently in treatment or on outpatient status at Fort Logan and had been, at some time, referred to the Center's Placement Department. Psychiatric diagnosis was not considered in selecting trainees, but patients had to have received vocational counseling before entering the program and had to have a particular job in view before they began training. Selections were made by Placement personnel under one or more of these criteria:

1. The patient was ready or nearly ready for employment.
2. He had demonstrated unfit interview techniques.
3. He had not had a job interview for six months.
4. He had not worked during the preceding twelve months.

Two or four trainees participated in each training period. Patients were paired and remained partners throughout the course. It was found that each could better solve his own problems when he had observed and discussed the difficulties encountered by his partner.

Procedure

The course was divided into two four-hour sessions. The first four hours were devoted to pre-interview instruction. Before actual instruction began, the patients were given a complete explanation of the purpose of the training and the procedures to be used. It was emphasized that the patient was engaging not in a therapy session but rather in a training program geared to his individual needs. While some of the points covered in the program might seem more than obvious, experience showed that many patients were quite naive about basic tactics for a successful interview.

At the beginning of the session, each patient filled out a sample application which was used throughout the first four hours. The application

served as a baseline from which the instructor determined the patient's essential training needs. Three general areas were considered:

1. *Appearance and behavior.* The importance of appropriate dress and good grooming was stressed, and each patient was given suggestions about suitable appearance for the particular job for which he was applying. Role-playing involving the patient-partners and the instructor provided each an opportunity to think from the employer's standpoint as well as from the interviewee's; during each episode the third member observed and criticized the portrayals. The correct behavior of both the instructor and the patient were used as positive examples. Negative examples were limited to distracting mannerisms, of which the patient might be unaware but which might cost him the job. Problems such as lack of eye contact with the interviewer or nervous gestures were easily observable in videotape reviews of the test interview and could be corrected more readily when the patient had an opportunity to view his own conduct.

2. *The patient's assets.* Patients often tend to overlook or minimize their positive qualifications. During the training period, the instructor helped each patient to assess his best points and suggested ways to present them most effectively. The patient was taught how to convey his willingness to work and how to relate information about his education, training, and past work history. Basic, but difficult, questions such as "Why do you wish to work for us?" were studied, and sample replies were prepared and discussed.

3. *The patient's deficits.* Because patients frequently fear the negative impact of reporting emotional illnesses, special attention was given to teaching each trainee to present accurate information without dwelling upon his illness. He was encouraged to emphasize his improvement and his eagerness to work. If his work history was detrimental, he was taught to give a factual account of it, but in the best light possible.

At the end of the first four-hour session, each patient was given a developed newspaper advertisement. The "help wanted" ad specified requirements set just above his ability; if he could type fifty words per minute, the requirement was set at sixty, so that the patient would have to "sell" the last ten words. The patient was then given his interview appointment time and place, the name of his interviewer, and a fresh application blank to complete and bring to the interview.

The Videotaped Interview

During the second four hours, the trainee was given two interviews, both videotaped, but each with a different interviewer. The interviewer was informed of the job the patient was seeking and was asked to conduct the interview realistically, but he had no advance knowledge of the patient other than the information contained in the patient's application.

In order to minimize the possibility of fantasies about the camera (9), the television equipment was set up in the interview room, but it was kept in a fixed position to reduce distraction to the occupants. The interview was conducted with only the patient, the interviewer, and the cameraman in the room, with the camera focused on both the patient and the interviewer. Any camera subject tends to feel apprehensive if others are present but he is the only person being photographed (10).

Interviews were limited to ten to fifteen minutes because learning seems to be hindered by lengthier videotapes (4). In another room, the instructor and the patient's training partner observed the interview through a one-way glass and then joined the patient and the interviewer to replay the tape. Because learning studies have indicated that active participation in the learning process facilitates retention of transfer, particularly when coupled with immediate feedback of performance, it was considered essential to view the tapes immediately (11). When mistakes were found, the tape was stopped for instruction and role-playing, but the tape also was stopped at moments when positive reinforcement could be given. It is important for patients to understand what they did well and why; positive comments about a job well done seemed to increase confidence, promote self-esteem, and foster a feeling of pride.

RESULTS

Of the 36 patients who completed the program, 27 (75%) obtained jobs. A few of these went back to former jobs, several moved up to better jobs than they had ever held, and some patients who had been judged "hard-core and unemployable" by the Placement Department found jobs after the interview training. Almost all obtained the specific jobs they were seeking at the beginning of the training period. Interviewing employers

were impressed by the behavior of the patients during interviews, and a few patients received spontaneous job offers from their interviewers.

The program provided from six to eight hours of instruction for each trainee, but it is felt that more time would be desirable. Patients could benefit from a greater number of interviews and a greater variety of interviewers. Additional tapes could be used as visual aids in the preliminary training sessions, and more sophisticated taping apparatus could increase the impact of the program.

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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.