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AN INVESTIGATION OF SEVEN ENVIRONMENTAL FACTORS UPON MENTAL ILLNESS AMONG PATIENTS IN AN INSTITUTION: CASE STUDIES

by
William Alfred Saunders

A dissertation submitted in partial fulfillment
of the requirements of the degree of
Doctor of Philosophy
(Education)
in The University of Michigan
1974

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CHAPTER I

INTRODUCTION

In years past, our society has tended to deny the existence of poverty and other environmental factors, but it has not been able to adequately deny the existence of mental illness. Among many Americans, the thought of mental illness becomes frightening. Many of them fear mental illness. They fear its victims and they fear those who devote much of their time working with the mentally ill, such as psychiatrists, clinical psychologists, social workers, psychiatric nurses, and even attendants. In many instances, the institutions that have been established throughout the country to provide care for the mentally ill are often referred to by such terms as "bug house," "loony bins," and "booby hatch." Reference is made to psychiatrists as "head shrinkers" and "nut crackers." Our society is becoming more and more aware of the problems of mental illness and more and more aware of the mental health problems of the lower socio-economic segment of our society, including the inadequate mental health services available to them.

People in the low socio-economic status are constantly bombarded with pleas and advice from the mass media, schools, and the professional community to seek help with family and individual emotional problems. When the decision is finally made to utilize such services, the low socio-economic individual becomes faced with long waiting lists and becomes discouraged and because of his financial condition, is unable to afford the high fees for private care.

The individual that is classified within the poverty level must contend with many daily situations until it becomes difficult for him to function in a way that is acceptable to society. The differences in the expectations of the poor and non-poor create such pressures upon the poor, and the lack of resources to adequately cope with these pressures places his mental health in jeopardy. Some of the differences of the poor and non-poor are that the poor are not as likely to be home owners as those who are classified as non-poor. Even though the relative recent trend of governmental agencies making it possible for many poor families to become home owners has not made a big impression upon eliminating poverty and mental disorders.

Families of low socio-economic status are not nearly as likely as middle class families to have life insurance or be covered by a pension plan to provide the security for a ripe old age and death. Many of these individuals of poverty became unemployed with the introduction of automation. The educational level of many unskilled laborers is so low that they are unable to qualify for other positions when mechanical devices are utilized to do the job they are able to do.

Those individuals who are classified as poor are not able to lay aside portions of their earnings into a savings account, and find themselves living from paycheck to paycheck. Along with this, the poor live in a world of money orders rather than of checking accounts. It is necessary for them to spend most, if not all, of their income for food and housing and are not nearly as likely to have telephones as higher income groups. There is one aspect in which the patterns of living expenses of the lower socio-economic groups are surprisingly not very different from families of higher economic status in their ownership of particular goods that are considered expensive, such as television sets, phonographs, washing machines, and automobiles. Many families that fall below the poverty line enjoy such

expensive durable goods. Many of these items are purchased by the installment plan. These low income individuals are not able to pay cash for high goods, and most of them have not established credit at a bank. As a result, these items are financed by a loan company where high interest rates are charged. These are just small elements of the many pressures that are constantly placed upon the poor that prevent them from maintaining their mental health. As a result, many of them are not able to secure help for their mental condition. Many receive aid from out-patient clinics near their community and others are committed to mental institutions.

This study is based upon a representative sample of patients at Manteno State Hospital, Manteno, Illinois. An investigation of seven environmental factors will be studied with the hope of determining if these factors were possible causes for hospitalization.

NEED FOR THE STUDY

There is a dire need for objective research dealing with the relationship of various environmental factors among patients already committed to state mental institutions. Prior to the 1950's, there were only a few studies concerned with the relationship between environmental factors and mental illness. Most of those studies were basically concerned with the frequency of patients receiving psychiatric treatment in relation to their socio-economic background. Other studies made investigations of mental illness in the total population, or in particular communities.

Inasmuch as it is important to investigate the effect of environmental factors upon mental illness among people in a given community, it is equally important to investigate the effect of environmental factors among patients already committed to a mental institution.

It is my intention that this study will present objective research, unbiased data, and appropriate conclusions, along with a deeper awareness of the

relationship of environmental factors upon mental illness among patients already committed to a state institution.

STATEMENT OF THE PROBLEM

This study proposes to show that there is a direct relationship of environmental factors upon mental illness among patients already committed to a state mental institution.

It will also examine the idea that the diagnosis of mental patients coming from low socio-economic backgrounds are classified as being psychotic rather than neurotic.

DESIGN OF THE STUDY

The method of research planned for this study is to select a random sampling of patients already committed to Manteno State Hospital. Upon the selection of subjects, the following steps are planned:

1. To determine if their childhood experiences were responsible for their hospitalization.

2. To discover if they were victims of broken homes.

3. To determine if they were children of poor physical health.

4. To investigate the social history of each subject to determine if they were products of parents with poor mental health.

5. To determine what portions of these subjects fall within the poverty level according to income prior to admittance.

6. To determine if there were occasions of work worries.

7. To determine if there were events of socio-economic status worries.

8. To determine what portions of these subjects coming from low socio-economic backgrounds are diagnosed as psychotic as opposed to neurotic.

DEFINITION OF TERMS

Comfortable - having accumulated resources sufficient to maintain self and family for at least four months.

Dependent - lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family.

Marginal - living on earnings but accumulating little or nothing,being on the margin between self support and dependency.

Mental Illness - A disease of the mind.

Neurosis - A disturbance of bodily function; thinking, feeling,and conduct due to emotional tensions which have developed as a result of deprivations, frustrations, and conflicts; a functional emotional disorder.

Poverty - total family yearly income of $3,500 or less.

Prevalence - total number of active cases in a population during some specified time.

Psychosis - a major mental disorder, usually involving the total personality; one's mental functions are so profoundly disturbed that he is incapacitated from participating in everyday activities.

The following chapter, Chapter II, will deal with the survey of related literature.

CHAPTER II

REVIEW OF RELATED LITERATURE

Mental institutions first made their entrance into this country before the Revolutionary War. It has only been within the past few decades that they have become large, complex and numerous. When mental hospitals first came into existence, they were strictly designed for custodial care. No emphasis was directed toward treatment or the causes of mental illness. Since World War I and II, newer, better designed, and better equipped buildings have been appearing throughout this country.

In conjunction with the trend toward improving living quarters, emphasis was also placed upon enlarged staff, and more competently trained and diversified personnel, and better methods of administration.

HISTORICAL BACKGROUND

When the early settlers became confronted with the problem of caring for persons who were mentally ill, they followed the practices that existed in England. During that time,there existed no understanding of the nature of mental illness. The "distraught" and "insane" were believed to be possessed by demons, the devil or witches, and they were looked upon with fear. In many instances, those persons considered as insane created civil disturbances and were driven from their homes and towns or jailed along with beggars and criminals.

> It was the families' responsibility to adequately care for a family member that became mentally ill. When families were able to keep a deranged member at home, the sick person was usually locked and chained in a barred room. When families were not able to adequately care for its mentally ill members at home, they were placed under the control of law enforcement agencies. When it became necessary for law officers to become involved, the ill person was taken to jail. In those instances, where witchcraft was suspected, torture and hanging usually followed.[1]

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[1]Albert Deutsch, The Mentally Ill in America (New York: Doubleday and Company, 1937), pp. 47-48.

Approximately sixty-five years ago, the causes of mental disturbances and mental disorders were thought to be entirely hereditary. In later years, as a result of constant research by biologists, psychologists, psychiatrists and sociologists, an agreement existed believing that constitutional, individual, and environmental factors did not operate independently, but were considered as parts of a combination of factors relating to difficulties of adjustment in personal and social relations. All preventive mental health programs do not deal with individuals as separate entities but their efforts are centered upon the person as a member of groups, of the community, and of society.

> The extensive research that has been conducted by cultural anthropologists, psychiatrists, psychologists, and sociologists, all indicate the great importance of the family in shaping personality. Students of personality perceive in disturbances and maladjustments of the relations between father and mother, parents and children, and between siblings as related to the causes of neuroses and psychoses.[1]

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[1]Arnold M. Rose, Mental Health and Mental Disorders (New York: W. W. Norton and Company, 1955), p. 4.

It has been observed that child-guidance counselors find behavior problems of children are derived from maladjustments in family relations. Attempts to deal with a child successfully often involve the feasibility of treating difficulties related to parents and in the relationship of the parents to each other. Therefore, the happy family, held together by ties of affection and companionship, is one of the best resources for good mental health.

Much of the literature centers upon the concept that the family is crucial in the rehabilitation of mental illness. Much of the research literature places emphasis upon the significance of the family in the prevention, cause, and treatment of mental illness. Prior to the 1950's, much of this literature reflected two major limitations. One was the one way focus upon the contribution of the family members to the emotional or mental illness of the individual. The second major limitation was the lack of concern with families in relation to individual family members.

> Among the numerous studies of child rearing patterns and parent-child relationships as causal factors in mental illness, to a great degree ignored the family unit by excluding the siblings of the mentally ill person, the relationship of the mother and her well children , and the affect of the ill child upon the entire family. Researchers have only given constant attention to the role of the total family within the past two decades.[1]

The idea of the mentally ill person being possessed by demons slowly subsided to the belief that the mentally ill were sick people. Immediately following the 16th century, monasteries and prisons ceased caring for mental patients because asylums were being established at a rapid pace.

> In 1756, the Pennsylvania Hospital at Philadelphia, made available cells or wards for the mentally ill, but the first hospital in this country specifically designed to care for the mentally ill was erected in Williamsburg, Virginia, in 1773.[2]

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[1]Paul H. Glasser, and Louis N. Glasser, Families in Crisis (New York: Harper and Row Publishers, Inc., 1970), p. 328.

[2]A. Deutsch, The Mentally Ill in America (New York: Columbia University Press, 1946).

The early asylums or hospitals were predominately patterned after penal institutions, and mentally ill persons were treated more like wild animals than ill humans. The general hospitals that provided cells or wards for the mentally ill, constructed these cells in the cellar of the building. The patients were kept in straight-jackets, often plunged in cold water unexpectedly and made to sit in cold water from two to six hours.[1]

As late as 1830, it was the custom to shave the heads of newly admitted patients, restrain them in straight-jackets, put them on a low diet and forced them to swallow large doses of laxatives. They were often confined in dark cells. If this procedure did not quiet the unruly and excited patient, other methods of torture were put into force. The early asylums were very similar to concentration camps where mental patients lived and died in the midst of the most incredible filth and cruelty.

As modern experimental science became more prominent, more scientific and humane approaches were applied to the mentally ill. Much of the humane

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[1]W. L. Russell, "A Psychopathic Department of an American General Hospital in 1808." American Journal of Psychiatry, 1941, Vol. 98, pp. 229-237.

approaches were reflected in the work of Benjamin Rush, the father of American Psychiatry, who encouraged more humane treatment for the mentally ill. Even though his medical theory was filled with astrological concepts, his basic remedies were bloodletting and large dosages of laxatives. Rush also invented and used a torture-like device known as the "tranquilizer."

The progress made by Benjamin Rush was further extended in 1848 when Dorothea Dix, a New England school teacher presented a memorial to the Congress of the United States, describing the deplorable treatment received by mental patients. She indicated how she had seen more than 9,000 idiots, epileptics and insane in the United States, all of them yearning for appropriate care and protection, many of them bound with chains, restrained with heavy iron balls, tied with ropes, isolated and abandoned. Through the efforts and concern of Miss Dix,[2] the legislatures were aroused to an awareness of the inhumane treatment received by mental patients. As a result, millions of dollars were appropriated to build adequate mental hospitals.

[1]G. Zilboorg and G. W. Henry, A History of Medical Psychology (New York: W. W. Norton and Co., 1941), p. 583.

[2]L. J. Karnosh and E. M. Zucker, Handbook of Psychiatry (St. Louis: C. V. Mosby, 1945), p. 18.

Dorothea Dix is credited with the establishment of approximately thrity-two modern mental hospitals, an astonishing accomplishment considering the ignorance and superstitution that existed in the field of mental illness. Her career ended with the responsibility of organizing the nursing forces of the Northern Armies during the Civil War.[1]

As a result of the work of Benjamin Rush and Dorothea Dix, much interest was aroused among many scientists, psychologists, and psychiatrists which led to the emergence of modern scientific theories and practices related to causes and treatment of mental illness. Great advances were made in psychiatric theory, centered around organic, psychological, and sociological causes of mental illness.

> During the early part of the eighteenth century, knowledge of anatomy, physiology, neurology, chemistry, and general medicine was on a rapid increase. The advances made by these sciences led to the understanding of organic pathology as an underlying factor of many physical ailments. This idea led early students of these sciences to

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[1]L. J. Karnosh and E. M. Zucker, Handbook of Psychiatry (St. Louis: C. V. Mosby, 1945), p. 18.

> view mental illness as a definite sickness based upon organic brain pathology. This concept represents the first great advance of modern science in the understanding and treatment of mental illness.[1]

In spite of the rapid pace of the understanding of mental illness, it was not until 1883 that Emil Kraepelin, a German psychiatrist, published a textbook which emphasized the importance of brain pathology in mental illness along with a system for classifying mental disorders. He noted that particular groups of symptoms of mental illness occurred together with adequate regularity to be regarded as specific types of mental disease, in much the same way physicians think of measels and other distinct physical ailments. He viewed each type of mental illness as separate and distinct from the others, and maintained the idea that its course was as predetermined and predictable as other ailments.[2]

As a result of these conclusions that Kraepelin had developed, widespread interest was generated in

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[1]James C. Coleman, Abnormal Psychology and Modern Life (Palo Alto: Scott, Foresman and Company, 1964), p. 43.

[2]Ibid., pp. 44-45.

accurate description and classification of mental disorders, and as a result of this process, the outcome of a given type of mental illness could possibly be predicted even though it could not be controlled.

The interest generated by Kraepelin, Dix, Rush and other prominent psychiatrists, in search for the etiology of mental disorders, stirred interest among other disciplines and became responsible for intensive research in anatomy, physiology, bio-chemistry, neurology, and other related fields; attempting to isolate the brain pathology believed responsible for various types of mental disorders.

As a result of the constant research among the various medical fields, the following advances had been made in psychiatry up to the year 1915:

1. The early concepts of demonology had finally been destroyed, and the organic viewpoint of mental illness as based upon brain pathology was well established.

2. For general paresis and certain other mental disorders, definite underlying brain pathology had been discovered and appropriate methods of treatment developed.

3. Mental illness had finally been put on an equal footing with physical illness, at least in medical circles, and for the first time, the mentally ill were receiving humane treatment based upon scientific medical findings.

4. A workable, though not yet completely satisfactory, scheme of classification had been set up.

5. A great deal of research was underway in biochemistry, anatomy, physiology and other allied medical sciences in an attempt to ascertain the brain pathology (or other bodily pathology which might be affecting the brain) in other types of mental illness and to clarify the role of organic processes in all behavior.

6. Emphasis had finally been placed upon the importance of public education for the understanding, early detection, and prevention of mental illness.[1]

These achievements can be viewed as remarkable feats because they represented the first major breakthrough in modern psychiatry and served as a basis for the present progress that has been made relating to the etiology of mental disorders.

Even though outstanding accomplishments had been achieved by the early part of the nineteenth century relating mental disorders to organic factors, many extremely puzzling aspects of the problem of mental disorders still existed. Many of the repeated clinical examinations and research studies failed to reveal any organic pathology in approximately half of the patients examined. It was also discovered that any given patient might exhibit some minor deviations in body chemistry but many "normal" people also exhibited body chemistry disorders. A large percentage

[1]N. D. C. Lewis, A Short History of Psychiatric Achievement (New York: W. W. Norton and Company, 1941), p. 84.

of other patients exhibited symptoms of psychic disorders and different organic deviations were revealed.

Many scientists believed organic symptoms should be revealed in all cases of mental disorders and their research methods were intensified and their laboratory techniques were refined. Many of the medically related disciplines became discouraged and concluded that a lost mind was lost forever, while others attempted to justify their conclusions by assuming that mental disorders were related to hereditary factors.

> A new current of psychiatric thought came upon the scene early in the twentieth century, challenging the common belief in organic brain pathology as the only cause of mental disorders. This new view maintained the idea that certain types of mental disorders might be caused by psychological rather than organic factors. This new view presented the belief that the many frustrations and conflicts common to everyday living might be so overpowering that individuals would recourse to the use of unhealthy and unacceptable responses in an attempt to make an adequate adjustment. This view further maintained that individuals who

> felt they had failed miserably in life might become chronically discouraged and depressed, or would seek to project the blame for their difficulties upon others.[1]

The psychological concept further believed that individuals might simply have learned particular patterns of behavior, such as irrational fears or phobias which were considered maladaptive. The followers of the psychological concept believed that when an accumulation of irrational behaviors existed, more extreme types of abnormal behavior developed.[2]

The acceptance of psychology as a major science was in its infancy early in the 1900's. It presented a rather naive approach to an understanding of human behavior and consisted primarily of experimental studies of the physiology of sense perception. In 1890, when William James, an early psychologist, published his book, Principles of Psychology, attempting to explain

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[1]David F. Wrench, Psychology: A Social Approach (New York: McGraw-Hill Book Company, 1969), pp. 87-92.

[2]Ibid., pp. 104-113.

memory, emotion, reasoning, habits, consciousness of self, hysteria and other aspects of human behavior were basically descriptive and speculative.

> The psychological concept of mental disorders gained in popularity throughout many European countries and later spread to the United States. This concept inspired Sigmund Freud, a Viennese physician, to develop steps toward an understanding of psychodynamics. While working in collaboration with an older physician, Joseph Breuer, they introduced the use of hypnosis in the treatment of neurotic patients. This process enabled the patients to freely talk about their problems and oppressions while under hypnosis. Following many experimental studies, Freud was able to dispense with the hypnotic state entirely by encouraging patients to speak freely about whatever came into their minds without regard to logic or decency. Freud"s concepts had direct effects upon further developments of the psychological viewpoint in relation to mental illness.[1]

Among the major accomplishments related to the work of Sigmund Freud were the following:

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[1]Karnosh and Zucker, op. cit., p. 136.

The development of Free Association and dream analysis as techniques to become acquainted with both the conscious and unconscious aspects of the mental life of mental patients. Freud used the information obtained to emphasize the dynamic role of unconscious processes in determining behavior and the importance of early childhood experiences in later personality adjustments and maladjustments.

The demonstration that abnormal mental phenomena were simply exaggerations of normal phenomena, and the symptoms exhibited by the patients represented the outcomes of their attempts to cope with problems in the best way possible.

The development of psychoanalysis as a therapeutic technique for the psychological treatment of the mentally ill. This technique is an intensive and long range therapeutic program attempting to restructure the personality of the patient in the direction of a greater integration and more effective methods of coping with the problems of life.

The development of a systematic theoretical framework which recognized the role of biological, psychological, and social factors in personality development and functioning. In this procedure, special attention was given to the conflicts arising within the patient as a result of the various social demands and prohibitions which are incompatible with basic biological needs. The comprehensive nature of psychoanalytic theory made possible

> the integration of material from various research areas such as, psysiology, neurology, psychology, sociology and anthropology which led to the consideration of man as a unified organism.[1]

Many students of psychoanalytic doctrines disagreed with various aspects of Freud's system and developed modified systems of their own. Among the prominent dissenters were C. G. Jung, a Swiss psychiatrist, who saw the mind as composed of three areas: 1) the conscious, 2) the personal unconscious, and 3) the collective unconscious. The conscious mind consisted of the perceptions, thoughts, attitudes, memories and feelings. Jung felt that the conscious mind was essential in adapting to the environment. The personal unconscious was composed of experiences that have been forgotten, suppressed, or repressed, and experiences too weak to have made a conscious impression in the first place. This may result in a multiple personality. The collective unconscious is the deposit of ancestral experiences from years past.

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[1]Wrench, op. cit., pp. 16-18.

Alfred Adler, a Viennese psychiatrist, also disagreed with Freud's theory and emphasized the use of psychotherapy to make changes in the life styles of patients. He concluded that the individual's conscious and unconscious goals, the methods used in achieving those goals, and the techniques for coping with problems of living lead to a relatively consistent life style.

> Among other major contributions supporting the psychological viewpoint of mental illness was seen in the work of the Russian physiologist, Ivan Pavlov, who discovered the phenomenon of the conditioned reflex among dogs and later extended his experiments with rats, cats, pigs, monkeys and chimpanzees with favorable results. Pavlov found three general reaction or constitutional types with his experiments with dogs: 1) an excitatory group, 2) an inhibitory group, and 3) a central group. Pavlov applied these findings to humans with certain modifications to account for the language factor. He distinguished two personality types: 1) the artistic type - intense, vivid and highly responsive to external stimulation, and 2) the thinking type - quiet, ruminative, and responsive to verbal concepts and ideas. In relation to mental

> illness, Pavlov believed the artistic type would be more prone to neuroses while the thinking type more prone to psychoses.[1]

The concept of Pavlov's reaction types continued to be investigated and his conditioning techniques and concepts of excitation and inhibition were major factors involved in paving the way for a vast amount of experimental work on the role of learning in maladjustment.

> In the early part of the twentieth century, sociology and anthropology had surfaced as independent scientific disciplines and was beginning to make rapid progress in understanding the role of socio-cultural factors in man's development and behavior. As a result of research findings by these disciplines, it became apparent that man is almost infinitely adaptable to a variety of situations and that his personality development is largely a product of the society in which he lives, of its institutions, values, traditions, ideas, technology and of specific family and other interpersonal relationships to which he is exposed. These research findings further concluded that there is a relationship

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[1]J. Wortis, ed., Pavlovianism and Clinical Psychiatry Vol. IV, Recent Advances in Biological Psychiatry (New York: Plenum Press, 1962), pp. 13-23.

> between sociocultural factors and mental disorders and that the stressful social and cultural factors in a society are related to the incidence and types of mental illness that occur in that society.[1]

As research procedures were continually being conducted to further develop the organic, psychological, and sociological viewpoints, a clearer understanding developed relating the role of these factors in the development of mental illness, and it became apparent that each factor was incomplete in itself. In some organic disorders, it was observed that some patient became depressed or withdrawn while others with the same organic symptoms were expansive and happy. In cases of psychoses associated with senile and arteriosclerotic brain damage, some patients became severely ill mentally with only a small amount of brain damage as other patients exhibited mild symptoms in spite of relatively extensive brain damage.

Investigators then concluded that the psychological reaction of patients to the brain damage and to the

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[1]L. G. Lowrey, Psychiatry for Social Workers (New York: Columbia University Press, 1946), pp. 121-125.

resulting change in life situations were viewed as vital factors in determining the patients overall symptom pattern. Due to the continued emphasis that has been placed upon the importance of the family, the organic, psychological and sociological investigators further concluded that the emotional support of family members and the type of home situation to which a mental patient would be returning upon leaving a mental institution, were significant factors in determining the future course of the patient.

> Psychiatric theory has indicated numerous variables to be considered in determining the etiology of mental disorders. Many individuals are prone to mental disorders when they have difficulties making adequate adjustments to stressful situations in life. There are many obstacles in life, both environmental and internal, which interfere with need gratification and complicate efforts in the life of an individual to maintain and actualize the self. Stress may occur on a biological or psychological level. Man strives to maintain and actualize himself on both the biological and psychological levels, and certain basic needs must be met on each level to achieve success. Various physical ailments produce stress on a biological level in that the basic adjustive demands involve the biological defenses of the body. Guilt is a source

> of psychological stress that may be controlled with ego defenses. Stress also occurs on group as well as individual levels. Economic depressions, unemployment, occupational ambitions, broken homes, deprivation, family atmosphere, health and interpersonal affiliations are examples of situations which place adjustive demands on individuals and on the group as a unit.[1]

Adjustment problems or stress situations may be classified as frustrations, conflicts or pressures. Frustration occurs when one's motives are defeated, either by obstacles that block progress toward a desired goal, or by the absence of an appropriate goal. These frustrations may be either internal or external. In many instances, frustrations occur from a conflict between two needs or valued goals in which the choice of either may lead to frustration with regard to the other. Conflicts that individuals must cope with may be classified into approach-avoidant, double approach, and double evoidant conflicts. In approach avoidant conflicts there exist strong tendencies both to approach and to avoid the same goal. An individual may desire to marry for sexual, social and security reasons, and at the same time, fears the responsibilities and loss of

[1]Wrench, Op. Cit., pp. 82-83.

personal freedom. He will approach and avoid marriage.

The double approach conflicts consist of competition between two or more desirable goals. An individual may be torn between duty and ambition, between loyalty to his mother and to his wife, or between present and future satisfactions. "Trying to approach both goals in a satisfactory manner may cause problems that the individual may not be able to cope with."[1]

The double avoidant conflicts occur when the individual is completely hemmed in. He may have to choose between unemployment and a job which he dislikes, between marrying someone he does not love and the possibility he will be unable to find anyone else. "Conflicts are major factors causing stress and often lead to such tension and inner turmoil that the individual's adjustive capacities are severely impaired."[2]

Problems of adjustment may also be a result of various pressures that complicate the strivings of an individual. Parents that must make sacrifices to send

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[1] Ibid., p. 85.

[2] Coleman, Op. Cit., p. 88.

and maintain their children in college may exert much pressure upon the students for high achievement. In many instances, the parent is faced with financial pressures in maintaining the home along with educational expenses. Many of these pressures are quite common among those individuals that fall within the poverty level. The high rates of unemployment and under-employment among those persons clustered around urban communities is another factor to be considered in the constant search for the etiology of mental disorders.

Those individuals that must cope with unemployment are faced with pressures in providing for their families. When they are successful in obtaining a job, it is often at the low end of the occupational scale. Many of them lack the necessary skills to sustain their self-respect or the respect of family and friends. Many of these experiences reinforce feelings of inadequacy resulting from repeated failure in obtaining and keeping decent jobs.

Among many families on the low socio-economic scale many wives and mothers are forced to seek employment and often earn more money than the husband. When situations

arise where the men stay at home without working, they are constantly confronted with their inadequacies and tensions arise between them and their wives and children. Pressures of this type are responsible for many husbands and fathers deserting their families and drifting from city to city seeking employment.

Children that are forced to grow up in homes without the presence of fathers are faced with many handicaps. Many of them spend the majority of their time on the streets. The culture of poverty resulting from disorganized families creates a system of ruthless and exploitive relationships. In many instances, they become involved in prostitution, dope addiction, casual sexual affairs and crime which creates an environment characterized by personal insecurity and tension, which often leads to mental disorders.

> The effects of poverty upon various communities have resulted in high rates of illegitimacy, high rates of narcotic addictions, a high proportion of children that do not attend school are from homes where one of the parents are absent, and

> high rates of juvenile delinquency, venereal disease and admissions to mental institutions have been high among those coming from low socio-economic environments.[1]

Many psychiatric opinions emphasize the importance of a continuous parent-child relationship, and this relationship was re-emphasized a few years ago by the collision of the ocean liner Andrea Doria. Two psychiatrists present at the disaster, Drs. Paul Friedman and Louis Linn, came to the conclusion that:

> The application of the 'women and children first' principle on the Andrea Doria resulted in some poignant, and in at least one case, tragic separations and isolations with possible disastrous psychological consequences. A modification of the 'women and children first' rule by insistence that a parent accompany the child, even if the only parent available be the father, would represent a sound application of modern psychiatric insight.[2]

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[1]August B. Hollingshead and Frederick C. Redlich, Social Class and Mental Illness: A Community Study (New York: John Wiley and Sons, 1958), pp. 387-397.

[2]Paul Friedman and Louis Linn, "Some Psychiatric Notes on the Andrea Doria Disaster," American Journal of Psychiatry, Vol. 114, No. 5 (November, 1957), p. 428.

Friedman and Linn referred to similar conclusions in the Freud-Burlingham report, relating to the effect of the wartime blitz bombing on the children of London, that "such disasters as war have comparatively little significance for children so long as they threaten their lives of material comforts, but become enormously important the moment they break up family life and uproot the first emotional attachments of the child within the family group."[1]

In the Midtown Manhattan Study,[2] Thomas S. Langner made a study relating the childhood broken home as a factor responsible for poor mental health. The data presented in the Midtown Study suggest that the childhood broken homes factor is related to poor mental health only under certain conditions. The study represented a total of 1,656 cases and Langner concluded that just over one-third of the sample respondents indicated that they did not always live together with both real parents up to sixteen years of age. Approximately three-fifths of

[1] Ibid., p. 429.

[2] Thomas S. Langner and Stanley T. Michael, Life Stress and Mental Health (London: The Free Press of Glencoe, Collier-Macmillan Limited, 1963), pp. 159-166.

these broken homes were due to the death of one or both parents. Slightly less than one-fifth resulted from the parents' divorce, separation or desertion. Respondents were twice as likely to lose their fathers as they were to lose their mothers before reaching age sixteen. Those who lost both parents or mothers by death prior to sixteen years of age were worse off than those whose fathers only had died by that time. Those whose fathers died were no worse off than those who came from unbroken homes.

In the low socio-economic group, those whose mothers died were markedly worse off in terms of mental health. There were twice as many deaths of mothers before the child was sixteen years of age in the low as in the high socio-economic status. The mental health risk associated with the death of the mother is also greater in the low SES. In the high SES, the death of fathers and mothers seems to have little relationship to mental health risk. The proportion of respondents whose childhood home was broken by divorce, separation, or desertion was twice as great in the high as in the low SES. "Approximately one-third of all three SES groups came from broken homes, indicating that the broken home

is not necessarily the product of poverty alone."[1]

Those respondents whose divorced or widowed parent later remarried were worse off than those whose remaining parent did not remarry. Therefore, remarriage cannot accurately be described as the "repair" of a broken home, but rather as an attempt to repair a broken home which more often fails as far as mental health of the step-children is concerned. The mental health of sons is best if their fathers did not remarry and worse if they did. The mental health of daughters is best if their mothers did not remarry, and worse if they did.[2]

Working mothers are sometimes considered to be the equivalent of a "semibroken home" for children. In both the low and high SES, children exhibit the best mental health if their mother worked part-time rather than full-time or not at all. Far from creating a "semibroken home," the part-time working mother appears to have healthier children. In the low and middle SES, part-time working mothers of children under eighteen "are themselves in better mental health than mothers who work full-time or not at all."[3]

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[1] Ibid., pp. 168-170.

[2] Ibid., pp. 176-181.

[3] Ibid., pp. 187-188.

It has frequently been reported that persons living in poverty areas appear to be apathetic, little motivated, unable to cooperate with each other in the solution of problems which they consider important. Instead of having love for one another as fellow human beings, they seek and achieve positive mutual attitudes through viewing themselves as all in the same boat, struggling for survival. Reports further indicate that the poor seem to devote their interest strictly to the self, the family, and the neighborhood. Their time perspective is foreshortened by the belief and attitude that it is useless to plan or think of the future. They seek their pleasures and rewards in the present and seek no solace in future happiness.

Many of these persons coming from low socio-economic areas find themselves faced with economic pressures, constant physical illness, unemployment and rejection, must find other methods of adapting to the difficult situations in life. Many utilize various methods of readjusting or coping with environmental situations. Some turn to crime, others to drugs and some develop functional disorders, usually neurosis or psychosis. These disorders represent relatively inefficient and unrealistic attempts of an individual to

establish intrapersonal and interpersonal integration under difficult circumstances.

Beulah C. Bosselman states it this way:

> The failure of individuals who possess either neurotic or psychotic symptoms to make more satisfactory adaptations usually result from a complicated interplay of constitutional and environmental conditions which interfere with the process of establishing and retaining adult status. Some of these conditions are innate within the organism; some develop very early in life and, therefore, strongly influence the basic personality pattern; some enter later in life to strengthen or disturb the balance achieved.[1]

The various symptoms exhibited by an individual are the direct expression of his striving for reconciliation of diverse elements within himself, as well as his striving for compromise with many demands of the outer world. The symptoms of many psychiatric illnesses may

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[1]Beulah C. Bosselman, Neurosis and Psychosis (Springfield, Illinois: Charles C. Thomas Publisher, 1964), pp. 3-5.

be thought of as mechanisms of defense, or as relatively inefficient and unrealistic attempts at adaptation under difficult circumstances.

Success in adaptation depends largely upon constitutional forces and the persistence of an intact nervous system. "External or internal injury to the nervous system impairs the tools for perception, comprehension and judgment necessary for satisfactory functioning."[1] In order to determine the etiology of a psychiatric syndrome, an evaluation must be made of inheritance, early interpersonal experiences, and evidence of damage to the nervous system, and the immediate life situation which precipitates the onset of symptoms. Symptoms cover a wide range and lines of distinction are not sharply drawn.

One of the major problems facing workers in mental health is the inability to identify the correct psychiatric illness by the behavior that is exhibited by the patient. As a result, many patients find themselves being treated for an illness they do not possess along with being hospitalized for long periods of time.

[1] Ibid., pp. 9-19

Many patients adopt certain undesirable behaviors from other patients after spending some time in a mental institution. In many instances, patients are able to make a quick adjustment to the hospital environment. They are not faced with the difficult pressures for survival; they are assured of three meals a day, a clean bed each night, medical care and clothing, and as a result, many patients find the mental hospital a place of refuge.

After a series of studies on mental institutions, Braginsky and Braginsky concluded that:

> . . . .long-term mental patients residing in open wards function as effective human beings and that they have created lives for themselves within the institution that satisfy their motivations, their needs, and their interests. The major determinant of the patient's life in a mental institution is the staff's assessment of his mental status. A patient's behavior is evaluated by the staff and decisions are made as to how the patient is to live on the basis of his interaction with the nurses and aides.[1]

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[1]Benjamin M. Braginsky and Dorothea D. Braginsky, "Mental Hospitals as Resorts," Psychology Today (March, 1973), pp. 22-24.

The Braginsky's experiments further demonstrated that "mental patients used cooperative strategies to stay on the good side of the staff, selectively censored information on psychological tests to create symptoms of mental illness and manipulated psychiatric interviews to avoid unpleasant outcomes or to gain desirable ones."[1]

Many patients admitted to mental institutions are usually diagnosed as being either within the neurotic or psychotic category.

> The psychoses differ from neuroses on the basia of loss of reality sense. In the psychoses, the patient's internal struggle is so intense in relation to his integrating capacity that he no longer attempts to adjust himself to the realities of the outer world. All of his energies are directed upon the conflict within himself. In psychosis, the functioning of the ego is primarily concerned with the conflictual process. The psychotic patient has lost his capacity for empathy, for sharing experiences with others and exhibits an attitude observed to be a detachment from, denial of, or gross misrepresentation of objective situations. He views the world as a projection of his own fantasies.[2]

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[1] Ibid., pp. 24-26.

[2] Edith Jacobson, Depression (New York: International Universities Press, Inc., 1971), pp. 168-171.

The patient diagnosed as neurotic is observed to have distortions of reality to fit his own needs. The neurotic patient preserves his interest in object-relationships and responds to the world about him in a generally understandable way except for the circumscribed disorder represented by his symptoms. The neurotic patient is able to recognize that his symptoms "are expressions of a disturbance within himself. He talks to himself relatively objectively, making an attempt to understand the meaning of his own behavior."[1]

The therapist who is working with the neurotic patient is able to establish rapport to the point of a mutual understanding of the facts of the patient's situation in respect to the outer world. When the psychotic patient talks to a therapist about his problems, it is only to present them as facts to be accepted at the patient's own evaluation,and not as objects for cooperative discussion and resolution. These distinctions between neurotic and psychotic patients are usually demonstrated in relation to the symptom-complex of depression.

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[1] Ibid., pp. 180-185.

SUMMARY OF RELATED LITERATURE

This historical review has traced the development of modern psychiatry from its early beginnings to the development of the organic, psychological and sociological points of view. This review has not been all inclusive, but it is designed to provide the reader with a general perspective of abnormal behavior.

Much emphasis has been placed upon adjustment as a function of the level and types of stress in relation to an individual's adjustive resources. It is generally agreed upon that the various factors exhibited in any maladjustive behavior may be classified as predisposing factors such as heredity and pathogenic family patterns which have developed into inadequate personalities, and emphasis was placed upon precipitating factors involving great degrees of stress, such as loss of a loved one, extreme and sustained pressure, or severe conflicts. The predisposing or precipitating factors may be predominantly biological, psychological or sociological. In many instances, all three aspects are involved, either reinforcing or counterbalancing each other, but each play an important role in an individual's behavior.

CHAPTER III

PRESENTATION AND ANALYSIS OF DATA

INTRODUCTION

The subjects for this study consisted of a total of 60 in-patients randomly selected from long-term wards at Manteno State Hospital, Manteno, Illinois. Each subject was placed in a group according to age. Ten subjects were placed in six different age group categories. Group one included ages 20-29, group two, ages 30-39, group three, ages 40-49, group four, ages 50-59. A random sample of all age levels was placed in a separate group. A random sample of those residents suspected of using the hospital as a place of refuge, all consisting of a series of short admissions, was placed in a group labeled, "Special Group."

Each of these groups were measured by the following factors:

1. Childhood Experiences;

2. Broken Homes;

3. Poor Physical Health;

4. Social History of Mental Illness Among Family Members;

5. Total Family Income Less than $3,000 Per Year;

6. Employment worries;

7. Socio-economic worries;

8. Diagnosis of psychosis or neurosis.

DESCRIPTIVE ANALYSIS

This study was undertaken to investigate the extent of the various factors selected as being a prominent factor in the life of the subjects prior to admission to an institution which may have been a factor responsible for their hospitalization. The information obtained

from each subject was compared to the information in each subject's social history for accuracy.

This study is descriptive and centers around two basic analyses. The first analysis assesses how income, childhood experiences, family history of mental illness, poor physical health, broken homes, employment worries and socio-economic worries are possible factors leading to mental stress experienced by the subjects that may have been a variable responsible for their hospitalization. The second analysis is related to the observation that the majority of these subjects are diagnosed as psychotic rather than neurotic.

The factors selected were divided into two categories, the pre-adult factors and the adult factors. The pre-adult factors consisted of childhood economic deprivation, poor physical health, broken homes and family history of mental illness. The adult factors consisted of total family income less than $3,000 per year, employment worries, socio-economic worries and a diagnosis of psychosis or neurosis determined the prognosis of each subject. Each of these factors was assigned a number and each subject was compared to the various factors and those subjects relating

to the highest number of factors were considered those with the highest poor mental health risk.

Childhood economic deprivation was determined by the problems of the subject's parents. If the parents were constantly faced with unemployment,financial problems, if the mother worked out of the home to earn money when school age children were at home, or if parents had hard times making ends meet. Those subjects that rated high among the group were classified as living in the midst of childhood economic deprivation and will be classified as having been a high poor mental health risk.

Childhood poor physical health is composed of childhood psychiatric symptoms along with the overall physical condition of the child. If the description of the childhood physical health reported to have been good or poor, it is assumed that poor health would indicate a high poor mental health risk, and good childhood physical health would indicate a low poor mental health risk.

The broken home factor is defined by determining if the subject lived together with both original parents until they were at least sixteen years of age.

Sub-factors in this category will be considered as to the reasons for the broken homes such as death, divorce, separation or desertion. Since most of the social ills that fall upon man have been attributed to the broken home, such as drug addiction, prostitution, juvenile delinquency, mental illness and others, the factor of the broken home is used to assist in determining the subject was a high or low poor mental health risk.

Family history of mental illness is described by determining if a member of the family had been hospitalized or received out-patient treatment from a psychiatrist or from a facility. It is believed that if a relative had been hospitalized or had received some form of mental treatment, the subject would have been a high poor mental health risk and classified as a low risk if no mental treatment was received by the relative.

The adult factors are described as those environmental factors that existed within the life style of the subjects prior to hospitalization. These factors may have caused excessive mental stress. The first adult factor is the total household income of $3,500 or less.

This figure was used because it represented the national poverty level during the time when these subjects were first admitted to the hospital.

Employment worries consisted of dissatisfied working conditions and job functions experienced by the subjects and do not include unemployment. It included those who found it necessary to move from job to job, and those who felt they were placed in occupations far below their educational level or those who felt they were over worked without due compensation. Those who worried about their work because of these conditions were considered to be a poor mental health risk.

Even though socio-economic status worries are closely related to work worries, it is felt that special attention should be given to socio-economic status and an individual's standard of living should be a separate entity. Assuming that attitudes toward occupational level and income might have an effect on a person's mental health and possibly may constitute symptoms of mental disturbances, subjects expressing negative attitudes toward their socio-economic conditions would be associated with the high poor mental health risk category.

Patients are usually diagnosed as being psychotic when their mental functioning is so impaired that they lose the capacity to meet the ordinary demands of life. The impairment may be the result of a serious distortion in their capacity to recognize reality. Deficits are developed in their perception, and language and memory becomes so distorted that mental functioning is lost. Psychoses may be the result of organic or non-organic disorders. The neurotic patient does not experience great distortion or misinterpretations of external reality nor gross personality disorganization; but are characterized by becoming anxious extending to panic, and is distinguished from normal situations of fear which occur in dangerous situations. Persons diagnosed as neurotic usually exhibit symptoms of hysteria, phobias, or obsessive compulsive reactions. Patients that are diagnosed as being psychotic are considered a high risk for long periods of hospitalization.

PRE-ADULT FACTORS

An investigation of the social history of the ten subjects in the 20-29 age category was performed and a check list was made with the pre-adult factors to determine how these subjects of this age category rated in comparison with the pre-adult factors. All of these subjects were interviewed to determine the accuracy of the information found within the social history. The early experiences remembered by these subjects were supported by the information found in the social history.

During the interview, each subject was questioned about the various problems their parents encountered. The major question asked that was the most relevant for this study was: "What would you say were the major problems or troubles facing your parents while you were growing up?" The response given by the subject was coded under the following factors: 1) none, 2) unemployment, 3) work, 4) financial, 5) siblings, 6) myself, 7) father-mother conflict, 8) father inadequate, 9) housing, and 10) neighborhood influences.

The responses given by the ten subjects indicated that three subjects felt finances accounted for the greatest problems facing their parents while they were young. Two subjects indicated unemployment as being the biggest problem. Two subjects indicated conflicts between father and mother accounted for the greatest problem. One subject expressed the feeling that inadequate housing accounted for the greatest problem. One subject indicated that he was the biggest problem that his parents had to cope with and one subject indicated that his parents had no problems. The subjects that indicated unemployment or financial problems were classified as living in an atmosphere of economic deprivation during childhood and were considered to be a high risk for poor mental health.

The childhood broken home factor is described by determining if the subject lived with original parents until sixteen years of age. Upon investigating the social history of each subject in the 20-29 age category, it was revealed that seven subjects did not live with their original parents to age sixteen and three lived with the original parents. The social history revealed that

three homes were broken due to the death of the father, two homes were broken by death of the mother, one home was broken by divorce and one home was broken by separation of the parents. The percentage of broken homes in this category appears to be consistent with the general belief that children from broken homes are considered to be a high risk for mental illness.

As investigation of the social history was made to determine how many of these subjects could be classified as having poor physical health during their childhood. The history revealed two cases of birth defects, two cases were described as having poor health in childhood, one case was described as having fair health. A description of the type of health problem was not listed. It is assumed that children having poor or fair health are higher risks for mental illness than those with good physical health.

It was revealed from the social history that four subjects in the 20-29 age category had a family history of mental illness among the immediate family. It was indicated that one subject's mother was hospitalized, one mother was constantly hospitalized for short periods of

time, and one mother was receiving psychotropic drugs from a mental health clinic and did not require hospitalization. The four subjects having a family history of mental illness are considered high risk for mental illness.

The pre-adult factors for the 30-39 age category were investigated in the same procedure as the 20-29 age category. Nine of the ten subjects reported to have been victims of childhood economic deprivation. Five subjects reported financial problems responsible for their economic deprivation, two subjects indicated unemployment of the father, and two subjects indicated the father was inadequate to sufficiently perform father duties.

It is not unusual for children to feel deprived when they compare their father's income or occupation with the occupations of their friends' income or occupation in the general atmosphere of economic striving is not classified as pathognomonic. The adult's recall of childhood economic deprivation is a combination of relative deprivation and objective reporting.

In relation to the childhood broken home factor, it was reported that six of these subjects were victims

of broken homes before the age of sixteen. Death of the father was responsible for three cases, death of the mother was responsible for one case, one case was attributed to separation, and indications were given that one case resulted from the desertion of the father.

The social history revealed that three of these subjects could be classified as having poor childhood physical health. All subjects in this age category had no birth defects, and all endured a normal delivery. Two cases were reported to have been sickly children throughout their childhood, and one case was injured in an automobile accident at the age of six which accounts for a leg deformity.

An investigation of the social history for subjects in the 30-39 age category indicated one case where the mother had been hospitalized for mental illness, and nine cases where neither the father or mother had been hospitalized or received treatment from an out-patient mental health clinic.

The 40-49 age category was investigated by the same procedure as the previous categories. Four of the ten

subjects in this age category were not able to respond to the questions asked in the interview because of impaired memory and the information was obtained solely from the social history. It was indicated that seven of these subjects could be classified as being victims of childhood economic deprivation. The social history revealed three cases of families with constant financial problems, two cases of the father not being regularly employed, one case indicated that a sibling was in constant trouble with the law and money was taken regularly from the household to assist the sibling that was involved with crime. One case indicated the father was inadequate to perform the responsibilities expected of a father.

There were five subjects in the 40-49 age category that lived in broken homes during childhood prior to the age of sixteen. Two cases reported the death of the father as being responsible for the broken homes, one case reported death of the mother as being responsible, one case reported separation, and one case reported desertion by the mother.

There were only two cases of the subjects in the 40-49 age category that could be classified as having

poor physical health during childhood. One case indicated sub-normal development during infancy and constant ailments existed throughout his childhood, and one case reported as having generally poor physical health during childhood.

An investigation of the social history of these ten subjects indicated that four of these subjects had records of family members with mental illness. Two cases indicated two mothers were confined to mental institutions, one case revealed that the father was receiving treatment from an out-patient clinic but had never been hospitalized, and one case indicated that a sibling was receiving treatment from a mental health clinic.

The ten subjects in the 50-59 age category were investigated to determine if they lived in the midst of childhood economic deprivation. The social history indicated that five of these subjects could be classified as living in childhood economic deprivation. It was indicated that two of these subjects lived in homes where the parents were constantly faced with financial problems, one subject came from a home where the father did not have regular employment. He performed odd jobs whenever they

were available, and two subjects came from homes where the father was never able to maintain a job for any length of time.

The social history indicated that six of these subjects in the 50-59 age category lived in broken homes prior to the age of sixteen. Two cases of broken homes resulted from the death of the fathers, one home was broken by death of the mother. There was one divorce case and one separation and one case of desertion by the mother that accounted for the broken homes.

The social history revealed three cases to be classified as having poor physical health during childhood. Two of the subjects were babies with normal deliveries, but were constantly ill throughout their childhood. One subject was the result of a premature birth and physical development was very slow.

The family history of mental illness indicates four subjects with a history of mental illness in the immediate family. In two of the cases, the mothers required hospitalization while the subjects were very young, one case indicated that the father was hospitalized, and one case revealed the hospitalization of a sibling.

The ten subjects included in the random sample were investigated by the same procedure as the subjects in the age categories. It was revealed that seven cases could be classified as living in the midst of childhood economic deprivation, one case indicated that father-mother conflicts constantly existed, two cases of regular unemployment for the fathers, and one case indicated that the father was inadequate to perform the duties expected of the father.

The broken home factor indicated five cases where the homes were broken prior to sixteen years of age. Two cases indicated the death of both mothers and fathers. Two cases revealed where the family was deserted by the fathers and one case indicated desertion by the mother.

The social history revealed four cases of childhood poor physical health among these ten subjects. All of the four subjects were born with normal deliveries. One subject developed a heart condition at an early age which resulted in constant physical problems throughout childhood. There were three subjects indicating constant illness throughout childhood, always having one physical ailment after another.

The family history of mental illness revealed two cases of mental illness in the immediate family. One case reported the mother to be in and out of a mental hospital for short periods of time, and during the time the mother was out of the hospital, treatment from an out-patient mental health clinic was necessary. One case indicated a sibling was receiving treatment from a mental health clinic.

The special group consisting of those subjects suspected of using the hospital as a place of refuge was investigated using the same procedure. All subjects of this category had a series of short admissions. It was found that six of these subjects could be classified as living in the midst of childhood economic deprivation during their youth. The social history indicates that financial problems accounted for two cases, and indications were given where the father, in one case, was inadequate to perform family responsibilities.

The broken home factor revealed four subjects living in broken homes prior to the age of sixteen. Death of the father accounted for one case and two cases revealed that the family was deserted by the father.

The social history revealed that six of these subjects could be classified as having poor physical health during their youth. Two of these subjects were of premature birth with slow physical development, three were classified as being constantly ill throughout their childhood, one subject was born with a physical defect that could have been corrected, but the parents were not financially able. This physical defect is believed to have presented problems for this subject throughout his childhood.

Indications were given that four subjects had histories of mental illness in their immediate families. Two cases revealed that the mother was confined to a mental institution, and two cases indicated the fathers were receiving mental treatment from an out-patient clinic.

ADULT FACTORS

An investigation of the social history of all subjects was made in relation to the adult factors. The history revealed for those ten subjects in the 20-29 age category, none appeared to have had employment

worries. Three of the ten subjects had never worked and lived at home until being hospitalized. The remaining seven had been employed prior to hospitalization but no indications were given to reveal if any worries existed pertaining to their employment.

In the area of socio-economic status worries, four of the ten subjects in this category appeared to have experienced socio-economic worries. Two of the subjects indicated they were concerned because they never could get ahead, one subject indicated the cost of living presented a worry because he could never afford many of the things he wanted. One subject responded by indicating how the lack of money prevented him from enjoying his job and his home.

The total family income for these subjects prior to hospitalization as indicated in the social history revealed four families with less than $3,500 total yearly income. Six of these subjects came from families with more than $3,500 yearly income. The four families below the $3,500 income level consisted of large families with four or more siblings.

The subjects in the 30-39 age category indicated that five subjects experienced employment worries. Two subjects felt they were not adequately paid for the work they performed, two of the subjects indicated they did not like the work they were doing because it was too strenuous but could not seek other employment because of their lack of education. One subject worried about his job because he felt his supervisor did not like him and was constantly threatened to be fired.

These subjects were investigated in relation to socio-economic status worries. Only two of the ten subjects gave indications of socio-economic status worries. One subject worried about getting ahead and one worried about his inability to meet the high cost of living.

The total family income for these ten subjects indicated three families with $3,500 income or less and seven subjects above the $3,500 income level. Even though many of the seven subjects whose income was above $3,500, the amounts over $3,500 were not that much higher, according to family size, to make a significant difference.

The 40-49 age category was investigated according to employment worries. It was revealed that four subjects had employment worries. One subject worried about his employment because he felt it was too dangerous. One subject was dissatisfied because he was never promoted after years of experience. One subject indicated concern because his lack of education kept him from obtaining the type of job he desired. One subject was not regularly employed, but only worked at odd jobs whenever they became available. He constantly worried about how long he would have to wait between jobs.

These subjects were investigated in relation to socio-economic status worries. Five of the subjects indicated the presence of socio-economic status worries and five gave no indication of such worries. Two of the five subjects with socio-economic worries felt that getting ahead was the cause of their worry, and three subjects expressed their difficulties in meeting the high cost of living as the reason for their worries.

The total family income of $3,500 or less indicated six subjects coming from homes where the total family income was less then $3,500 and four subjects were from families where the total family income exceeded $3,500.

Those families above the $3,500 income level were not high enough to make a significant difference.

The 50-59 age category was investigated in terms of employment worries. It was revealed that five of the ten subjects expressed worries about their particular employment. Three subjects expressed dissatisfaction with the work they were doing. One subject worried about the distance of travel involved in maintaining his employment, and one subject felt other employees were making his job more difficult.

The socio-economic factor revealed six subjects expressed worry in reference to their worry about socio-economic status. Four of the subjects related their worry to the difficulties involved in getting ahead and two subjects felt their greatest worry was the inability to meet the demands of the high cost of living.

In relation to the family income factor, there were three subjects coming from homes where the total family income was above $3,500.

The ten subjects in the random sample category were investigated in relation to the employment worry

factor. It was discovered that seven of the ten subjects gave indications of employment worries. Four of the seven subjects with employment worries indicated dissatisfaction with their jobs and were unable to obtain more desirable occupations. Two subjects felt the salaries they were receiving were inadequate for the duties performed. One subject possessed a poor work record and expressed concern about being released from his employment.

The ten random sample subjects were investigated in relation to the socio-economic status factor. The data indicate six subjects were constantly worrying about their socio-economic status. Three of the six subjects felt their greatest concern was the difficulty involved in getting ahead. Two subjects indicated their greatest worry was basically concerned with attempting to meet the high cost of living. One subject indicated a large amount of worry but was not sure what he worried about.

The ten random sample subjects were investigated in relation to the total family income factor. It was revealed that eight of the ten subjects had experiences

of employment worries. Three of the eight subjects expressed concern about being underpaid, one subject gave indications that his health condition prevented him from being efficient on his job and worried about being released. Two subjects gave indications of worry but could not identify any particular aspect of their employment that created the worry.

An investigation was performed relating these ten subjects to the socio-economic status factor. It was revealed that five of these subjects gave indications of socio-economic status worries. Two of the subjects related their worry to the difficulties involved in getting ahead, and three subjects felt that the inability to adequately meet the high cost of living created their greatest worry.

These ten subjects were also investigated in relation to the total family income factor. The data reveal that six of these subjects came from homes where the total family income was less then $3,500 prior to hospitalization, and four subjects came from homes where the total family income was above $3,500 a year.

PSYCHOSES AND NEUROSES

Upon admittance to a mental facility, the mental patient is interviewed by a psychiatrist and is given a diagnosis. This diagnosis is determined through the medium of a personal relationship established by the diagnostician who elicits and observes a range of psychological functioning which he considers relevant on theoretical grounds for understanding the disorder so that he can present recommendations which stand a good chance of being acted upon as a basis for dealing with the disorder.

A correct diagnosis is a difficult and delicate matter to obtain because it rests on a number of achievements: 1) the sensitivity with which the clinician has used himself in eliciting the functioning, 2) the thoroughness with which the clinician has observed this functioning, 3) his theoretical position and his grasp of that position, 4) the astuteness with which he formulates a recommendation, and 5) the preparation in in the relationship with the patient for presenting the recommendation as well as the tact with which it is presented.

Each subject in this study was seen by a diagnostician after being admitted by the intake unit at the hospital. The records indicate that eight subjects in the 20-29 age category were diagnosed as psychotic while only two subjects were diagnosed as neurotic. All ten subjects in the 30-39 age category were diagnosed as psychotic. Six subjects in the 40-49 age category were diagnosed as psychotic and four subjects were diagnosed as neurotic. Seven subjects in the 50-59 age category were diagnosed as psychotic and three subjects were diagnosed as being neurotic. Among the ten random sample subjects, nine were diagnosed as psychotic and only one diagnosed as neurotic.

Among the special group, those suspected of using the hospital as a place of refuge, eight subjects were diagnosed as psychotic and two were diagnosed as neurotic. It was interesting to note that the daily nursing notes on the subjects in the special group indicated that only three of the eight subjects diagnosed as psychotic showed signs of psychoses when they were not being interviewed by a psychiatrist or a psychologist. This information supports the theory that many patients are able to manipulate the staff in order to maintain their residency in the hospital.

TABLE 1

FREQUENCY DISTRIBUTION AMONG SUBJECTS BY PRECIPITATING FACTORS

AGE	NO.	CHILDHOOD EXPERIENCES		BROKEN HOMES		POOR PHYSICAL HEALTH		SOCIAL HISTORY		INCOME		EMPLOYMENT WORRIES		SOCIO-ECONOMIC WORRIES		PSYCHOSIS OR NEUROSIS	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	P	N
20-29	10	2	8	7	3	5	5	4	6	4	6	2	7	4	6	8	2
30-39	10	9	1	6	4	3	7	1	9	3	7	6	4	2	8	10	0
40-49	10	7	3	3	7	2	8	4	6	6	4	4	6	5	5	6	4
50-59	10	5	5	6	4	3	7	4	6	3	7	5	5	6	4	7	3
RANDOM SAMPLE *	10	7	3	6	4	4	6	2	8	4	6	7	3	6	4	9	1
SPECIAL** GROUP	10	6	4	4	6	6	4	5	5	6	4	8	2	5	5	8	2

*Sample of all age levels, 20-26.

**Random sample of patients suspected of using the hospitals as a place of refuge. Not included in age groups.

CHAPTER IV

SUMMARY, PROCEDURES, AND FINDINGS

SUMMARY

This study has traced the development of modern psychiatric thought from its early beginnings to the development of the organic, psychological and sociological trends of thought. Much emphasis was placed upon adjustment as a function of the level and type of stress in relation to an individual's adjustive resources. Psychology, sociology, psychiatry, and other disciplines, agree that the various factors exhibited in any maladjustive behavior may be classified as predisposing factors such as hereditary and pathogenic family patterns which have developed into inadequate personalities, and emphasis was directed upon precipitating factors involving various degrees of stress, such as loss of loved one, extreme and sustained pressures, or severe conflicts. It was concluded that the predisposing or precipitating factors may be predominantly biological, psychological or sociological.

These three factors become involved, either as a reinforcement or as a counter balance to each other, but each has a special role in an individual's behavior.

The cases observed in this study are a representative sample of patients from a typical state mental institution. Each subject was compared to the various selected factors as being prominent factors in their lives prior to admission to an institution, which may have been possible factors leading to their hospitalization.

This study is involved with two basic analyses. The first analysis assesses how income, childhood experiences, family history of mental illness, poor physical health, broken homes, employment worries and socio-economic worries as being possible factors leading to mental stress experienced by these subjects that may have been a variable responsible for their hospitalization. The second analysis is related to the observation that the majority of these subjects are diagnosed as psychotic rather than neurotic and that the diagnosis has an influence on the length of time hospitalization is required.

PROCEDURES

The subjects for this study were randomly selected from patients residing upon eight chronic wards at Manteno State Hospital. All identification numbers of the 297 residents were listed and every third number was chosen to be included in this study. Upon selection, each subject was placed in the appropriate age group category. Ten subjects were placed in six separate age group categories. Group one included ten subjects within the 20-29 age range; group two consisted of ten subjects within the 30-39 age range; group three included ten subjects within the 40-49 age range;; group four consisted of ten subjects within the 50-59 age range. A random sample of all age levels were placed in a separate cell. A random sample of those residents suspected of using the hospital as a place of refuge, all consisting of a series of short admissions, and functioning on a high level while residing at the hospital; all of voluntary status, were placed in a separate cell.

Each group was compared to the following factors:

1. Childhood Experiences - This factor was defined as the experiences the subjects had during childhood that may have been a factor responsible for poor mental health. An investigation of the social history was made to determine if there was any record of such experiences. An interview with each subject able to respond and with available relatives, was held to determine if any experiences were remembered. The major question asked during the interview that was most relevant to this study was: What would you say were the major problems facing your parents while you were growing up? The responses were coded under the following factors: (1) none, (2) unemployment, (3) work, (4) financial, (5) siblings, (6) myself, (7) father-mother conflict, (8) father inadequate, (9) mother inadequate, and (10) housing and neighborhood influences.

2. Broken Homes - This factor was identified by determining if the subject lived with original parents until sixteen years of age. This was determined by patient interview, social history and interview with available relatives.

3. Poor Physical Health - The poor physical health factor was determined by investigating the social history and interviewing available relatives to discover if the subject experienced poor physical health during youth.

4. History of Mental Illness in Family - The information obtained from the social history and interviews with available relatives, indicated the number of family members that were victims of poor mental health.

5. Total Family Income - The figures related to this factor indicated the total family income for the subjects of this study prior to hospitalization. Particular interest was given to those whose income was $3,500 or less. The information was obtained from the social history of each subject.

6. Employment Worries - This factor was defined as experiences involved in maintaining employment and does not apply to unemployment. The subjects that were able to respond were interviewed, and since

all subjects could not adequately reply to questions, the information was obtained from the social history and available relatives.

7. Socio-Economic Status Worries - The socio-economic status factor was related to the attitude of the subject toward his occupational level and income and its possible influence upon good or poor mental health. The information was obtained from the social history and available relatives.

Each subject was compared to each of these factors and those subjects relating to the highest number of factors were classified as being a high poor mental health risk prior to hospitalization.

DIAGNOSIS OF PSYCHOSIS OR NEUROSIS

Each patient entering the hospital is given a provisional diagnosis. An evaluation is made of the patient's mental condition, thought process, thought content, effect, mood, orientation, speech relevancy and coherency, memory, insight and judgment. The

patient is then given a provisional diagnosis within the general classification of psychosis or neurosis.

FINDINGS

The data in this study indicate that the factors of childhood experiences, broken homes and socio-economic worries were predominant factors among all age groups. The childhood experience factor is closely related to financial and unemployment problems. The data and information obtained indicate that those subjects with unpleasant childhood experiences resulted from the lack of available finances and not necessarily from unpleasant experiences. Those experiences would best be described as childhood economic deprivation. Most children feel economically deprived when their income and occupation is compared with the income and occupation of their peers.

The data indicate that more homes of these subjects were broken as a result of death of the mother, father or both parents. The mental health risk associated with the death of the mother is greater,

especially among low-socio-economic families. When the father dies, the mother is either forced to obtain employment or remarry, attempting to hold the family together.

All of the subjects in this study lived in a large urban community prior to their hospitalization and the data suggest that people in the low socio-economic status, especially those in large communities, are faced with a situation of deprivation and their chances are very limited to effectively cope with the mental stress the situation creates.

The subjects in this study that experienced only one of these factors, showed no difference in their behavior than those subjects possessing two or more factors. The mental health risk of persons possessing one factor, in many instances, can be as great as those possessing two or more factors, if they are unable to effectively cope with the situation.

It was further observed in this study that the majority of the sixty subjects were diagnosed as

psychotic. There were eight subjects in the 20-29 age range; ten subjects in the 30-39 age range; six subjects in the 40-49 age range; seven subjects in the 50-59 age range; nine subjects among the random sample of all ages and eight subjects in the special group, suspected of using the hospital as a place of refuge, were diagnosed as psychotic.

The subjects in the random sample of all age levels and in the special group showed no major difference than those subjects in the various age groups.

All of the subjects diagnosed as psychotic have been given a poor prognosis. Many of them have been hospitalized for long periods of time. Many of them have had a series of short admissions. Their diagnosis is determined by the extent of their loss of contact with reality, distortion of perception, regressive behavior and attitudes, diminished control of elementary impulses and desires, or abnormal mental content, including delusions or hallucinations.

RECOMMENDATIONS

The following recommendations result from the findings in this study:

1. Mental health agencies should direct more attention to the establishment of a variety of mental health day care centers, especially in metropolitan areas providing preventive measures and treatment programs. Such facilities would lower the number of patients admitted to state institutions. The cost of providing care for each patient in an institution would be lowered significantly. Patients requiring hospitalization would benefit from more effective treatment due to the lower staff patient ratio. Patients attending day care centers would be more cooperative with treatment in familiar community settings. Establishing mental health day care centers in the community would help to keep the family mobilized and involved in treatment.

2. Community mental health centers and other community mental health agencies should provide telephone service for crisis situations utilizing a variety

of mental health practices and non-professional personnel with mental health professionals for consultation and back-up.

3. Treatment of mental disorders by community health centers, behavior therapists and crisis intervention centers should avoid psychiatric labels and divert more attention to specific problems and behaviors and keep the individual in a non-depreciatory environment, since many of the undesirable behaviors are learned.

4. Public school systems should provide mental health preventive measures within the schools by establishing discussion groups for students to explore a variety of topics, such as, getting along with peers, teachers and parents, assisting the students to begin coping with problems at an early age. In establishing such discussion groups, school administrators should be sensitive to the needs of various ethnic groups by selecting group leaders who are familiar with the various problems and able to relate to the students.

APPENDIX A

DATA COLLECTION INSTRUMENT

DATA COLLECTION INSTRUMENT

AGE	NO.	CHILDHOOD EXPERIENCES		BROKEN HOMES		POOR PHYSICAL HEALTH		SOCIAL HISTORY		INCOME		EMPLOYMENT WORRIES		SOCIO-ECONOMIC WORRIES		PSYCHOSIS OR NEUROSIS	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	P	N
20-29																	
30-39																	
40-49																	
50-59																	
RANDOM SAMPLE																	
SPECIAL GROUP																	

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