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An Analysis of the Comparative Effectiveness of Day Center Treatment and Out-Patient Treatment for a Psychiatric Population

John T. Gallagher
Western Michigan University

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AN ANALYSIS OF THE COMPARATIVE EFFECTIVENESS OF
DAY CENTER TREATMENT AND OUT-PATIENT TREATMENT
FOR A PSYCHIATRIC POPULATION

by

John T. Gallagher

A Thesis
Submitted to the
Faculty of the School of Graduate Studies in partial fulfillment
of the
Degree of Master of Arts

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John T. Gallagher
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Western Michigan University, M.A., 1969
Psychology, clinical

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INTRODUCTION

This paper is concerned with presenting a program of treatment for psychiatric populations and evaluating its effectiveness. This program of treatment is described extensively in Appendix I and is embodied in St. Joseph Lodge, a psychiatric day center affiliated with the William Upjohn DeLano Memorial Clinic, a psychiatric out-patient clinic. The crucial question is: "Is St. Joseph Lodge a useful addition to the DeLano Clinic?"

The day center or day hospital for mental patients is a relatively new concept in treatment. It has its origins in the Soviet Union but was first introduced into Western literature in 1947, when Cameron reported on his work in Canada. It has only been in the last decade that day treatment has gained any prominence as a form of treatment. A recent survey (Glasscote et al, 1969) identified 139 day programs nationally and estimated a total caseload of all partial hospitalization facilities, including those not known to the authors, as 12,250 -- a slight fraction of the approximately 500,000 in-patient caseload, not to mention the out-patient caseload. Therefore, despite its rapid growth in recent years, it is still a little used form of treatment.

Research on day programs has been sparse to date, as, in fact, has been psychotherapy research in general, i.e., in terms of establishing the validity of treatment. This author believes that the paucity of good psychotherapy research has been due to a number of causes:
1) Clinicians, in general, have failed to see the importance of rigourous research until recently and have usually not been trained in research methods.

2) Subjective treatment methods have seemingly led to subjective research.

3) The needs of the researcher often conflict with the needs of the patient or clinician, thus making research difficult.

4) The problems of achieving adequate control in clinical situations are immensely difficult and research is therefore either not done or is inadequately controlled. Some of these problems are met and dealt with in this study.

Reviews of research on day programs are available (Glasscote et al, 1969; Meltzoff and Blumenthal, 1966). In addition, a good review of in-patient "therapeutic community" research is also found in Meltzoff and Blumenthal. In general, these reviewers did not find any adequately designed or controlled research. Most of the research done compared in-patient to day treatment. Despite the limitations of this research, Kramer (1967) concluded, "... no definitive evidence has been marshalled to date to prove that, for certain cases, partial hospitalization is more effective than full time hospitalization. The most valid conclusion would seem to be that day care is no less effective than traditional methods of patient care." (p. 1303) If this conclusion is valid, day treatment which is usually less expensive than in-patient treatment is probably justified. By the same token, to justify its existence in relation to out-patient treatment, day treatment would have to show itself superior for certain types of patients.
Not covered in these reviews is a study by Guy et al (1969) comparing out-patient treatment reported as being only chemotherapy and day treatment also utilizing chemotherapy. Results were obtained with ratings by an "Independent Assessment Team" specifically hired for that purpose. Their findings were in favor of the day treatment in comparing the two groups on global measures of improvement, but not on measures of more specific symptomatology. They further state, "Our findings indicate that, for schizophrenics with schizo-affective features, the day hospital is the treatment of choice. For the neurotically anxious and depressed (nonschizophrenic) patient, however, out-patient chemotherapy is as effective and significantly more rapid than partial hospitalization in terms of immediate outcome criteria." (p. 337) Further, hospitalization rates for the two groups did not differ but day treatment patients required shorter hospitalizations. The reported improvement in schizophrenics was in communication and accessibility. They also report on some predictor variables. It is the present author's opinion that these findings should be looked upon with caution. Using the "Independent Assessment Team" is supposed to eliminate biased ratings but this seems to be only an assumption; it seems as if this team was aware of which treatment each subject was receiving and, being hired to evaluate the effectiveness of the day center, a bias for day center treatment might be suspected. In addition, as Goldstein et al (1966) emphasize, the long range reliability of rating scales is in serious doubt. The
main criticism against this study is, however, the method of selecting and assigning subjects. The subjects were all referred to the day center, seen by the day center staff and deemed acceptable, assessed on the rating scales, and then randomly assigned. The feelings of rejection and resentment that this might have raised and the possible eroding of motivation by being switched to another facility are factors clouding the results. Further, the effects of this rejection are not even measured because of the timing of the pre-treatment assessment.

Wilder et al (1966) report on a two year follow-up study on emergency psychiatric patients assigned either to a day program or to in-patient care. In this, they clear up one of the difficulties of an earlier study (Zwerling and Wilder, 1964); that is, they put all subjects with organic brain syndrome, all of whom had been assigned to the in-patient unit, into a separate group. The results, however, did include all of those assigned to both treatments including those rejected by the day program staff (25%) for reasons other than organic brain syndrome. The results also include another 25% of the total day center sample that spent time on the in-patient unit during their stay at the day center. Raters were used for the two year post-treatment evaluation only. The results must be limited to a study on the applicability of day treatment rather than an evaluation of its relative effectiveness because of the complications in the samples. In general then, they found that certain acute psychiatric patients could be treated in a day program.
One of the more extensive pieces of research done to date is that by Meltzoff and Blumenthal (1966) comparing 69 male veterans, mainly schizophrenics, seen either at a Veterans Administration out-patient clinic or at the adjoining Day Treatment Center over an eighteen month period. They sought to answer a similar question to that asked in this study: "Is the day treatment center a worthwhile addition to an out-patient treatment facility?" (p. 117) The problem of rejecting patients from day treatment, discussed above in connection with Guy et al (1969), was handled fairly well by Meltzoff and Blumenthal. However, the concomitant problem of "bouncing back" some control (out-patient) patients to the referring therapist seems not to have been controlled. This involved an unspecified percentage of the control group and would seem to cast a shadow of uncertainty over the results. For instance, many of these therapists may have believed that their patients could gain no more by seeing them or would never gain anything from individual treatment and therefore referred the patient to the day center only to be told to see him some more. In addition to the effect on the therapist, it may be a bias to compare those individuals just beginning a treatment (day patients) to those continuing in a treatment (some of the control patients).

Meltzoff and Blumenthal used rating scales and objective criterion (hospitalization and employment) to evaluate the two groups at three month intervals. The rating scales were designed by the authors to measure interpersonal relations, self-concept, affective control, motivation, mood, dependency, adjustment to the family and...
use of community facilities. Reliability of these scales was estab­lished on a short term interval, leaving the above questions as to long term stability in doubt, and possibly clouding the results fur­ther. This study also used the independent assessment team approach and the same criticism would apply.

These authors found that day patients did significantly better than controls in terms of hospitalization, community adjustment and self-concept. Detailed analyses of the data are made in terms of patient characteristics, time intervals, outcome measures, etc. that are well worth careful examination. Possibly the most interesting finding is that the patient lowest in adjustment at the beginning of the study benefited the most from day treatment as opposed to outpatient treatment. It seemed as if low and highly adjusted day patients would often converge in their adjustment, at times to the detriment of highly adjusted day patients.

There are many similarities between the treatment so exten­sively described by Meltzoff and Blumenthal and the treatment at St. Joseph Lodge described in Appendix I. The Lodge's program was pat­terned, in part, after Meltzoff and Blumenthal's program. However, there are also many important differences. One of these differences involves the population served; whereas Meltzoff and Blumenthal's program generally serves male veterans with a history of psychiatric hospitalization, St. Joseph Lodge serves a preponderance of female civilians who may or may not have histories of hospitalization. Another important difference is the length of treatment. At St. Joseph Lodge the length of treatment averages about two months,
while Meltzoff and Blumenthal suggest that the length of stay for their patients should be at least a year.

One problem with comparing research in day programs is the vast divergence of programs. The treatments themselves are usually inadequately described in the research reports, making comparisons and replications difficult. Meltzoff and Blumenthal describe their treatment in considerable detail as this paper also tries to do in Appendix I.
PURPOSE

The type of research involved in this study would be classified as applied research in Edwards and Cronbach's (1966) system of survey, applied and critical research. Applied research is concerned with obtaining answers to practical questions; often this research is used for administrative purposes in particular settings. The question for the administrator then is: "Is the day center a useful adjunct to the out-patient clinic?" Meltzoff and Blumenthal (1966) state:

Neither the program innovator nor the researcher can make these value judgments for the administrator. It is, however, the innovator's obligation to state what the program purports to accomplish, how it is expected to do so, and the researcher's (obligation) to determine whether or not the goals are being achieved. (p. 114)

The present author being innovator and researcher must supply all of this information to the administrator. The specific methods and goals of the program are presented in Appendix I and the research evaluation shall be done in terms of these goals. The two general, inter-related questions to be answered are: "Is the day program achieving its goals?" and "How does day treatment compare in its effectiveness to out-patient treatment for this population?"

This study is, then, an outcome study to determine the validity of a treatment program as opposed to a process study to determine what is involved in treatment. Simple outcome studies such as this one are usually all that is needed for administrative research but they do have important shortcomings. Not the least of these shortcomings is a possible zero net effect through the interaction of
positive and negative variables. A retreat into simple process research is not seen as the answer. Rather, the answer is found in the study of process variables as they relate to outcome (Cartwright, 1966).

In the general field of psychotherapy research, process studies are pursued vigorously but without a foundation of outcome research to draw on. Indeed, the effectiveness of psychotherapy, as opposed to nothing, has yet to be shown (Goldstein et al, 1966; Schofield, 1964)! Goldstein et al go on to state:

Only after we have been able to demonstrate that we can consistently produce a particular change in behavior as a result of a particular manipulation does it seem advisable to expend effort in studying the 'process' involved in the manipulation. (p. 10)

They further recommend in investigating the absolute efficacy of a type of treatment, that types of treatment be compared with less expensive types of treatment, observing what happens as we approach zero, calculus fashion, rather than compare treatment to no treatment (an approach extremely difficult, if not impossible, in psychotherapy research). We might, then, say that the purpose of evaluating outcome in this study is not only what is dictated by its administrative nature but also what is dictated by whatever small niche this research may find in the company of basic research in treatment methods. Almost all day treatment research is, by necessity, administrative research. It seems as though it will take an accumulation of such research to lead to any inferences of a more basic nature.
DESIGN

The type of design often recommended for simple outcome research is the Solomon Four Group Design (Solomon, 1949). This design is recommended because of possible interaction effects of pre-testing with treatment and/or post-testing. In the present research such a design was viewed as undesirable. Pre-testing is done routinely at both the day center and the out-patient clinic and as such can be considered an integral part of both treatments. Generalization to future populations at these facilities would then require that pre-testing be retained for all subjects in this research. The undesirable consequences of removing some of the pre-tests was considered greater than the possibility of differential interactive effects of pre-testing on post-testing between groups, although, presumably these effects would be equal. Therefore, a simple two group design was used, with a treatment group receiving day treatment and a control group receiving out-patient treatment.

In designing research in psychotherapy, there is not only a universe of subjects to be sampled but a universe of therapies, a universe of therapists, a universe of therapist variables and a universe of outcome measures (Goldstein et al, 1966; Patterson, 1960). Being an applied study, the universe of therapies is not sampled in the present research; a comparison of the therapies of the two particular settings is all that is of interest. The lack of sampling of therapies and settings limits the generalizability of findings, a fundamental differentiation between this applied
research and basic research.

Sampling the universe of therapists within these settings, by contrast, may be an issue in the present study. In the day center, each patient is handled on a staff-wide basis rather than having a particular therapist. This makes the sampling of therapists not applicable to the day program. The control patients in this study were each treated by one of four therapists on the clinic staff (universe) of nine therapists. With almost half of the clinic staff involved this is considered an adequate sample. This was despite the fact that it was not a systematic sample but fell by chance depending on the selection of control patients (they had already been assigned a therapist before their selection as controls).

Relatively little is known about the important variables in the universe of therapist variables making sampling for this kind of study difficult. Perhaps the most researched therapist variable shown to be of importance is the A-B variable (Betz, 1962). Unfortunately, this variable has been demonstrated only with male therapists and some of the staff members of the day center were female, thus eliminating the use of this dimension. The problem of therapist variables consequently went uncontrolled in this study.

The universe of outcome measures has also been generally neglected in psychotherapy research, with most studies using only one measure. The need for more than one measure stems from the wide disagreement as to which measures are meaningful, which in turn, stems from the different expectancies as to what the outcome of psychotherapy should be. Considering this problem, Goldstein et al
(1966) suggest:

What is badly needed in every psychotherapy research program is a research plan which incorporates several different outcome measures, preferably methodologically, if not conceptually, independent. (p. 49)

Accordingly, a number of outcome measures have been used in this study. Hopefully, they represent an adequate sample of the universe of outcome measures.

The outcome measures have been chosen to evaluate the goals of the day center (see Appendix I). Rating scales usually used in day treatment research have not been used because of the doubts discussed above and because of financial limitations. Three types of measures are used to evaluate outcome and attainment of goals:

1) Objective, "practical" criteria such as employment and hospitalization (see Webb et al, 1966 for a review of such measures).

2) Standardized tests, one of which, at least, is in wide clinical use.

3) Patient self ratings.

Hunt (1949) calls for the evaluation of the outcome of psychotherapy by the client, others whose lives are directly affected by the client, and society in general. An attempt is made in this research to comply with Hunt's request on all but the evaluation by society -- perhaps, the "practical" measures reflect the subject's contribution to, or detriment from, society and thereby indirectly reflect what society might say.

The dependent variables or outcome measures are as follows:

1. Hospitalization during the time of the study (H)
   Due to the short time period of the study this is a simple
yes or no category gathered as post-treatment data. This measure is designed to evaluate the goal "avoidance of hospitalization".

2. **Employment at the conclusion of the study (E)**  
This is also a simple yes or no category gathered as post-treatment data and compared with employment at the time of entering treatment. This measure is designed to evaluate, in part, the goal "facilitate social adjustment".

3. **Useful skills obtained during this study (US)**  
This is also a simple yes or no category evaluated by the subjects themselves as post-treatment data. The definition of "useful" is up to the subject. This measure is designed to evaluate the goal "education in translatable skills". It is not, however, used in comparing the general effectiveness of the two treatments as it is the only goal not also included in the control treatment.

4. **Independent of treatment (I)**  
This is another yes or no category involving whether or not the subject was under psychiatric treatment anywhere at the termination of the study. This measure is designed to evaluate the goal "foster independence from a need for treatment".

5. **The Community Adaptation Schedule (CAS), (Roen and Burns, 1968)**  
This is a standardized paper and pencil test administered as both a pre- and a post-test. It yields total scores as well as scores for sub-categories representing areas of social adjustment. It is designed to evaluate, in part, the goal "facilitate social adjustment".

6. **The Minnesota Multiphasic Personality Inventory (MMPI), (Hathaway and McKinley, 1943)**  
This is a standardized paper and pencil test of wide clinical use given here as both a pre- and a post-test. It is designed to measure psychopathology on a number of different scales. Direct changes in scale elevations can be compared, average elevations can be compared or profile configurations can be compared. It is designed to evaluate, in part, the goal "improvement of the clinical condition of the individual".

7. **The Interpersonal Check List (ICL), (LaForge and Suczek, 1955)**  
This is a standard paper and pencil test given both as a pre- and a post-test to whomever the subject was living with in the closest relationship, generally the spouse. The relative was to describe the subject on this measure. If the subject lived alone, this test was not used; this, plus non-cooperation of the relatives, made this measure used in fewer cases than any of the other measures. It is used to evaluate, in part, the goal "improvement of the clinical condition of the individual".

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8. **Self Ratings (SR)**

The subjects rated their post-treatment clinical condition on a five point scale: much worse (1), worse (2), same (3), improved (4), much improved (5). This is to evaluate, in part, the goal "improvement of the clinical condition of the individual".

The discerning reader will probably note that there is, at least, a theoretical overlap in what these methods measure as, indeed, there is a clear overlap in goals of the day program. It is hoped that, rather than being detrimental, this overlap will allow the measures to reinforce one another and more or less cross-validate each other.

It is hoped that the small sample of subjects in this study is compensated for, at least in part, by the comparatively large sample from the universe of outcome measures. On this point, Edwards and Cronbach (1966) state:

> Effort to refine measurement has the same beneficial effect on the power of an investigation as adding to the number of cases; the fanciest and largest studies can be no better than the evaluating tools. (p. 75)

Perhaps the undesirability of this small sample is also offset by the opportunity to look at individual subjects, an opportunity not always feasible with large samples. It might also be said that a statistically significant difference obtained on a small sample is more clinically meaningful than an equally statistically significant difference on a large sample, although it is not usually as stable.

This research was a "single blind" study, i.e. the subjects were unaware that they were objects of research while the staff of both treatment facilities were aware of this. However, the research did not interfere in any way with the ordinary operation of the two
facilities. Hopefully, any effect from the therapists' awareness of the research was obviated by being present in both groups and by using outcome measures independent of the therapist.

The "hello-goodby effect" (Hathaway, 1948) should have similarly been equal for each treatment, or if anything, have worked to the benefit of the out-patient clinic, being the more intense one-to-one relationship. Concern over a "placebo effect" would seem to be unwarranted. The placebo effect can be regarded as an effect generated by both the expectations of the therapist and the patient. Therefore, any effect such as this would be considered an important effect of treatment itself and included in the comparative evaluation. In other words, the placebo effect is a part of psychotherapy.

One effect that cannot be dismissed easily is a new program as opposed to the well-established out-patient clinic. It can only be said that the day center attempts to use this effect by keeping up enthusiasm in both patients and staff with a continually changing program. Further research when the day center is well-established would be able to ferret out the effect of "newness" per se by comparison with the present study and cast additional light onto this study.
SUBJECTS

Criteria for selection of subjects are detailed in Appendix I. Referrals for the day center were channeled through the out-patient clinic. The clinic staff did not inform the patients that they were being referred for day treatment but that they were being referred to evaluate what type of treatment would be best suited for them. Foreknowledge of day treatment did not occur in any of the subjects. Random assignment of those patients judged acceptable by the day center staff was then to have taken place (in practice, no referrals were found unacceptable). Unfortunately, the referrals were fewer than anticipated and all referrals were accepted for day treatment with none for out-patient treatment. This non-cooperation by the day center staff was an instance of the clinical needs taking precedence over the research needs. Therefore, a number of cases were drawn from the recent out-patient clinic files who fit the criteria for day center treatment and if their therapists thought they were good candidates for day treatment, they were included in the Out-patient group without having contacted the day center staff. In essence, the first nine referrals were put in the treatment (Day Center) group and the next seven referrals were put in the control (Out-patient) group. One member of each group could not be located at the conclusion of the study. This left eight treatment subjects and six control subjects on which the data are presented.

The method of selecting subjects, of course, was not as desirable as the planned random assignment would have been but it did
approach it. Perhaps it was one more step removed from the unattainable random sample (Goldstein et al, 1966) than the random assignment would have been and one step closer than the "patched up" design discussed by Campbell and Stanley (1963). In other words, confidence in the results was slightly affected rather than negated.

Tables I and II show the two groups compared on demographic variables. Using the .05 level of confidence, there were no significant differences between the two groups on these variables, leaving the assumption that these two samples were drawn from the same parent population intact. There was, however, a tendency, albeit non-significant, for the Day Center sample to be younger and better educated. This could possibly have given them somewhat of a clinical advantage (Meltzoff and Blumenthal, 1966; Guy et al, 1969).

The one treatment variable extraneous to the comparison of treatments was psychotropic drugs. This was not directly controlled for fear of interfering with the ordinary procedures of the two facilities. Therefore, a statistical comparison using the same methods as in Table II was made on the use of psychotropic drugs in Day Center and Out-patient subjects. 78.6% of the total sample took drugs during the study as part of treatment. This group comprised 62.5% of the Day Center subjects and 100% of the Out patients. This difference was not significant ($p = .154$) at the .05 level of confidence but does show a tendency for more Out-patients to receive psychotropic drugs than Day Center patients. This trend might have given the control group somewhat of a clinical advantage. It was presumed that this advantage offset the advantage that the Day
TABLE I

Demographic Data for Day Center (n<sub>DC</sub>=8) and Out-patient (n<sub>OP</sub>=6) groups taken at the time of pre-testing.\textsuperscript{1}

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total $\bar{X}$</th>
<th>DC $\bar{X}$</th>
<th>OP $\bar{X}$</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>age</td>
<td>31.1</td>
<td>27.8</td>
<td>35.7</td>
<td>1.399</td>
</tr>
<tr>
<td>education</td>
<td>11.4</td>
<td>12.4</td>
<td>10.0</td>
<td>2.034</td>
</tr>
<tr>
<td>number of hospitalizations</td>
<td>1.4</td>
<td>1.3</td>
<td>1.5</td>
<td>.274</td>
</tr>
</tbody>
</table>

\textsuperscript{1}All of the tests of significance in this paper are two-tailed tests.
### TABLE II
Demographic Data on the Subjects at the Time of Pre-testing. All Percentages are Rounded.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>% Total</th>
<th>% DC</th>
<th>% OP</th>
<th>p</th>
</tr>
</thead>
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<tr>
<td>sex</td>
<td>male</td>
<td>21.4</td>
<td>25.0</td>
<td>16.7</td>
<td>.461</td>
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<tr>
<td></td>
<td>female</td>
<td>78.6</td>
<td>75.0</td>
<td>83.3</td>
<td></td>
</tr>
<tr>
<td>race</td>
<td>Caucasian</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>other</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>marital status</td>
<td>married</td>
<td>57.1</td>
<td>50.0</td>
<td>66.7</td>
<td>.349</td>
</tr>
<tr>
<td></td>
<td>other</td>
<td>42.9</td>
<td>50.0</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>prior hospitalization</td>
<td>yes</td>
<td>57.1</td>
<td>50.0</td>
<td>66.7</td>
<td>.349</td>
</tr>
<tr>
<td></td>
<td>no</td>
<td>42.9</td>
<td>50.0</td>
<td>33.3</td>
<td></td>
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<tr>
<td>employment</td>
<td>employed</td>
<td>7.1</td>
<td>12.5</td>
<td>0.0</td>
<td>.571</td>
</tr>
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<td></td>
<td>unemployed</td>
<td>92.9</td>
<td>87.5</td>
<td>100.0</td>
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<td>religion</td>
<td>Protestant</td>
<td>71.4</td>
<td>62.5</td>
<td>83.7</td>
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<td></td>
<td>other</td>
<td>28.6</td>
<td>37.5</td>
<td>16.3</td>
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<td>drugs</td>
<td>on</td>
<td>78.6</td>
<td>62.5</td>
<td>100.0</td>
<td>.154</td>
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<tr>
<td></td>
<td>not on</td>
<td>21.4</td>
<td>37.5</td>
<td>0.0</td>
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</tbody>
</table>

2The sample size is too small for $\chi^2$ or other statistical techniques for comparing proportions. The probability of each arrangement of proportions is computed directly without reference to the normal curve by the following formula:

$$p = \frac{(a+b)! (c+d)! (a+c)! (b+d)!}{N! \ a! \ b! \ c! \ d!}$$

where a, b, c, and d are frequencies in a 2 x 2 contingency table and N is the total number of subjects. (Walker and Lev, 1953, p. 104)
Center group had by tending to be younger and better educated.

The two groups were also compared utilizing their scores on pre-treatment measures. This was, perhaps, the most important of the methods used herein to establish equality between the groups. In other words, if we are to use these measures to make judgments about the relative effect of treatment, then it is imperative that there be no significant pre-treatment differences between groups on these measures. Employment was a dependent variable as well as demographic variable; as can be seen in Table II, there was no significant difference between groups on this variable before treatment. In Table III, the two groups were compared on the pre-treatment measure: MMPI, ICL and CAS. As can be seen by inspection of the table, there were no significant differences between groups as shown by the "t" test.

It is reasonable to conclude from the foregoing that there are no significant differences between groups. It follows, then, that any differences in the direction or amount of change between the two groups can be attributed to the respective treatments.

\[ ^3 \text{MMPI pre-treatment Welsh codes for average K-corrected T scores for each group are: Day center: 827'43061-9/ F-KL?; Out-patient: 8'234176'0-9/ F'LK?’} \]
### TABLE III

Data From the Pre-Treatment Test Taken by the Day Center (DC) and Outpatient (OP) Groups. MMPI Entries are Average T Scores for all Subjects ($n_{DC}=6$; $n_{OP}=5$) on all Scales Except Scale 5. CAS Scores Presented are the Mean Of and Total Mean Scores for Each Group ($n_{DC}=8$; $n_{OP}=4$). ICL Entries are Mean Adjustment Scores (See Procedure) For Each Group ($n_{DC}=4$; $n_{OP}=3$).

<table>
<thead>
<tr>
<th>Measure</th>
<th>DC</th>
<th>OP</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMPI</td>
<td>61.74</td>
<td>67.42</td>
<td>1.040</td>
</tr>
<tr>
<td>CAS</td>
<td>3.57</td>
<td>3.58</td>
<td>.080</td>
</tr>
<tr>
<td>ICL</td>
<td>19.3</td>
<td>31.3</td>
<td>.774</td>
</tr>
</tbody>
</table>
PROCEDURE

The treatment for the Day Center group is detailed in Appendix I. There were, of course, individual variations of the treatment for each subject. During the four months covered by the study, the group attended the Lodge an average of 16.3 times with a range of 4 to 31. These times in attendance were generally for the whole day. At the conclusion of the four months, one member of the Day Center group was deceased, one member had stopped coming to the Lodge but was seeking help elsewhere and four members had terminated treatment at the Lodge and were not being seen elsewhere.

Treatment for the Out-patient subjects was one-to-one psychotherapy combined with chemotherapy. One hour contacts were generally held, concentrating on either "supportive" or "insight" therapy. Therapists for the Out-patient group were all experienced psychotherapists; they included three psychiatrists and one psychiatric social worker. In one case, in addition to one-to-one psychotherapy, the subject was seen conjointly with her spouse. The goals expressed by these therapists fit rather closely with those of the day center (see Appendix I). The goal "education in translatable skills" however, was absent in the out-patient treatment. The day center goal "improvement of the clinical condition of the individual" was often expressed by the out-patient clinic therapists as "maintain on even level of clinical adjustment" or "prevent psychotic slippage". Consequently the goal "foster independent from a need for treatment" was not as strongly expressed for the out-patient.
treatment. This difference in expectations is considered to be an important difference between the two types of treatment. At least in the treatment philosophy of the day center, the expectation placed on the patient is considered to be one of the most important aspects of treatment. It was considered fair to compare the two treatments on the goal "clinical condition" for this was the main concern of each treatment method even though the aim may have been towards different points on the continuum. In other words, most would agree that, if possible, it is better to improve the clinical status of the individual than to maintain it.

Out-patient subjects had an average of 6.0 treatment sessions with the out-patient clinic, with a range of 3 to 10. There is, of course, considerable difference in the amount of time spent in treatment between the two groups. However, the study is designed to compare the two treatments as they stand, not how they would be if an equal amount of time was spent at each facility. What the out-patient clinic could do by having patients in for all day psychotherapy a number of times a week will always be only a matter of speculation as far as this clinic is concerned.

All pre-testing was done either shortly before, soon after, or at the time the subjects entered their prospective treatments. Post-testing took place either when the subject terminated treatment or at the conclusion of the study. Due to the absence of control over the activities of the subjects, there was some variation between groups as to time elapsed between tests. None of these
variations were significant, however. At the time of post-testing, the subjects were tested at their own respective treatment facilities and instructed that the testing was to evaluate their progress in treatment. Relatives filling out the ICL were also instructed that the testing was to evaluate the patient's progress in treatment.

Unfortunately, not everyone was able to be given all of the tests. This was due to a number of reasons such as uncooperativeness by either the subject or the relative filling out the ICL, invalidation of the test because of failure to understand or follow the directions (tests were invalidated not because of scores on validating scales on the MMPI or CAS but because of failure to fill them out correctly or to complete them), or having had one of the tests in the preceding six months. There were enough outcome measures on everyone, however, to make a judgment of improvement based on at least three variables.

Data for measures, Hospitalization (H), Employment (E), Useful Skills (US), Independence from treatment (I), and Self Ratings (SR) were obtained by means of the "Progress Evaluation Form" shown in Appendix IV. These forms were the same for each group except that the letterhead on which the form was typed was the letterhead of the particular treatment facility attended by the subject. In addition to the data from this form, variables H, E, and I were cross-checked with treatment personnel and families to verify their accuracy. In no case was there any disagreement. Variables SR and US were not cross-checked because they can only be rated by the subject.
The average interval between pre- and post-tests with the MMPI was 148 days for the total sample. There was no significant difference between the average intervals of Day Center and Out-patient groups (t = .786). The first 420 items of the booklet form of the MMPI were used as is common in the practice of both facilities. This method misses two items on the K scale and twenty items on the O scale. If the subject scores eleven or more on the K scale, one is added to his total K raw score while the O raw score from the back of the answer sheet is doubled and added to the front for the total raw score. This is almost identical to the method suggested and researched by Olson (1954). The loss in accuracy from such a procedure is only slight. However, any loss is of little concern here as the K and O scales were not used in the comparative analysis of groups. In addition, the scales used were scored without the K-correction in order to avoid the complication that might be introduced by the K-correction factor. That is, a rise in the K scale has been positively correlated with success in therapy on occasion (eg. Schofield, 1956; Kauffman, 1956) and might interfere with looking for the desired lowering in the clinical scales. In addition, the use of K-corrections with scales 4, 7 and 8 makes them less reliable in psychiatric populations (Rosen, 1953).

A few days after beginning treatment, one of the day center subjects took his own life — he was not known to be-suicidal by the day center staff. Despite his short stay at the day center, this man was in the treatment and his tragic death can only be regarded
as a therapeutic failure. Post-treatment data for this man can be obtained by assigning him the worst possible score on all measures but the standardized test, where his post-treatment scores cannot be conjectured. A direct group comparison by means of the scores on these tests was, therefore, impossible. An indirect method was adopted where each individual was rated as improved, worse or no change on each measure. The suicidal victim was then rated as worse on each measure were this applied. This allowed inter-group comparison on each individual measure as well as an overall inter-group comparison using all measures scored, because they were all scored in the same way.

Average MMPI profiles and average pre-to post-test changes could still have been computed for each group but no inferences could have been drawn from this data because of the absence of data on the deceased subject. The suicidal victim, then, was labeled as "worse" on the MMPI and the ratings of the others were obtained by the following procedure:

1. On scales ?, F, 1, 2, 3, 4, 5, 6, 7, 8 and 9 the change in T score points was computed for each individual. An average of those changes was obtained only from those scales where the subject scored ≥ a T of 60 on either the pre- or post-test. If this average change exceeded 10 T score points (one standard deviation of the standardization sample), it was labeled as a significant change in that direction; if not, there was no change. A significant plus T score average was rated as "worse" and a significant minus T score average was rated as "improved".

2. An MMPI expert unconnected with the research was given the complete MMPI profiles on each subject with only a code number as identification. The expert was unaware of which group each pair of profiles belonged in. He was instructed to rate each subject as "significantly improved", "no sig-
significant change" or "significantly worse". The definition of significant was left up to the expert. This method was used in addition to that described above because it was thought possible that a change in code-type could indicate a significant change not reflected in the average change in scale evaluations.

3. The judgment of improved (Im), worse (W) or no change (NC) was then a matter of following the tendency, for example: Im + NC = Im; W + NC = W; Im + W = NC.

The interval between pre- and post-testing with the ICL averaged 100 days for the total sample. There was no significant difference between Day Center and Out-patient groups on their respective mean intervals (t = 1.818). The ICL is not ordinarily scored to yield a gross measure of maladjustment. It is, however, constructed in such a way so that each item is on one of four different levels of adjustment (Leary, 1956; LaForge and Suczek, 1955). Leary's arrangement of the test items is done so that each level of adjustment is in a different column. Therefore, a gross adjustment score can be obtained by totaling the number of items checked for each column and entering these totals in the formula: (2Lcolumn 1 + Lcolumn 2) - (Lcolumn 3 + 2Lcolumn 4). The higher the score, then, the higher the level of clinical adjustment as rated by the relative. A significant change from the pre- to post-test was one that exceeded one standard deviation (16.3) of the total sample on the pre-test. If this change was in the plus direction it was labeled as Im; if it was in the minus direction, it was labeled W.

The CAS pre- and post-testing interval averaged 101 days for the total sample. There was no significant difference between average intervals for the Day Center and Out-patient groups.
(t = 1.0514). The determination of significant change as shown by the CAS was determined in the following manner:

1. The change in the mean total score for each individual was compared to the standard deviation for out-patients reported on this score in the manual (Roen and Burnes, 1968, p. 10). A change greater than one standard deviation was labeled $I_m$ when it was in the plus direction and $W$ when it was in the minus direction; any other change was labeled $N_C$.

2. The CAS is the type of test where the questions that apply are the only ones answered. Therefore, a special score, the Common Item Total (CIT)\(^4\) was devised to check on the mean total score. This score was the sum for each individual of all the items actually answered by everyone in the total sample. There were 64 such items on the CIT with one item falling under Chapter I, twenty-nine falling under Chapter IV and the rest fairly evenly distributed among the chapters. If the pre- to post-test change on the CIT exceeded one standard deviation of the total sample on the pre-testing (17.2), then it was labeled as a significant change in that particular direction. Because the CIT is a check on the mean total score, the resultant designations of change must agree, otherwise there is no change in the composite of the two.

3. It is conceivable that a person may make significant gains or losses in one social area and not another. Therefore, the major chapters of the CAS were also examined for significant change in the same manner as the mean total score. Whichever way the majority of significant changes were leaning for an individual determined the label $I_m$ or $W$ for the composite chapter score. If these changes balanced out or if there were no chapters exceeding the standard deviation, an individual's composite chapter score was $N_C$.

4. The final determination of rating ($I_m$, $W$ or $N_C$) on the CAS was made by looking at the two ratings from the two composite procedures and following the trend in the same manner as were the two ratings from the MMPI.

The statistical tests of significance used on the data were the "t" test and the direct computation of probability ($p$) discussed pre-

\(^{4}\)Note that this is not the same score as the Common Question Total (CQT) used in the manual.
viously. The .05 level of confidence was chosen for the significance level and all tests were two-tailed, making $p \leq .025$ the value of $p$ needed for significance at this level.
RESULTS

Hospitalization (H) was an outcome measure where the subject could only be rated as worse (W). No one was hospitalized at the beginning of the study. No Day Center patients were hospitalized during the study as opposed to two in the Out-patient group. The suicide victim from the Day Center group and the two hospitalized patients from the Out-patient group were all rated as W on this measure. The percentage of the Day Center sample rated as W was 12.5 while the percentage of the Out-patient sample rated as worse was 33.3. This trend in favor of day treatment was not enough to be called significant (p = .330). In summary, there was no significant difference between the two types of treatment on H.

Employment (E) status of the subject was converted to a rating of Im, NC, or W by comparing pre-treatment to post-treatment status. Ratings were converted to scores (Im = 3; NC = 2; W = 1) and the "t" test was applied. The Out-patient mean of 2.33 on E was not significantly greater than the Day Center mean of 1.75 (t = 2.172) but it approached it. At the termination of the study, 33.3% of the Out-patients were employed as compared to none of the Day Center patients (p = .165). In summary, there was no significant difference between groups on E although the Out-patients tended to do better.

Independence from treatment (I) was an outcome measure where the subject could only be rated as Im. 16.7% of the Out-patients and 50.0% of the Day Center patients were independent of any treatment at the termination of the study. These values were not significant.
(p = .210). In summary, there was no significant difference on I between groups, although the Day Center group tended to do better.

Table IV shows score changes and ratings for each individual on the Community Adaptation Schedule (CAS). On the final rating there were 37.5% improved from the Day Center and 0.0% improved from the Out-patient group. This difference was not significant (p = .225). There were 50.0% of the Out-patient group and 25.0% of the Day Center group rated as worse on the final rating. This difference was not significant (p = .339). Final ratings were converted to scores in the same manner as those under E. The mean Day Center score was 2.125 while the mean Out-patient score was 1.50. The difference between means was not significant (t = 1.517). In summary, the Day Center patients tended to show greater improvement on the CAS but there were no significant differences between groups.

Table V presents score changes and ratings for each subject measured on the Minnesota Multiphasic Personality Inventory (MMPI). On the final rating, 42.9% of the Day Center group were improved while 20.0% of the Out-patient group were improved. These proportions were not significant (p = .354). On the other hand, 28.6% of the Day Center subjects were rated as worse while 20.0% of the Out-patients were rated as worse. These proportions were not significant either (p = .447). Scores were obtained from final ratings as with E above. The mean score for the Day Center group was 2.143 while the mean score for the Out-patient group was 2.0. The difference between means was not significant (t = .308). The Welsh
TABLE IV

Differences Between Pre- and Post-testing Mean Scores on the CAS are Shown for Each Individual on the Major Chapters (I Through VI) and the Grand Total (T). Also Shown are the Differences Between the CIT Scores for Each Subject. The Ratings (R) Resultant From Each of these Scores are Given as well as The Final Ratings (FR). Standard Deviations (SD) From the Manual for I, II, III, IV, VI, and T and From Pre-testing for CIT are Given at the Top of Each Column. See Pages 32 and 33 for the Procedure Used in the Determination of Ratings.

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<th>Subject</th>
<th>I (SD)</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
<th>R</th>
<th>T</th>
<th>R CIT</th>
<th>R</th>
<th>FR</th>
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<td>-.60</td>
<td>-.02</td>
<td>-.08</td>
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<td>W</td>
<td>-.06</td>
<td>NC</td>
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<td>-.06</td>
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<td>+.59</td>
<td>NC</td>
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<td>Im</td>
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<td>Im</td>
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<td>NC</td>
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<td>NC</td>
<td>-3</td>
<td>NC</td>
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<td>-.65</td>
<td>-.07</td>
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<td>-.35</td>
<td>NC</td>
<td>-.22</td>
<td>NC</td>
<td>-26</td>
<td>W</td>
</tr>
</tbody>
</table>

(Suicide)
TABLE V

Pre-to Post-test Changes in T Score on Each Critical MMPI Scale (1 Through 9) is Presented on Each Individual Taking the MMPI. The Average Change (X) is Then Shown as Well as the Resultant Ratings (R). The Expert's Ratings (ER) and the Final Rating (FR) for Each Individual are Shown in the Last Two Columns. See Procedure for Determining Critical Scales and Ratings on Page 31.

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<th>Subject</th>
<th>F</th>
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<th>3</th>
<th>4</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<th>X</th>
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<th>FR</th>
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</table>
code on the average post-treatment MMPIs of the Day Center was 4'237086-19/FK/ L?: while the code for the Out-patients was 28734'160-9/F-L/K?:. These codes are on K-corrected scores. They were not used for the comparison of the groups in this study but are presented simply to allow comparison to the pre-treatment codes and to other research. In summary, there were no significant differences between the two groups on MMPI changes. Day Center subjects tended to receive a higher percentage of both W and Im ratings on the MMPI but these proportions were also not significant.

The Interpersonal Check List (ICL) ratings gave 33.3% of the Out-patients group an improved rating as opposed to 0.0% of the Day Center group. These proportions were not significant (p = .429). 25.0% of the Day Center subjects were rated as worse on the measure while 0.0% of the Out-patient group were so rated. These proportions were also not significant (p = .571). Assigning scores to the ratings as with E above, the mean Day Center score was 1.75 and the mean Out-patient score was 2.33. The difference between means was not significant (t = 1.387). In summary, the Out-patients tended to do better on the ICL but there was no significant differences between groups.

Self Ratings (SR) of "much worse", "worse", "no change", "improved" and "much improved" were converted to scores of 1, 2, 3, 4 and 5 respectively. The average SR score for the Day Center patients was 3.38 and the average SR score for the Out-patient group was 3.67. There was no significant differences between these means.
(t = .874). "Worse" and "much worse" were then combined under the rating W, "improved" and "much improved" ratings combined under the rating Im, and "no change" became NC for comparison of proportions and for use in the overall comparison of groups. 75% of Day Center patients were rated Im as opposed to 50% of the Out-patients. These proportions were not significant (p = .280). 25% of the Day Center patients were rated W as opposed to 0% of the Out-patients. These proportions were not significant (p = .308). 0% of Day Center patients were rated as NC while 50% of Out-patients were so rated. These proportions were not significant but approached significance (p = .055). In summary, there were no significant differences between groups on SR but ratings for Day Center patients tended to be either Im or W while ratings for Out-patients tended to be either Im or NC with Day Center patients tending to show a greater rate of Im ratings.

The overall comparison of groups using all of the foregoing measures is shown in Table VI. This was considered the critical comparison of effectiveness between treatments. The average final score for the Day Center group was 2.17, exactly the same as that of the Out-patients group. There was no difference between treatments on the overall comparison. On the final rating, 75% of the Day Center patients were rated Im while 50% of the Out-patients were so rated. These proportions were not significant (p = .268). 25% of the Day Center patients were rated as W as opposed to 16.7% of the Out-patients. These proportions were also not significant (p = .461).
TABLE VI

Ratings For All Subjects on Each Measure (H Through SR) is Shown. Also Shown are Final Scores (FS) and Final Ratings (FR) Determined by Average Ratings For Each Individual Where W = 1, NC = 2, and Im = 3, With the Average Taken Only From Those Measures on Which the Subject Was Rated. FR Was Determined From the FS Where Im ≥ 2.33, W ≤ 1.67 and NC for the Rest.

<table>
<thead>
<tr>
<th>Subject</th>
<th>H</th>
<th>E</th>
<th>I</th>
<th>CAS</th>
<th>MMPI</th>
<th>ICL</th>
<th>SR</th>
<th>FS</th>
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<tr>
<td>DC-1</td>
<td></td>
<td>NC</td>
<td></td>
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<td>W</td>
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</tr>
<tr>
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<td>NC</td>
<td>Im</td>
<td>NC</td>
<td>NC</td>
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<td>Im</td>
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<td>Im</td>
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<tr>
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<td>NC</td>
<td>Im</td>
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<td>Im</td>
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<tr>
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<td>W</td>
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<td>W</td>
<td>W</td>
<td>W</td>
<td>1.00</td>
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</tr>
<tr>
<td>OP-1</td>
<td></td>
<td>Im</td>
<td></td>
<td>NC</td>
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<td>Im</td>
<td>2.67</td>
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</tr>
<tr>
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0% of the Day Center patients were rated as NC while 33.3% of the Out-patients were so rated. These proportions were not significant \( p = .164 \). In summary, there was no difference between groups on the overall measure of effectiveness. The Day Center tended to have a high percentage of subjects rated as Im, a higher percentage rated as W, and a lower percentage rated as NC. None of these trends were statistically significant.

Table VII shows the intercorrelations of outcome measures from Table VI. Measures I and H were not included because they could only be rated one way or not at all. The spread of correlation coefficients may add credence to the use of multiple outcome measures. It is interesting to note that the highest \( r \) with FS was SR and that the lowest were with E and the ICL.

The question of whether or not the day center is fulfilling its goals was examined by using the data already presented, sometimes in new combinations. The goal "avoidance of hospitalization", however, only uses one measure and was examined by referring back to the results on H. 33.3% of the Out-patient group were hospitalized as opposed to 12.5% of the Day Center group (the suicide victim); this difference was not significant. With actually none of the Day Center patients hospitalized, it could be said that the day center fulfilled this goal but not significantly better than the out-patient clinic.

The goal "facilitate social adjustment" was evaluated by combining the results of E and CAS for each individual, obtaining
TABLE VII

Correlation Coefficients Between the Ratings Obtained on Various Measures (Im = 3, NC = 2, W = 1) are Shown. Correlations With the Final Score are Also Shown. All Data for rs are Taken from Table VI. The Suicide Victim's Scores are not Included.

<table>
<thead>
<tr>
<th></th>
<th>E</th>
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<th>MMPI</th>
<th>ICL</th>
<th>SR</th>
<th>FS</th>
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</thead>
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<td>.10</td>
<td>.16</td>
</tr>
<tr>
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<td>-</td>
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<td>-.78</td>
<td>.56</td>
<td>.72</td>
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<tr>
<td>ICL</td>
<td>.78</td>
<td>-.78</td>
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<td>-</td>
<td>.31</td>
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<tr>
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<td>.72</td>
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<td>.23</td>
<td>.92</td>
<td>-</td>
</tr>
</tbody>
</table>
averages for each group and comparing these averages in the same way that FS was derived and compared above. On this combined score the Day Center patients had a mean of 1.94 while the Out-patients had a mean of 2.08. The difference between the means was not significant (t = .496). E and CAS ratings have been examined by themselves above and there were no significant differences. It cannot be said, then, that the day center fulfilled the goal "facilitate social adjustment" any better than the out-patient clinic.

The goal "improvement of the clinical condition of the individual" was examined in the same manner using measures SR, MMPI, and ICL. The mean score for Day Center patients was 2.27 while the mean score for Out-patients was 2.28. The difference between means was not significant (t = .087). As reported above there were no significant differences on the individual measures. It cannot be said, then, that the day center fulfilled the goal "improvement of the clinical condition of the individual" any better than the out-patient clinic.

The goal "education in translatable skills" was evaluated by examining the outcome measure, useful skills (US). 71.4% of the Day Center patients responded "yes" to the question as opposed to 16.7% of the Out-patients. These proportions were not significant, but approached it (p = .073). It could be said, then, that for this sample, the day center fulfilled this goal but it cannot be said that it fulfilled it any better than the out-patient clinic which does not have this as one of its goals.
The goal "foster independence from a need for treatment" was evaluated simply by outcome measure I. The Day Center group tended to do better (50%) than the Out-patients (16.7%) but not significantly. It cannot be said, then, that the day center fulfilled this goal any better than the out-patient clinic.
DISCUSSION

The results indicate that there were no significant differences between the two types of treatment. It might be said from this, then, that there were no vast differences in effectiveness between the two programs, but because of the small sample size there may be differences that were not shown in this study. At any rate, day center treatment did not show up as the magical form of treatment desirable for everyone. Day Center patients tended to do better on outcome measures SR, I, CAS and H while Out-patients tended to do better on E and ICL. A trend for the Day Center patients to receive a higher percentage of Im and W ratings and for the Out-patients to receive a higher percentage of NC ratings was noted on the MMPI, SR and the overall, final ratings. None of these trends were statistically significant.

The 75% improvement rate for the Day Center correlates highly with the improvement rate reported in Guy et al (1969) for a longer period of treatment. The 50% rate of improvement reported in this study for Out-patients also correlates closely with the improvement rate of out-patients in Guy et al. The reported hospitalization rates of 12.5% for Day Center patients and 33.3% for Out-patients in the present study compare well with the 15% for day center patients and the 25% for out-patients reported in Meltzoff and Blumenthal (1966) after three months. It might be noted that after eighteen months 64% of out-patients and 30% of day patients had been hospitalized during Meltzoff and Blumenthal's study. Employment rates
after eighteen months were 30% for day center patients and 14% for out-patients, while in the present study, 0% of the Day Center patients and 33.3% of the Out-patients were employed after four months.

The poor performance shown by the Day Center Group on E in this study may be due to a number of factors. First, the design of this part of the research was weak in that it was not known which subjects in which group desired or needed employment. With a huge percentage of women in each group, this is certainly an important question. Second, a dependency on the day center may have mitigated against seeking employment although this dependency is not borne out by the day center's rate of independence from treatment. Third, employment is a rather long-range goal of the day center and not applicable to patients until termination. Being a long range goal, it is also one that has not yet received the necessary attention from the personnel at the Lodge where their program of vocational guidance is only now evolving. Without this service, it may be that attending the Lodge inhibits a certain amount of motivation to seek employment from arising as well as uses some of the time that might otherwise be spent seeking employment.

As shown in Table VII, employment had a low correlation with final scores and other measures but had a high positive correlation with the ICL. It might be speculated that ratings by spouses depended a lot on the contribution of the patient to the material well-being of the family. The ICL's negative correlation to the CAS
and the MMPI might even bring on speculations about an upset balance in a "sick" family in which the identified patient improves, but the family views him as worse. It is more likely, however, that the ICL was not a good measure to start with. The reliability of the adjustment score used from this test is unknown. The assumption that the reliability of the scores used by the test constructors would carry over to other ways of scoring the test may have been a false one. However, without further evidence, it must stand as an outcome measure and be viewed, albeit with caution, as a measure touching areas seemingly untouched by most of the other measures.

The finding that self ratings correlated highest with final scores was rather surprising. It would seem to indicate that the idea that self ratings are a biased outcome measure (eg. Hathaway, 1948) may be unjustified with this population. The patient may be the best judge as to how a treatment has helped him. This seems reasonable since in the present population it is usually the patient that states that he has a problem in the first place. A different relationship might be found in populations where treatment is not voluntary.

It is often desirable in studies such as this to derive some sort of measures or criteria for selecting those subjects who benefit most from the respective forms of treatment. This was not done in this study because the groups were considered too small to be split any further. Meltzoff and Blumenthal's finding that those patients with a better initial adjustment do worse under day treatment might
be examined, however, in an anecdotal rather than scientific manner. The individual (DC-1) with the highest pre-treatment adjustment, as shown by the lowest MMPI profile and the highest Grand Total mean score on the CAS, was the only subject that got worse under day center treatment save the suicidal case. In the Out-patient group, the best pre-treatment scores on these measures went to two different individuals (OP-3 for the MMPI, OP-5 for the CAS), one of which received the final rating of W, the other Im. On the other hand, the individual in the Out-patient group that had the worst adjustment on these pre-treatment measures (OP-6) showed no change at the end of the study. The individuals looking the worst at pre-treatment time in the Day Center group on these two measures (DC-6 for the CAS, DC-7 for the MMPI) both showed improvement on the final rating. This anecdotal evidence, then, agrees with Meltzoff and Blumenthal's finding that the poorly adjusted do better under day treatment while the better adjusted benefit more from out-patient treatment.

Volunteers who work at St. Joseph Lodge are often out-patients or former day center patients who show a good level of adjustment. From the foregoing findings in this study and in Meltzoff and Blumenthal's study, the fear might be expressed that such volunteer work at the day center might be detrimental to these people. A controlled study was not done to evaluate this possibility but a group of volunteers were tested during the same time as the subjects in this paper. This was done without the benefit of a control group.
However, with merely a check on the possibility of regression in mind, the control of using a standardized test was deemed sufficient. Three volunteers who either had been or still were out-patients, were tested with the CAS both pre- and post-treatment. All of these volunteers showed moderate gains on their post-treatment CAS scores. It would seem, then, that the fear of regression in the volunteers was not realized. Regression for the better adjusted in the day center seems to be true, so far, for the patients and not for the volunteers.

The generalizability of research findings to other facilities and to future operations of the facility studied is limited by how accurately the conditions studied fit the conditions to which the generalizations are to be applied. For instance, an unforeseen difficulty has arisen in generalizing the results of the research reported herein to future day populations at St. Joseph Lodge. This difficulty is the changing nature of the population and form of treatment. In this research all subjects were either treated only at the day center or only at the out-patient clinic. A large percentage of the population at the day center is now being treated at both facilities simultaneously. In addition, a number of in-patients come to the Lodge during the day and return to the hospital in the evening. It is clear that neither of these combinations of treatments are evaluated in this study and that further research would be required to evaluate the effectiveness of such procedures. Such research would require at least five different treatment groups:
day treatment only, out-patient treatment only, combined day and out-patient treatment, in-patient treatment only and combined in-patient and day treatment. It is felt that any further research should be delayed for at least a year to eliminate any effect that the newness of the program might have. Such research should also be done over a longer length of time and on a larger group of subjects to allow follow-up data and generation of predictive measures. Assessments might also be made at more than two points in time to allow a look at changes as they relate to time passage. Process research could then follow.

Several recommendations to be considered by day center personnel based on findings from this research might be made:

1. The often cited danger of treating the suicidal patient in a day facility was realized in this study. It would seem more desirable for these patients to be treated on an in-patient basis.

2. The family of the day center patient should be more involved in the treatment.

3. A greater emphasis should be placed on vocational adjustment for those patients where this is applicable. Assistance both before and after terminating treatment at the day center may help in this regard.

4. The referral for day center treatment who shows fairly good adjustment should either be referred to out-patient care or be used in a volunteer capacity at the day center. Day treatment should be reserved for those showing only marginal adjustment. The CAS and MMPI may be helpful in making these judgments.

5. Self-evaluation may be a good method of judging an individual's progress in treatment.
SUMMARY

An administrative study was done comparing the effectiveness of day center treatment and out-patient treatment on the type of patient that day center treatment is designed for. Prior day center research was reviewed and problems in research design were discussed.

A group of eight day center patients were compared to a group of six out-patients after four months of treatment. No significant differences were found between treatments, using multiple outcome measures. Day center treatment tended to have both a higher percentage of subjects improved (75%) and subjects worse (25%) than out-patient treatment (50% and 16.7%). This balanced out to no overall difference in effectiveness. The results, in general, agreed with prior day center research except that some prior research had indicated a significant overall superiority for day treatment.

Recommendations for further research were made as were recommendations for the day center's operation.
BIBLIOGRAPHY


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APPENDIX I

Operational Plan for St. Joseph Lodge

Introduction

By Federal definition a comprehensive mental health program is not complete unless there are provisions for an out-patient day care center. Accordingly, St. Joseph Lodge is set up as a day center for mental patients under the auspices of the DeLano Memorial Clinic. The purpose of the center is to serve the community as a mental health facility and in particular to serve the disturbed individual and his family.

The day center (also known as day hospital, day care center, day treatment center, day school and so forth) has a relatively short history with most centers set up only in the last few years. Despite the newness of this technique, however, there is some evidence that it is a valid and useful technique. Moreover, it is possible that many patients now handled in 24 hour psychiatric units could be successfully treated in a day center.

Goals

The day treatment center is a creation of society and society dictates that the goal of such a center should be the return of the patient to the community as a productive and socially adjusted member. At the same time, however, the individual involved has his own individual needs that treatment should be directed towards. With
both of these positions in mind it is possible to state a number of general goals of the day center. These general goals are used as a guide to the staff and patients of the center and as the basis for evaluating the program:

1. Avoidance of hospitalization: This will definitely be a goal for every patient even though the possibility of hospitalization may be minimal in some cases. For those patients referred in lieu of hospitalization, as well as those who are former in-patients, this will definitely be a major goal. The staff must be careful here and be able to admit failure to attain this goal when the situation warrants it. That is, non-hospitalization should not be stubbornly adhered to when the condition of the patient and his wishes indicate hospitalization.

2. Facilitate social adjustment: This goal is to improve the status of the patient with regard to family, community, employment and "others" in general. This calls for improvement in social behavior and a learning or re-learning of social skills for use in interpersonal relations and relations with social units.

3. Improvement of the clinical condition of the individual: This goal is directed towards improving whatever group of actions, beliefs, symptoms, dynamics, etc. there are about this individual that might be described as composing his disorder or bothering him or others. This goal might also be stated: "Improvement of the individual's level of adjustment".

4. Education in translatable skills: The goal here is to teach the individual (or help him to re-learn) skills that are useful to him in an occupational sense. This would include vocational training, or training in a hobby to use during leisure time. The emphasis is on skills that will be useful after leaving the day center.

5. Foster independence from a need for treatment at the day center: This goal is to counteract any dependency on the center that may develop. It also implies that this goal is successfully attained only when the patient no longer needs treatment at the center or similar facilities. A need for less intense treatment at an out-patient clinic may still exist but this would not mean that this goal was not fulfilled. It should be noted that this goal implies that a
tentative limit for treatment at the day center be aimed at for each patient. This averages about three or four months.

Setting

The building is located in a Nazareth college building off the campus. Its separation from the hospital is considered an advantage in maintaining the type of atmosphere desired. There are two large living room type areas, a large kitchen, a game room, a sewing room, an art room, a woodshop and a community office. The remainder of the building is used for offices. The physical setting is arranged in such a way as to closely resemble a home or other social milieus in the community.

More important than the physical setting is the atmosphere. This atmosphere is closely tied to the underlying philosophy of the center. Essential to this philosophy is the elimination of the "sick role" by placing the responsibility for behavior back on the individual. He is not referred to as a "patient" but rather as a "member" or a "participant" (the label "patient" is used in this paper, however, for clarity inasmuch as the staff could also be regarded as members or participants.) The day center is not referred to as a "day care center", "day hospital", or "day treatment center" because these labels imply a passive recipient that comes to be treated. The center is referred to as "St. Joseph Lodge" or simply as the "day center". In accordance with this line of thinking, an attempt is made to make the atmosphere free and voluntary with the
responsibility put on the patient. The patient is encouraged to partake in certain activities but never forced. The distinction between staff and patients is not completely eliminated but this is done to a great extent -- not only to eliminate the "sick role" but to eliminate the "doctor role" as well. The social barriers between staff and patients are torn down as much as possible to allow free interaction.

An attempt is made to make the atmosphere at the center like that of a miniature social system wherein social skills can be learned or re-learned and tested with a minimum of threat. Therefore the center attempts to be as tolerant, accepting and as anxiety free as possible while still incorporating social censure for inappropriate behavior. This censure is made more powerful by a sense of belonging.

Lastly, and perhaps most importantly, the patient-staff community attempts to be geared towards change and progress. An effort is made to maintain a condition of constant self-evaluation and search for improvement. This implies a willingness to discard useless methods, no matter what the investment, and replace them with new ones.

Staff

It has been suggested that one of the primary sources of difficulty in the day center is the failure to clearly delineate staff roles, duties and responsibilities. In the day center, the members
of the various mental health professions must step out of their traditional roles. The difficulty usually encountered is that there are no new roles for them to step into and the traditional class structure of the professions is broken down.

The solution to this problem is not seen in a return to the traditional roles but in a clear definition of the new role that all the day center staff will share. The ultimate responsibility for the center falls to the head of the DeLano Clinic and more immediately to the social worker directly in charge of the day center. After this necessity, however, all members of the staff regard themselves and the patients as equals. Distinctive "therapeutic" roles are determined on skill rather than educational background. Further, the person to whom a patient goes for individual counseling or advice is the member in whom the patient feels the greatest confidence, be he part-time volunteer, full-time staff member or even another patient. The staff is further expected to be aware of the effect of their attitudes and expectations on the patient, i.e. the staff should expect the patient to achieve all of the goals that have been mapped out for him and promote such an attitude as to foster freedom, informality and progress. No one is regarded as hopeless and the patient is found to be communicating at all times no matter how bizarre the medium. Lastly, all staff members work to promote independence and responsibility on the part of the patient and discourage dependency unless it is necessary for ultimate independence. Further definition of the staff roles are made clear by the remainder
of these plans as well as by the individual staff assignments for each patient.

The full-time staff is composed of the director who is a psychiatric social worker, a secretary, two licensed practical nurses, a teacher and two aides. A psychologist comes in two days a week and a psychiatrist comes in for one half day a week. A dance instructor, a cooking instructor, a sewing instructor and an arts and crafts instructor lend their services on a part-time basis. Some of the volunteers are out-patients and it is felt that helping others is therapeutic for them. Trainees from various school curriculums are also available.

Patients

The patients come from that geographical area served by the DeLano Clinic. Their number in attendance is not to exceed twenty. It is felt desirable to keep the membership as full as possible at all times to preserve the continuity of the social system.

Below are listed the criteria for admission to the day center. These criteria are listed in largely negative terms, i.e., who should not be admitted. By stating conditions for rejection rather than acceptance, it is felt that a greater number of those people who can profit from the day center will be accepted. The criteria are as follows:

1. The patient may be judged to have sufficient disturbance to require extensive treatment although he is marginally adjusted enough to live at home. Therefore, some patients
may be referred in lieu of hospitalization or immediately after release. It should be noted, however, that this is not a hard and fast rule. That is, any patient could be admitted who is felt to be able to profit from the day center.

2. The patient should not be employed or should only have partial employment. Full employment would usually preclude attendance, or if it did not, it would take more away from the patient's home life than is desired.

3. The patient should not be one who is considered to be a possible interference to the welfare of the group. This would eliminate assaultive patients, homicidal patients, aggressive homosexuals, con-men or any other who might harm or exploit members of the group. The setting and atmosphere will be free, informal, voluntary, etc. without the restraints and safeguards necessary to undertake helping these other individuals.

4. Other than the above specifications, patients should not be eliminated because of diagnosis, or the chronicity or acuteness of their illness.

5. Since attendance is voluntary, a willingness to attend is necessary.

6. Male or female patients are accepted but they should be 17 years of age or older.

7. The patient should not have physical difficulties that would hamper attendance or require special attention that the staff is not prepared to give.

8. Patients that are severely mentally retarded should not be accepted. They are in need of a different type of special attention than will be available through this program.

9. The patients must be judged to be able to profit from the experience in one way or another. Just "day care" is not available.
Admission Procedures

Referrals are taken from anywhere including the patient himself. A certain amount of information is needed by the day center staff, however, to help in arriving at a decision to admit. This information usually includes:

1. Recent psychological test results. Specifically, results of the Minnesota Multiphasic Personality Inventory (MMPI) and the Community Adaptation Schedule (CAS).

2. A social history and an evaluation of current social status and abilities.

3. Information concerning any physical anomalies or defects of the patient.

If this information cannot be made available from other sources, the patient is evaluated at the Lodge. This information is important not only in deciding admission and type of treatment but also in the subsequent evaluation of the effectiveness of the program.

Usually the decision to admit is made before all of this information is gathered. The day center staff reviews what information it has and interviews the applicant. If possible, the patient's family is included in the interview in order to "explore their resistances, answer questions, reassure appropriately and begin the involvement of the family in the treatment process." (Kraft, 1964, p. 83). This interview also allows for referral to other facilities if the day center is not appropriate for the patient, as well as a chance for the patient who is to be accepted to form an initial relationship with the staff and ease the beginning of attendance at the day center.
At the time of this interview a decision is made as to whether or not to admit the patient to the center. This decision is made openly in front of the patient to demonstrate to the patient that is accepted the open nature of the center or to indicate to the patient who is rejected the reasons for doing so. This decision is based on:

1. The criteria for admission stated above.
2. The willingness of the patient to attend.
3. Whether or not the day center can benefit the patient.
4. Whether or not the needs of the patient require so much individual staff time as to take away from the group to a damaging extent.
5. Whether or not there is an available position.

Initial Treatment Planning

After a decision is made to accept an individual into the program, a time is set aside for a meeting of some of the staff and the patient to plan the treatment for the patient. At this meeting a tentative plan is mutually agreed upon and drawn up. This plan, of course, is modified should changing conditions warrant it. The plan contains:

1. Goals individualized to the patient. One of these is a date to aim at for terminating treatment (flexible, of course).
2. An agreement signed by the patient stating: "I will work hard to make the needed adjustments in my behavior and will feel free to seek help from the staff in this effort."
3. Desirable modes of behavior that the patient is to work towards achieving. These are usually in small steps to be achieved over a period of time.
4. Assignments of modes of behavior for the staff to use in interacting with this patient. This includes both particular staff assignments (e.g., a volunteer might be assigned for academic tutoring) and general modes of interaction (e.g., the staff shall encourage this patient to partake in social activities.)

5. A selected list of activities available at the center is agreed upon for the patient to partake in.

6. A big brother or sister (a patient who has been a member for some time) is assigned to the new patient. The "old" patient has previously agreed to this.

It should be noted that the bywords of this center are freedom, creativity and responsibility. These bywords hold for both the staff and the patients. Nothing in the stated plans for the patients, or in this paper for that matter, is taken as a hard and fast rule. The written plan for each patient is thought to be desirable, however. It gives a structured guide for both the patient and staff and insures mutuality of expectations. As an additional guide and as an introduction, the new patient is given an "Orientation Booklet" (see Appendix II).

The treatment plan is entered in the patient's file and the patient is able to re-examine it upon request. The patient is ordinarily included in further planning meetings concerning his case. These planning meetings on the individual patient take place as needed but with a maximum interval between meetings of three weeks.

Record Keeping

In addition to the ordinary administrative records, a number of treatment records are kept. These can be arbitrarily divided into the following categories:
1. **Individual.** There is a permanent file on each patient containing tests, plans, ratings or other information pertaining to the individual. The weekly checklist in Appendix III is kept in this file and is filled in by a staff member at the end of each week that the patient comes to the center. The progress evaluation form shown in Appendix IV is filled out by the patient and also kept in his file.

2. **Activities.** The leaders or instructor of various activities record who participated in that activity each day and the approximate time for each individual. He may also make any other salient comments on his record sheet. If it is an activity with easily discernable criteria for success, it is suggested that the leader also keep records of achievement.

3. **Meetings.** A log book is kept of the "organizational meetings" (patient self-government, see section on treatment methods) wherein the minutes of each meeting are kept by the secretary of the organization.

4. **Attendance.** The patients sign themselves in and out each day and register the times for these occurrences. The patient should also call in when he will not be able to come as scheduled, as he would do on the job. In addition to the "member" book for signing in, there is a "guest" book to register any guests, including the patient's family.

**General Treatment Plan**

The general treatment plan can be thought of as serving as a bridge from the treatment goals to the specific methods of treatment. The listings below are not meant to imply any particular order of hierarchy. It can also be seen that they are by no means independent of each other.

1. **Alter the environment of the patient during a significant portion of the day.** This is accomplished by the very fact of attendance at the day center. It is implied that the environment plays a significant part in the abnormal behavior of the individual. The object, then, is to put the individual into a new environment for a time where his abnormal responses will...
supposedly be weaker and there will be a greater chance of eliminating abnormal responses and substituting "healthy" responses.

2. Break up pathological behavior patterns and allow for the learning of new behavior patterns. The day center tries to discourage any pathological behavior and encourage new responses to the same situations. Broad opportunities are afforded for trying out new modes of behavior in a relatively non-threatening day center environment. The staff and the other patients are prepared to offer guidance as to what constitutes acceptable behavior. The particular behavior dealt with depends on the individual patient.

3. Foster generalization of new responses to nontreatment settings. A gradual, supervised contact with other settings is pointed to here. As treatment progresses, more and more contact with the community is made. Field trips, community projects, contact with other agencies, and guidance in dealings with the home environment play a part.

4. Increase involvement with the community. This is important in order to end the withdrawal of the individual, to generate a concern over things outside of the self, to foster a sense of belonging in the community, and to help establish activities that can be engaged in after leaving the day center.

5. Alter any environmental situations contributing to pathology. The individual is still functioning in the nontreatment environment during the major part of the day and will return fully to it after leaving the center. Because the environment may play a part in generating or aggravating pathology, attempts are made to alter it, where possible. This also implies changes in the individual so that he can meet the demands of the environment; eg., vocational training. Improvements in economic level, home situation, and family attitudes are also examples of environmental modifications aimed at by the day center.

6. Stimulate motivation for self-improvement. It has been found that different patients have different reasons for coming to the day center -- some for improvements, some for escape and some for other reasons. Motivation for self-improvement must be enhanced in all of these individuals, especially for those seeking escape, for in the day center the responsibility for improvement is placed on the patient. The atmosphere of the center is
felt to be such as to foster this motivation. Beyond atmosphere, the methods used with each individual vary greatly.

7. **Foster self esteem and a positive self-concept.**
The attitude of the staff that the individual is worthwhile, capable and able to handle responsibilities plays a big part. Beyond this, again, treatment is highly individualized. Success in various endeavors is often beneficial for many individuals, therefore the staff tries to help the patient gain new successes.

8. **Foster responsibility and independent.**
Responsibility and opportunities for independent action are put directly on the patient. The free atmosphere plays a part, as well as the delegation of responsibilities. Many patients have to accept responsibility in small increments at a time. In some cases this objective indicates a gradual withdrawal from attendance at the day center. Other agencies or resources, such as employment commission representatives, might initially be brought to the day center but eventually the patients have to go to them.

9. **Facilitate adjustment to termination of treatment.**
The aforementioned gradual withdrawal from treatment helps here as does specific counseling of the individual making the adjustment. An attempt is made to make transition as easy as possible and retaining the improvements made in the center as likely as possible. Referrals to other agencies is sometimes done.

10. **Facilitate continued adjustment**
A follow-up program is adhered to in order to periodically check on the former patient and counsel him when needed. Additional use of other agencies may be made at this time. Return to the day center is not ruled out if it is called for.

**Treatment Methods**

In this section those specific methods used to implement the treatment plans and to achieve the treatment goals will be outlined. It is expected that this section will be the most frequently changed throughout the history of the day center. The methods used can be
based on any theory or on no theory — there is no preference. The day center attempts to use methods that fit into the overall rationale of the center. It is felt that, as much as possible, methods that have been shown effective by the research literature should be used as a starting point to be modified by experience.

The specific methods are enumerated below according to logical groupings with no regard to sequence or importance. Missing from the list are those things which have previously been discussed such as atmosphere, treatment planning, etc., which might be thought of as treatment methods.

1. Individual Counseling. Intensive individual psychotherapy is not available at the day center. If this type of treatment is felt to be needed, it can be obtained elsewhere without jeopardizing the individual's membership in the center. There are, however, a number of ways in which individual counseling can take place: a) A patient may seek help from a staff member and ask to talk to him on a one-to-one basis (or vice versa), but a regularly scheduled succession of interviews is not made. b) Patients informally counsel other patients. c) Staff meetings concerning the individual's case affords an opportunity for counseling on a many therapists-to-one patient basis. d) Imparting advice on how to behave or counseling in any other area, for that matter, often takes place as an unplanned event in the course of everyday-center activities. This takes place whenever the need arises as seen by the staff, the patient or both. At times, some specific techniques that have been used for such on-the-spot counseling seems desirable such as those used by Redl (1959) and Wineman (1959) in the "life-space interview". e) Individual counseling in various areas may take place with some of the resource personnel such as employment counselors, clergymen and so forth. f) The individual is requested to have at least one exit interview if he wants to leave the program before the agreed upon termination. This gives the staff a chance to ascertain why the individual is leaving, straighten out any misunderstandings that may have arisen, arrange for follow-up and referrals to other agencies and to give counseling on making the adjustment to leaving. g) Individual counseling can be given as a planned part of
the preparation for termination of treatment and varies among individuals in terms of number of sessions and duration.

2. **Small Group Activities.** The staff and patients find many opportunities to work on problems of the individual with a small group process. Social interaction can be an important vehicle for change as well as often being the problem area itself. The specific types of groups are as follows:
   a) Interest groups are those regularly scheduled group meetings designed to meet a particular need or interest of the patients; they probably resemble traditional group therapy more than any other groups at the center. There are four interest groups. The "problems in living" group centers on personal problems of adjustment especially as they relate to other members of the group. A staff member usually acts as group leader. The "family living" group centers on the individual's adjustment to family life. A staff member usually acts as leader of this group also. The "community affairs" group centers on discussions of current affairs and community problems and what can be done about them. It is hoped that the members will eventually evolve this group into some kind of community service club. The "creative expression" group centers on creative and new ways in which the individual can express himself. Resource people are often brought in to lead this group and there is as little limitation as possible on medium of expression. b) There are various committees that have certain jobs to perform. These committee positions are staff selected or selected by the patient government. There are clean-up crews consisting of both staff and patients with rotating crew leaders on each crew. At times, there also are refreshment committees, planning committees, a committee for publishing a newsletter and other committees that fit a particular need. c) There are, of course, informal groupings formed by the patients themselves. These are usually not broken up as they are part of everyday life and important to the patients.

3. **Large Group Activities.** Large group activities are those involving all of the day center community: a) The day center organizational meeting is a patient self-governmental structure run on a democratic basis. It has a rotating chairman and secretary with two week terms. They are picked at random from among those who are ready to accept the responsibility. The purpose of this organization is to suggest treatment changes, physical changes and activities. It also handles disagreements, takes complaints, and acts as disciplinarian. b) Field trips planned by the center
organization are activities for the whole center or large portions of it. The emphasis is on trips or other outside activities which help to reintegrate the individual to the community. c) Other activities are sometimes planned for the total group such as bringing in guest speakers from organizations around the community.

4. Individual Activities. The patient has an opportunity to do things independently and may be helped by staff or other patients in these endeavors. The patient sometimes needs to withdraw momentarily from the interpersonal situation. These activities also serve as a "practice" or "training" period for the patient in using his time when he is alone away from the center. Some of the activities that the individual can do are as follows:

a) Reading material is available emphasizing self betterment and bibliotherapy. A very small library at the center is set up but care is taken so that all reading needs are not taken care of and the individual has to use the public library. The center is used as an initial stimulus with the aim towards eventually having the patient use the public library system on his own.

b) Writing materials are available. Some individuals are able to express themselves easier in writing.

c) Art supplies (and instruction, if desired) are also available for self-expression and for personal enjoyment.

d) Domestic activities such as cooking, sewing and housecleaning can be done.

e) A stereo is available for individual listening as well as in connection with group functions.

f) The individual may also work individually on various projects in the center or outside of it. For instance, some individuals made gifts for hospitalized children.

5. Education and training. Education and training covers a number of areas -- academic, vocational and avocational and so is very individualized. Academic tutoring is usually done so that a patient can pass the high school equivalency test. Training for a specific vocation is very limited at the center; perhaps introductions to secretarial and janitorial work will be tried. For any further training, other agencies are used. Guidance in how to seek a job, how to take an interview, how to act on the job, etc., is sometimes offered, however, along with vocational testing. Training is offered in leisure time activities such as dancing, art, and woodworking. Homemaking instruction is also available, individually or in groups, emphasizing sewing and cooking.

6. Environmental change. Changing the environment is done at times both inside and outside of the center. Physical and social environmental changes are attempted and vary widely.
depending upon what is needed and how much, if any, change can be made. Family treatment is used at times. Members of the patient's family are welcome to come and visit almost any time. Home calls by a staff member are done occasionally. There is a family night once a month when the patient's family is formally invited to attend activities planned by the patient community. At this time the staff is able to work on pathological family interactions in the setting of the activities and counsel with members of the patient's family in private.

7. **Recreational Activities.** Some of the activities are basically recreational in nature with an aim towards enjoyment, learning and interpersonal contact. Examples of recreations outside the Lodge are golfing and bowling. There is a pool table, chess set, cards and various other games available at the center itself.

8. **Chemotherapy.** Chemotherapy is available to the patients through the consulting psychiatrist who comes in one morning a week.

9. **Other activities.** There is a coffee time every morning as well as a lunch hour where a good deal of interaction takes place. In addition, coffee is always available in the kitchen so that it might be used as a setting to ease communication.

**Treatment Techniques**

In general, a treatment technique might be described as a mode of behavior or set of attitudes on the part of the staff which is supposed to enhance a change for the better in the patient's behavior or attitudes. It is evident that much of this has already been discussed in other sections of this paper; there will be no need to reiterate the previous points here. The previous section on "Treatment Methods" dealt primarily with activities whereas "Treatment Techniques" deals with modes of staff behavior applicable to many activities. However, this distinction often does not hold and arbi-
trary decisions were made as to under which section a particular point was to be discussed.

The following is a list written up in the form of suggested techniques to be used by the staff. Techniques are often closely allied to a particular theory and there are wide variations in staff theoretical approaches and previous experiences with different techniques. Therefore, what is offered here is merely a list of suggestions and certainly not an exhaustive list.

1. The patient and his activities should be oriented towards the present time and should be action oriented.

2. Supportive behavior towards the patient can be helpful but an excess could result in over-dependency. Examples of supportive behavior are encouragement, reassurance, direct assistance and expressions of confidence in the patient.

3. The patient should be treated with acceptance, permissiveness and tolerance while still allowing for censure of unacceptable behavior.

4. There is value for the patient in self-expression as well as value in communication in general. On the part of the staff, self-expression, overtures of communication towards the patient and encouragement of patient self-expression will all be helpful to the patient.

5. Understanding the patient is helpful.

6. Operant techniques are felt to be useful, especially as they may be used to approximate the ordinary social milieu. That is, social reinforcers and punishers can be useful in bringing about socially approved behavior in the patient. Shaping (the gradual approximations leading to a desired response) and fading (gradual change of the stimulus conditions under which the desired response takes place) should enhance the patient's treatment and make changes more comfortable for him. However, operant techniques should not be used when they conflict with the philosophy of the day center.

7. Democratic approaches are therapeutic.
8. There is value in respecting the patient, treating him as an adult and expecting adult behavior from him. It is essential that treatment at the day center is never a "belittling" experience.

9. There is value for the patient in helping others, showing a concern for others and understanding others. The staff should try to enhance these behaviors.

Inservice Training

Inservice training takes two forms, orientation of new staff members and ongoing training of all staff members. In both types it is kept in mind that the greatest teachers are probably experience and the patients themselves.

The type of training that the new staff member will need varies widely depending upon his skills and previous experience. The volunteer usually needs quite a bit more of an orientation, training and supervision than does the new professional. This paper is a starting point for training. A bibliography of suggested readings is also given to the new staff member so that it may be used for a further foundation of the individual's training.

The continuing training of all staff members is three-fold. First, it involves experience on the job and personal readings and research. Second, daily staff meetings coupled with treatment planning and evaluation meetings are a part of the overall learning experience. Third, a weekly seminar is held as a formal training activity. This meeting is attended by all staff members and takes place at the time of the usual Thursday morning staff meeting. The purpose of this seminar is to improve the staff's knowledge and
competence in the area of day treatment. Individual staff members are often assigned subjects to explore and report on so that the seminar members might discuss them. Examples of subjects discussed are other day centers, new treatment methods, theories of psychopathology and other facilities in the local community.
APPENDIX II

The following is a reproduction of the contents of the orientation booklet for new members.

St. Joseph Lodge
Adult Day Center
2710 Nazareth Rd.
Kalamazoo, Mich
49001
Phone: 382-3232

Dear Friend:

The members of St. Joseph Lodge welcome you as a new member. We hope that you can enjoy and profit from the time you spend with us. This booklet is to introduce you to the Lodge and give you some idea of what to expect during your association with us.

WHAT IS ST. JOSEPH LODGE?

St. Joseph Lodge is affiliated with the William Upjohn DeLano Memorial Clinic. Its purpose is to help people, who are having problems in living make a better personal and social adjustment. St. Joseph Lodge is here to help you help yourself. We will all work as a team to help each other accomplish our individual goals.

WHAT IS EXPECTED OF YOU?

The responsibility for making the needed changes in your behavior is put on you, although the rest of us will be here to help you whenever necessary. We won't criticize you if you don't always succeed, as long as you are trying. Our motto here is "Freedom, Creativity, and Responsibility" so we do not have a lot of rules. It is however, expected that you treat everybody else with respect and follow these simple guidelines:

1. If you cannot come in on a day you are scheduled you should call in.
2. Sign in and out on the register.
3. You should notify the staff if you intend to quit coming.
4. You are expected to do your share of the work.
5. You are expected to obey the rules made by the member-government organization.

WHAT WILL YOU DO HERE?

All of the activities offered at St. Joseph Lodge are open to your participation. You will develop with the staff a flexible schedule of activities that as closely as possible follows your particular interests. Then you will assist in the identification and listing of those objectives that you would like to achieve through your membership in the center. There will be opportunities for you to learn various skills that range from sewing, cooking and art to gardening and woodworking. There will also be opportunities for academic improvement as well as job training and job counseling. The center offers a variety of recreational facilities for both indoor and outdoor participation. There will be group discussion and activities such as reading, writing, art and music appreciation are available. If the members choose, there may also be field trips and guest speakers. Members of the staff as well as visiting consultants will be available for counseling when and if you need it.

SCHEDULE

The center is open from 9 A.M. to 4 P.M. Monday through Friday. Staff meetings are held from 8 A.M. to 9 A.M. and again from 4 P.M. to 5 P.M. You may attend these meetings if you wish, except for those that are concerned with another member's case. You will be asked to attend staff meetings to evaluate your progress and make plans. Some conferences might also be held with your family. Members of your family are welcome to come anytime, but there is a regular family night set aside for Tuesday evenings from 7 P.M. to 9 P.M. Lunch is from twelve to one daily --- you can either bring your lunch or complete kitchen facilities are available for those who wish to prepare something. St. Joseph Lodge is at the
end of the Gull Road bus line from downtown Kalama-
zo.

THE STAFF

The daily, full-time staff will consist of: William Birch-director, Linda Willis-secretary, Sandy Brigman-nurse, Marybeth Thorrez-aide, and Nancy Druckenbrodt-aide. John Gallagher and Dr. Almario Garaza will comprise part-time staff positions on a regular weekly basis. Visiting instructors, counselors and volunteers will provide us with additional assistant personnel as will those members who have special skills to share. Staff definition, as such, will be primarily for administrative purposes only, and during center operation, staff will combine with the member population to produce a common social community.
APPENDIX III

Weekly Checklist
WEEKLY CHECKLIST

NAME ______________________  DATE _______________  FILLED IN BY _________________

(Initial)

ATTENDANCE ON __________________ FROM ___ TO ___

_________________________ FROM ___ TO ___

_________________________ FROM ___ TO ___

STRUCTURED ACTIVITIES PARTICIPATED IN BY THE PATIENT

________________________________________________________

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OTHER ACTIVITIES OF PATIENT THIS WEEK

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CHECKLIST: CIRCLE THE APPROPRIATE LEVEL ON EACH DIMENSION FOR THE PATIENT THIS WEEK. INDICATE DAY OF THE WEEK BY M,T,W,TH, OR F. EXCEPT FOR GENERAL CONDITION ALL RATINGS SHOULD BE INDEPENDENT OF OTHER DAYS.

<table>
<thead>
<tr>
<th>GENERAL CONDITION</th>
<th>MOOD</th>
<th>DEPENDENCE-INDEPENDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(As compared to last week)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. MUCH WORSE</td>
<td>1. DEPRESSED</td>
<td>1. EXTREMELY DEPENDENT</td>
</tr>
<tr>
<td>2. WORSE</td>
<td>2. MOOD SWINGS</td>
<td>2. SOMEWHAT DEPENDENT</td>
</tr>
<tr>
<td>3. SAME</td>
<td>3. APATHETIC</td>
<td>3. EVEN BALANCE</td>
</tr>
<tr>
<td>4. IMPROVED</td>
<td>4. EUPHORIC</td>
<td>4. SHOWS CONSIDERABLE INDEPENDENCE</td>
</tr>
<tr>
<td>5. MUCH IMPROVED</td>
<td>5. HEALTHY</td>
<td>5. EXTREMELY INDEPENDENT &amp; RESPONS</td>
</tr>
</tbody>
</table>

| INTEREST IN OTHERS | | AMOUNT OF INTERACTION WITH OTHERS |
|--------------------| | |
| 1. NONE | | 1. EXTREMELY WITHDRAWN |
| 2. POOR | | 2. SLIGHT INTERACTION |
| 3. AVERAGE | | 3. MODERATE INTERACTION |
| 4. GOOD | | 4. GOOD INTERACTION |
| 5. GOOD DEAL OF CONCERN | | 5. VERY GOOD INTERACTION |

| COOPERATIVENESS | | TREATMENT HERE SEEMS TO: |
|-----------------| | |
| 1. VERY UNCOOPERATIVE | | 1. BE HIGHLY DETRIMENTAL TO THE PATIENT |
| 2. UNCOOPERATIVE | | 2. BE SOMEWHAT DETRIMENTAL TO THE PATIENT |
| 3. BORDERLINE | | 3. HAVE NO EFFECT ON THE PATIENT |
| 4. COOPERATIVE | | 4. BE SOMEWHAT BENEFICIAL TO THE PATIENT |
| 5. VERY COOPERATIVE | | 5. BE HIGHLY BENEFICIAL TO THE PATIENT |

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DID THE PATIENT EXHIBIT ANY PARTICULARLY UNDESIRABLE BEHAVIOR THIS WEEK? (Describe)

__________________________________________________________

__________________________________________________________

DID THE PATIENT EXHIBIT ANY PARTICULARLY DESIRABLE BEHAVIOR THIS WEEK? (Describe)

__________________________________________________________

__________________________________________________________

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COMMENTS: (GENERAL BEHAVIOR PROGNOSIS, SUGGESTIONS, IS ANYTHING IN TREATMENT PARTICULARLY EFFECTIVE OR UNEFFECTIVE, ETC.)

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APPENDIX IV

Progress Evaluation Form
PROGRESS EVALUATION FORM

THIS FORM IS MAINLY FOR OUR BENEFIT. BY EVALUATING YOUR PROGRESS, WE CAN EVALUATE OUR OWN PROGRAM BY TELLING US WHAT THE GOOD AND BAD POINTS WERE AND MAKING SUGGESTIONS FOR CHANGE.

NAME: ___________________________ DATE: ________________

CURRENT ADDRESS: __________________________________________

PHONE NUMBER: _________________

COMPARSED TO WHEN YOU BEGAN TREATMENT HERE, HOW IS YOUR GENERAL CONDITION NOW: (CIRCLE ONE)

1. MUCH WORSE
2. WORSE
3. SAME
4. IMPROVED
5. MUCH IMPROVED

TREATMENT HERE SEEMS TO BE:

1. HIGHLY DETRIMENTAL TO ME
2. SOMEWHAT DETRIMENTAL TO ME
3. NOT EFFECTING ME
4. SOMEWHAT BENEFICIAL TO ME
5. HIGHLY BENEFICIAL TO ME

ARE YOU CURRENTLY EMPLOYED (CHECK ONE)
FULL TIME ( ) PART TIME ( ) UNEMPLOYED ( )

HAVE YOU BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS SINCE BEGINNING TREATMENT HERE?
YES ( ) NO ( ) IF YES, HOW MANY TIMES AND FOR WHAT LENGTH OF TIME?

__________________________________________

__________________________________________

ARE YOU CURRENTLY UNDER TREATMENT FOR EMOTIONAL DIFFICULTIES BY ANY AGENCY INCLUDING THIS ONE? YES ( ) NO ( ) (IF YOU ARE NOW TERMINATING TREATMENT HERE YOU WOULD NOT INCLUDE THIS AGENCY)
LIST THE AGENCIES WHERE YOU ARE NOW RECEIVING TREATMENT FOR EMOTIONAL DIFFICULTIES: ____________________________

__________________________________________

__________________________________________

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HAVE YOU GAINED ANY SKILLS (HOBBIES, VOCATIONAL SKILLS, ETC.) WHILE IN TREATMENT HERE THAT ARE USEFUL TO YOU? THESE SKILLS COULD EITHER BE GAINED HERE OR ELSEWHERE. YES ( ) NO ( )
LIST THESE SKILLS AND WHERE YOU LEARNED THEM
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

HAVE YOU GAINED IN YOUR SOCIAL ADJUSTMENT (SKILLS IN RELATING TO OTHER PEOPLE)? YES ( ) NO ( )
LIST AND COMMENT ON ANY ASPECTS OF THE TREATMENT HERE THAT YOU THOUGHT WERE GOOD __________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

ANY SUGGESTIONS FOR IMPROVING OUR TREATMENT OR SERVICES?
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

LIST AND COMMENT ON ANY ASPECTS OF THE TREATMENT HERE THAT YOU THOUGHT WERE BAD OR THAT YOU DISLIKED __________________________________________
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________________________________________

ANY OTHER COMMENTS ON OUR PROGRAM, HOW IT AFFECTED YOU, WAYS THAT YOU HAVE CHANGED, OR ANYTHING ELSE? ____________________________
________________________________________
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