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SOCIALIZATION OF THE YOUNGER PSYCHIATRIC PATIENT--THE COMMUNITY AND THE HOSPITAL-A DUAL RESPONSIBILITY.

BY- GIORDANO, JOSEPH AND OTHERS
AMERICAN ORTHOPSYCHIATRIC ASSN., NEW YORK, N.Y.

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TO ASSIST YOUNG, MENTAL PATIENTS IN OVERCOMING SOME OF THEIR SOCIAL DEFICITS, TWO RESOCIALIZATION PROJECTS (PRE- AND POST-DISCHARGE) WERE INITIATED TO MOVE THE PATIENT FROM A MENTAL HOSPITAL SETTING INTO THE LARGER COMMUNITY, WITH A COMMUNITY CENTER AS THE LEARNING GROUND. CAREFULLY SELECTED PATIENTS FROM THE HOSPITAL WERE GIVEN THE OPPORTUNITY TO WORK AS VOLUNTEER ASSISTANT LEADERS IN "Y" COMMUNITY CENTER PROGRAMS. ASSIGNMENTS WERE DETERMINED BY THE PATIENT'S PSYCHOLOGICAL NEEDS AND INTERESTS, THE HOSPITAL'S TREATMENT PLAN, AND THE NEEDS OF THE CENTER. PHASE ONE PREPARED PATIENTS FOR DISCHARGE THROUGH PARTICIPATION IN A CORE GROUP. AFTER DISCHARGE, THE PATIENTS REMAINED IN THE CORE GROUP WHILE PARTICIPATING IN NON-PATIENT ACTIVITY GROUPS WITHIN THE CENTER. THE FINAL PHASE INVOLVED LEAVING THE CORE GROUP TO PARTICIPATE AUTONOMOUSLY IN COMMUNITY CENTER ACTIVITIES. BECAUSE THE PATIENT'S FAMILY IS ALSO INVOLVED IN THE ADJUSTMENT STRUGGLE, THE NEED TO DEVELOP A PROGRAM INVOLVING THE FAMILY IS DISCUSSED BY THE AUTHORS. THESE TWO PROGRAMS PROVIDED PATIENTS WITH--(1) AN OPPORTUNITY TO LEARN SOCIAL SKILLS, AND (2) A CHALLENGING STIMULUS WHICH COUNTERACTED THE EFFECTS OF INSTITUTIONALIZATION. THE EFFECTIVENESS OF THE PROGRAM WAS A DIRECT RESULT OF COLLABORATION BETWEEN HOSPITAL AND COMMUNITY CENTER, AND CONTINUITY OF TREATMENT. THIS PAPER WAS PRESENTED AT THE 45TH ANNUAL MEETING OF THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION (CHICAGO, MARCH 21, 1968). (CG)

SOCIALIZATION OF THE YOUNGER PSYCHIATRIC PATIENT: The Community and the Hospital - A Dual Responsibility

by

Joseph Giordano, A.C.S.W.*

Abraham Lurie, Ph.D. **

Harold Ron, Ph.D. ***

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* Supervisor of Group Services, Hillside Hospital
** Director of Social Work, Hillside Hospital
*** Field Work Director, Hillside Hospital - Educational Alliance Project

The debilitating effects of mental illness—distortion of reality and the inability to communicate with other human beings—often leaves a mentally ill patient socially isolated. He can no longer enjoy himself, he has limited ability to use time purposefully and this vacuum leads to frustration and a destructive preoccupation with himself.

For the younger patient it is even more devastating. The 20th century emphasis on youth creates for the socially inadequate patient, societal pressures that do not permit him to lead an isolated life and the young patient very often does not have the life experience or ego strength to fall back upon to help him endure the pressures.

This paper will describe the development of two socialization programs to help these young patients overcome some of their social deficits. The programs were a collaborative effort of Hillside Hospital, The Educational Alliance Community Center and the Samuel Field YM - YWHA.

An individual enters a hospital because of his inability to function adequately in the community. His disintegration is most evident in vocational, educational and social roles. Through a structured program the ego damage can be reconstituted. This necessary structive and constancy is provided through Hillside Hospital's treatment focus on individual psychotherapy and social rehabilitation, within a milieu therapy program.

The patient who has had difficulty in problem-solving because of inner conflict and environmental stress is helped in a carefully controlled setting to work on possible alternate solutions.

This type of treatment approach provides for the establishment of social roles, responsibility and opportunities to learn and relearn appropriate behavior. The use of reality-oriented groups and activities is part of the preparation for community living and is started early in the individual's hospitalization.

Introducing opportunities for the individual to "test himself out" in the community, while still having the protection of the hospital, will better prepare the patient when he is discharged. However, the progress the patient has made while in the hospital can "crumble" shortly after discharge if after-care socialization resources, along with other after-care services such as individual therapy, are not adequate. It is with this recognition that Hillside Hospital developed a community resocialization program for pre and post discharge patients.

The impetus for the development of these programs included the need for:

1) Continuity of treatment.
2) Involvement of the patient's family in the socialization process.
3) Involvement of the patient and his family in the vocation-

al, educational and related resources in the larger community.

4) The development of closer understanding and collaboration between the hospital and the community at large.

5) Aiding community centers to experiment and develop similar programs for their own marginal populations.

THE HILLSIDE HOSPITAL - SAMUEL FIELD YM-YWHA PROJECT

Hillside Hospital and the Samuel Field 'Y' are located close to one another. Collaboration between the two institutions began five years ago through occasional social contact between adolescent groups.

It was then proposed that a few carefully selected patients from Hillside Hospital work as volunteer assistant leaders in the 'Y' community center program.

To use a patient as a community volunteer creates a role that can not be duplicated within the hospital. Inherent in being a volunteer is the concept of the "helper role."[1] The importance and status of being a volunteer gives the patient a new view of himself. It becomes an ego building device which supports the healthy aspects of the patient's personality. The non-hospital setting gives the patient a realistic experience and he shares the expectations of other 'Y' volunteers.

The patient-volunteer worked in all aspects of the 'Y's' program— nursery school, social clubs, special activities, day camp

and in the office. Assignments were determined by the patient's psychological needs, interests, the hospital's treatment plan and the needs of the center. All patients participated in a volunteer seminar given at the center, which was also attended by community volunteers.

The following is an example of the effect this program had on a particular patient:

> Miss A., a twenty-five year old teacher, entered the hospital because she could not function at her job. She denied her hospitalization, avoided activities, derided staff and the purpose of activities. However, she was outstanding at working with other patients, moderating folk dancing, group sings, etc.
>
> She was referred to the 'Y' to work as a group aide in their camp program. She refused. Slowly, and defiantly, she finally moved into the orientation program. At first she dressed inappropriately for meetings and held up the program to change her clothes. She was very concerned that people would discuss she was a mental patient. At her very first meeting at the campsite she wore high heels and feigned a sprained ankle.
>
> The 'Y' program leader approached her and pointed out the effect of her behavior. She immediately responded, "I'm a mental patient." She frequently used this response to avoid taking responsibility for her job. She resisted the program for weeks, but never missed her day at camp. Slowly she began to apply her skills as a leader and teacher. The camp leader acknowledged her abilities, but she shied from this recognition.
>
> A concentrated effort was made by both the 'Y' and hospital staff to help Miss A. to accept these skills as hers. She began to move to use herself more positively at the camp and dramatic changes took place when the head counselor, a supervisor in the school system, offered her a job after discharge from the hospital
>
> She left the hospital, was reinstated in the New York City school system, and now points to this experience as the turning point in her hospitalization.

In addition to the volunteer program, patients also participated in the regular center program, taking part in social groups, college courses and special interest groups. In this area little or no additional support or staff time was required from the center. The hospital, however, was active, through its liaison worker, in giving support to the patient, when needed.

> A nineteen year old female patient was very manipulative and resisted participation in hospital activities. She was interested in modern dance and was referred to the program offered at the 'Y'. Initially, here too, she resisted. She met reluctantly with the hospital social worker who introduced her to the 'Y' worker. She responded to this 'Y' worker and decided to use the dance program. When approached by the hospital social worker to discuss the program, she replied with indifference and a shrug of her shoulder.
>
> After nine weeks in the program she approached the hospital social worker asking him if he could get together five or six patients interested in forming an evening modern dance group at the 'Y'. He told her to initiate this on her own and to use the Hillside Herald (patient newspaper) to draw interested patients. She did this. Four patients responded and she formed her group. After leaving the hospital she joined her neighborhood community center.

Our experience, covering some five years, indicated:

1) This community experience for the patient introduced normative behavioral expectations into the period of hospitalization.

2) Patients achieved and, in many instances, surpassed the community center's requirements for volunteers. The patients were more involved because they not only had to demonstrate they could do a job, but also they had to prove

this to themselves.

3) The program afforded patients an opportunity to "test" themselves in a real situation. Even when the placement did not work out, it provided an experience which was ultimately helpful to the patient's individual therapy.

4) Resocialization is more effective for the hospitalized patient when it is community-oriented and begun during hospitalization.

5) The status attached to the role of the patient-volunteer role gave the patient additional motivation to seek out new experiences in and out of the hospital.

6) Patients found that they were able to move into community socialization programs and a number obtained jobs as counselors and specialists in other community agencies.[2]

There were inherent values in the volunteer role for patients. The ability to function in a helping role strengthened the patient's ego. The hospital, by involving the patient while he was still hospitalized, was, in essence, conveying an attitude that he could perform in a "well" role.

This experience also tended to reduce the secondary handicaps of hospitalization and gave staff an opportunity to deal with the "stigma of hospitalization" earlier instead of at the point of discharge.

Two months prior to the patients' discharge, the social worker

began to motivate the patient to participate in an after-care socialization program and arranged for the patient to make frequent visits to the center while still in the hospital. Upon discharge, the patient, having already been oriented to the center, found it a welcome source of support rather than a new experience he must learn how to utilize. (The socialization phase is preparatory to the Hillside Hospital - Educational Alliance program.)

THE HILLSIDE HOSPITAL - EDUCATIONAL ALLIANCE PROJECT

Hillside Hospital and the Educational Alliance have had extensive collaborative experiences working with discharged young mental patients and their families.[3] The union began five years ago when the N.I.M.H. granted funds for a joint program for the resocialization of ex-mental patients in a community center. After its completion in 1965, the program was continued independently by both institutions. As a result of this collaboration and the experience with the resocialization program described in this paper, another demonstration-research project has been initiated. We are presently in the beginning stages of a five-year project on family-centered socialization of ex-mental patients.

Resocialization of the Ex-Mental Patient

The purpose of the resocialization project was to gradually move the patient from the hospital setting into the larger community, using the community center and its facilities as a learning

ground where the ex-patient could improve his social skills. A four-phase rehabilitation program was initiated. While still hospitalized, the patient participated in a "core" group which offered him support, reality-testing and the opportunity for corrective experiences.[4] Phase one was a direct preparation for discharge. After discharge, the patient continued in the core group and was moved along toward phase three, when he also participated in non-patient activity groups within the center. The final phase was leaving the core group to become autonomously involved in community center activities in the same manner as other members of the community.

The group served as a "testing ground" for the social experiences of the ex-patients within the center and outside. It was made clear in a mutual contact that the core group was only as a "transitional" step to help the patient move into outside groups. This was purposely done to prevent over-indentification with the ex-patient group itself. The ex-patient had four months to join in at least one ongoing community center group. After ten months he had to withdraw from the core group entirely.

The core group experience offered the ex-patient the opportunity to work out his post-discharge conflicts and fears about vocation, education and social adjustment.

Family Centered Program

One of the major findings of our previous demonstration project was the younger the ex-patient, the more difficulty he had

in sucessfully achieving social rehabilitation.[5]

It was concluded that disturbed family relationships have considerable impact on the discharged patient in his attempt toward community adjustment. Lack of communication and family interference in the area of jobs, academic and vocational expectations, or their indifference toward his role and status interfered with the patient's need for independence.

We then began to involve the families in the patient's struggle, drawing on them as a resource in helping the patient's post-hospital adjustment to community life.

After one year's experience working with the families and their mentally ill children the need for the development of an additional demonstration project on a much larger scale was indicated.[6] We are involved in that program now. The specific aims of the new project are:

1) To demonstrate methods for facilitating status-role adjustment of both adolescent young and adult ex-mental patients through a family centered group work program in a community center. Specific attention is being given to adjustments in the area of family life, peer relationships, work and education.
2) To explore how the parents of the ex-patients can play a more supportive role in status-role adjustment of the ex-patient both within and outside the family.

3) To evaluate the effectiveness of the proposed family centered program described above and to ascertain the kinds of individuals for whom this program is most effective.

RESULTS OF HOSPITAL AND POST-HOSPITAL PROGRAMS

Although our investigation is continuing, the initial programs did offer some conclusive evidence:

1) A follow-up study indicated that patients who utilized either or both of our socialization programs made greater use of facilities within their own communities than those patients who did not participate.
2) To the patient, the community center represented a reality setting. He was able to draw on the center's facilities and programs as a source of strength and support in the area of socialization. Many patients who left the program returned when they felt a need for support.
3) Both programs provided a continuity of treatment by providing the patient with a supportive structure to help him through his hospitalization and the transition back to the community.
4) Some ex-patients were able to use the community center program experience to get jobs at community centers.
5) The concept of resocialization should include the family, and the family should be utilized through such techniques as multi-family counseling and integration in community center programs.

6) The stigma of hospitalization was minimized by the patient's acceptance and participation in the community center.

THE COLLABORATIVE PROCESS

We have outlined the content of the two resocialization programs and would now like to turn from the content to analyze the process by which these institutions collaborated.

Many collaborative efforts tend to remain "static," never altering their programs, year after year, even when the needs of the patients change. For example, in recent years there has been an increasing rise in the number of young adult patients in psychiatric hospitals. This shift has presented many problems for after-care agencies whose services still focus on older patients. Another problem exists in research-demonstration programs which provide a service only for the life of the grant. The details of the projects are published, papers presented at conferences, and then the service dies....

Although the goal of the cooperative effort between Hillside Hospital and the two community centers was to develop a resocialization program, what became equally important was the process of the collaboration. In achieving a capacity to work effectively together, the institutions greatly increased their commitment to each other as well as to the goal of their collaboration.

Each of the socialization programs developed independently,

with the hospital taking the initiative by reaching into the community to develop resources. The Educational Alliance program developed first as a federally-supported research-demonstration program. When the project was completed the services continued, jointly supported by the center and the hospital. The identification of the need to involve the families of the patients in this post-hospitalization program led to experimentation and then to another research-demonstration program. In contrast, the Samuel Field 'Y' program developed slowly and without any formal design.

Both programs were shaped and changed by periodic evaluations. As additional needs were identified, the hospital and the centers responded by instituting new approaches.

The need for resocialization programs and for the planning and implementation of such programs demands of the hospital that it take the initiative in this change in the welfare community. Some aspects of this role are:

The Hospital as the Initiator. Both programs demonstrated basic social welfare change models. Although the social work staffs of each institution were in favor of the idea, without the commitment of the two institutions to carry it through, as well as the collaborative effort to obtain financial support for the demonstration program, the idea might have died. The Educational Alliance in co-sponsoring the research-demonstration was introducing an external agent, the hospital, to help institute the socialization program.

The external agent in the volunteer patient program at the Samuel Field 'Y' was also the hospital. The 'Y' staff had a commitment to mental health concepts. The attitudes of the community towards mental illness had to be considered. The 'Y' staff used Hillside as the outside force to persuade its Board. It also confronted them with the traditional mandate of the center to serve the total community and the corollary that this makes it imperative to continue to experiment with new structures to involve the marginally functioning in socialization programs designed to restore them to fuller involvement in their community.[7]

Implicit in this role is an aggressive approach and a concern with the community on the part of social workers. To develop resources even on a small scale will have an impact.

The Social Worker as a Mediator. A great deal of the responsibility for such collaboration rests with the director of department and/or agency. It is his role to "mediate" the various forces within his institution— staff and Board— and to undertake and carry out the program. For example, to educate the community that it should permit hospitalized psychiatric patients to work with their children in the center was no easy task. The 'Y' director had to convince not only the Board, but his staff. We have found in both projects that staff, even with adequate orientation, reacted with the same stereotype attitudes about mental illness as the community.

The Social Aspect of Collaboration. The process of the two resocialization projects not only involved three highly complex institutions interacting with one another, but more significantly, it dealt with people and their interpersonal relationships. In the process of developing collaborative programs we tend to look at the total institution and forget that behind these organizations are people. They must be the motivating force if a change is to occur. Working towards a change involves a relationship between the change agents within each institution and a clear idea of the degree of intervention necessary to achieve the goals.

Communication. Communication between agencies is frequent and necessary. Our experience has been that communication is facilitated when channels are structured in advance. We found that whenever it is feasible, the line of communication should be between a member of one discipline in one setting and his co-equal in the other setting. Otherwise, a situation may develop where the worker responsible for the planning of a service with a patient is unaware of current developments in his case. The bypassing of a worker, particularly in a multi-disciplinary setting, has other serious consequences. It may dilute the worker's relationship with his patient as well as destroy his usefulness in planning for needed services.

SUMMARY

Patients who showed marked signs of alienation and reduced social interaction were able to utilize the pre and post socialization programs. These programs provided the young mental patient with an opportunity to learn social skills and a stimulus to challenge his potentials and abilities. The effectiveness of the resocialization programs resulted from the collaborative process and a continuity of treatment. The treatment process started early in patients' hospitalization and continued after discharge. The involvement of the patient with the community not only gave him an opportunity to test himself, but helped to counteract the effects of institutionalization. The patient was able to utilize community resources during his hospitalization and continued to do so, after his discharge.

Both resocialization programs developed through a special relationship among community, hospital, family and patient.

FOOTNOTES

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7. Coltoff and Rosenberg, op. cit. p. 259