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Post Hospital Community and Social Adjustment of Schizophrenics in an Aftercare Rehabilitation Setting

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POST HOSPITAL COMMUNITY AND SOCIAL ADJUSTMENT OF SCHIZOPHRENICS IN AN AFTERCARE REHABILITATION SETTING

by

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LIFE

Marian Laura Fitzgibbon is the daughter of Adeline (Hargraves) Fitzgibbon and Gerald F. Fitzgibbon. She was born on April 28, 1954 in New York City.

She attended elementary school in Norwalk, Connecticut and graduated from Central High School in 1972. In 1976 after three years of study at Boston College and one year of study abroad at the Loyola University Rome Center, she was awarded a Bachelor of Arts degree in History. The degree was awarded with honors.

She entered the Guidance and Counseling program in September, 1977 on a part-time basis. She also began working at The Grasmere Residential Home where she is currently employed as the training coordinator.

Marian did a practicum at a community drug center in Chicago, counseling drug abusers and another practicum at Regina Dominican High School in Wilmette, counseling adolescent girls.

While completing her Masters, she received a grant for individual research from the Illinois Department of Mental Health and Development Disabilities. She also received a tuition scholarship from Loyola University for the academic year 1980-1981.

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CHAPTER I

INTRODUCTION

Caring for our mentally ill is a pervasive problem. A major concern involves both where and how the psychiatric patient should be treated in order to reach optimal level of functioning. Smith (1968) has referred to the community mental health movement as the "third mental health revolution".

> The first mental health revolution unshackled the insane. By calling them sick it managed to treat them as human. Its monuments are the great usually isolated mental hospitals. The second revolution came from the spread of dynamic psychiatry (mainly Freud's) and was characterized by individual, one to one psychotherapy. Now the third revolution throws off the constraints of the doctor-patient model. The idea that mental disorder is a private misery and relates the trouble and the cure to the entire web of social and personal relationships in which the individual is caught (Smith, 1968, p. 19).

According to Segal and Aviram (1978), the efficiency, efficacy and therapeutic value of caring for recovering individuals in psychiatric hospitals should be questioned. They advocate that the ex-psychiatric patient should be placed in privately owned facilities where their cost of care is partly subsidized by the state or local government.

> Reports of the failures of state hospitals have led us to seek more appropriate methods of care. We have moved to a system of community care hoping to find better treatment and increased recovery (Segal and Aviram, 1978, p. 7).

The community mental health movement, then, can be viewed as an extension of psychiatric hospitalizations and it is perhaps a more realistic alternative if the goal is rehabilitation. If the community is to

accept a major responsibility in the rehabilitation of the ex-psychiatric patient, it must devise effective programs and methods to evaluate these programs in order to maximize rehabilitation for individuals being discharged from psychiatric hospitals.

Need for the Study

The current trend in the hospitalization of psychiatric patients is to reduce the length of the hospitalization and therefore hopefully decrease institutionalization and dependence on the hospital. In doing this, there has been a growing concern about how to best prepare these individuals for adequate functioning upon discharge (Mosher, Fenisilver, Katz, and Weinckowski, 1970). This present investigation advocates the use of the intermediate care facility (ICF) or "halfway house" as a viable treatment alternative for those individuals no longer in need of in-patient care but unable to function independently in the community at time of discharge.

Since treatment of our mentally ill is so quickly moving in this direction, there is a great need to evaluate these aftercare programs in relation to their effect on rehabilitation. Are they working toward the stated goals of rehabilitation and social integration or is the community care system establishing its own potentially chronic population outside the psychiatric setting? In evaluating the aftercare program, it is essential also to evaluate the people living there. The emphasis of the ICF halfway house is the provision of a temporary residence as a transitional environment immediately following hospitalization and before resumption of independent living. All patients, however, do not use the facility in this ideal sense--

transitional living. There is a need to determine through specific measures if a pattern can be established among discharged psychiatric patients regarding their use of the intermediate care facility.

Purpose of the Study

The purpose of the study, then, is to demonstrate that positive adjustment among ex-psychiatric patients can be enhanced by a comprehensive aftercare program.

The concepts of locus of control and premorbid adjustment have been utilized as potential indicators for social and community adjustment. This investigation will explore the relationship between locus of control, level of premorbid adjustment and community and social adjustment among schizophrenics discharged from psychiatric hospitals to a rehabilitation aftercare program.

Definition of Terms

Locus of control - or internal vs. external control of reinforcement is a generalized expectancy that refers to the way in which an individual views his/her behavior and the occurrence of reward or punishment. Rotter I-E Scale (1966) will be utilized to measure this concept.

Premorbid adjustment - level of social, sexual and work adjustment reached prior to the onset of illness. Premorbid adjustment will be measured by the General Information Questionnaire (DeWolfe, 1966) and scored on the Phillips Scale of Premorbid Adjustment (Phillips, 1953).

Process-reactive distinction - based on premorbid adjustment, it is used to subclassify schizophrenics and reduce heterogeneity by subclassing schiozphrenics.

Aftercare facility - the intermediate care facility (ICF) or halfway

house. In this study, one facility was used, The Grasmere Residential Home.

Primary counselor - a staff member of the ICF who has the major responsibility in planning the rehabilitation program of a particular resident.

Resident - an individual residing in the halfway house.

Social adjustment - the level at which the individual appears to adapt to the aftercare facility, as measured by the primary counselor on the Social Adjustment Behavior Rating Scale (Aumack, 1968).

Community adjustment - the level at which the individual resident perceives himself or herself in reference to community life. This will be measured by the Community Adaptation Schedule (Roen and Burnes, 1968).

Institutionalization - increasing dependence on the institutional environment. The breakdown of external social roles and the loss of a place in society.

Limitations of the Study

The subjects in this study cannot be considered a random sample for several reasons. Only residents admitted over a specific time period were assessed. The residents included in the investigation all have the same diagnosis (schizophrenia) and there is a limitation in the age group (20-40 years old). Also, individuals who did not stay the entire six month assessment period were dropped from the study. This selection process naturally limits the external validity (Campbell and Stanley, 1963). This sample can be considered representative of schizophrenics, aged 20-40, who are discharged from

psychiatric hospitals to the Grasmere Residential Home and who reside there at least six months.

An apparent weakness in this study is the lack of control for institutionalization. A younger population has been selected to attempt to control for subjects with lengthy hospitalization histories.

Organization of the Study

This study is organized under five major headings. Chapter I has introduced the research problem and stated the need and purpose of the study, definition of terms, and the limitations imposed by its design. Chapter II reviews the literature as it pertains to community and social adjustment in a comprehensive aftercare program. This chapter also reviews the literature pertaining to the instruments used in this study: The Community Adaptation Schedule, the Social Adjustment Behavior Rating Scale, Phillips Scale of Premorbid Adjustment, the General Information Questionnaire, and Rotter's Scale of Internal-External Control; the chapter also states the hypotheses. Chapter III outlines the design of the study which includes a review of the subjects, setting, instruments, training of raters and proposed method for data analysis. The data is analyzed in terms of the study's hypotheses in Chapter IV. Chapter V examines the results and then summarizes the investigation and offers recommendations for future research.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

A major and ever increasing problem in the field of mental illness is not the hospitalized but the formerly hospitalized patient. In the last decade hospitals have reported a decline in the number of beds occupied by psychiatric patients. Statistics also indicate that the length of hospitalization has become substantially shorter. To some extent though, it appears that the mental health dilemma has not improved but has transferred its focus. The problem has gone from the hospital to the community: length of stay in hospitals has declined and fewer beds are needed, but readmission rates have increased (Freeman and Simmons, 1963).

There is substantial evidence supporting the claims that psychiatric hospitalizations alone cannot foster rehabilitation in the community. Forsythe and Fairweather (1961) did not find a significant relationship between hospital behavior and later community adjustment. Williams and Walker (1961) found that a patient's chances of rehospitalization were unrelated to his condition at discharge. Mendel and Green (1967) state that hospitals are not being used appropriately. They feel a major problem is the feeling of alienation and isolation imposed on patients by being in a psychiatric hospital and therefore not an active contributing member of society. These authors caution mental health professional regarding the use of the psychiatric

hospital. Ruesch, Brodsky, and Fisher (1964) feel that hospitalization encourages dependency and social isolation.

Hospitals, unfortunately, are not discharging people into the community who are restored to health and able to resume active and responsible roles in the community. Instead, patients are being discharged after minimal improvement. They receive little continuity of care after discharge. In a study done by Purvis and Miskimins (1970), it was found that hospitalization alone was insufficient for adjustment to the community after discharge. A comprehensive community oriented follow-up program was the most useful method for increasing adjustment of former psychiatric patients. Pasamanick, Scarpitti and Dinitz (1967) have shown that returning psychiatric admissions to the community with support and medication is more effective than hospital based treatments.

After conducting a community based "aftercare program" for discharged psychiatric patients, Kasser and Cohen (1966) concluded that the prevention of rehospitalization and "a gradual degree of adjustment" to the community can be a result of a structure follow-up program. Studies done by Beard, et.al. (1963), Hornstra and McPartland (1963), and Mendel and Rapport (1963), indicate that community aftercare programs tend to minimize the need for rehospitalization.

The use of the ICF or halfway house is an alternative for individuals not in need of in-patient care and yet unable to maintain independent functioning in the community (Segal and Aviram, 1978). Ex-psychiatric patients are often not accepted into "normal" community life. Their behavior, according to Black (1978) turns out to be

inconsistent in relation to community expectation. The function of the halfway house is to provide temporary residence as a transitional environment immediately following hospitalization and before beginning independently living (Landy and Greenblatt, 1965).

The formal development of the halfway house is recent, but there have been sheltered situations in the past that parallel the philosophy of the halfway house. One of the earlier was in Britain. The British Mental Health After-Care Association placed psychiatric patients in private homes or convalescent homes (Apte, 1968). In 1879, The After-Care Association was founded as a voluntary association to establish intermediate care situations for ex-psychiatric patients (Jones, 1972). It was hoped that with the establishment of these facilities, hospitalizations could be prevented. Glasscote, et.al. (1971a) suggested that the recent interest in halfway houses is twofold: the realization that our treatment of the mentally ill has not proven beneficial; and the increased concern for individuals playing an active role in society.

Halfway houses in the United States developed their present form in the 1950's; Rutland Corner House opened in Boston in 1954. In 1969, a survey by Glasscote and associates estimated 128 halfway houses in the U.S. The halfway house is literally midway between the hospital and the community. It can serve people that cannot function independently and yet can no longer benefit from an institutional setting. The current definition used by the National Institute of Mental Health defines halfway houses as "residential facilities in operation seven days a week, with around the clock supervision (or a staff member living in the halfway house), and providing room, board,

and assistance in the activities of daily living" (Goldmier, 1977, p. 6). Definitions of the halfway house usually emphasize its aims as a transitional living facility. Glasscote, et.al. (1971a) feel that halfway houses may also serve as more permanent facilities for people who are not ready or able to move fully into the community. They define halfway house as a "nonmedical residential facility specifically intended to enhance the capabilities of people who are mentally ill, or who are impaired by residual deficits from mental illness, to remain in the community, participating to the fullest possible extent in community life" (p. 11).

Within the halfway house itself, measures are needed to assess which individuals will use the facility as a transitional living facility and thus be more adapted to the community and which individuals will maintain long term residence in the halfway house.

Community and Social Adjustment

A number of scales have been developed to measure community and social adjustment. The idea of community adjustment evolved from the dissatisfaction with intrapsychic measures as evaluation criteria (Harris and Brown, 1974). Community adjustment refers to an individual's lifestyle within his or her environment and emphasizes achievement in daily life (Roen, Ottenstein, Cooper and Burnes, 1966). The Community Adaptation Schedule (CAS) was developed as a research tool for use in community mental health research (Roen and Burnes, 1968). The concept represents an attempt to define the positive attributes of mental health in terms of an individual's relationship to their environment. Several studies have been reported in the development of

the CAS. In an early study, Roen, Ottenstein, Cooper and Burnes (1966) compared aftercare patients and normal individuals on a preliminary version of the CAS. On most of the variables the patients received scores that indicated less adjustment. A study was done by Harris and Brown (1974) on the relationship between the CAS and The Personal Orientation Inventory (POI), a measure of positive mental health emphasizing the relationship of the individual to himself or herself. The POI (Shostrom, 1964) was devised to measure self-actualization, a concept that has evolved from the work of Maslow (1962). The self-actualizing person, as measured by the POI, is one who functions autonomously, has a realistic self-image and tends to live in the present. Since the concepts of community adjustment and self-actualization both focus on positive mental health it was hypothesized that there would be a positive relationship between the CAS and POI. The results of the study confirmed this hypothesis.

One drawback of both the CAS and POI is that they are self-report scales only. Although measures have been built into the scales to control for inconsistencies in answering, they are still limited by only reflecting an individual's perspective of himself or herself.

The Social Adjustment Behavior Rating Scale (SABRS) has been utilized where the responses of a significant other is desired. It was developed to measure two aspects of psychiatric patients' social adjustment: work level and socialization level. Work level refers to one's work potential, ranging from complete dependency to an ability to maintain and support others. Socialization level refers

to one's social interaction potential, ranging from complete social isolation to mature social interaction.

The SABRS (Aumack, 1968) was used in a study by Price (1968) in assessing schizophrenics conceptual performance along a dimension of pathology. Price felt the use of behavior criteria would serve to reduce variability within pathology groups and allow a generalization of results to a larger proportion of schizophrenic patients.

Premorbid Adjustment

Besides actual measures of community and social adjustment, the process reactive distinction (level of premorbid adjustment) in schizophrenia had been utilized in predicting patients who will improve and patients who will not improve psychiatrically. According to Phillips (1953), maturity in the premorbid period, primarily the work record and social adjustment, appears to be related to a potential for improvement (good premorbid adjustment). The more inappropriate the thoughts and behavior, the less likely improvement will occur (poor premorbid adjustment). The Phillips Scale (1953) was developed to assess a patient's potential for improvement. The scale was constructed from a number of case histories of schizophrenic patients. It has proved reliable in reducing heterogeneity in schizophrenia.

Higgins (1972) sees the process-reactive distinction as a valid one that describes two different ways of looking at the world. Process schizophrenia usually develops early in life and the individual has a long history of unusual behavior. There is usually no evidence of one precipitating event leading to the onset of illness. The individual tends to resist treatment; the prognosis is poor. Reactive

schizophrenia develops suddenly, usually following an emotionally disruptive event. The individual usually suffers anxiety and guilt. This is often coupled with irrational ideations or delusions. The reactive schizophrenia, however, has a much greater potential for recovery due to their usual amenability to therapy and investment in change.

There is some evidence that process schizophrenics function at a lower level of personality organization as inferred from Rorschach responses (Belmont, Birch, Klein and Pollack, 1964). Pugh and Ray (1965) found process schizophrenics to be more labile while reactive schizophrenics show more socially appropriate behavior. Higgins (1972) reported that studies presented to the APA found that process schizophrenics differ significantly from normal patients. There was also a difference between the process and reactive schizophrenics. The difference between normal subjects and reactive schizophrenics did not reach the significant level.

The General Information Questionnaire (GIQ) has been utilized in determining adjustment when records of a patient are not sufficient to use the Phillips Scale (DeWolfe, 1966). The GIQ can be used to gather information from schizophrenic patients and this information can be used in categorizing the individual as "process" or "reactive" using the Phillips scale.

Locus of Control

Using the GIQ rated on the Phillips Scale, Lottman and DeWolfe (1972) compared the process-reactive distinction to another form of adjustment: locus of control. Rotter's (1966) concept of locus of

control (I-E) refers to a person's perception of the relationship that exists with their behavior and subsequent events (Ducette and Wolk, 1972). Individuals with internal control see their behavior as contingent on life experiences; individuals with external control see themselves as controlled by external forces (i.e., luck or fate). Individuals cannot be labelled as all internal or external, but a person may be described as more internal or external than another. The investigation by Lottman and DeWolfe (1972) found that process schizophrenics were more externally controlled than reactive schizophrenics.

In the literature concerning adjustment and I-E, Hall (1964) found a positive relationship between external control and maladjustment. Shybut (1968) used a modified I-E scale and found that the more severe the psychiatric impairment, the greater the external control in the patient. A study by Hersch and Scheibe (1967) indicated that locus of control was consistently related to social adjustment and internals showing better adjustment over externals. This study also indicated that internally controlled individuals described themselves as having more positive attributes such as: higher levels of activity, effectiveness and independence. Lefcourt (1966) feels that a belief in one's own control is a potential indicator for satisfactory adjustment in life. A study done by Steinberg et.al. (1974), used Rotter's I-E Scale to predict post-hospital adjustment of independent functioning. No significant changes were found in I-E scores, but there were significant negative correlations between I-E and independence scores. This would support Lottman and DeWolfe's (1972) finding that within

schizophrenia, locus of control is a characteristic based on premorbid adjustment and not a result of current symptomology.

This investigation will examine a possible relationship between locus of control (as measured by the I-E Scale), level of premorbid adjustment (as measured by the GIQ and the Phillips Scale) and the community and social adjustment (as measured by the CAS and SABRS).

The Hypotheses of the Study

1) Positive social adjustment among schizophrenics can be enhanced by a comprehensive aftercare program.

2) Schizophrenics displaying a good premorbid adjustment will improve in community adjustment to a greater extent than schizophrenics displaying a poor premorbid adjustment.

3) Schizophrenics with a more internal locus of control will show more improvement in community adjustment when compared to schizophrenics with a more external locus of control.

CHAPTER III

METHOD

The purpose of this study is to explore the relationships between locus of control, level of premorbid adjustment, and community and social adjustment among schizophrenics discharged from psychiatric hospitals to a rehabilitation aftercare program. This chapter presents the methodology used to achieve this purpose. First, the subject population and the setting will be described. The materials and instruments used, the selection and training of raters, and the procedure for collecting the data will then be presented. Finally, the design and the statistical methods used to indicate the significance of the data will be described.

Subjects

The 55 subjects in this study were individuals, aged 20-40, diagnosed as schizophrenic, who entered a psychosocial rehabilitation program over a four month period. The diagnosis of schizophrenia was established prior to their entering the facility, usually by the psychiatrist of the discharging hospital. Table 1 presents a summary of the demographic data on the subjects.

Setting

The Grasmere Residential Home is a psychosocial rehabilitation program located in Chicago's uptown neighborhood. The home is a three-story structure and has a capacity of 222 beds, most of which

Table 1

A Summary of Demographic Data

	Frequency	Percent
Sex		
Male	29	53%
Female	26	47%
Age		
20-24	9	16%
25-29	22	40%
30-34	12	22%
35-40	12	22%
Race		
Black	9	16%
Caucasian	44	80%
Hispanic	2	4%
Religion		
Catholic	23	42%
Jewish	6	11%
Protestant	25	45%
Other	0	0%
None	1	2%
Marital Status		
Single	43	78%
Divorced	12	22%
Married	0	0%

are occupied. There are 15 clinical staff employed. The Grasmere was established as a residential care program in the mid 1960's when the community mental health movement began. In 1972 Grasmere was issued a license as a residential facility and in 1975 when federal regulations required certification at the intermediate level of care (ICF), Grasmere received this certification. Grasmere is also licensed by the Illinois Department of Public Health as an ICF and has a city of Chicago Board of Health license as a halfway house (See Appendix A).

Materials

Demographic Data Questionnaire (Face Sheet). This information was obtained during the admission process. All pertinent demographic information was typed on a standard form and placed in the resident's chart.

General Information Questionnaire. The General Information Questionnaire (GIQ) was devised to elicit case history information from those schizophrenic patients who did not have sufficient records to obtain direct measures from the Phillips scale. The process-reactive score was assessed by the GIQ in all cases since it has been shown to be a reliable estimate of the Phillips Scale score.

The GIQ (DeWolfe, 1966) consists of 58 items, 53 being multiple choice; the other are five short answers. An example of a multiple choice question would be: How many friends did you have between the ages of six and twelve? (real friends, not just people you knew by name). The choices would range from no real friends to more than ten friends. An example of a short answer question would be: What groups or organizations do you belong to? The forms for males and females

are essentially the same with slight differences appropriate to the gender of the individual (e.g., male form refers to "wife" and female form refers to "husband"). The questionnaire was usually finished in 15 to 20 minutes.

Validity studies have shown that neither clinical expertise or psychological sophistication are needed to accurately assess individuals on the GIQ.

Phillips Scale. The Phillips Scale (1953) was developed from case histories of a number of schizophrenic patients. Data which seemed to differentiate between those who improved and those who did not improve were selected. The material falls into three categories: a) the premorbid history, b) possible precipitating factors and, c) signs of the disorder. The category or premorbid history contains six subsections: recent sexual adjustment, social aspects of sexual life during adolescence and immediately beyond, social aspects of recent sexual life: 30 years of age and above, social aspects of recent sexual life: 30 years of age and below, history of personal relations and recent premorbid adjustment on personal relations. The possible precipitating factors category contains two subsections: personal stresses and environmental stresses. The signs of the disorder category contains three subsections: affect and mood, impulsivity and thought processes.

In establishing individual subsections, the dividing point between the improved groups was assigned a value of three. Data was arranged according to significance of improvement or nonimprovement away from the score of three. Each score ranged from zero to six,

with zero being a score showing good improvement and six being a score showing little or no improvement. The number of subsections in the section differs according to the degree of discrimination in the subsection. For example, in the area of sexual adjustment it was possible to arrange case history information in seven steps of increasing adequacy of adjustment. The steps were assigned scores from zero to six. For other sections that amount of discrimination was not possible.

Rotter's Scale of Internal-External Control. Rotter's Scale of Internal-External Control (I-E) is a scale consisting of 29 items, including six filler items. The scale takes approximately 15 to 30 minutes to complete. Each item consists of a pair of alternatives lettered a or b. The subjects were asked to select the one they believed to be true and were told it was a measure of personal belief; therefore, there were no right or wrong answers. For example: a) One of the reasons we have war is that people don't take enough interest in politics; and b) There will always be wars, no matter how hard people try to prevent them.

The significant construct validity of the scale is shown by predicted differences in behavior for individuals above and below the median of the scale. The hypotheses that are strongly supported are that an individual with more internal control will: 1) probably be more alert to his/her environment and capable of coordinating current information and future behavior and 2) cognizant of means to improve his/her environment (Rotter, 1966).

Social Adjustment Behavior Rating Scale. The SABRS was used to measure

social adjustment. It was designed to be measured by a significant other. The scale contains 78 items and takes approximately 20 minutes to answer. The counselor was asked whether the person did or did not have the specific behavior in question. For example, "Is able to behave appropriately outside the home?" is a typical question on the socialization level. "Can handle occasional frustrations on the job?" is a typical question on the work level. The scale was first used in 38 VA hospitals, each contributing 1% of current male psychiatric patients. The scores suggested that the scale differentiates over a wide range of behaviors and the scores were normally distributed.

When used to measure the effectiveness of a small experimental "milieu therapy" ward of schizophrenic patients, significant scores were obtained and no change was reported for the control group (Aumack, 1968). The score on this scale was a partial operational definition of adjustment.

Community Adaptation Schedule. The CAS was also used to measure community adjustment. The CAS (Roen and Burnes, 1968) is a self report scale and is designed to elicit three modes of responses: actual behavior, affect and cognition. Responses to the items are rated on a six point scale. Subjects were asked to circle the number above the phrase that best described them. The scaled answers are arranged so that the higher number scores mean better adjustment and lower scores mean less adequate adjustment. The 217 questions of the CAS are divided into six chapters, each interested in the individual's interactions with the community. The six chapters include work community which is answered only by wage earners. It asks questions about

satisfaction with current employment and income. The second chapter is family community and is answered by everyone. It asks about satisfaction with current family and home situations. The third chapter is social community and is also answered by everyone. Questions concern social life and satisfaction in this area. The fourth chapter is larger community (answered by everyone) and this section entails questions about activities outside the home and satisfaction with leisure time activities. The fifth chapter is commercial community. Also answered by everyone, it includes questions about budgeting, financial matters, and the person's future in this area. The final chapter is professional community, completed by everyone. Questions concern the extent of using social service agencies and the satisfaction with them (See Appendix B). Studies concerning construct validity for the CAS indicate that the person who was adjusted to his or her community as measured by the CAS score was usually more affable, reliable and self actualizing (Cook and Josephs, 1970).

According to Weissman (1975), the most definitive application of the scale has been in multi-treatment studies of aftercare. The items include a combination of lifelong behavior and current behavior and, therefore, becomes potentially less sensitive for evaluative research. This consideration should be kept in mind in relation to the present study.

Selection and Training of Raters

Each new resident was assigned a primary counselor on admission. For the most part, counselors were assigned on an arbitrary basis unless the psychological history indicated a difficulty in working

with individuals of a specific gender, race or religion.

Each primary counselor carries a caseload of 20-25 residents. If an individual on their caseload was participating in the study, they became the rater for that individual. The primary counselor serves as the direct service provider in the program. They are responsible for skills training, activities and behavioral programs.

Two in-service meetings were held for the purpose of training the raters in assessing individuals on the SABRS and in scoring the GIQ on the Phillips Scale. The first meeting was used to explain the SABRS. To illustrate the use of the instrument the experimenter chose individuals from each raters' caseload, not participating in the study, and asked the rater to assess that resident on the SABRS. The instrument was scored for each individual and was followed by a discussion of the differing levels of social adjustment. The second meeting was used to explain the construction of the Phillips Scale and how the GIQ could be utilized when insufficient case histories existed.

Each subject was rated on the SABRS three days after admission and again in six months by the second rater who remained constant throughout the study. On a random basis this second rater did a second SABRS on a subject three days after admission. The reliability measurements were assessed for socialization level, work level and total social adjustment level. Reliability coefficients were very satisfactory for the SABRS measurement of socialization level (r = .916), work level (r = .911) and total measurement (r = .936).

Procedure

On admission to the Grasmere Residential Home, the I-E, GIQ and

the CAS were administered to alternate subjects. As described in the previous section, the scales determined locus of control, level of premorbid adjustment and level of community adjustment. Each individual was given a description of the research and requested to sign a consent form if he or she wished to participate (See Appendix C). All subjects received an identification number, thereby retaining anonymity. Numbers were assigned in chronological order for the two groups. Dates of admission were recorded so that the posttests were administered on the appropriate date (six months later).

Each new resident was assigned a primary counselor. The new resident's orientation involved a three day structured program, including complete physical, vocational and socialization assessments, as well as orientation to the procedures of the home and the surrounding community. During this three day period, there was an initial staffing, including all clinical staff, to plan the course of treatment for the individual. After this period, the individual was assessed on the SABRS by the primary counselor. A second judge rated a random sample of subjects so that the inter-rater reliability could be assessed on the SABRS; this second judge remained constant throughout the study.

After one month, a comprehensive long-term treatment plan and the first in a series of short term (three months) plans were constructed conjointly by the primary counselor and the resident. The short term goals were re-assessed and revised every three months. They reflected intermediate steps toward the long-term goals. The primary counselor also did a weekly note on the individual, charting progress with respect to various aspects of the program.

The post-test date was six months after admission. Subjects who were not pre-tested, were rated after six months on locus of control, level of premorbid adjustment and community adjustment. They too were rated on social adjustment by their primary counselor. The group that was pre-tested was asked to assess themselves again on the CAS. They were not required to take the I-E or the GIQ for a second time. The clinical staff member that did the random second rating also did all of the SABRS second ratings. No tests were scored until all 55 subjects had been post-tested. This was done to avoid any bias on the part of the counselors or the experimenter.

Design and Statistical Analysis

A separate sample pre-test post-test design (Campbell and Stanley, 1963) was utilized. All subjects were post-tested at the designated six month follow-up date. The pretest-posttest group and the posttest only group were placed in their respective cells. Cells were determined by two independent variables: locus of control and premorbid adjustment. The scores of the behavior and community adjustment scales (dependent variables) were placed in appropriate cells (See Table 2). As indicated by Table 2, the data was analyzed in the following manner. Regarding community adjustment (CAS score) the effects of locus of control and premorbid adjustment were analyzed in a two (internal or external locus of control) by two (process or reactive schizophrenia) analysis of variance. An additional 2X2 analysis of variance (same independent variables) were performed on social adjustment (SABRS score). For those subjects who were pre-tested, the effects of the treatment program on community adjustment (CAS) and

Table 2

Statistical Design for Cell Placement

Locus of Control		Pretest Premorbid Adjustment Process	Pretest Premorbid Adjustment Reactive		Pretest Premorbid Adjustment Process	Pretest Premorbid Adjustment Reactive		Posttest Premorbid Adjustment Process	Posttest Premorbid Adjustment Reactive		Posttest Premorbid Adjustment Process	Posttest Premorbid Adjustment Reactive
	Internal	CAS	CAS	I	SABRS	SABRS	I	CAS	CAS	I	SABRS	SABRS
	External	CAS	CAS	E	SABRS	SABRS	E	CAS	CAS	E	SABRS	SABRS

Locus of Control		Posttest Only Premorbid Adjustment Process	Posttest Only Premorbid Adjustment Reactive		Posttest Only Premorbid Adjustment Process	Posttest Only Premorbid Adjustment Reactive
	Internal	CAS	CAS	I	SABRS	SABRS
	External	CAS	CAS	E	SABRS	SABRS

social adjustment (SABRS) was examined by appropriate *t*-tests within each of the four cells generated by the locus of control and premorbid adjustment matrix.

Selected demographic information (age, sex, race, and marital status) were also examined to insure that their contribution as determinant factors was minimal.

CHAPTER IV

RESULTS

The results will be discussed in the following format: first, the relationship between the two independent variables will be examined; the three hypotheses of the study will be discussed with regard to community adjustment (CAS scores); and, finally, the three hypotheses will be discussed with regard to social adjustment (SABRS scores).

The Relationship Between Locus of Control and Premorbid Adjustment

A chi-square analysis of the locus of control (2) by premorbid adjustment (2) table (See Table 3) demonstrated that the distribution of subjects was significantly different than that expected, X^2 (1) = 5.36, $p < .05$. The difference in mean premorbid adjustment scores between the internal and external group is also noteworthy, although it did not reach significance, t (53) = $p < .10$. Means are reported in Table 3.

Another point that deserves comment regards the consistency of measurement of these two variables over time. To check the assumption that locus of control and premorbid adjustment are stable characteristics irregardless of treatment or time, locus of control and premorbid adjustment scores of the pretest-posttest group and the posttest only group were compared. Although no difference was found for the premorbid adjustment scores, the difference between locus of control scores

Table 3

Subject Distribution in the Premorbid Adjustment by Locus of Control Matrix

		Premorbid Adjustment Process	Reactive		Premorbid Adjustment ($\bar{X}$)
Locus of Control	Internal	10	13	23	$\bar{X}$ = 14.91
	External	21	11	32	$\bar{X}$ = 17.00
		31	24		
Locus of Control ($\bar{X}$)		$\bar{X}$ = 10.84	$\bar{X}$ = 8.62		

Note: X^2 (1) = 5.36, $p < .05$.

for the pretest-posttest group ($\bar{X}$ = 10.70, N = 27) and those for the posttest group only group ($\bar{X}$ = 9.07, N = 28) approached significance, t (53) = -1.79, $p < .10$.

Locus of Control, Premorbid Adjustment and Community Adjustment

To test for the hypotheses of this study with regard to community adjustment, CAS scores (pre- and post-test) from the pretest-posttest group were compared by using correlated t-tests. There was an overall improvement on the total CAS score from pretest to posttest within the pretest-posttest group. On the pretest ($\bar{X}$ = 140.03, N = 27) and on the posttest ($\bar{X}$ = 151.07), t (26) = -2.83, $p < .01$. Additionally, overall improvement was found on the CAS summation score. For the pretest ($\bar{X}$ = 499.07, N = 27) and on the posttest ($\bar{X}$ = 534.18, N = 27), t (26) = -2.37, $p < .05$. A closer look at the more specific subsections showed an increase from pretest to posttest within the pretest-posttest group concerning work level: pretest ($\bar{X}$ = 3.96, N = 27) and posttest ($\bar{X}$ = 9.07, N = 27), t (26) = -4.47, $p < .001$. To test for the effect of the pretest, the posttest (pretest-posttest group) and the posttest (posttest only group) were analyzed through the use of t-tests. There was no significant difference on seven of the ten scored subsections of the CAS. There were significant differences on larger community, commercial community and the affect score. On the subsection of larger community, the posttest only group ($\bar{X}$ = 19.85, N = 28) and the pretest-posttest group (17.96, N = 27) differed significantly, t (53) = 2.57, $p < .05$. The same was true for the subsection of commercial community; the posttest only group ($\bar{X}$ = 20.00, N = 28) and the pretest-posttest group ($\bar{X}$ = 17.85, N = 27) had significant differences

in scores, t (53) = 2.37, $p < .05$. Finally a difference was indicated in the affect of subjects: the posttest only group ($\bar{X}$ = 4.23, N = 28) and the pretest-posttest group ($\bar{X}$ = 3.90, N = 27), t (53) = 2.64, $p < .05$.

To test the second and third hypotheses, a 2 (premorbid adjustment) by 2 (locus of control) analysis of variance with follow-up t-tests were used. Although the overall analysis did not result in significant effect of premorbid adjustment on community adjustment, there was one specific finding: on the CAS summation scores the reactive group ($\bar{X}$ = 587.70) was found to score significantly higher than the process group ($\bar{X}$ = 520.4), t (53) = 2.97, $p < .01$.

Locus of control was a significant factor on several subsections of the CAS. The difference between mean CAS summation scores of the internally controlled group ($\bar{X}$ = 532.60, N = 10) and the externally controlled group ($\bar{X}$ = 453.83, N = 12) reached significance, F (1,18) = 8.787, $p < .01$.

The CAS mean pretest (pretest-posttest group) also reached significance in terms of locus of control. The internally controlled group ($\bar{X}$ = 21.69, N = 10) scored significantly higher than the externally controlled group ($\bar{X}$ = 15.45, N = 12), F (1,18) = 6.033, $p < .05$. Additionally, in the subsection of larger community the internally controlled group ($\bar{X}$ = 20.60, N = 10) and the externally controlled group ($\bar{X}$ = 17.83, N = 12) differed significantly, t (20) = 2.23, $p < .05$. Then on the professional community subsection, the internals ($\bar{X}$ = 18.60, N = 10) and the externals ($\bar{X}$ = 12.75, N = 12) differed significantly, t (20) = 2.34, $p < .05$, again in favor of the internals.

Although the overall analysis of the CAS posttest did not result in significant effect, there was one significant finding within the subsections. The CAS cognition estimate was found to be significant with regards to locus of control. Internals ($\bar{X}$ = 91.90, N = 55) were found to score higher than externals ($\bar{X}$ = 88.50, N = 55), F (1,43) = 4.18, $p < .05$.

A further finding was the significance of sex on the CAS professional community subsection; the difference in scores for the females ($\bar{X}$ = 17.06, N = 15) and the males ($\bar{X}$ = 13.08, N = 12) reached significance, F (1,15) = 5.32, $p < .05$.

Locus of Control, Premorbid Adjustment and Social Adjustment

The scores on the SABRS will be analyzed in terms of the three hypotheses of the study.

To test the first hypothesis, with regard to the SABRS score, the (pre- and post-test) of the pretest-posttest group were compared by using correlated t-tests. The results are summarized in Table 4. As Table 4 indicates, significant improvement was reflected over the six month period on the socialization level, work level and the total SABRS score.

To test the second and third hypotheses a 2 (premorbid adjustment) by 2 (locus of control) analysis of variance with follow-up t-tests was utilized. The overall analysis of the SABRS total score between the reactives ($\bar{X}$ = 24.23, N = 24) and the process ($\bar{X}$ = 20.83, N = 31) did reach significance, F (1,43) = 5.69, $p < .05$. In the subsection of socialization level there was a significant finding on the posttest (pretest-posttest group and the posttest only group), reactives

Table 4

Within Group Pretest-Posttest
Comparison of the Means on the SABRS

Variable		N	Mean	t-Value
Socialization Level	Pre	27	20.925	
	Post		23.370	-5.53***
Work Level	Pre	27	16.629	
	Post		19.333	-3.32**
SABRS TOTAL	Pre	27	19.000	
	Post		22.111	-4.96**

**$p < .01$
***$p < .0001$

($\bar{X}$ = 20.54, N = 24) and process ($\bar{X}$ = 17.96, N = 31 reached significance, t (53) = $p < .05$. A premorbid adjustment by locus of control interaction effect was noted when analyzing work level posttest, F (1,43) = 5.70, $p < .05$. A closer analysis of this interaction determined a relationship between internal locus of control and reactive schizophrenia. The combination of these two specific variables indicated more improvement in work level than the other variable combinations. Internal reactives ($\bar{X}$ = 23.07, N = 14) showed more improvement than the other three combined (internal-process, external-reactive, and external-process) groups: ($\bar{X}$ = 17.93, N = 33), t (45) = 4.10, $p < .001$.

In all areas of the SABRS pretest (pretest-posttest group) internals scored significantly higher than externals. On the total social adjustment score: internals ($\bar{X}$ = 22.20, N = 10) and the externals ($\bar{X}$ = 16.58, N = 12), F (1,18) = 6.64, $p < .05$. Scores significantly differed on the subsection of work level, the internals ($\bar{X}$ = 20.10, N = 10) scored higher than externals ($\bar{X}$ = 14.66, N = 12), F (1,18) = 6.14, $p < .05$. Finally, the socialization scores for the internals ($\bar{X}$ = 23.70, N = 10) and externals ($\bar{X}$ = 18.25, N = 12), F (1,18) = 4.81, $p < .05$ also reached significance. Overall significance was not reached for the total SABRS score but the work level subsection posttest did reach significance; internals ($\bar{X}$ = 21.04, N = 23) and externals ($\bar{X}$ = 17.95, N = 24), t (45) = 2.45, $p < .001$.

A discussion of these results will be presented in Chapter V.

CHAPTER V

DISCUSSION

The discussion of the study will be presented in two sections. The first section will analyze the experimental findings and their relation to current research. The second section will discuss methodology and implications for future research.

Experimental Findings

The hypothesis that positive social adjustment among schizophrenics can be enhanced by a comprehensive aftercare program was confirmed by this study. Although causality cannot be determined due to extraneous variables, the operational definitions and hypotheses concerning community adjustment were confirmed. On the CAS total score, there was significant change in scores from the pretest to the posttest in the pretest-posttest group. Analysis also indicated significant score differences in the summation scores and work scores. These findings indicate that community adjustment increased over time on the total CAS score. Especially noteworthy was the increase on the work level subsection. These findings appear to parallel those of Purvis and Miskimins (1970), whose findings strongly supported the fact that high vocational adjustment and general community adjustment were achieved through a comprehensive aftercare program.

To help in controlling for lack of objectivity or inconsistent perspective on the part of the resident, the SABRS was utilized in

assessing social adjustment by the primary counselor. On the two subsections (work and socialization level) and the total score there was significant increase in scores over the six month period. One interpretation of this finding could be that over this six month period each resident became a "member" of the halfway house and therefore behaviors which were once considered objectionable now became acceptable in light of rater familiarity and tolerance of each resident. However, there are two controls in this study that appear to contraindicate such a conclusion. First, there is the objectivity of the SABRS scale. Counselors were asked for specific behavior criteria, not impressions. A scale such as this was utilized so as to counteract the ambiguity that is possible through other types of questionnaires relying on assessments of attitude and intrapsychic change. Secondly, a second rater was chosen to assess inter-rater reliability. The reliability coefficients on the socialization level, work level, and total score adjustment reflected strong agreement on all levels between raters. The high reliability coefficients and objectivity of the scale aid in reflecting behavior change enhancing social adjustment.

To test for the effect of the pretest, the posttest of the pretest-post-test group and the post-test of the posttest only group were compared on the CAS scores. The analysis indicated no significant difference on the sections of work community, family community, social community, and professional community. There were significant differences in the sections of commercial community and larger community. On the three modes of response there were no differences noted in behavior and cognition but there was a difference noted in

affect. In reviewing the CAS questionnaire as an aid in elucidating why the subsections of larger community, commercial community and affect would be significantly higher for the posttest only group, it became clear that many of the questions posed to the residents in these sections were not germane to their lifestyle. The questions in the larger community subsection of the CAS ask questions about involvement in organized religion, importance in keeping up with current events and views on local politics. The commercial community asks questions about money management, savings programs, and modern technology as it is used in the home.

It appears that much of the pretest group relied on memory in answering the CAS for the second time due to the feeling that the questions were not applicable to them. However, the posttest only group was seeing the scale for the first time and perhaps had not formulated a decision. The more technical and abstract emphasis of these sections could also be a contributing factor in the difference between the affect score from the pretest-posttest group to the posttest only group. Feedback that was received by the experimenter concerning the CAS clearly indicated that although residents felt enthusiastic about the scale on the pretest, they failed to show the same enthusiasm on the posttest, verbalizing dissatisfaction with the length of the test and the time factor involved in finishing the scale.

All 55 subjects were scored on each of the scales and then were placed in the appropriate cell. The cells were designated by the dependent variables of locus of control and premorbid adjustment (See Table 3). The analysis indicated that the process group was more

externally controlled than the reactive group. This finding corresponds with the finding by Lottman and DeWolfe (1972); process schizophrenics were more external in control than reactive schizophrenics.

There is some controversy about the stability of premorbid adjustment over time. To check the stability of these characteristics, the premorbid adjustment scores of the pretest-posttest group and the posttest only group were compared. No significance was found, which seems to indicate that premorbid adjustment is more than a fluctuating characteristic. The pretest-posttest group was compared regarding locus of control and the findings approached significance. Smith (1970) indicates a significant change in locus of control over a six month period for those admitted to a psychiatric hospital in a state of crisis. Since residents are not assessed as being in a state of crisis on admission, the change in scores cannot be attributed to a change from crisis to normalcy. There can only be conjecture at this point due to the lack of statistical data, but the variable of time in the halfway house could be a contributing factor in changing the locus of control score. This assumption is contrary to that of Steinberg, et.al. (1974) and Lottman and DeWolfe (1972) who indicate that locus of control is a stable characteristic and not the result of current symptoms. The implications for future research will be discussed in the second section of this chapter.

In discussing the second and third hypotheses, the CAS will be discussed first in regard to premorbid adjustment and locus of control. The SABRS will then be discussed in terms of the two

independent variables. The second hypothesis, that reactive schizophrenics will improve in community adjustment more than process schizophrenics, was confirmed by CAS and SABRS scores. Also the third hypothesis, that internally controlled subjects would improve more than externally controlled subjects, was also confirmed by the CAS and SABRS scores.

An overall analysis of the CAS on premorbid adjustment did not show significance. The summation score, however, did indicate the reactive group scoring significantly higher than the process group.

Locus of control was a significant factor on several subsections of the CAS: the summation, mean pretest, larger community and professional community. In each case the internally controlled group received scores significantly higher than the externally controlled group. These findings are supported by Phares (1973) research in which internals were shown to be better able to influence the course of their lives through interaction with the environment. There is a noteworthy finding on the CAS posttest which reflects the level of cognition of the resident. Again the internals scored significantly higher than the externals.

To analyze if there was any significance in the premorbid adjustment by locus of control (See Table 3) an analysis was done using premorbid adjustment (2) by locus of control (2) by sex (2) by age (4). Significance was found on the subsection of professional community between males and females. Females scored significantly higher in this area than males. This finding was interesting and it indicates that women are more apt to utilize social service agencies and express

satisfaction with them than males. This finding could be reflective of our society in that it enables women more avenues for assistance than it does males.

The overall analysis of the SABRS and premorbid adjustment reflected significant findings. On the subsection of work level, socialization level and total social adjustment score the reactives scored higher than the process. These findings are supported by DeWolfe (1974). He found that poor performance on tasks of process schizophrenics were due to essentially three factors. The first was their thought processes which were blunted by poor cognitive development. The second was their lack of desire to require germane information to accomplish a task and the third was the lack of involvement in task demands. Data presented at the APA and reported by Higgins (1972) found that process schizophrenics have larger than normal personal space requirements. Due to the size of the halfway house and the close proximity of all residents and staff, it seems reasonable that the reactive schizophrenics would improve more than the process because they would not have difficulty with close contact.

In all areas of the SABRS pretest on locus of control, the internals scored significantly higher than the externals. The work level posttest indicated the same relationship between reactive and process schizophrenics.

A premorbid adjustment by locus of control effect was noted when analyzing the work level posttest. The combination of internal locus of control and reactive schizophrenia appears foremost in assessing potential for increase in work level.

This study seems to clearly indicate that reactive schizophrenics who are more internally controlled adjust best to the community within a comprehensive aftercare program. Although unaccounted for extraneous variables were present, it seems plausible to evaluate the aftercare program as an effective contribution to rehabilitation and social integration.

Information on locus of control and premorbid adjustment should be considered as tools for decisions concerning ward placement, community placement, and time of discharge.

Now that we see the heterogeneity involved in a group previously perceived comparable, how do we assess them in terms of the same rehabilitation model? This study seems to indicate that we should not. It seems a disservice to each resident to formulate treatment plans and long term goals based on often times scanty social histories and global diagnoses.

This study clearly delineates a group that can use the halfway house as a transitional living facility and those that will use it as more of a permanent residence. Nonetheless, with the overall distinction between process-reactive schizophrenia, internal-external control and the subsequent empirical evidence, there is very little change in terms of residents actually using the halfway house as a transitional living facility. It appears that the lumping together of ex-psychiatric patients does not prove beneficial to the higher functioning residents due to the unavoidable reinforcement of inappropriate behavior and increased potential for institutionalization. The resident population of this particular halfway house is 210 with a

clinical staff of 15 covering each 24 hour period. It is therefore difficult for residents to receive individualized attention. Many learn that one way to receive attention is to act out behaviorally. Again, due to the home's size, the lines for meals, medication, and money are similar to those in institutional settings. Another aspect inhibiting the potential of the halfway house concept is the welfare system. The system exemplifies the benefits of remaining disabled so as to continue receiving monetary benefits. This study chose to explore a halfway house that is attempting to overcome some of these inhibiting factors.

Implications for Future Research

A question that arose during the study was the factor of environmental stability and its role in increased social and community adjustment. It is possible that a stable environment over a particular length of time could account for the change in scores. Possible future research could involve a comparative study of patients admitted to a long term psychiatric hospital, patients discharged to a halfway house, and patients discharged back to their family. After a specified period they could be tested on the CAS and SABRS.

This study indicated, as defined by operational definitions of community and social adjustment the subjects did improve. Although not negating extraneous variables, it is assumed the treatment component of the halfway house was an integral factor in the improvement. Another relevant study could include these instruments for residents in other halfway houses. It could be used as an evaluative measure for the home, but, could also indicate that differing subgroups attain

increasing community adjustment in different settings.

The finding in this study indicated a less than significant change in locus of control from externally controlled to more internally controlled over a six month period. It is possible that the six month period was not long enough to reach a significant change. Therefore, a follow-up study is indicated for all subjects who were pretested on the locus of control scale in this study to assess if there is a significant change over a one year period.

This study has utilized the CAS and the SABRS in assessing community and social adjustment and the use of premorbid adjustment and locus of control in assessing potential for community adjustment. The potential for research is pervasive. There is not only a great need to evaluate programs but also to further specify criteria appropriate for placement. In delineating groups among the psychiatric population and specifying characteristics, we stand an improved chance of reducing heterogeneity, establishing different models for rehabilitation according to subgroups, and reaching optimal level of functioning.

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APPENDIX A

THE GRASMERE

A Psychosocial Rehabilitation Program

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THE GRASMERE REHABILITATION PROGRAM

I. PHILOSOPHY OF THE PROGRAM

Grasmere is a privately owned community based residential program which rests on two basic premises;

1) every human being has the right and the ability to maximize his own unique potential for a functional and fulfilling life;

2) within the boundaries set be genetics and physical disability, all non-functional aspects of a person's life style have been learned and, therefore, have the real potential for being repaired through new learning.

Because of these two assumptions, the program is essentially a contractual arrangement between the resident and the Home to effect positive and identifiable changes in the resident's life. Since this contract must be tailored to the uniqueness of the individual, the Long-Term Plan becomes, in effect, a description of the program as it exists for that person. On the other hand, since we do not have an infinite range of services and delivery styles, we work with those people whose needs coincide with our expertise.

II. THEORETICAL CONTEXT FOR THE PROGRAM

Describing an ongoing program is similar to asking an individual to give you a description of himself, since programs tend to have an organic life of their own. When someone does this, he usually has to give you not only a picture of what he is doing now but also an idea of what influences have brought him to where he is now and what goals and plans he has for the future, this being based on the Gestalt principle that past, present and future are all a part of the real present (cf. Lewin's concept of psychological space).

Although it is true that "there is nothing new under the sun" this is at the same time untrue, especially in the field of therapeutic intervention. No program is entirely a replication of another or an exact implementation of a theory, and no program is entirely unique and without precedent. Consequently, in order to place the Grasmere program in perspective, I would like to refer to some of the theoretical concepts which provide a frame of reference for the program. I do this acknowledging the fact that people assimilate ideas according to their own style and choose from among possible interpretations and approaches. This presentation of concepts is necessarily selective and truncated, as it represents a static and random sampling of the ideas and experiences which have influenced those of us who have formulated the program.

Differences in goals of rehabilitation and psychotherapy: Rehabilitation is aimed at restoring the individual to a productive place

in the community, productive being loosely defined as that which makes for a fulfilled life. Psychotherapy is oriented more toward internal emotional and characterological changes. Often both are necessary for a person who has been traumatized by any sort of disability or institutionalization. However, even though they are almost always 'together', this doesn't mean they are the same thing.

The need to experience competence: In his now classic article published in 1949, Robert White proposed that all animals, and especially human beings, have a basic biological, as well as psychological, need for 'competence', by which he meant efficacy in dealing with their environment.

The therapeutic milieu and the therapeutic community: Starting with Maxwell Jones and George Fairweather, therapeutic programs have evolved which emphasize the effectiveness of the total atmosphere and which involve both client and staff in a therapeutic alliance. The assumption here is that everyone is a member of the community and a possible therapeutic agent for every other person.

Internal vs. external locus of control: Part of the research in this area points to the fact that persons institutionalized in psychiatric facilities very often fall towards the external locus end of the scale; i.e., they assume that all effects which they experience are due to forces outside of themselves and not under the control of their own behaviors. This concept emphasizes that the goal of therapeutic intervention with individuals is movement from this external to an internal position, since the latter is correlated with successful functioning in the community.

The relationship between coping and deviant behavior: This is the neo-Freudian (Lois Murphy) approach to the concept of defense mechanisms wherein the ego is allowed to develop ways of interacting with the world which not only are survival oriented but also are congruent with the behavior of others. It is a health oriented rather than a disease way of looking at adaptive behavior. It also includes to some extent the ideas of R. D. Laing on the schizophrenic response to the perceived world.

Deviant behavior as learned: This does not preclude the possibility that there is biological insufficiency or abnormality, nor does it deny the effects of emotional and environmental stresses on the individual. It emphasizes the role of learning in the formation of behaviors geared toward the individual's survival and interaction with his world and is derived from principles of reinforcement theory.

The Humanistic premise that therapeutic change is only possible in the context of an I-Thou interaction between human beings who accept and value the intrinsic worth and dignity of each other.

There are other writers whose ideas are similar to those mentioned above: Glasser and the concept of reality therapy; Azrin and Allyon and the use of direct behavior modification in the elimination of psychiatric symptoms; Schneidman and Faberow whose work on suicide seems especially relevant to dealing with depressed persons; Lazarus and the concept of multimodal therapy; Silligman and the concept of learned helplessness.

III. PROGRAM CONTENT

The Grasmere program integrates vocational, recreational, social and behavioral sub-programs. In each of these, the goal is the same, i.e., that the person obtain an optimal level of functioning in an environment that is supportive. The following is a brief description of these sub-programs:

The vocational program consists of a graduated series of work settings. Individuals participate in these settings according to their capabilities and personal employment goals. The most sheltered type of vocational placement is involvement in the licensed internal work program. Here individuals perform tasks in various departments of the Home. A more structured and more demanding work setting is the sheltered workshop which is operated on the premises by Trilogy, Inc. There are two of these, and they stress the establishment of work habits related to an industrial setting.

These internal programs are used for either of two purposes. The first is to provide long-term employment for those who by reason of either age of functional level are inappropriate for vocational programs outside the Home. The second purpose is to provide a transitional program for persons who are preparing to enter other training positions who are in a temporary crisis, or who are waiting out the referral process to either a training or employment program.

The third level in this series is a diverse group of sheltered workshops and training programs run by various community agencies. The major resources at this time are Trilogy, Inc., a community based workshop, Japanese American Service Committee Workshop, Chicago School and Workshop for the Retarded, Chicago-Read Central Workshop, Jewish Vocational Services Workshop and Diagnostic Center, Thresholds, and Chicago Goodwill Rehabilitation Training Center. The following table presents a typical monthly summary of the vocational involvement of Grasmere residents. Also included under vocational program are the use of community-based, day-long therapy programs and local educational programs. Among those used are Chandler Park, Edgewater-Uptown Day Program, Barclay Day Hospital, Northwestern University Hospital Day Treatment Program, Chicago Community Colleges, Urban Progress Center programs and Ravenswood Day Center.

AGE AND TYPE OF VOCATIONAL INVOLVEMENT FOR RESIDENTS
GRASMERE RESIDENTIAL HOME AS OF APRIL, 1979 (TOTAL CENSUS 201)

	Under 26	26 35	36 45	46 55	56 65	Over 65
In-Home Workshops	6	9	12	21	16	7
Grasmere Work Program	9	15	3	4	7	2
Grasmere Pre-vocational Program	1	1	0	0	0	0
Community Workshops	0	1	7	10	3	4
Training Programs	0	0	0	0	1	0
Competitive Employment Full-Time	0	1	0	1	0	0
Competitive Employment Part-Time	0	0	0	1	0	0

TOTAL 142 or 71% of Census

Some residents begin at an even lower level of development with respect to vocational skills. This is especially true among the younger residents whose academic and social learning has been interrupted or stopped due to repeated or lengthy instutionalizations. At a crucial period (middle to late teens) they have identified as "patients" and, consequently, have developed the repetoire of feelings, thoughts and actions appropriate to this social definition of themselves. For them the vocational aspect of the program initially consists of training in the role behaviors of an autonomous adult (e.g., decision making, personal responsibility, social responsibility). It also involves a great deal of one-on-one counseling to help the person learn to incorporate these behaviors into an adult self-concept. In addition, for those whose basic academic skills are below survival level, there is tutoring in reading, writing, arithmetic and English as a second language. For those somewhat more skilled, there is an in-Home pre-GED program.

The social skills training and the recreational programs may be described together, since the activities available in the Home often serve to meet goals of both. The social skills training program not only aims at improving social interaction skills but also at establishing community living skills. Again, it operates for people who differ widely in functional level. At one end are those persons requiring the re-establishment of minimal communication skills to reverse the process of isolation often brought about by long years of institutionalization. For those already able to communicate, there are both structured and unstructured groups and activities available. These, again, demand varying degrees of active participation and referrals are made in accordance with individual needs. At the other end are those whose social skills are adequate and who wish to learn to enhance the quality of their social encounters so as to bring more joy into their lives.

The recreational aspect of the program aims at preparing individuals

to adequately structure leisure time in a reinforcing way. Activities such as movies, concerts and table games are low in social demand and often serve as an easy entry for a person who is comfortable being with others but not adept at direct social involvement. Exercise groups, ping pong, pool tournaments and discussion clubs involve residents to a greater degree of social interaction. Skill groups such as cooking club and writer's group are oriented towards special interests and activities of daily living. All skills groups are planned, have a definite cycle duration and a syllabus outlining what is covered in each meeting.

Structured activities are an important part of most Long-Term Care Plans. They are scheduled to complement the vocational skills training and, thus, are offered in the traditional non-work hours (i.e., evenings and weekends).

For both social and recreational development, the younger and more active residents are encouraged to utilize community resources and contacts to decrease dependence upon organizational support. There is an Activities Advisory Board, composed of residents, which organizes many of the special events and field trips. The table below presents a typical schedule of a week's activities. This schedule is revised every week and is available the day before that week begins in order to insure that people can make decisions concerning which activities they may choose to attend.

The term behavioral program is used to refer to those aspects of the Grasmere Program which address themselves to particular individual needs that do not fit into the description of the other programs. Examples of these are re-establishing habits of basic hygiene, clothing, room care, budgeting and managing money, alleviation of crisis distress, restructuring of dynamic factors (psychotherapy). Outside of short-term crisis intervention, psychotherapy is a service which we seek from other community resources. These programs are often in the form of 'contracts' entered into by the resident and the staff and sometimes include, as parties to the contract, members of the resident's family or personnel of other service agencies.

IV. STAFF

If the program as described above is to be an effective and positive experience for the individual resident, it must take place within the context of a supportive and therapeutic environment. A major factor in creating such an environment is the selection of staff who bring to their job not only functional ability but also personal attributes that facilitate personal growth and development. This approach to staff selection extends to all departments of the Home, not just to the areas which are specifically clinical. Maids, cooks and maintenance people are equally responsible for the preservation of a therapeutic atmosphere. The following

HAPPENINGS AND EVENTS
May 19 - May 25, 1979

SATURDAY	9:00 am	Community Adventures Group	Staff	Community Room
May 19	8:00 pm	Birthday Party	Staff	Dining Room
SUNDAY	2:00 pm	Theatre Experience	Rich	Dining Room
May 20	3:30 pm	Bible Study Group		Dining Room
	7:00 pm	Rummy	Jeanette	Dining Room
	8:00 pm	Yoga	Bobbi	3rd Fl. TV Room
	8:00 pm	Photography Group	Lee	Beauty Shop
MONDAY	10:00 am	What's Going On	Staff	Community Room
May 21	2:00 pm	Bingo	Martha	Dining Room
	8:00 pm	Thinking Grasmere	Rich	Dining Room
	8:00 pm	Pokeno	Jeanette	Community Room
	8:30 pm	Arts and Crafts	Becky	Community Room
TUESDAY	10:00 am	What's Going On	Staff	Community Room
May 22	2:30 pm	Bingo	Jeanette	Dining Room
	6:30 pm	Baseball: Central Plaza	Staff	Lincoln Park
	7:30 pm	Pre Vocational Group	Lee	Dining Room
	7:30 pm	Social Group	Bob	Dining Room
	8:00 pm	Women's Beauty Shop	Carvie	120 Shop
	8:30 pm	Job Mart	Lee	Dining Room
	8:30 pm	Activity Advisory Board	Bob	Dining Room
WEDNESDAY	10:00 am	What's Going On	Staff	Community Room
May 23	2:30 pm	Horseracing	Jeanette	Dining Room
	6:30 pm	English as a Second Language	Susan	120 Shop
	7:15 pm	Stitch in Time	Sally	Community Room
	7:30 pm	Dance Classes	Becky	Dining Room
	8:30 pm	Exercise Group	Sally	Gym
THURSDAY	10:00 am	What's Going On	Staff	Community Room
May 24	2:30 pm	Bunco	Jeanette	Community Room
	6:30 pm	Library Films	Staff	Bezazian Library
	7:00 pm	Education Classes	Marie	120 Shop
	7:00 pm	Women's Hygiene Group	Jean	Beauty Shop
	7:15 pm	Cooking Group	Marian	Kitchen
	8:00 pm	Self Expression Group	Bobbi	3rd Fl. TV Room

FRIDAY	10:00 am	What's Going On	Staff	Community Room
May 25	2:00 pm	Library Films	Herman	Dining Room
	7:00 pm	Bunco	Jeanette	Community Room
	7:00 pm	Mind Relaxation Group	Fred	3rd Fl. TV Room
	8:00 pm	Men's Hygiene Group	Fred	Beauty Shop
	8:00 pm	Women's Exploration Group	Carvie	3rd Fl. TV Room
	8:00 pm	Create a Card	Jean	Community Room

OUR BASEBALL SEASON STARTS THIS WEEK. COME OUT AND JOIN THE FUN AND CHEER ON OUR TEAM.

INFORMATION ON FREE EVENTS FOR THE WEEK AND INFORMATION ON CHURCHES AND SYNAGOGUES IN THE AREA MAY BE OBTAINED FROM THE FRONT DESK.

descriptions include the responsibilities of those persons who provide direct clinical service.

Administrator: This person is responsible for the overall management of the facility. He directly supervises the provision of all support services, including those that are resident oriented and those that are administrative in nature. He is ultimately responsible for selecting all staff and consultants to the Home and for insuring compliance with all governing and regulatory bodies.

Director of Clinical Services: This person is responsible for planning and administering the clinical program in the Home. In consultation with the Administrator, he establishes clinical policies and procedures within the framework of a rehabilitation model. He is responsible for insuring that all support services are coordinated with the clinical program. He is responsible for the orientation and training of all clinical staff, consultation on individual cases, maintenance of inservice training and coordination with the Administrator in those decisions where administrative and clinical demands overlap. He is responsible for maintaining the unified, rehabilitative approach in all aspects of the Home's functioning and is on call at all times for emergency situations.

Intake Coordinator: This person is responsible for the intake and admission process of all new residents. He is also the liaison person with referring agencies. In addition, he serves as the systems control person for insuring continuity and quality of care within the program.

Program Coordinators: These people serve as the primary direct service providers in the program. They are responsible for maintaining the social skills training, the recreational and the behavioral programs, and, at times, they are also involved in some of the pre-vocational skills training. Specifically, they fulfill this responsibility by performing three major interrelated types of work:

1) acting as an ombudsman for a small (25-30) group of residents. This entails assisting them in planning their program, maintaining all necessary notes and forms, and expediting referrals to various community programs.

2) acting as a facilitator and crisis intervention worker for any of the residents in the Home and as a back-up person in implementing programs initiated by another program coordinator. This is to insure that residents receive consistent messages and see the whole staff as equally available to them.

3) conducting and being responsible for planning two or three structured social skills training or recreational groups.

The program coordinator is, in effect, part social worker, part vocational counselor, part recreational therapist and part personal advocate/counselor. We believe that if we are to maintain a unified "whole person" perspective of the resident, we cannot compartmentalize his being into nice, tidy, departmental or "caseload" units. The program coordinators also work some evening and weekend hours so that the program runs sixteen hours per day, seven days per week and is backed up by a consistent, informed and coordinated night staff.

Activity Coordinator: This individual is responsible for the creation and maintenance of programs designed to teach basic interpersonal and social skills and to encourage use of community oriented leisure-time activities. He is responsible for training program coordinators in the use of groups as teaching devices and is a resource person for residents desiring to set up specialized interest groups. He is responsible for obtaining and maintaining all supplies needed for groups, for keeping all necessary program documentation and for coordinating all major special events in the Home.

Vocational Services Coordinator: This person is responsible for providing counseling to residents and consultation to program coordinators with respect to vocational and educational programs. He provides direct supervision to persons in the internal work program and is a liaison with the community-based workshops. He also conducts vocational groups within the Home and develops contracts outside the Home for the education, training and employment of residents. He is responsible for conducting all personnel procedures with respect to work program participants and for maintaining all necessary program documentation.

Health Services Coordinator: This registered nurse is responsible for assuring twenty-four hour nursing service. He is responsible for all medical records and for conducting staff and resident training in the use of psychotropic medications. In addition to these specific duties, the registered nurse is the primary source of physical care for the residents. It is his responsibility to be aware of their physical status and to be alert to any signs of physical illness. The nurse is the person who arranges for all outside medical consultations and is the liaison to the consulting psychiatrists and general practitioners. He is also responsible for working with residents and program coordinators on behavioral programs which involve health care of medication maintenance.

Licensed Practical Nurse: This individual is responsible for passing medication and for providing any necessary nursing care when the Registered Nurse is not in the facility. He is also trained to give emergency first aid treatment.

V. PROGRAM IMPLEMENTATION

In this section the process by which an individual resident moves through the Grasmere program is described. The intake procedure usually starts with a phone referral from a worker in another agency and/or hospital. At this time, the general appropriateness of the Grasmere program and the minimum requirements for placement are explored. Criteria which exclude an applicant's acceptance include: recent serious homicidal or suicidal behaviors, typically combative behaviors, and medical conditions involving the need for extensive personal or nursing care. If none of these exist, the potential resident and his worker are invited for a pre-placement interview. During this interview, the possibilities which the Grasmere program holds are explored. Following the interview, a decision is made concerning acceptance to the program and assignment to a particular program coordinator. Concurrently, the prospective resident decides if he wants to commit himself to this type of program.

Once admitted, the individual is assigned to a program coordinator who then has the primary responsibility for that person's program. Immediately after intake, at the weekly clinical staff meeting, background and recommendations regarding a new resident are presented to the entire staff. During the first week the new resident is given an orientation program which includes specific appointments with each of the coordinators. The results of these meetings are summarized by the program coordinator and the resident and translated into a provisional goal-oriented treatment plan. At the end of one month a comprehensive Long-Term Plan is constructed by staff and resident and the first of a series of specific short-term (three month) goals is identified. These operationally defined goals are assessed and revised every three months and reflect intermediate steps toward the long-term goals. In addition, weekly notes chart the progress of a resident with respect to various facets of his program.

Termination of an individual from participation in the program is usually made in a joint decision by the resident and staff, and can take many different forms. One possibility is return to a psychiatric facility based on the need for either more intensive treatment or a more structured living arrangement. A second is admission to a physical hospital or nursing home based on the need for more direct nursing or medical care. A third possibility is admission to another residential care facility based on the need for a different type of program orientation. A fourt alternative is discharge into independent community living based on the ability of the individual to function adequately without institutional support. A fifth alternative is return to the individual's original family situation. The sixth possibility is a decision for the person to remain in the Home but for the program to shift to one of maintenance and sustaining care, based on the ability of the

resident to maintain himself adequately in a semi-structured residential setting.

The exceptions to this joint decision process fall basically into two categories: 1) unilateral decision by the resident to move out against medical advice; and 2) unilateral administrative discharge for gross violations of Grasmere community mores, persistent involvement in illegal activity, or disruptive behavior, or active alcoholism. These latter are made by consultation between the Administrator and the Clinical Director and reasonable efforts are made to effect any alternate living arrangement for the person.

VI. POPULATION DISTINCTIONS IN THE PROGRAM

Although every individual's program is to some extent unique, there are similarities due to the characteristics of particular populations. The program has proved, in its fifteen year history, to be appropriate for four different groups of people.

The geriatric group includes persons approximately fifty-five years of age and older. This age grouping is used because of the relatively low probability of these individuals obtaining competitive employment. For this group the aim is to establish a comfortable and maximal level of participation and to maintain this level in accordance with the person's physical capability. For many, this means participation in a comparatively undemanding work activity program. For others, where vocational involvement is precluded, it centers around participation in the in-Home activities program. For still others, no organized involvement is appropriate and the effort of staff is toward the maintenance of personal care and informal social contacts.

The middle-aged group includes primarily persons between the ages of forty and fifty-five years who have experienced long histories of institutionalization. This history may have consisted of either a small number of long hospitalizations or a chronic pattern of short-term admissions. The emphasis with this group is on decathecting the hospital as part of their life style. Therefore, the efforts of staff are directed toward assisting them to establish and maintain viable contacts inside and outside the Home which help anchor them in the community. There is also a decided effort to direct them to vocational and/or training programs which will address the need to overcome institutionalized patterns of behavior.

The young adult group includes persons between twenty-five and forty years of age. Often, these persons are seen as capable of eventually attaining competitive employment and independent living. However, they typically have sporadic work histories and an unstable adult role definition. Therefore, a much more directed

effort is made to build vocational and social skills through the use of high level workshop and/or training programs and through group recreational and social activities.

The adolescent group includes persons from eighteen to twenty-five. There are two major subgroups here with very different needs. Some of these young people have been in and out of some form of agency care for a good portion of their lives, while others are experiencing only a first or second placement and residential care is an alternative to hospitalization. Successfully completing developmental tasks is the foundation of the program for these persons, especially the shift from external to internal means of impulse control.

VII. EXCLUSIONS

Experience has indicated that there are particular groups who need more specialized programs of rehabilitation who therefore do not benefit from the Grasmere program. Describing these groups may be helpful to individuals responsible to referral services.

Acting out Adolescents: By this is meant that group of adolescents whose form of response is physically destructive in nature or whose main area of conflict is that of dealing with authority figures. Grasmere has neither the physical restrictions nor the controlling atmosphere necessary for successfully working with such persons.

Adults with a Decided and Repeated History of Combative Behavior: Due to the small staff-resident ratio and the normative limits of behavior which are set in the Home, Grasmere is not equipped to deal with those individuals who cope through combative behavior.

Active Alcoholics or Drug Addicts: In addition to requiring more stringent physical controls, this group often does not respond favorably to an expectation oriented, motivational structure.

Currently Suicidal Persons with a Continuing History of Suicide Attempts: For this group, the small staff-resident ratio and emphasis on independence often present a serious threat to their physical safety.

Extremely Institutionalized Individuals: Because of the type of program and the need for the personal involvement of the resident in the program, Grasmere cannot provide adequate service to those individuals whose hospitalization experience has virtually destroyed all motivation for community living. Grasmere does not have structured, long-term programs for minimal personal care and rudimentary living habits.

APPENDIX B

C A S
Community Adaptation Schedule

Sheldon R. Roen, Ph.D. — Alan J. Burnes, Ed.D.

Form 5-A

The following survey has questions which describe the community in which you live, and your life within it. Answer all questions about *yourself* as things are now if you are living in the community, or as things were before if you are presently living away from home.

Please answer the questions on the answer sheet provided. Please do not write in the survey booklet. Beneath each question you will find answers that range from 1 to 6. For each question, choose the number of the answer that best fits you and write this number in the appropriate space for that question on the answer sheet. Answer every question except where the directions allow you to skip those that do not apply.

EXAMPLES

A. If you are working full time, you would answer the first question by putting the number 4 [4 full time] in the blank on the answer sheet for the first question.

B. If you do not work for wages, but have charge of the housework, you would begin with question 22. If your feeling about housework is dislike, you would put a 2 [2 Dislike] in the blank on the answer sheet for question 22.

Answers are not meant to be right or wrong and will vary from person to person. Your replies will be kept strictly confidential.

I. WORK COMMUNITY

A. EMPLOYMENT. *ANSWER THIS SECTION ONLY IF YOU ARE NOW WORKING FOR WAGES. OTHERS SKIP TO QUESTION 32.*

1. How much time do you put in at work now?

1	2	3	4	5	6
One to two Days per week	About half time	Three to four days per week	Full time	Slightly more than full time	Much more than full time

2. How do you feel about working?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like Some	Like	Like very much

3. If you had time available, would you put in additional work hours for more pay?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

4. How long have you been unemployed during the past year?

1	2	3	4	5	6
Over half the year	Three to six months	One to two months	Over a week	Several days	Continually worked

5. Do you think you could find a job as good as or better than your present one within four to six weeks, if necessary?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

6. How would you rate your performance in your work?

1	2	3	4	5	6
Very Superior	Superior	Above Average	Below average	Poor	Very poor

7. How do you feel about your present job?

1	2	3	4	5	6
Like very much	Like	Like Some	Dislike some	Dislike	Dislike very much

8. Are your present duties ones that make best use of your work skills?

1	2	3	4	5	6
Never	Very Seldom	Seldom	Sometimes	Often	Always

9. What is your present annual income?

1	2	3	4	5	6
Below $2,000	$2,000-$3,499	$3,500-$4,999	$5,000-$6,999	$7,000-$10,000	Over $10,000

10. How does your income match your expenses?

1	2	3	4	5	6
Much higher	Moderately higher	Slightly higher	Slightly lower	Moderately lower	Much lower

11. Do you feel that you can (or will) earn more in this job or one like it?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

12. How does your present income compare with your previous income?

1	2	3	4	5	6
Much less	Less	About the same	Somewhat more	More	Much more

13. As far as you know, how do your co-worker's wages compare with yours?

1	2	3	4	5	6
Much less	Less	About the same	Somewhat more	More	Much more

14. Would you say you have had money problems?

1	2	3	4	5	6
Never	Very Seldom	Seldom	Often	Very Often	Always

15. How do you feel about changing your job?

1	2	3	4	5	6
Very happy where I am	Don't want to	Would mind	Wouldn't mind	Want to	Want to very much

16. Do you feel that you will try to qualify for a more highly skilled job?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

17. How many of your co-workers do you consider friends?

1	2	3	4	5	6
Five or more	Four	Three	Two	One	None

18. Are you satisfied with your job as others seem to be with theirs?

1	2	3	4	5	6
Much less	Less	About the same	Somewhat more	More	Much more

ANSWER THIS SECTION IF YOU ARE ONLY EMPLOYED PART-TIME OTHERS SKIP TO QUESTION 22.

19. How much time do you spend looking for full time work?

1	2	3	4	5	6
None	Hardly any	Very little	Some	Much	Very much

20. How do you feel about working full time?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

21. Do you think you could work full time?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

B. HOUSEWORK. *ANSWER THIS SECTION ONLY IF IT IS EXPECTED THAT YOU HAVE CHARGE OF THE HOUSEWORK. OTHERS SKIP TO QUESTION 27.*

22. What is your feeling about housework?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like Some	Like	Like very much

23. How are you managing the housework?

1	2	3	4	5	6
Very well	Well	Fairly well	Not Well	Poorly	Very Poorly

24. How much of your housework is done by others?

1	2	3	4	5	6
Almost all	Most	Some	Little	Hardly any	None

25. If you had to, could you do all the housework yourself?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

26. In general, how do you feel you manage your housework in comparison to how others manage theirs?

1	2	3	4	5	6
Much better	Better	Somewhat better	Less Well	Poorly	Very poorly

C. FAMILY CARE. *ANSWER THIS SECTION ONLY IF YOU HAVE CHILDREN UNDER 16 LIVING AT HOME AND IT IS EXPECTED THAT YOU ARE IN CHARGE OF THEIR DAILY CARE. OTHERS SKIP TO QUESTION 35.*

27. How much of the care of your family are you able to accomplish by yourself?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly any	None

28. How do you feel about being responsible for the children's care?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

29. How do you think you manage the needs of your family?

1	2	3	4	5	6
Very poorly	Poorly	Not well	Fairly well	Well	Very well

30. How much of an effort is it to care for your family?

1	2	3	4	5	6
Very easy	Easy	Somewhat easy	Somewhat difficult	Difficult	Very difficult

31. Do you feel your management of your family's needs should be improved?

1	2	3	4	5	6
Not at all	Hardly at all	Little	Some	Much	Very much

32. Do you feel that your efforts are appreciated by your children?

1	2	3	4	5	6
Not at all	Hardly at all	Little	Some	Much	Very much

33. How much cooperation do you get at home?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly any	None

34. In general, do you think you get as much cooperation in your home as others get in theirs?

1	2	3	4	5	6
Much less	Less	Somewhat less	Somewhat more	More	Much more

D. WORK POTENTIAL OF HOMEMAKERS. *ANSWER THIS SECTION ONLY IF YOU ARE A HOUSEWIFE WHO DOES NOT HOLD DOWN AN OUTSIDE JOB. OTHERS SKIP TO QUESTION 39.*

35. During your life what was the total time you worked for wages (part or full time)?

1	2	3	4	5	6
Never	A few months	About a year	Two or three years	Four or five years	Over five years

36. How would you feel about holding down a job?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

37. Do you have any training or abilities for some particular job?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

38. Do you expect to work anytime in the future?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

E. UNEMPLOYMENT. *ANSWER THIS SECTION ONLY IF YOU USUALLY EARN A LIVING BUT ARE NOW UNEMPLOYED. DO NOT ANSWER IF YOU ARE RETIRED. OTHERS SKIP TO QUESTION 44.*

39. Over the past few weeks how often have you tried to find work?

1	2	3	4	5	6
Haven't tried	Hardly at all	Less than a day a week	About a day a week	Most weekdays	Every workday

40. How do you feel about <u>not</u> working?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

41. Do you think you will find work soon?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

42. Has anyone helped you try to find work?

1	2	3	4	5	6
Not at all	Hardly at all	Little	Some	Much	Very much

43. Do you think you are able to work full time?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

F. VOLUNTEER WORK. *TO BE ANSWERED BY EVERYONE.*

44. Over the past few years, have you done volunteer work without pay?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

45. In general, how do you feel about doing volunteer work?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

46. In general, would you do volunteer work if it were asked of you?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

G. WORK HISTORY. *TO BE ANSWERED BY EVERYONE.*

47. At what age did you start working either part time or full time?

1	2	3	4	5	6
Didn't	Over 25	25-21	20-17	16-14	Below 14

48. For how many different employers have you worked?

1	2	3	4	5	6
Over Seven	Six or Seven	Four or five	Two or three	One	None

49. With regard to work, are you where you thought you would be at your age?

1	2	3	4	5	6
Very much below	Below	Somewhat below	Somewhat above	Above	Very much above

II. FAMILY COMMUNITY

H. GENERAL LIVING CIRCUMSTANCES. *TO BE ANSWERED BY EVERYONE.*

50. How much non-working time do you spend at your home?

1	2	3	4	5	6
All	Almost all	Most	Some	Very little	Hardly any

51. How do you feel about home?

1	2	3	4	5	6
Very dis-satisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

52. Do you think your home living circumstances need improvement?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly at all	Not at all

I. SPOUSE. *ANSWER THIS SECTION ONLY IF YOU ARE LIVING WITH YOUR HUSBAND OR WIFE. OTHERS SKIP TO QUESTION 66.*

53. In general, how much non-working time do you spend with your spouse?

1	2	3	4	5	6
All	Almost all	Most	Some	Very little	Hardly any

54. How do you feel you get along with your spouse?

1	2	3	4	5	6
Very poorly	Poorly	Not well	Fairly well	Well	Very well

55. In general, how much do you agree with your spouse in regard to such things as budget, friends, child care, home management, and recreation?

1	2	3	4	5	6
Not at all	Hardly at all	Little	Some	Much	Very much

56. How would you rate the interest which your spouse has in your daily experiences.

1	2	3	4	5	6
Very much	Much	Some	Little	Very little	Almost none

57. How often do you have very pleasant experiences with your spouse?

1	2	3	4	5	6
More than once a week	Once a week	Once or twice a month	Less than once a month	Hardly ever	Never

58. How do you feel about your sexual life with your spouse?

1	2	3	4	5	6
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

59. How easy is it for you to express your personal emotional feelings to your spouse?

1	2	3	4	5	6
Very easy	Easy	Fairly easy	Somewhat difficult	Very difficult	Extremely difficult

60. How do you think your spouse feels about his or her sexual life?

1	2	3	4	5	6
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

61. How often do you and your spouse have serious arguments?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

62. In general, how much love do you have toward your spouse now as compared with when you were first married?

1	2	3	4	5	6
None	Much less	Less	About the same	More	Much more

63. How would you rate your marriage?

1	2	3	4	5	6
Very happy	Happy	Somewhat happy	Somewhat unhappy	Unhappy	Very unhappy

64. How does your marital relationship compare with others you know who are married?

1	2	3	4	5	6
Much worse	Worse	Somewhat worse	Somewhat better	Better	Much better

65. How would your friends rate your relationship with your spouse?

1	2	3	4	5	6
Very close	Close	Somewhat close	Somewhat distant	Distant	Very distant

J. CHILDREN. *ANSWER THIS SECTION IF YOU HAVE AT LEAST ONE CHILD OVER 4 YEARS OF AGE. OTHERS SKIP TO QUESTION 73.*

66. Of the time available for it, how much time do you spend with your children?

1	2	3	4	5	6
All	Most	Much	Some	Hardly any	None

67. In general, how do you get along with your children?

1	2	3	4	5	6
Very poorly	Somewhat poorly	Somewhat well	Well	Very well	Extremely well

68. Do any of your children come to you with their troubles?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

69. How easy is it for your child(ren) to express personal emotional feelings to you?

1	2	3	4	5	6
Very easy	Easy	Fairly Easy	Fairly difficult	Difficult	Very difficult

70. In general, how do you feel about your child's (ren's) activities?

1	2	3	4	5	6
Very satisfied	Satisfied	Somewhat satisfied	Somewhat dissatisfied	Dissatisfied	Very dissatisfied

71. How does your relationship with your children compare with most other families?

1	2	3	4	5	6
Much better	Better	Somewhat better	Somewhat worse	Worse	Much worse

72. How much interest do you have in your children's daily experiences?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

K. PARENTS. *ANSWER THIS SECTION ONLY IF EITHER OF YOUR PARENTS ARE LIVING. OTHERS SKIP TO QUESTION 96.*

73. How often do you discuss important matters or do things with your parent(s)?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

L. OTHER RELATIVES. *TO BE ANSWERED BY EVERYONE. THE FOLLOWING SECTION IS ABOUT RELATIVES OTHER THAN PARENTS, SPOUSE, OR CHILDREN WHO DO NOT LIVE IN YOUR HOME. IT INCLUDES BROTHERS AND SISTERS, AUNTS AND UNCLES, COUSINS AND IN-LAWS.*

85. How many relatives do you have some personal contact with, even if it is only by letter?

1	2	3	4	5	6
None	One or two	Three or four	Five or six	Seven to ten	Over ten

86. How many of these relatives do you feel close to?

1	2	3	4	5	6
Over eight	Seven or eight	Five or six	Three or four	One or two	None

87. How often do you see or talk to these relatives?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very Often

88. Have these other relatives who do not live in your home been of help to you?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly at all	Not at all

89. How do you feel about these relatives helping you?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

90. How many of your relatives live within one-half hour drive?

1	2	3	4	5	6
Over eight	Seven or eight	Five or six	Three or four	One or two	None

91. How many times have you talked with relatives over the past month?

1	2	3	4	5	6
None	One or two	Three or four	Five or six	Seven or eight	Over eight

III. SOCIAL COMMUNITY

M. GENERAL SOCIAL LIFE. *TO BE ANSWERED BY EVERYONE.*

92. How would you rate your social life?

1	2	3	4	5	6
Very inactive	Inactive	Somewhat inactive	Somewhat active	Active	Very active

93. How do you feel about your social life?

1	2	3	4	5	6
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

74. How do you feel about getting together with your parent (s)?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

75. How do you feel toward your parent (s)?

1	2	3	4	5	6
Very distant	Distant	Somewhat distant	Somewhat close	Close	Very close

76. How much time do you spend with your parent (s)?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

77. How do you feel about your parent (s)?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

78. How easy is it for you to express personal emotional feelings to your parents?

1	2	3	4	5	6
Very easy	Easy	Fairly easy	Fairly difficult	Difficult	Very difficult

79. Do you think your parent (s) are satisfied with you?

1	2	3	4	5	6
Not at all	Hardly at all	Some	Much	Very much	Completely

80. How often do you have serious arguments with either or both parent (s)?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

81. How much interest do your parents have in your daily experiences?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

82. In general, how much do you agree with your parent (s)?

1	2	3	4	5	6
Not at all	Hardly at all	Some	Much	Very much	Completely

83. In general, can you count on your parent (s) for help?

1	2	3	4	5	6
Always	Very much	Much	Some	Hardly at all	Not at all

84. How does your relationship with your parent (s) compare with other families you know?

1	2	3	4	5	6
Much worse	Worse	Somewhat worse	Somewhat better	Better	Much better

94. In general, how do you feel about participating in clubs or groups?

1	2	3	4	5	6
Like very much	Like	Like somewhat	Dislike somewhat	Dislike	Dislike very much

95. In general, how do you feel about your social acquaintances?

1	2	3	4	5	6
Very distant	Distant	Somewhat distant	Somewhat close	Close	Very close

96. How many social acquaintances do you have?

1	2	3	4	5	6
None	Hardly any	Few	Several	Many	Very many

97. In general, do you think your social acquaintances are dependable?

1	2	3	4	5	6
Never	Very rarely	Rarely	Sometimes	Usually	Always

98. On the whole, how would you describe the people you know in the town or city where you live?

1	2	3	4	5	6
Very unfriendly	Unfriendly	Somewhat unfriendly	Somewhat friendly	Friendly	Very friendly

N. FRIENDS. *TO BE ANSWERED BY EVERYONE.*

99. How many personal friends do you have at the present time?

1	2	3	4	5	6
None	One	Two	Three	Four	Five or more

100. How do you feel toward them?

1	2	3	4	5	6
Very close	Close	Somewhat close	Somewhat distant	Distant	Very distant

101. How do you think they feel towards you?

1	2	3	4	5	6
Very distant	Distant	Somewhat distant	Somewhat close	Close	Very close

102. Do your friends give you help when you need it?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

103. What are your feelings toward the friend with whom you spend the most time?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

104. Do you have as much contact with personal friends as you want?

1	2	3	4	5	6
Always	Usually	Sometimes	Seldom	Very rarely	Never

105. How much time do you spend with your friends?

1	2	3	4	5	6
None	Hardly any	One or two hours per month	Few hours per week	Many hours per week	At least an hour per day

106. In general, how often when you go out do you go out with friends?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

107. In general, what has your social life been like?

1	2	3	4	5	6
Very active	Active	Somewhat active	Somewhat inactive	Inactive	Very inactive

108. How often do you see or talk with your friends?

1	2	3	4	5	6
Daily	More than once a week	A few times a month	About once a month	Seldom	Never

109. In general, how do you feel about your friendships?

1	2	3	4	5	6
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

110. In general, do you think your friends consider you a good friend?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

D. DATING. *ANSWER THIS SECTION ONLY IF YOU ARE IN A POSITION TO DATE. OTHERS SKIP TO QUESTION 117.*

111. How often do you date?

1	2	3	4	5	6
Never	Seldom	About once a month	A few times a month	Weekly	More than once a week

112. How do you feel about being with the opposite sex?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

113. Would you date more if you had the opportunity?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

114. How often do you think about getting married?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

115. How do you feel about getting married?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

116. Do you think you will eventually get married?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

P. PEOPLE AT WORK. *ANSWER THIS SECTION ONLY IF YOU ARE PRESENTLY EMPLOYED. OTHERS SKIP TO QUESTION 121.*

117. How do you find the social relationships at work?

1	2	3	4	5	6
Very unsatisfying	Unsatisfying	Somewhat unsatisfying	Somewhat satisfying	Satisfying	Very satisfying

118. How many of your co-workers do you consider friends?

1	2	3	4	5	6
None	One	Two	Three	Four	Five or more

119. In general, how do you feel toward your co-workers?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

120. Do you think you will get to know some of them better?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

Q. NEIGHBORS. *TO BE ANSWERED BY EVERYONE*

121. How often do you visit with your neighbors for a half hour or more?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

122. How would you rate their interest in your experiences?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly any	None

123. In general, how do you feel about your neighbors?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

124. Could you count on a neighbor for help if you needed it?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

125. Do you think neighbors should go out of their way to help one another?

1	2	3	4	5	6
Always	Very much	Much	Some	Hardly at all	Not at all

126. How do you feel toward your neighbors?

1	2	3	4	5	6
Very unfriendly	Unfriendly	Somewhat unfriendly	Somewhat friendly	Friendly	Very friendly

127. How many neighbors do you consider as personal friends?

1	2	3	4	5	6
None	Almost none	Very few	Few	Many	A great many

128. In general, how do people in your neighborhood act toward one another?

1	2	3	4	5	6
Very unfriendly	Unfriendly	Somewhat unfriendly	Somewhat friendly	Friendly	Very friendly

IV. LARGER COMMUNITY

R. RECREATION. *TO BE ANSWERED BY EVERYONE.*

129. How often do you go out for such recreation as movies, theater, or sporting events?

1	2	3	4	5	6
Very often	Often	Somewhat often	Rarely	Very rarely	Never

130. How do you feel about these activities?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

131. Do you think you would do these things more often if you had the opportunity?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

132. About how many hours <u>per day</u> do you spend doing such things as reading, watching TV, or working on a hobby by yourself?

1	2	3	4	5	6
Over three	Three	Two	One	Less than one	None

133. How do you feel about having more network time given to scheduled entertainment broadcasts and less to news?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

134. In general, would you rather spend your recreation time alone or with others?

1	2	3	4	5	6
Always alone	Mostly alone	More often alone	More often with others	Mostly with others	Always with others

135. If you had the opportunity, do you think you would spend more time in active recreation (like bowling, tennis, golf, or swimming)?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

S. RELIGION. *TO BE ANSWERED BY EVERYONE.*

136. How often do you go to religious services?

1	2	3	4	5	6
Never	Seldom	Few times a year	Once or twice a month	About once a week	More than once a week

137. How much satisfaction do you get from religion?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

138. Do you consider yourself a religious person?

1	2	3	4	5	6
Completely	Very much	Much	Some	Hardly at all	Not at all

139. How much time per week beyond religous services do you spend on activities (related to religion,) such as family ritual, affiliated clubs and groups, prayer, etc.?

1	2	3	4	5	6
None	Hardly any	Very little	Fairly much	Much	Very much

140. Considering that you have or will have a child, would you want religion to become a major part of his or her life?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

T. ORGANIZATIONS AND GROUPS. *TO BE ANSWERED BY EVERYONE. THIS SECTION IS ABOUT SUCH ORGANIZATIONS AS P.T.A., ATHLETIC, RELIGIOUS, POLITICAL, SOCIAL, LABOR, PROFESSIONAL, AND BUSINESS.*

141. How many different organizations or clubs do you belong to?

1	2	3	4	5	6
Over four	Four	Three	Two	One	None

142. How do you feel about participating in groups?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

143. How often do you attend group functions?

1	2	3	4	5	6
More than once a week	About once a week	More than once a month	About once a month	Seldom	Never

144. How much satisfaction do you get from group activities?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

145. In general, what do you think about people belonging to organizations?

1	2	3	4	5	6
Of no importance	Unimportant	Somewhat unimportant	Somewhat important	Important	Very important

U. COMMUNICATIONS. *TO BE ANSWERED BY EVERYONE.*

146. How often do you read a newspaper or news magazines?

1	2	3	4	5	6
Never	Seldom	Less than once a week	Once a week	Daily	More than one daily

147. How much importance do you attach to keeping up with current events?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

148. How many of the following do you use in learning of events around you (radio, TV, newspapers, meetings, magazines, etc.)?

1	2	3	4	5	6
None	One	Two	Three	Four	Five

149. About how much time would you say you devote to current events (TV and radio news and programs, discussions, public meetings, newspapers, etc.)?

1	2	3	4	5	6
None	A few hours per month	About an hour per week	Two or three hours per week	Four or five hours per week	Over five hours a week

150. Are you usually bored by or disinterested in information about financial matters or news?

1	2	3	4	5	6
Very much	Much	Somewhat	Little	Very little	Not at all

151. Would you be in favor of using public communications media more for information and less for entertainment?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

152. How do you feel about the network giving news priority over scheduled entertainment programs?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

V. EDUCATION. *TO BE ANSWERED BY EVERYONE.*

153. Over the past year how often did you listen to or attend educational lectures or discussions?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

154. Do you think you will ever further your formal education?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

155. How much of your reading do you do to obtain new knowledge or information (other than for recreation only)?

1	2	3	4	5	6
None	Hardly any	Little	Some	Much	Very much

156. In general, how does your education compare with that of your social acquaintances?

1	2	3	4	5	6
Much better	Better	Somewhat better	Somewhat worse	Worse	Much worse

157. How much formal education do you have?

1	2	3	4	5	6
Didn't complete elementary school	Didn't complete high school	High school graduate	Some non-college study beyond high school	Some college	College

W. MOVING. *TO BE ANSWERED BY EVERYONE*

158. How would you feel about moving from your present home?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

159. Do you think you will move over the next few years?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Possibly	Very likely	Definitely

160. If you had to move, would you move to a different community?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

X. CIVIC COMMUNITY. *TO BE ANSWERED BY EVERYONE.*

161. In general, how interested are you in politics?

1	2	3	4	5	6
Not at all	Hardly at all	Little	Some	Much	Very much

162. How does your knowledge of local government officials and activities compare with that of others in your community?

1	2	3	4	5	6
Much more	More	Somewhat more	Somewhat less	Less	Much less

163. How much time do you spend keeping up with local political issues?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly any	None

164. How often have you sought information or aid from police and fire department services?

1	2	3	4	5	6
Never	Almost never	Seldom	Sometimes	Often	Very often

165. How do you feel about the police?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

166. How would you feel about being selected for jury duty?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

167. How would you compare the way in which your local government is run with other localities of the State?

1	2	3	4	5	6
Much worse	Worse	Somewhat worse	Somewhat satisfied	Better	Much better

V. COMMERCIAL COMMUNITY

Y. FINANCES. *TO BE ANSWERED BY EVERYONE.*

168. How much money do you save?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly any	None

169. How do you feel about your savings program?

1	2	3	4	5	6
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat	Satisfied	Very

170. Do you think you show good money habits or good money sense?

1	2	3	4	5	6
Definitely not	Very rarely	Rarely	Somewhat	Usually	Definitely

171. Would you say you have had money problems?

1	2	3	4	5	6
Never	Very seldom	Seldom	Often	Very often	Always

172. How have you planned for your old age?

1	2	3	4	5	6
Very well	Well	Fairly well	Not well	Poorly	Very poorly

173. How do you feel about your system for paying bills that are mailed to you?

1	2	3	4	5	6
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Satisfied	Very satisfied

174. Are you interested in keeping informed about financial matters or news?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

175. How would you compare your financial status with that of your friends?

1	2	3	4	5	6
Much worse	Worse	Somewhat worse	Somewhat better	Better	Much better

176. Do you think you have your debts under control?

1	2	3	4	5	6
Definitely not	Poorly	Somewhat poorly	Well	Very well	Definitely

Z. SHOPPING. *TO BE ANSWERED BY EVERYONE.*

177. In general, how do you feel about shopping?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

178. Do you think looking for bargains is generally worthwhile?

1	2	3	4	5	6
Definitely not	Very rarely	Rarely	Sometimes	Usually	Definitely

179. Do you find it gives you a "lift" to buy something special?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

180. How many charge accounts do you have?

1	2	3	4	5	6
None	One	Two	Three	Four	Over four

AA. TRANSPORTATION. *TO BE ANSWERED BY EVERYONE.*

181. How often do you drive a car?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

182. Do you plan to take any special, overnight trips this year?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

183. How often do you use any form of transportation?

1	2	3	4	5	6
Daily	Almost daily	More than once a week	About once a week	A few times a month	Seldom

184. Do you feel that transportation is a problem for you?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

185. Do you take leisure trips on weekends and holidays?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

186. In general, would you rather spend your recreation time alone or with others?

1	2	3	4	5	6
Always with others	Mostly with others	More often with others	More often alone	Mostly alone	Always alone

BB. MODERN TECHNOLOGY. *TO BE ANSWERED BY EVERYONE.*

187. If you had the funds to buy as many as you wanted, how many electrical appliances would you have in your home? (such as washer, dryer, hi-fi, air conditioner, rotisserie, tape recorder, FM radio, hair dryer, dishwasher, etc.)?

1	2	3	4	5	6
One or two	Three or four	Five or six	Seven or eight	Nine or ten	More than ten

188. How do you feel about using automatic devices in your household routine?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

189. How much would you be interested in hearing about new automatic devices as they are developed?

1	2	3	4	5	6
Very much	Much	Some	Little	Very little	Not at all

CC. HOUSING. *TO BE ANSWERED BY EVERYONE.*

190. For how many years have you owned or mortgaged your own home?

1	2	3	4	5	6
None	About one	Two	Three	Four	Over four

191. Do you feel that your home living circumstances need improvement?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly at all	Not at all

192. How much rent or mortgage do you pay each month?

1	2	3	4	5	6
Less than $50	$50 to $75	$76 to $100	$101-$125	$126-$150	Over $150

193. How do you feel about owning a house, whether or not you now own one?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

194. How many bedrooms are there in your house?

1	2	3	4	5	6
Over four	Four	Three	Two	One	None

195. Would you be willing to invest more of your income in making your home more comfortable or attractive?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

196. How do you feel about staying at your present address?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

ANSWER ALL OF THE QUESTIONS IN THIS SECTION IN RELATION TO THE LAST COMMUNITY YOU LIVED IN FOR OVER TWO YEARS.

VI. PROFESSIONAL COMMUNITY

DD. SOCIAL SERVICE AGENCIES. *TO BE ANSWERED BY EVERYONE. THIS SECTION IS ABOUT SUCH HELPING AGENCIES AS FAMILY SERVICE, WELFARE DEPARTMENT, VETERANS SOCIAL SERVICE, CHILD GUIDANCE OR MENTAL HEALTH AGENCIES, RELIGIOUS, SOCIAL AGENCIES, VISITING NURSES, ETC.*

197. From how many social agencies have you or your family sought help?

1	2	3	4	5	6
None	One	Two	Three	Four	Over four

198. How do you feel about such social agencies?

1	2	3	4	5	6
Like very much	Like	Like some	Dislike some	Dislike	Dislike very much

199. What amount of contact for reasons of personal or family difficulty have you had with the agency that has serviced you most?

1	2	3	4	5	6
None	One or two sessions	Three to five sessions	6 to 10 sessions	11 to 20 sessions	Over 20 sessions

200. Would you be in favor of efforts to expand these services?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

EE. OTHER COMMUNITY SERVICES AND ACTIVITIES. *TO BE ANSWERED BY EVERYONE. THIS SECTION IS ABOUT SUCH COMMUNITY SERVICES AS MEDICAL AND DENTAL CLINICS, WELL BABY CLINICS, SCHOOL EXTENSION PROGRAMS, TOWN RECREATION PROGRAMS, COMMUNITY SPONSORED RECREATION CENTERS (YMCA, POOLS), ETC.*

201. Have you participated in community services outside of those your work may have required?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

202. How do you feel about these services for yourself or family?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

203. Do you think you will have occasion to make use of these services?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

FF. INDIVIDUAL PROFESSIONALS. *TO BE ANSWERED BY EVERYONE.*

204. Do you have a family physician, lawyer, dentist, accountant, banker, etc. whom you feel free to call on because he knows you or your family?

1	2	3	4	5	6
None	One	Two	Three	Four	More than four

205. Do you feel it is important to have such professionals readily available?

1	2	3	4	5	6
Definitely not	Probably not	Don't think so	Think so	Probably	Definitely

206. How often do you consult any one of these professionals?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

207. Do you prefer a professional who also knows you personally to one who does not?

1	2	3	4	5	6
Much less	Less	Somewhat less	Somewhat more	More	Much more

GG. SCHOOLS. *TO BE ANSWERED BY EVERYONE.*

208. Have you participated in organized discussions of school planning: for example, building, the budget, election of board members, PTA?

1	2	3	4	5	6
Very much	Much	Some	Little	Hardly any	None

209. How do you feel about the quality of educational services in your area?

1	2	3	4	5	6
Dislike very much	Dislike	Dislike some	Like some	Like	Like very much

210. Would you support a measure to raise more tax money for improvement of schools?

1	2	3	4	5	6
Definitely	Very likely	Likely	Unlikely	Very unlikely	Definitely not

211. Of the time available for it, how often do you use public school areas (such as the gym, arts and crafts, meeting rooms, school grounds, playing fields)?

1	2	3	4	5	6
Very often	Often	Sometimes	Seldom	Hardly ever	Never

212. Would you favor using more tax money for opening school property to general community use?

1	2	3	4	5	6
Definitely not	Very unlikely	Unlikely	Likely	Very likely	Definitely

213. Would you be in favor of raising salaries of teachers?

1	2	3	4	5	6
Very much	Much	Some	Little	Very little	Not at all

ANSWER THE FOLLOWING SECTION ONLY IF YOU HAVE CHILDREN IN SCHOOL.

214. How often do you visit your child's school?

1	2	3	4	5	6
Never	Hardly ever	Seldom	Sometimes	Often	Very often

215. How much do you participate in the PTA?

1	2	3	4	5	6
Very active	Active	Somewhat active	Somewhat inactive	Inactive	Very inactive

216. Do you know your child's (ren's) teacher?

1	2	3	4	5	6
Not at all	Hardly at all	Little	Somewhat	Well	Very well

217. Would you do volunteer work in the schools or elsewhere if it were asked of you?

1	2	3	4	5	6
Very unlikely	Unlikely	Somewhat unlikely	Somewhat likely	Likely	Very likely

PLEASE CHECK YOUR ANSWER SHEET TO SEE IF YOU HAVE ANSWERED ALL QUESTIONS WHICH APPLY.

THANK YOU

APPENDIX C

Consent Form

Post Hospital Community and Social Adjustment Among Schizophrenics in an After Care Rehabilitation Setting

I, _____, state that I am over 18 years of age and that I wish to participate in a program of research being conducted by Marian Fitzgibbon, who has fully explained to me the procedures, risks, benefits and alternatives involved and the need for the research; has informed me that I may withdraw from participation at any time without prejudice; has offered to answer my inquiries which I may make concerning the procedures to be followed; and has informed me that I will be given a copy of this consent form. I freely and voluntarily consent to my participation in the research project.

_____ _____

(Signature of Staff Member) (Signature of Volunteer)

_____ _____

Date Signature of Witness to oral explanation and signature of volunteer.

APPENDIX D

Within Groups Correlated t-tests on the SABRS

Variable	Number of Cases	Mean	Standard Deviation	Standard Error	(Difference) Mean	Standard Deviation	Standard Error	Corr.	2-Tail Prob.	T Value	Degrees of Freedom	2-Tail Prob.
Socialization Level - Pre	27	20.9259	5.791	1.114	-3.4444	3.238	0.623	0.834	0.000	-5.53	26	0.000***
Socialization Level - Post		24.3704	5.343	1.028								
Work Level - Pre	27	16.6296	5.450	1.049	-2.7037	4.232	0.814	0.651	0.000	-3.32	26	0.003**
Work Level - Post		19.3333	4.446	0.856								
Total - Pre	27	19.0000	5.262	1.013	-3.1111	3.262	0.628	0.789	0.000	-4.96	26	0.000***
Total - Post		22.1111	4.560	0.878								

* = $p < .05$
** = $p < .01$
*** = $p < .001$

Within Groups Correlated t-tests on the CAS

Variable	Number of Cases	Mean	Standard Deviation	Standard Error	(Difference) Mean	Standard Deviation	Standard Error	Corr.	2-Tail Prob.	T Value	Degrees of Freedom	2-Tail Prob.
CAS Work Pre	27	3.9630	3.252	0.626	-5.1111	5.938	1.143	0.254	0.201	-4.47	26	0.000***
CAS Work Post		9.0741	5.863	1.128								
CAS Family Pre	27	14.5556	5.866	1.129	-0.4074	4.822	0.928	0.685	0.000	-0.44	26	0.664
CAS Family Post		14.9630	6.248	1.202								
CAS Social Pre	27	24.0000	7.550	1.453	-2.3704	7.606	1.464	0.392	0.043	-1.62	26	0.117
CAS Social Post		26.3704	6.058	1.166								
CAS Larger Pre	27	19.1852	3.340	0.643	1.2222	3.434	0.662	0.363	0.062	1.85	26	0.076
CAS Larger Post		17.9630	2.667	0.513								
CAS Commercial Pre	27	17.2222	3.286	0.632	-0.6296	4.456	0.858	0.230	0.248	-0.73	26	0.469
CAS Commercial Post		17.8519	3.860	0.743								

Variable	Number of Cases	Mean	Standard Deviation	Standard Error	(Difference) Mean	Standard Deviation	Standard Error	Corr.	2-Tail Prob.	T Value	Degrees of Freedom	2-Tail Prob.
CAS Professional Pre	27	15.2963	5.823	1.121	2.000	7.590	1.461	-0.132	0.510	1.37	26	0.183
CAS Professional Post		13.2963	4.159	0.800								
CAS Total Pre	27	140.0370	11.931	2.296	-11.0379	20.230	3.893	0.203	0.310	-2.83	26	0.009**
CAS Total Post		151.0741	18.937	3.644								
CAS Sum Pre	27	499.0741	69.158	13.309	-35.1111	76.960	14.811	0.611	0.001	-2.37	26	0.025*
CAS Sum Post		534.1852	96.369	18.546								
CAS Cognition Pre	27	3.7370	0.670	0.129	-0.0074	0.593	0.114	0.482	0.011	-0.06	26	0.949
CAS Cognition Post		3.7444	0.408	0.079								
CAS Mean Pre	27	20.3704	2.290	0.441	-0.7852	2.051	0.395	0.677	0.000	-1.99	26	0.057
CAS Mean Post		21.1555	2.717	0.523								

Variable	Number of Cases	Mean	Standard Deviation	Standard Error	(Difference) Mean	Standard Deviation	Standard Error	Corr.	2-Tail Prob.	T Value	Degrees of Freedom	2-Tail Prob.
CAS Affect Pre	27	4.0593	0.395	0.076	0.1519	0.349	0.067	0.560	0.002	2.26	26	0.032*
CAS Affect Post		3.9074	0.342	0.066								
CAS Behavior Pre	27	3.0519	0.433	0.083	0.0037	0.403	0.078	0.512	0.006	0.05	26	0.962
CAS Behavior Post		3.0481	0.379	0.073								

* = $p < .05$
** = $p < .01$
*** = $p < .001$

APPROVAL SHEET

The thesis submitted by Marian L. Fitzgibbon has been read and approved by the following Committee:

Dr. Gloria J. Lewis, Director
Associate Professor and Chairperson, Guidance and Counseling, Loyola

Dr. Manuel S. Silverman
Associate Professor, Guidance and Counseling, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

January 27, 1981
Date

Gloria J. Lewis
Director's Signature