

UNIVERSITY OF MANITOBA

A FOLLOW-UP STUDY OF A TOKEN ECONOMY PROGRAM AT
SELKIRK HOSPITAL FOR MENTAL DISEASES

by

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ABSTRACT

A group of 19 patients who had been on a token economy ward while hospitalized, was compared with a matched group of traditional ward patients on the Katz Adjustment Inventory, a measure of post-hospital adjustment. Both patient and informant ratings were obtained. In addition, groups were compared on community tenure and some behavioral indices of adjustment. The only significant main effect of treatment was on the KAS scale of Symptom Discomfort, on which token patients scored significantly higher than control subjects. There was one significant interaction between treatment, length of hospitalization, and sex on the patient form of Level of Satisfaction with Free-Time Activities and one significant main effect of sex, females scoring higher than males on the informant ratings of Level of Socially-Expected Activities. One other interesting finding was that token economy patients had a higher recidivism rate than control patients. A number of possible explanations for these results were discussed.

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INTRODUCTION

Changing attitudes toward mental hospital populations, as well as the implementation of new programs and techniques, have been accompanied by a decrease, since 1953, of the total resident population of public mental hospitals (Paul, 1963). The contribution of psychoactive drugs to this decline has been well recognized and, similarly, such innovations as the "Therapeutic Community" concept (Jones, 1953; Stanton & Schwartz, 1954) and treatment of patients in the community (Pasamanick, Scarpitti, & Dinitz, 1967) represent attempts to come to terms with the problem of institutionalization of potentially functional members of society.

Freeman and Simmons (1963) pointed out however, that although the total resident population has decreased, and length of hospital stay has, in the past decade, also declined, readmission rates have increased. Paul (1969) furthermore noted the presence of a group of "hard core" chronically-hospitalized patients, who occupy approximately two-thirds of the hospital beds and who do not contribute to the statistical decrease in total population. These two discouraging factors — the presence of a chronic population for whom no single treatment has been proven effective (Fairweather & Simon, 1963; Gurel, 1966; Piotrowski & Efron, 1966; Sanders et al., 1967; Vitale, 1964) and the increased recidivism — point to the necessity of developing more effective treatment techniques and/or evaluating present techniques in an attempt to determine their relative efficacy.

The present study was an attempt to evaluate a behavior therapy

program which purports to deal with both the chronicity and recidivism aspects of the mental hospital dilemma.

I. TOKEN ECONOMIES:

The application of operant conditioning procedures to mental hospital populations has been gradually gaining acceptance since the first report of the modification of the psychotic behavior of a severely regressed patient in 1954 (Lindsey & Skinner, 1954).

A program instituted in 1961 and first reported by Ayllon and Azrin (1968), implemented and demonstrated the efficacy of a "token economy" in which any reinforcements, (for example: food, passes), which, in the traditional ward are offered non-contingently, were made contingent upon the performance of certain desirable behaviors. The motivating environment described involved patients who were most resistant to any other psychotherapeutic or management programs. The patients were, therefore, mainly chronic or very unmanageable and, in general, the procedure used here attempted to emphasize the positive aspects of behavior, that is, those behaviors "incompatible" with psychotic or disordered behavior. Thus tokens, which could be exchanged in various pre-determined numbers for the "good things in life" were awarded to the patients in a manner which optimized the various dimensions of experimentally-derived laws of behavior. The tokens, for example, represented a tangible type of conditioned stimulus to bridge the delay between response and reinforcement (Ayllon & Azrin, 1968). The experimental basis for the use of conditioned reinforcement has been demonstrated by such investigators as Wolfe (1936), Cowles (1937), and Kelleher (1957). A further example of the implementation of experimentally verified procedures was discussed by Ayllon and Azrin (1968, p.60) as the "probability of

behavior rule" or the Premack Principle (Premack, 1959) which stated that high probability behaviors, or those in which the individual engaged most frequently, can serve as reinforcers for low probability behaviors. Thus, a behavior such as eating or television watching was used to reinforce such a low probability behavior as washing one's face or working.

Other reports of token economies have similarly been based on these as well as several other experimental findings. Atthowe and Krasner (1968) measured a baseline performance of sixty chronic schizophrenic male patients for about six months and following this, instituted about eleven months of a token economy. Gericke's (1965) report differed slightly from the above two in that more responsibility was accorded the nurses and attendants in isolating behaviors to be reinforced. Reports of token cultures have also been published by Steffy, Hart, Craw, Tormy, Marlett, and Fenz (1966) and, as well, many non-reported token economies have been set up along the same operant conditioning principles.

The present study involved such a program at a Provincial Hospital in Selkirk, Manitoba. (For specific details pertaining to this program, see Appendix A.).

Philosophically, the Selkirk program is similar to that of Fairweather, (1964) which, although not literally a token economy, incorporated many of the same principles as the operant systems described, and was included by Davison (1969) in a review of operant conditioning of ward-wide behaviors. The basic assumption that "mental illness" could best be viewed in terms of inadequacy of one's social skills led Fairweather to set up an experimental ward divided into four groups

managed by patients themselves, to which were referred behavior problems traditionally handled by the professional staff. Patients were paid contingent upon progressively more responsible behavior and promotions were dependent upon the recommendations made for each patient.

Subsequently, Fairweather, Sanders, Maynard, and Cressler (1969) reported such a patient-run community involving chronic patients, but this program took place away from the hospital and was self-sufficient within the larger community.

Most of the token economies discussed have reported experimental evaluations or various indices of their effectiveness.

Ayllon and Azrin (1968), in evaluating the effectiveness of their program, conducted a series of experiments which asked primarily two questions:

(1) Was the behavior maintained at a higher level because the reinforcer was given for the behavior?

(2) If the behavior was maintained at a higher level, then how much higher was this level?

In a series of six experiments, an A-B-A-B or A-B-A (counterbalanced) research design was used. The first experiment, which studied the relationship of ward reinforcement procedure to the performance of patients on off-ward assignments, resulted in the patients' totally discontinuing working on a previously preferred job when reinforcers were no longer forthcoming for that job. When reinforcement was reinstated, all patients immediately resumed the job which now afforded them reinforcement. This experiment, as well as five more, in general demonstrated that:

(1) Tokens were effective in changing voluntary job choices from

preferred to non-preferred jobs.

(2) When tokens were administered noncontingently, a decrease in job attendance ensued.

(3) The removal of the tokens from the ward economy while still leaving the back-up reinforcers freely available led to a significant decline in job performance. When tokens were no longer exchangeable for back-up reinforcers, the behavior decreased dramatically (Ayllon & Azrin, 1968).

Atthowe and Krasner (1968) in their studies found significant increases in such behaviors as attendance at group activities, going out on passes and engaging in social interaction. Also twice as many patients were discharged in the eleven months of token economy as in the preceding eleven month period, although half of these patients returned within nine months. An experiment, similar to the suspension of token reinforcement studies of Ayllon and Azrin (1968) and Atthowe and Krasner (1968) was conducted at Spruce House, a community-located token economy reported by Henderson (1969) and Henderson & Kelley (1969) which offers programs directed toward three objectives: work habituation, social adjustment, and counter-symptom conditioning (p.246). The investigation with respect to the effect of suspended reinforcement on social performance, was performed by Scoles and Henderson (1968). Using an A-B-A design, it was found that there was a decline in the production of reinforceable behaviors during the phase when reinforcement was suspended.

Henderson and Scoles (1970) also presented preliminary follow-up data from the subjects admitted to Spruce House as opposed to two control facilities to which groups were alternatively and randomly

admitted — a state hospital and a general hospital. It was found that, while the operant facility tended, on the average, to keep its patients longer, the average length of total hospitalization and of rehospitalization was shorter for the graduates of Spruce House. Possibly due to lower duration of rehospitalization for experimental subjects, the graduates of the operant facility spent more time in the community and more time employed than did control subjects.

To some extent behavior ratings have also been used to investigate outcomes of token economies. Steffy, Hart, Crow, Marlett, and Fenz (1966) used as a measure of the generalization of effects of their programs, the scores on the Minimal Social Behavior Scale (Farina, Arenberg, & Guskin, 1957) and found that the patients who had demonstrated social improvement also improved on this scale.

A behavior rating type of evaluation was further investigated by Gripp and Magaro (1970). In their token economy an attempt was made to quantitatively measure behavior changes by comparing schizophrenic patients on a token ward with control patients on other wards, on a number of behavior rating scales. The results showed an overall decrease in those scale factors most associated with psychotic behavior.

The studies described above, with the exception of that of Henderson and Scoles (1970) all evaluated token economies on the basis of an improvement of in-hospital functioning. As was pointed out by Davison (1969), however, operant conditioning programs have not made:

" an appreciable contribution to the goal of equipping adult mental hospital patients with the means of coping successfully in the outside world." (p.269).

The one post-hospital variable that was considered in these studies has been rate of successfully discharging patients from the hospitals. This has been investigated by Atthowe and Krasner (1968), Lloyd and Abel

(1970), Schaefer and Martin (1969).

But rate of discharge has been found to be negatively related to length of hospitalization. They found that the token system discharged residents with a significantly greater number of years of continuous hospitalization than did the two comparison programs.

Unlike the actual token economies, Fairweather's (1964) program did include a questionnaire-type follow-up beginning on the day that each patient left the hospital. Compared to a matched control group, the experimental group revealed that they felt more frequently that they had been helped and were more optimistic about future employment. The experimental group also spent fewer days in the hospital, stayed out longer, used less medication, and achieved better employment records. It was also found, however, that recidivism was not affected by the experimental "small group" program.

Although this last study involved more acute patients as opposed to chronic patients typically involved in token economy studies, Fairweather, et. al. (1969) did demonstrate good results with chronic patients.

To evaluate this community-based program, a matched group of 75 patients received traditional hospital treatment as well as Fairweather's program of group decision-making treatment. The results showed that within a supportive sub-community, chronic mental patients can manage their daily affairs and attain a better adjustment (gainful employment, higher self-evaluation, better interpersonal relationships) than a control group.

The present study attempted to apply a number of the approaches and findings discussed above in order to evaluate the post-hospital adjustment of patients of the token economy ward at Selkirk Mental

Hospital compared to a group of matched controls from other wards. The patients on the token program, as can be seen in Appendix A, were given the same treatment by nurses, attendants, and psychiatrists while in the hospital, as the control group, but were each assigned to a psychologist, who designed programs for each patient, to be carried out by the staff in an effort to modify the patient's behavior. The present experimenter acted as a psychologist for some of these patients for several months in 1971.

A behavior rating scale was used in this follow-up study and length of hospital stay, as well as several other variables which will be shown, based on the literature reviewed in the area of "prognostic studies" to be significant, were used as bases for matching with a control group.

II. PROGNOSTIC STUDIES:

Matching patients for comparative evaluation is largely based on a number of prognostic investigations which have attempted to identify background factors differentiating patients with good outcomes from those with poor outcomes. These studies, as well as most follow-up studies (studies attempting to identify pre - and post-hospitalization factors related to good adjustment), have dealt mainly with schizophrenic patients. The present study, though dealing also to some extent with schizophrenics, also included other diagnostic categories, thereby making generalizations from many of the prognostic findings tenuous. Prognostic studies are, furthermore, marked by their inconclusiveness, and lack of agreement in specifying prognostic variables.

One background variable given considerable attention has been

length of mental hospital stay, or time spent either continuously or intermittently, in the hospital. Not only is this variable tied in with chronicity and severity of disturbance but, it was found, the hospital itself is instrumental in producing hospital dependency and its resultant antisocial behaviors. (Bockoven, 1963; Goffman, 1961; Kahn, 1959; Kantor & Gelineau, 1965; Lehrman, 1969; Sommer & Osmond, 1961; Ullmann, 1967). Several theories have been developed to explain the behavior commonly seen in institutions, for example "Institutional neurosis" (Barton, 1959), "Institutionalism" (Miller, 1961; Wing, 1962), "chronicity" (Sommer & Witney, 1961), "Institutionalization" (Martin, 1955), and "Social Breakdown Syndrome" (Gruenberg & Zusman, 1964) are all terms used to refer to behavior disturbances enhanced and/or precipitated by the hospital social situation. Social Breakdown Syndrome is the most descriptive of these terms and consists of:

"withdrawal or anger and hostility as well as combinations of these two, leading to more or less severe destruction of the affected person's relationships. Withdrawal is manifested as lost interest in social functions such as work responsibility, housekeeping, and ordinary social obligations. Loss of concern about personal appearance and cleanliness leads eventually to the standard picture of the deteriorated, dilapidated, unresponsive, soiling, helpless, vegetative creature who in former times inhabited our mental hospital back wards." (p. 385)

Gruenberg and Zusman (1964) further described S.B.S. (Social Breakdown Syndrome) as a result of the interaction between a susceptible person and a particular kind of environment, while Gruenberg (1963) offered a tentative 7-stage formulation of the pathogenesis of S.B.S., suggesting that community-oriented treatment centres could help prevent such a syndrome.

In view of the above discussion of the influence of hospital experience, it is not unexpected that short length of hospital stay

has repeatedly been found to be associated with successful adjustment. (Ellsworth, 1962; 1968). Mueller (1960) found that the better adjusted patient obtained a release more often than his more poorly-adjusted counterpart. Fulkerson and Barry (1966) demonstrated that amount of improvement, as measured by perceptual and motor tests in a test-retest design, was related to subsequent length of hospital stay. These findings are consistent with that of Honigfeld and Gillis (1967), that a pernicious positive relation, not dependent on patient age, exists, between increasing length of hospitalization and increasing severity of schizophrenic illness.

In fact, the previous duration of mental hospital life was referred to by Brill and Patton (1962) as "the most important single fact with respect to prognosis." (p.266). Finally, in one of the most comprehensive longitudinal follow-up studies done with psychotic patients, Michaux et al., (1969) showed that two out of the five background variables which best predicted rehospitalization during the posthospital year were: (1) number of prior hospitalizations, and (2) years hospitalized before last admission. Similarly, in-patient experience was effective in predicting adjustment. The finding that length of hospital stay is significantly related to successful outcome has been confirmed by others (e.g. Pishkin & Bradshaw, 1960; Lewinsohn, 1967; Rosen, Klein, & Shahinian, 1969) and would thus seem a critical variable upon which to match experimental and control groups for purposes of outcome evaluation.

A second variable, age, has not been as conclusively demonstrated as a prognostic indicator but has been given some emphasis. (Brill & Patton, 1964; Paul, 1969). This variable has been discredited by

other investigators as not being an important variable. (Chase & Silverman, 1941; Peretz, Alpert & Friedhoff, 1964; Brown, Carstairs & Topping, 1958; Freeman & Simmons 1963; Michaux, Katz, Kurland, & Gansereit, 1969). However, since age is related to social competence (Zigler & Phillips, 1953) it is nevertheless necessary to take age into account in matching subjects, in spite of the dearth of evidence pointing to age as an important prognostic factor.

Education is, similarly, related to social competence in the general population (Phillips & Zigler, 1953). Although this variable has not been thoroughly investigated as a prognostic indicator, Michaux, et al., (1969) found it to be an important variable in the prediction of rehospitalization. Relapsers, they found, were comparatively low in educational level.

Sex differences have also been found in patient adjustment. Angrist, Dinitz, Lefton, & Pasamanick (1967) have found that male ex-patients have more difficulty in assuming a productive work role than female ex-patients, perhaps, as they suggested, because house-keeping is an easier activity to handle satisfactorily. Freeman and Simmons (1963), using the criteria of full-time employment, found that only 23-31% of ex-patients who were males functioned adequately after release (P.49) while from one-half to two-thirds of patients who were females assumed responsibility for household chores (p.54). Peretz, Alpert, and Friedhoff (1964), however, found that sex was not related to outcome of schizophrenic patients.

The variable most consistently related to good prognosis, is marital status, and, according to Farina, Garnezy, and Barry (1963), this finding has been replicated often enough in prognostic studies of schizophrenic patients that it can be considered to be established as

"one of the more reliable facts about schizophrenic patients"(p. 627). Chapman, Day, and Burstein, (1961), Counts and Devlin (1954), Jenkins and Gurel (1959), Lendemann, Fairweather, Stone, and Smith (1959), Mason, Tarpy, Sherman and Haefner (1960), all reported that male married schizophrenic patients recovered more rapidly than single patients. Farina, Garnezy, Zalusky and Becker (1962), Orr, Anderson, Martin, and Philpot, (1955), demonstrated a similar relationship for female patients, although nearly one-half of the subjects in the latter study were not schizophrenic. Peretz, Alpert, Friedhoff, and Zubin (1964) found that married patients fared better than single patients — both male and female and similar results were obtained by Holmboe and Astrup, (1957) and Malamud and Bender (1939). In the study by Farina, Garnezy, and Barry (1963), schizophrenic patients were traced for $5\frac{1}{2}$ years or more. Nonrecovered patients were less likely than recovered patients to be married.

Miller (1965, 1967), however, in a study of more than 1000 patients released to a California Bureau of Social Work, found marriage to be positively associated with good prognosis only in the absence of marital discord, thus qualifying the above findings. Furthermore, unlike Freeman and Simmons (1963), who found that patients who returned to a parental situation were hospitalized less frequently, but functioned more poorly than patients returning to parental homes.

Finally diagnosis has also been investigated as a prognostic factor. Many of these studies have, as previously mentioned, involved schizophrenic patients and have not found differential prognosis for different schizophrenic subclassifications. (Brown, Carstairs, & Topping, 1958; Brown, 1959; Peretz, Alpert & Friedhoff, 1964). When

the populations were broadened to "psychotic with functional disorders" (Freeman & Simmons, 1963), diagnosis was still not found to be significantly related to community tenure or to post-hospital performance levels. On the other hand, a series of papers by Angrist, Lefton, Dinitz, and Pasamanick (1961a, 1961b, 1962a, 1962b.) did find diagnosis to be one of the few psychiatric variables significantly related to both rehospitalization and to adequacy of post-hospital functioning. Still dealing with this broader classification into diagnostic categories, Michaux et al., found that schizophrenics typically had a poorer level of early adjustment than other groups and that schizophrenics were more often readmitted than nonschizophrenics.

These prognostic variables, as well as others that have, in some studies, been identified, for example, prehospital adjustment (Briggs, 1958; Peretz, Alpert, & Friedhoff, 1964; Vestre, & Lorei, 1967) and socioeconomic status (Angrist, Lefton, Dinitz, and Pasamanick, 1961a, 1961b, 1962, 1962b.) do not account for most of the variance in patient outcome. (Sanders, Smith, & Weinman, 1967). Other studies have, therefore, attempted to take into account sociopsychological factors in the patient's post-hospital environment to help explain post-hospital adjustment. The most important aspect of these studies, as they relate to the present study, is that they point out areas which must be considered in understanding post-hospital adjustment.

III. FOLLOW-UP STUDIES:

The Carstairs group in London, England, conducted investigations of post-hospital outcome of discharged male patients between the ages of 20 - 65, more than two-thirds of whom were schizophrenic. The minimum length of hospitalization prior to discharge was two years and the mean

was 6.5 years. At the time of release 14% had been rated as recovered, 65% as relieved and 21% as not improved. (Brown, Carstairs, and Topping, 1958; and Brown, 1959.).

One year following discharge 31.6% of these ex-patients had relapsed, 25.8% had made a poor adjustment, 17.4% a partial adjustment and 25.2% a full adjustment. The investigators found little relationship between outcome and patient's age, diagnosis or length of hospitalization. Successful outcome was, however, associated with patient's clinical status or severity of impairment at the time that he was discharged and the settings to which he went upon discharge. Those ex-patients who went to live with siblings or in lodgings had a greater success rate than those who took up residence with parents, wives, or in large hostels. Even after allowing for the fact that sicker patients are sometimes released to parents but rarely to lodgings, the results were found to be significant. The implication, according to the experimenters, of these findings was that schizophrenic patients function better when family pressures are minimal, and more poorly when subjected to the usual pressures of family life.

A series of follow-up studies undertaken by Freeman and Simmons, (1963) concerned essentially with understanding the linkages between the social and psychological characteristics of the family settings and family members of ex-patients and the course of the first year of post-hospital experience, took as their point of departure the perspective that:

"whatever the etiology of mental diseases, they manifest themselves prominently by psychological decrements which may affect the social behavior and interactions of the individual in adverse ways and have adverse socio-psychological effects on those around him. Hence psychiatric rehabilitation should be concerned especially with optimal restoration of social roles and social functioning within the

social systems significant for the patient, such as family, job, various associations, and participations in the general life, of the community."

There were two distinct phases in this series of investigations.

The earlier pilot studies were concerned with the concept of "tolerance of deviance" as the critical variable in post-hospital outcome. "Tolerance of deviance" was operationally defined as "the continued acceptance of the former patient by his family members even when he fails to perform in instrumental roles". Such an hypothesis was congruent with the findings of these earlier studies; for example, patients whose primary role in the family was that of child, as opposed to that of a spouse, stayed out of the hospital despite low performance, suggesting that structural differences in the position of the patient in the family were related to differential tolerance of their deviant behavior. Also structured questions on attitudes and personality suggested that the social-psychological characteristics of the family were associated with post-hospital success or failure.

Results of the exploratory study confirmed this tolerance of deviance concept in that significant differences were found between patients who succeeded in remaining in the community and those who returned to the hospital. More patients with low performance levels, who, nevertheless remained in the community, were in family settings in which they occupied the kin role of child and more patients who were returned to the hospital occupied the role of spouse or lived alone. Thus mothers appeared to be more tolerant than wives.

A second exploratory study was done in which several hypotheses derived from the tolerance of deviance proposition, involving the correlates of instrumental performance were tested. In this study of 182

male, discharged, patients, Freeman and Simmons (1963) found that the following variables were associated with a low level of post-hospital functioning: (1) the presence of other males in the home who could play the roles and perform the duties otherwise expected of the patients, (2) lower class socioeconomic status, (3) low expectations on the part of the family, (4) residence with female relatives who were "atypical" in personality (authoritarian, anomic, frustrated, rigid, and withdrawn compared with relatives of high level patient(s)). High level performance on the other hand, was related to being the sole bread-winner of middle class status, and high expectations for functioning. Thus far, results still seemed to support the tolerance of deviance hypothesis. Low functioning patients who succeeded in remaining in the community differed from high functioning patients on those variables predictable on the basis of different tolerance of deviance on the part of their families.

As was pointed out by Freeman and Simmons (1963), one critical limitation of the above position was the lack of information on unsuccessful former patients, that is, those who had returned to the hospital. Also, the authors noted that a number of variables associated with performance level among patients studied were retrospective in nature. Two subsequent investigations which (1) included relatives of female as well as male patients in the study group and (2) employed a two-stage design, such that a priori predictions could be made regarding post-hospital performance, cast considerable doubt upon the original hypothesis. This larger study involved 649 patients released during a six-month period in 1959 from 9 state and 3 V.A. hospitals in Massachusetts. It was found that 63.9% of the male and 60.2% of the female patients succeeded in remaining out of the hospital for at least one year.

These investigations found social class and expectations of significant others regarding performance levels to be significantly related to performance, but not to hospitalization. Specifically, four areas were significantly related to whether patients were rehospitalized or remained in the community at least a year: (1) social participation (2) work (3) the occurrence of bizarre behavior (4) the degree to which patients presented a management problems for families. However, there was no significant difference between the proportion of patients hospitalized from conjugal homes and from parental homes. This led to a revision of the tolerance of deviance hypothesis. Although it was still maintained that different tolerance of deviance was helpful in understanding differential instrumental performance, a similarly adequate understanding of community tenure would require a focus on differential psychiatric status.

Despite the inability of the "tolerance of deviance" hypothesis to completely explain success and failure in ex-mental patients, later studies provided more evidence in support of the role played by sociological factors in post-hospital adjustment. The type of living arrangements and employment have been related repeatedly to community stay. (Brown et al. 1958; Forsyth & Fairweather, 1961; Lorei, 1967; Sherman, Ging, Moseley, and Bookbinder, 1964; Vitale and Steinbach, 1965; Whol, 1964).

A series of papers by Angrist, Lefton, Dinitz, and Pasamanick (1961a, 1961b, 1962a, 1962b.) resulted in qualifying the "tolerance of deviance" hypothesis one step further.

This particular outcome study series involved female, acutely ill discharged patients who were interviewed along with their significant others and who were evaluated in terms of their mental status by two staff psychiatrists. Also, 100 former patients, in one study (1961b), were compared in functioning with their "normal" neighbors who lived ten

house numbers away.

Results showed that individual variables, such as length of previous hospitalizations were not significantly related either to post-hospital performance or to community tenure. Such sociological variables as marital status, family type (conjugal or parental) and expectations by self and significant others of performance were related to post-hospital functioning. This provides further support for the emphasis on social interactional variables as significant correlates of hospital adjustment.

One, not unexpected, finding was that the ex-patients were significantly inferior in their functioning to the "normal" control group, the greatest difference being in psychological status.

With respect to the "tolerance of deviance" hypothesis, these writers concluded from the above results that, rather than tolerance of deviance influencing performance, it was performance that influenced tolerance of deviance. Significant others base their expectations on past performance history. To the extent to which they have witnessed adequate functioning, they will come to expect the same level of adequate functioning. This would explain the relationship between tolerance of deviance and post-hospital functioning, and the lack of relationship between tolerance of deviance and community tenure.

In the present study it was impossible to control for each of the sociopsychological variables discussed as demonstrating relevance to patient outcome. Specifically, patients were matched on the background variables: age, sex, education, marital status, diagnosis, length of hospital stay. Further, the variables discussed by the previous follow-up studies were taken into account for the criteria chosen as measures of community adjustment.

The measures or methods used in evaluating psychiatric treatment have, in general, been of four types: (1) observational methods (2) structured interview (3) life table analysis and (4) outcome index, (Burdock & Hardesty, 1964).

Burdock and Hardesty (1964), in their review of quantitative techniques for the evaluation of psychiatric treatment, explained and gave examples of each of these. The first, observational methods, is exemplified by the Ward Behavior Inventory, consisting of items descriptive of the behavior of a hospitalized mental patient, designed for dichotomous ratings by the psychiatric nurse or attendant. An example of structured interview was the Structured Clinical Interview, consisting of open-ended questions constituting standard stimulus material, to be used by the interviewer. It resembles a projective technique in that the questions are ambiguous.

The third technique mentioned, life table analysis, is used primarily where the natural course of the disease leads to early death and thus does not have much relevance to the present study.

With respect to the first technique mentioned, (observational methods) it has been found that it is possible to maintain a good degree of validity by using community informants' ratings (usually relatives) as it is by using staff ratings. Fulkerson and Barry (1966), using length of hospital stay as an operational measure of adjustment, found that length of hospital stay could be predicted equally well from both a staff-rated scale and a relative-rated scale. It was, in fact, concluded by Ellsworth, Foster, Childers, Arthur and Kroeker (1968) in a review of the literature, that with one possible exception (rehospitalization), staff and relatives' ratings appeared equally valid in assessing patient

adjustment and functioning. This contention was held in spite of the widespread acceptance of the notion that relatives are biased and should therefore not be used as raters. (Buss, Fischer, and Simmons, 1962; Ellsworth & Clayton, 1959; Freeman & Simmons, 1963; Lewinsohn and Nichols, 1964; Gove, 1965.) The present study therefore employed community informant ratings as an essential part of the outcome measure.

This study also made use of ex-patient self reports. Although patients' self-ratings are generally poor measures of adjustment (Fairweather et al., 1960; May, 1964; Vestre & Lorei, 1967; Small, Small, & Gonzalez, 1965) Ellsworth et al. (1968) have found patient self-ratings to be valid adjustment measures of outcome.

The particular scale used in the present study was the Katz Adjustment Scales (KAS, Appendix B), first presented by Katz and Lyerly (1963), with its underlying rationale, operational criteria, and studies dealing with discriminative validity. It was again used in the study by Michaux et al., (1969) which comprehensively investigated the course of in-community adjustment of 139 patients discharged from Spring Grove State Hospital in Maryland. Their longitudinal study involved administration of the KAS to both informants and former patients at monthly intervals and thus provided some conclusive evidence of the validity of the scale.

The present study, as a "token economy" evaluation, differed from previous studies both in the area of "follow-up" studies and in the area of "token economy" studies. Previous follow-up studies; though using the same general format, did not evaluate specific treatment programs, but, rather, evaluated general outcome of hospitalization (eg. Freeman & Simmons, 1963; Michaux, Katz, Kurland & Gansereit, 1969). Previous "token economy" studies (eg. Ayllon and Azrin, 1968; Atthowe & Krasner,

1968) have mainly focused on the patient's improvement while still in the hospital. Although some of these studies have isolated single variables to be used as indices of post-hospital success, such as length of total hospitalization (Henderson & Scoles, 1970) discharge rates (Birky et al., 1971), and employment (Fairweather et al., 1964), they have not investigated a broad range of post-hospital functioning and adjustment. The present study attempted to investigate the effectiveness of a specific treatment program and used as criteria of effectiveness a broad range of psychological and sociological variables.

If in-hospital improvement, which has been demonstrated by others (eg. Ayllon & Azrin, 1968; Steffy et al., 1966) generalizes to post-hospital improvement, it would be predicted that "token economy" patients should be better adjusted than traditional ward patients. Since one aspect of the behavior therapy program is the extinction of symptomatic behavior, it was hypothesized that "token economy" patients should get lower scores on KAS form S1 (Symptom Discomfort). Since the behavior therapy program also provides training in "socially-expected activities", form S2 (Level of Performance of Socially-Expected Activities) should also be answered more satisfactorily by "token economy" patients. The same hypotheses were made with respect to the relatives' ratings of the corresponding scales.

METHOD

Subjects:

There were two groups of subjects. Subjects in the experimental group were those patients who had been at Selkirk Mental Hospital in Manitoba, and who had completed the behavior therapy program on Ward D-10. There were 19 subjects in each group — 9 females and 10 males, ranging in age from 15 - 39. The control subjects were former patients who had spent an approximately equal length of time in hospital and who had been in the hospital at approximately the same time as the behavior therapy group. They had not, however, been exposed to the D-10 program. The two groups were matched as closely as possible with respect age, sex, education, length of hospitalization, marital status, and broad classification of diagnosis. (eg. behavior disorder, neurosis, schizophrenia, etc. according to the Manual for the Classification of Psychiatric Diagnosis, 1969).

In addition, each of the experimental and control subjects was asked for the name of one community informant, preferably a parent or spouse, who was also included in the study.

In the selection of an appropriate informant, the general rule, as specified by Katz and Lysterly (1963), was that the informant should be sufficiently involved with the patient to be able to report on the patient's recent behavior in the home and have some knowledge of his outside activities. This was, in most cases, a parent if the patient was living with his parents or a spouse if the patient was married. If neither a parent nor a spouse was available or sufficiently involved with the patient, attempts were made to contact a sibling, roommate, landlord, or close friend. If the patient had spent much of his time

during the past several months in the hospital, or had never left the hospital, a staff member who was well-acquainted with the patient, was used as an informant.

Procedure:

All patients and informants were administered verbally the forms of the KAS dealing with Symptom Discomfort, Level of Performance of Socially-Expected Activities, Level of Expectations, Level of Free-Time Activities, and Satisfaction with Free-Time activity.

The Katz Adjustment Scale (KAS):

This scale was constructed, according to Katz and Lyerly (1963), in order to develop measures of adjustment and social behavior. Since adjustment, as conceptualized by the authors on the basis of previous psychological literature and the dictionary definition, has both the personal and social reference, the administration of the scale requires information from both the individual whose level of adjustment is being considered, and a significant other in his social environment.

The specific operational measures of adjustment used include both objective and subjective facets. These operational measures are: (a) Clinical Adjustment or freedom from symptoms of psychopathology, as manifested in the patient's complaints and social behavior (Form R1) (b) Adequate Social Functioning, or performance of occupational, self-care, community, and home responsibilities and the level of free-time activity expected (Forms R2, R3, R4, R5, S2, S3, S4, S5,) (c) Social Adjustment, or the patient's degree of subjective discomfort with symptoms and manner of functioning (Form S1), (d) Social Behavior, or the quality of the patient's behavior, as manifested in the relative strengths of tendencies to relate in characteristic ways to other people (Form R1). The first two of these operational measures are objective

in their intent, while the third and fourth reflect the subjective or attitudinal aspects of adjustment.

Validity:

Katz and Lyerly (1963) presented the results of two studies investigating the discriminative validity of the KAS. In a comparison of well and poorly adjusted groups of patients, the scales were shown to discriminate well, approximating very closely expert clinical judgement which was used as the criterion. The second study involved a large number of newly admitted acute schizophrenics. The reports of patients and relatives on patient behavior prior to hospitalization were found to be capable of providing a profile of measures of symptomatic and social behavior, which had high internal consistency, and stable relationships with the other measures in the profile.

The areas covered by this scale are, for the most part, those that have been attributed greatest importance in previous follow-up studies. The first form of the scale, KAS form S1 (Patient report of symptom discomfort) and form R1 (Relative ratings of patients symptoms and social behavior) deals with one aspect of adjustment, the importance of which has been attested to by Brown et al. (1958) and Brown (1959), who found that successful outcome was associated with the patient's severity of impairment at the time of discharge. Similarly, Freeman and Simmons (1963) found significant differences in the reports of relatives of successful and unsuccessful patients with regard to symptomatic behavior and problems of management, and that symptomatic behavior was a key variable in rehospitalization. Michaux et al. (1969) found the two best predictors of late post-hospital adjustment were the scales of general psychopathology and suspiciousness. At month one, they found

that patients whose outcome was to be relatively unsuccessful were usually those whose informants described them as excessively suspicious, and rated them highly on a variety of heterogeneous symptoms.

Both patient and informant forms (S2 & R2) of Level of Performance of Socially-Expected Activities deal with a main area of investigation of Freeman and Simmons (1963) previously discussed. Michaux et al. (1969) found that both the patient and informant scale of SEA were successful predictors of late global adjustment. SEA was also found to be an effective predictor for both respondents of rehospitalization and one of the variables which discriminated most between month to month adjustment between relapsers and non-relapsers.

The third KAS form deals with level of expectations of both patients and informants. The second of the exploratory studies discussed by Freeman and Simmons (1963) showed that low level patients tended to reside with relatives who did not expect them to perform or to participate in social activities even six months after release from the hospital. Patients with high performance levels lived with relatives who did expect them to work and to become socially active within three months after hospitalization. Angrist, Dinitz, Lefton, and Pasamanick (1962a) found both self and others' expectations for the subject to be important in relation to rehospitalization and post-hospital functioning, and Lorei (1964) found that relatives' attitudes as measured by questionnaire were related to patient length of stay out of the hospital. The previously discussed tolerance of deviance hypothesis centres on this issue of significant others' levels of expectations for the patient. Michaux et al. (1969), consistent with this, reported that informants expected less of relapsers than of non-relapsers, in terms of social behavior at Month

twelve, when they had first left the hospital. LOE (level of expectation) was, furthermore, one of only two successful patient scales successfully predicting adjustment, (month twelve) and patients' reports on LOE predicted end-of-year adjustment somewhat more accurately than those of informants. Finally, relapse, they found, was not predicted by the early expectations of either informant but was predicted by both respondents' reports of social performance and by the discrepancy between expectation and performance.

KAS forms RS4 (Level of free-time activities) and S5 (Level of satisfaction with free-time activities) have not been individually investigated in the previous follow-up literature, but the informant form of FTA (free-time activities) was found to be one of the four variables discriminating most often from month to month between relapsers and non-relapsers, but has not proved a particularly satisfactory predictor in other cases. SFA (satisfaction with free-time activities) as reported by informants, on the other hand, was relatively more successful. It was a monthly discriminator between relapsers and non-relapsers.

In addition to this scale, some concrete, behavioral indices of adjustment were used in an effort to determine whether these would distinguish between the two groups. They were phrased and rated as shown in Appendix C.

Analysis of Results:

The total scores on each of the forms of the KAS were obtained by adding up the scaled scores on each of the separate items. The main effects of treatment, sex, and length of hospitalization as well as the interaction effects of these three factors were computed. The division between short and long hospitalization was taken to be $1\frac{1}{2}$ years. (Paul, 1969).

RESULTS

Table 1 gives the results of ten separate analyses of variance for each of the five patient and five informant scales of adjustment. The analysis was a 2 x 2 x 2 design, in which the factors were: Treatment (token or control) x sex (male or female) x length of hospitalization (short or long).

Only one significant ($F = 4.92$, $df = 1/30$, $p < .05$) main effect of treatment was found. On the patient form of the Symptom Discomfort scale, token patients had significantly more symptoms than control patients.

One other significant ($F = 4.88$, $df = 1/30$, $p < .05$) main effect was observed on the sex factor. Informants saw the level of Socially -Expected Activities to be higher for females than for males.

Two significant interactions were noted on the patient form for Level of Satisfaction with Socially-Expected Activities. The interaction between sex and hospitalization was significant ($F = 4.44$, $df = 1/30$, $p < .05$) as was the three-way interaction between treatment, sex, and hospitalization. ($F = 5.21$, $df = 1/30$, $p < .05$). This latter interaction is shown in Figures 1 - 4.

Table 2 shows the correlations between corresponding forms of the patient and informant parts of the KAS. None of the correlations for the token group reached significance. For the control group, however, patient and informant scales were significantly related on Symptom Discomfort ($p < .01$) and Level of Socially-Expected Activities. ($p < .05$).

The results of nine of the responses on a supplementary questionnaire are given in Figure 5. As can be seen from the graph, there was very little difference between token and control groups on most of the

questions.

Eleven token economy patients as opposed to seven control patients put in seventeen or more hours at work per week. Six token in contrast to 8 control patients have spent more than 25% of their time since discharge working full-time; 1 token and 4 control patients have spent more than 25% of that time working part time.

One other major difference was that 3 token in contrast to 8 control patients spent more than an average of one hour per day doing housework.

Table 1

F values for 2 x 2 x 2 analysis of variance
for each of the patient and
informant scales

Scales	Treat- ment (1)	Sex (2)	Length of hospi- taliza- tion (3)	1 x 2	1 x 3	2 x 3	1 x 2 x 3
S1	4.92*	3.56	0.01	0.05	1.18	0.34	0.03
S2	0.03	0.34	0.00	0.00	0.00	0.54	0.01
S3	2.00	0.01	0.74	0.31	0.36	1.82	0.31
S4	0.27	0.00	0.77	2.17	0.18	2.37	3.08
S5	1.16	0.04	1.99	0.15	0.00	4.44*	5.21*
R1	0.00	1.24	1.56	0.08	0.00	0.23	0.00
R2	0.57	4.88*	3.09	-0.00	3.43	0.41	0.00
R3	0.20	0.18	0.29	0.15	0.00	0.23	2.15
R4	0.49	2.41	0.18	1.28	0.88	0.02	0.21
R5	0.10	3.27	1.29	0.00	0.38	2.09	0.04

*p < .05

Explanation of Scales

- S1 - Symptom Discomfort (Patient form)
- S2 - Level of Performance of Socially-Expected Activities (Patient form)
- S3 - Level of Expectation (Patient form)
- S4 - Level of Free-Time Activities (Patient form)
- S5 - Satisfaction with Free-Time Activities (Patient form)
- R1 - Symptoms and Social Behavior (Relative form)
- R2 - Level of Performance of Socially-Expected Activities (Relative form)
- R3 - Level of Expectation (Relative form)
- R4 - Level of Free-Time Activities (Relative form)
- R5 - Satisfaction with Free-Time Activities (Relative form)

Table 2
 Correlations between patient and informant
 ratings on the KAS forms

Scales	Token Group Correlations	Control Group Correlations
S1 - R1	+.416	+.611**
S2 - R2	-.182	+.479*
S3 - R3	-.294	+.359
S4 - R4	-.273	+.105
S5 - R5	+.152	-.137

* $P < .05$

** $P < .01$

Figures 1 - 4

Graphs of significant interaction effect on S5

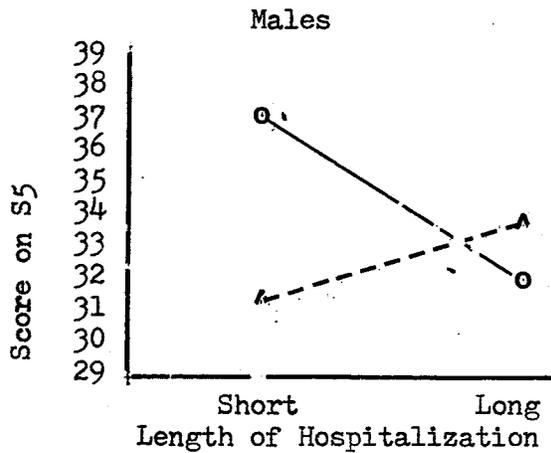


Fig. 1 S5 Scores x Hospitalization (males)

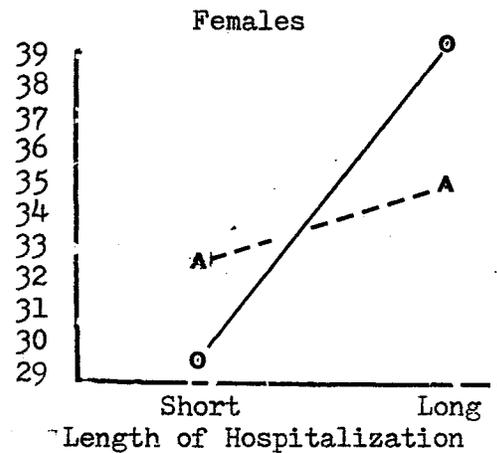


Fig. 2 S5 Scores x Hospitalization (females)

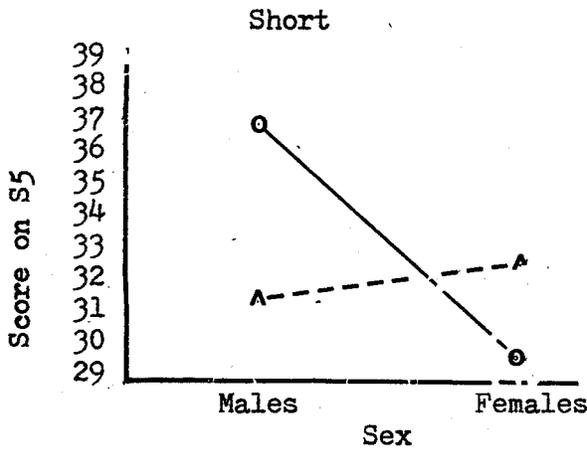


Fig. 3 Scores x Sex (Short Hospitalization)

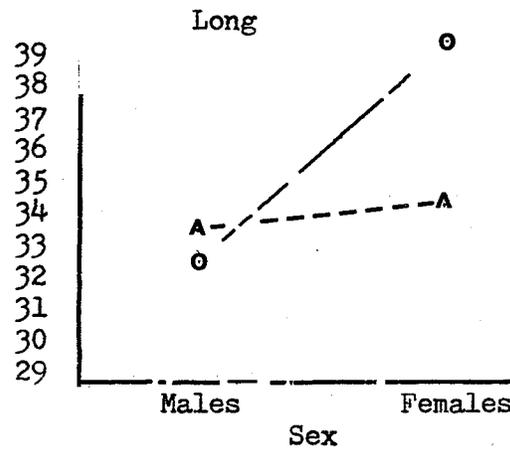


Fig. 4 Scores x Sex (Long Hospitalization)

— Token Group
 - - - Control Group

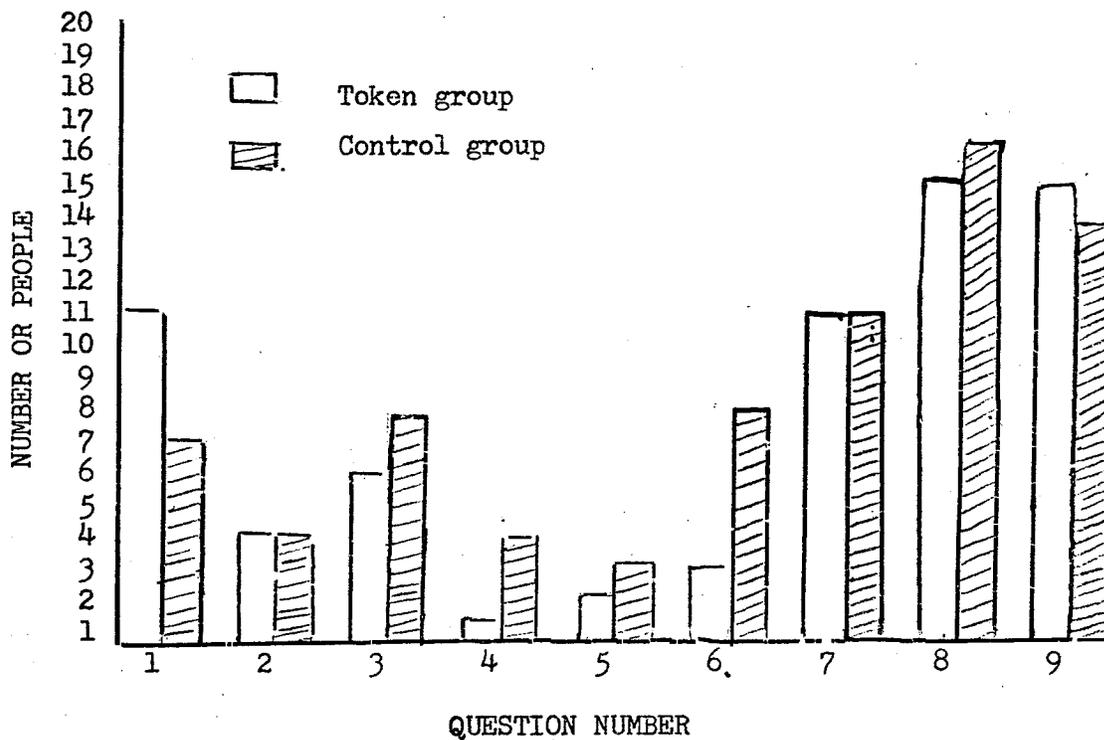


Figure 5. Number of people answering questions as specified below.

Specification of Questions

1. Number of people having put in 17 or more hours of work per week over the past two weeks.
2. Number of people earning \$150 per month or more from work.
3. Number of people having spent more than 25% of their time since discharge working full-time.
4. Number of people having spent more than 25% of their time since discharge working part-time.
5. Number of people spending 8 or more hours per week attending and preparing for job-related courses.
6. Number of people spending more than an average of one hour per day cleaning the house and doing laundry, cooking, etc.
7. Number of people having serious arguments with parents once a month or less.
8. Number of people claiming to have one or more close friends.
9. Number of people who go out (movies, etc.) once every 2 or 3 months or more.

DISCUSSION

Several experimenters have noted the apparent absence of a relationship between successful adjustment while in the hospital and successful community adjustment (Ellsworth, Foster, Childers, Arthur, & Kroeker, 1968). Freeman and Simmons (1963) further found that the kind of treatment while in the hospital or even presence or absence of treatment was unrelated to eventual successful functioning. There is, therefore, some basis for expecting a discrepancy between in-hospital improvement findings reported by other investigators (Ayllon & Azrin, 1968; Atthowe & Krasner, 1968; etc.) and the present results which deal with post-hospital functioning and which provide no evidence that token economy patients have more promising futures than regular ward patients.

It appears that there is some discontinuity between in-hospital and post-hospital adjustment, such that patients may be functioning on a higher level while in the hospital and while under specific contingencies of reinforcement, but that once they leave the hospital their comparative level of functioning is no longer high. In phase 4 of the program under consideration patients are no longer given or fined tokens. This situation is supposed to be analogous to the outside world where the newly discharged patient will similarly never be so immediately and tangibly reinforced; phase 4 should, therefore, act as a bridge between the token economy and the outside world. Although the individual is no longer reinforced with tokens, his behaviors are still recorded, and verbal reinforcement, especially for those areas in which the patient has improved, is not withheld. Thus the individual's adaptive behaviors are maintained on a schedule of very potent conditioned reinforcement in the hospital, where stimuli of the hospital environment will most

likely set the occasion for behaviors for which he has previously been reinforced. Outside the hospital, however, that situation changes, and, in many instances the contingencies of reinforcement may be reversed. Tantrum behavior, for example, which in the hospital is ignored or fined, is, if it occurs in a public place, generally reinforced with attention and concern on the part of others. The hospital environment is so completely different from the outside world that the ex-patient, especially the individual who has been in an institution for a long period of time, must become sensitive to stimulus cues in the outside world. A topic of conversation which may, in the hospital be appropriate, or at least tolerated, may be entirely inappropriate in a casual conversation with neighbors.

To maximize the discharged patient's chances of coping successfully once he is in the community, it would be necessary to teach him to become aware of different cues in his new environment and in interpersonal relationships. He must learn the new contingencies of reinforcement under which society operates, and the sometimes subtle reinforcement which is delivered. Otherwise he will be confronted with an old pre-hospital environment which, in the past, had been associated with maladaptive behaviors; at the same time no one will deliver a token for behaviors which, in society, are taken for granted. He will furthermore be unable to respond appropriately to unfamiliar stimulus cues in order to obtain society's rewards, and extinction of the behavior which had been conditioned with tokens is likely to result.

Similar principles could explain some of the present trends discovered. There was no statistically significant difference between the behavior therapy and control groups on Level of Performance of

Socially-Expected Activities, Level of Expectations, Level of Free-Time Activities, and Satisfaction with Free-Time Activities in either patient or informant groups. Patients' records showed scores that were consistently higher in the behavior therapy than in the control group on all forms except Free Time Activities. Thus the token economy patients do see themselves as functioning on a higher level than do control patients but significant others do not share this viewpoint. Furthermore, the correlations between patient and informant ratings on the respective scales are generally higher for the control group. This difference between perception of functioning by ex-patients and informants can be understood with respect to the token program. In the hospital, there are very sharp quantitative distinctions between good or desirable and undesirable behaviors. In the outside world this is not true, and, as these results indicate, the ex-token patient may be unable to see his functioning as others see it.

Most of the previous literature (Brown et al., 1958; Forsythe & Fairweather, 1961; Lorei, 1967; Sherman, Ging, Mosely, & Bookbinder, 1964; Vitale & Steinbach, 1965; Wohl, 1964) is in agreement about the importance of employment as an indicator of good adjustment in society. In comparing these two groups with respect to employment by means of a supplementary questionnaire, it was found that eleven of the token economy patients were working seventeen or more hours a week, whereas seven of the control group were working this amount. In terms of income, however, only four patients in each group were earning \$150 or more per month. Although there were more token economy than control former patients currently employed, only six token economy and eight control patients had been working full time greater than twenty-five per-

cent of the time since discharge. There is, therefore, not an appreciable difference between the two groups in employment, providing further support for the absence of noticeable differences in outcome between the groups.

The one exception to the general absence of significant differences between treatment groups is on the scale of Symptom Discomfort. Here the token economy patients reported a greater number of symptoms than the control patients. This seems at first, confusing in view of the token ward philosophy whereby a great number of somatic complaints are discouraged and seen as "attention seeking". Although such "attention seeking" behavior may have been extinguished while the patient was in the hospital, in the interview situation the subject is actually given cues that readily occasion positive responses to symptoms which may or may not ordinarily concern the individual. Evidence for this lies in the absence of a difference between groups on informant ratings of symptoms.

Symptom discomfort has, however, been found to be one of the most important indicators of rehospitalization (Freeman & Simmons, 1963; Angrist et al., 1961a; 1962). The present findings could support this contention. Of the total number of patients discharged, six out of eighteen of the token group and only one of eighteen in the control group were rehospitalized. Of those out of the hospital for longer than six months, one of ten token patients and one of seventeen control patients returned within one year. Of the patients who were in the community longer than one year one of three token patients returned within two years, compared to three of twelve control patients. Thus the token patients did have a greater incidence of rehospitalization, especially during the first six months.

There are, of course, alternative explanations for these findings. It could be that the commonalities in treatment between token and control groups are stronger than the differences. Both groups were in the same hospital where many of the same facilities were used and where token patients were not restricted from contact with other staff and patients. It was frequently observed by the experimenter that, while in hospital, patients learned to discriminate between general hospital staff who tolerated many psychotic and undesirable behaviors and token staff who did not. Thus a patient could graduate from the token program while having changed his behavior only in a very limited way. He may have simply learned to discriminate between those who would tolerate these behaviors and those who would not.

One question posed was whether or not there were effects of treatment that depended upon sex of the patient or his length of stay in the hospital, a variable which has previously been related to severity of disturbance (Jenkins & Gurel, 1959; Lendeman, Fairweather, Stone, & Smith, 1959; Ellsworth & Clayton, 1959; Ellsworth, 1968; M^cKeener & May, 1964; Schooler, Goldberg, Boothe & Cole, 1967). There was only one scale where this was found to be the case. On the patient form of Level of Satisfaction with Free-Time Activities, male, short-term token patients and female long-term token patients appeared to be more satisfied than other groups with their own level of activities.

People who obtained high scores on this scale, however, seemed to be either generally satisfied with what they were doing, or simply apathetic. Therefore it is difficult to interpret the interaction effect in terms of poor versus good adjustment. Support for the suggestion that male token patients who were relatively short-term are more satis-

fied with their level of activities was found in some of the answers given to interview questions. Those former patients who seemed most positive in their view of the token program were males who were there for a short time and who could specify the ways in which they improved and the kinds of behaviors which were modified. Those with negative opinions about the program, on the other hand, were generally unable to specify why they had been placed on a behavior ward or what benefit they had derived from it.

In general, there was little difference in the number of positive and negative statements made about the subjective benefits derived from their hospitalizations by either control or experimental groups.

Another significant finding was the superiority of females over males on the informant form of the scale for Socially-Expected Activities. This is in accord with the findings of Freeman and Simmons (1963) who suggested that females appear to function on a higher level than males, probably because housework is an easier duty to perform effectively than is a job in an interpersonal context. In the present study there were only two women who were housewives (both in the control group), but it is very likely that females are reported by informants to be functioning on a higher level than males because there seem to be fewer expectations of females in our society.

Before interpreting these results to imply that there is no demonstrable effect of token economy, it is necessary to consider some of the factors which may have influenced the results;

(1) Criteria for assigning patients to D-10: Although attempts were made to match experimental with control patients on factors which would have some bearing on post-hospital adjustment, the question of

why certain patients were originally placed on the token ward still remains. Almost invariably the behavior therapy patients were first tried on one or more other wards before being transferred to D-10 and in several cases D-10 was a last step before assigning the patient to a chronic unit. Thus there may be a difference in severity of disorder which may or may not be controlled for by age, length of hospital stay, or diagnosis. If, in fact, the token group contained more chronic patients, their prognosis would be poorer regardless of the kind of therapy received. The greater incidence of rehospitalization in the token group may well be reflection of the difference between the two groups. People referred to the token ward, in general, seem to be more chronic types of patients who have become very dependent on the hospital; requiring them to become more self-sufficient by following the token economy procedure is one attempt to break this dependency, but the high rate of recidivism suggests that it would be discouraging to attempt to estimate the efficacy of such a plan. Although there are few well-controlled studies showing a clear relationship between community adjustment and rehospitalization (Fairweather et al., 1960; Lorei, 1964; Marks, Stauffacher, & Lyle, 1963) Freeman and Simmons (1963) discovered two stages of rehabilitation — stage 1 being community tenure, and stage 2, social adjustment. It is stage 1 rehabilitation that appears to be tied in with hospital dependency and it is this stage that is particularly deficient in the token group.

(2) There may have been a bias in that none of the control patients had had previous contact with the interviewer, while many of the behavior therapy patients had known the interviewer while they were still in the hospital. This may have resulted in the token patients being less

inclined to try to put on a good front or, on the other hand, control patients may have been trying less to impress a total stranger.

(3) Matching token patients with controls was difficult and far from ideal. Matches were best with respect to sex, marital status, and diagnosis and next best with regard to age and education. Length of stay, although the most important variable, was the most difficult to match, and it was necessary to tolerate considerable discrepancy. In several instances it was necessary to rematch when control subjects could not be located or refused to be interviewed. Because of this the average length of stay of the behavior therapy group turned out to be somewhat longer than that of the control group, and this too may have biased the results.

(4) This leads to a related problem of interviewing subjects. There were several refusals and several of the former patients either could not be located or had moved out of town. In contrast, the easiest people to locate were those who were still in hospital or who had been readmitted. This may be an additional bias against both groups, but affecting the behavior therapy group more since there was less flexibility in patients that could be chosen for subjects from the experimental group.

(5) In each of the groups a number of the informants were nurses. A recent study by M^CReynolds and Coleman (1972) reported gains in staff expectations about the treatability of patients after the implementation of a token economy. Part of the large discrepancy between patient and informant ratings observed to a greater extent in the token group may be attributable to higher levels of expectations on the part of nurses on the token ward.

Furthermore, nurses on the token ward are required to become proficient at discriminating between different levels of performance of specifiable behaviors and at judging behaviors critically. They may therefore be more critical raters than nurses on other wards.

(6) Three of the control group were married whereas everyone in the token group was single. Many studies have established a relationship between marital status and schizophrenic outcome or prognosis (Mason, Tarpy, Sherman, & Hoefner, 1960; Sherman, Mosely, Ging & Bookbinder, 1964; Farina, Garnezy, & Barry, 1963) and this leads to a question of whether the results of the control group were spuriously elevated because of this factor or whether the higher number of marriages is indicative of higher functioning. A study by Turner, Dopkeen, and Kabreche (1970) suggests that there is a process of selection by marriage in which those individuals who are married are those who are more socially adjusted.

(7) The patients for this study were drawn from one mental hospital, and the token economy patients from one ward in that hospital. It is therefore impossible to make any statements about the success of token economies in general based on the findings of this one study.

In summary, the present results do not suggest a difference in level of post-hospital functioning between a token economy group and a group of patients having received traditional treatment, although there appears to be a difference in community tenure in favor of the latter group. This may indicate that token economies are only effective for management of patients within the hospital setting, but serve no long-term purpose, such as providing the newly discharged patient with the necessary skills for adequate functioning in the community. However, to make any conclusive statements it would be necessary to perform a

study in which patients are randomly assigned to token economy and traditional wards at the time of admission, and are administered these questionnaires at some specifiable times after discharge. It would further be advisable to sample a large number of hospitals which have token economy programs, before forming definitive conclusions.

Such a study could avoid many of the problems discussed. If assignment to wards were random it would not be necessary to suspect that one group was originally more chronic or hospital dependent. The length of hospitalization variable could similarly be controlled if this study were carried on on a long-term basis. With a large enough sample it would be possible to get a uniform group of informants and to investigate the interaction of treatment effects with such variables as marital status and type of home environment to which the patient returned. Finally a large sample and a large research staff would be needed to ensure that the majority of the individuals be located and interviewed at the time of follow-up.

If in fact these results do reflect the inadequacy of this type of token program to achieve long-term beneficial effects it is perhaps necessary to investigate ways in which such a program could be improved to bring the patient into closer contact with the environment to which he should ultimately return. Such improvements may only begin in the hospital and would have to be continued when the individual is discharged. Half-way houses and sheltered workshops, which have only been minimally developed as part of this program, perform important functions in serving as stepping stones for the patient leaving the hospital and in providing the individual with a "supportive roommate" (Paul, 1969) in the community.

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APPENDIX A
BEHAVIOR MODIFICATION PROGRAM
SELKIRK HOSPITAL FOR MENTAL DISEASES

PREFACE

This booklet has been prepared for the use of residents, families of residents and for those who work with residents. It represents an attempt to explain a new approach to treating "mental illness" in general and, more specifically, to explain the specific application of this approach at the Selkirk Hospital for Mental Diseases. This new approach is called Behavior Modification and is based on principles of learning which have been well-established in psychological laboratories. The following information is intended to explain this new approach.

I. WHAT IS "MENTAL ILLNESS?"

The quotes around "mental illness" are there for a purpose. The Behaviour Therapist does not see psychiatric problems as illnesses - "... a psychiatric disturbance is not an illness per se, but in most cases is an acquired way of life which can be modified through new learning". Behaviour Modification is very similar to other forms of therapy in the sense that all therapies seek to bring about a change in the residents thinking, feeling and outward behaviour. This change implies a learning process.

II. THE PHILOSOPHY BEHIND THE BEHAVIOUR
MODIFICATION APPROACH.

Almost all behaviour is learned. Learning starts when we are infants. We learn to eat by ourselves, to walk, etc. But, we also learn attitudes towards ourselves and others. Through our particular learning experiences (our successes and failures), we come to see ourselves as worthwhile people or possibly as useless individuals. We may learn to feel comfortable in social situations or to feel out of place and uncomfortable because we haven't learned how to talk with people, how to give and take, etc. We all experience anxiety at times and we, of course, all learn ways of dealing with this unpleasant feeling. Some may learn to handle it by facing directly the situation causing the anxiety and solving the problem. Others, however, may learn to deal with anxiety by staying away or withdrawing from a situation where they feel uncomfortable. Still others may learn to strike out in anger whenever they become tense and anxious. To the extent that our learned attitudes and behaviours are appropriate (do not in any way hurt ourselves or others) we are considered relatively "normal". But, to the extent that they are inappropriate, we are considered "abnormal" by those around us, and many times by ourselves!

III. HOW IS BEHAVIOUR LEARNED?

A. We learn when something we do is followed by a pleasant outcome.

Ways of behaving which "pay-off" or are rewarded are learned. For example, if we do a good job at work and are given a raise, the behaviour "of doing a good job" has been rewarded. And, we are likely to continue doing a good job. Again, if we get dressed up and people pay a lot of attention to us and compliment us, the behaviour of "dressing up" has "paid off." The more times that we behave in a certain way and are "paid off", the more likely we are to engage in that particular behaviour. These two examples deal with normal, adaptive behaviour. However, the same rules apply to other less appropriate behaviour. For example, if we throw a "temper tantrum" and people notice us, talk to us and perhaps promise to do what we want in order to quiet us, then "temper tantrum behaviour" has "paid off" and is likely to occur again.

B. We also learn when something we do allows us to avoid an unpleasant situation.

If we are very anxious (an unpleasant feeling) in a social situation, we feel very uncomfortable. If we leave the situation, or stay home, we feel less anxious and are learning the behaviour of "avoiding" things that are unpleasant. In this situation the "pay off" involves our being less anxious - less uncomfortable. If we play "sick" and find that we are allowed to stay home from work or school, "playing sick" becomes a learned way of avoiding situations we don't want to face.

IV. WHAT ARE THE "PAY OFFS?"

Anything which we need or want can be a "pay off". Some "pay offs" are the same for all people. For example, we all want and need attention, approval and love from others. Many things that we do are done in order to obtain these pay offs. Other "pay offs" differ from one person to the next. For children, candy or the opportunity to use the car may be "pay offs". Adults, on the other hand, may find cigarettes, money, a little peace and quiet, etc. very rewarding. A list of some of the "pay offs" available to persons in this program are listed on Page

V. HOW ARE THESE TREATMENT IDEAS BEING APPLIED AT THE SELKIRK HOSPITAL FOR MENTAL DISEASES?

With this approach, we try to foster the ideas that the resident is not to passively sit back and expect the staff to give out medication, offer therapy, etc. and miraculously "cure" him. Instead, we will expect the individual to take an active part in his own treatment. We feel that the residents are capable of controlling their behaviour much better than has previously been thought and we expect this from them. Each person is expected to do as well as he possibly can at any given time. Obviously, we would not expect the same things from an individual just entering the hospital as we would from one who has been here for some time. Nor would we expect exactly the same thing from two different people who have been in the hospital the same length of time. There are individual differences and learning is a gradual process. However, we do feel that at any given time, most, if not all, residents are capable of taking some responsibility for their personal appearance, for making their bed and keeping their possessions in order, for becoming involved in at least some minimal socializing, taking part in activities, doing some work, etc. In other words, within limits, we expect them to behave in a way that is as much like what would be expected of them outside the hospital as possible.

We feel that the most effective way of accomplishing this is not to communicate to people that they are sick and helpless, but rather that they are responsible human beings with definite capabilities and skills. We attempt to build on these skills so that they may develop the kinds of abilities which are necessary for a successful full life in our society. In order to do this we recognize that people will not learn new ways of behaving just because they are asked to, but will rapidly learn new ways of behaving if the behaviour brings gratifications of various kinds. Although the specific incentives we employ will not usually be available in the same form outside, other incentives will be, for we only reward those behaviours that are judged to be appropriate and hence will be rewarded, in various ways, in our society.

We also expect persons in this program to learn to gradually control their inappropriate behaviour, or inappropriately learned ways of gaining the things they want and need. To encourage this, we ignore or do not "pay off" for inappropriate behaviours such as screaming, throwing things, keeping completely to oneself, playing sick, talking in a strange way, etc. We "pay off" only for the more appropriate behaviours of working, talking sensibly, helping others, socializing, etc.

In order to implement these ideas, we have instituted what has come to be called a "token economy" in which residents may earn tokens for appropriate behaviour which they may subsequently exchange for privilege of various kinds. This is based on the idea that, in life, very few things are unearned. Even friendship is earned by our behaviour. If, for example, we behave in ways which are threatening, disgusting, frightening, or otherwise inappropriate we will not have our friends for long. They can get the same gratifications elsewhere without having to put up with this unpleasant behaviour.

We realize that people do not dispense tokens in society, and so as a person progresses, we will fade out the tokens and substitute for them rewards (reinforcers) which are more similar to those to be found outside the hospital. At all costs what we wish to avoid is shaping up behaviour which will turn people into good patients, but ineffectual citizens. Excessive dependency on the hospital is an example of such behaviour.

The program is set up in a series of four phases preceded by a one-week orientation period. People proceed as their behaviour improves through Phases I to IV, each successive phase bringing more and more privileges in terms of money, cigarettes, interesting work, and autonomy. Minimum time in each phase is two weeks. Phase IV can be regarded as preliminary to discharge from the hospital. The speed at which people progress through the phases is entirely up to them.

So that persons in the program and their relatives will be familiar with what is expected of them, a copy of the general ward rules follows. In addition to these rules each person has an individualized program which is directed towards his specific behaviours. In case of a discrepancy between the general rules and the individual rules (and these will be kept to a minimum), the individual program takes precedence.

ADMISSION TO WARDOrientation

During the first week on the ward persons will be placed on the following program. There will be no weekend or day passes the first weekend spent on the ward unless there are special circumstances. Residents can, however, go on outings which are part of groups.

Day I - Orientation and reading program outline. No tokens will be earned or spent. Persons will complete Reward Survey, Fear Survey and Assertiveness Questionnaire.

Day II - Attend groups (unless otherwise specified). Tokens will be earned as below but not assessed. Fines will not be assessed on this day only.

Day III - Temporary Program Begins

	<u>Behaviour</u>	<u>Maximum Tokens Daily</u>
I	Grooming	10
II	Table Manners	6
III	Groups (unless otherwise specified) 1 for attendance, 4 for participation each period	20
IV	Reading paper and answering questions	12
V	Laundry	25/week
VI	Current affairs	15/week
VII	Exercise Program	10

This will give residents the opportunity to become familiar with their surroundings, the general program, the other residents, staff, etc. so that they will feel comfortable and at ease. It will also give the other residents and staff the chance to get to know the new residents. At the end of this period an individual program will be drawn up as soon as possible. Early during their stay all persons will take a number of aptitude, achievement, and other psychological tests, and will be awarded tokens on the basis of how well they do. The better a person does, the more tokens he will earn.

Phase I

Once a program is drawn up, all patients will begin in Phase I. During this phase, token reinforcement will, to the extent this is possible, take place immediately after the appropriate behaviour has occurred. Persons in this phase will be working at jobs around the hospital, attending groups, school, C.T., etc. During the first week of their program they will be eligible to exchange up to 15 tokens per day @ 2¢ each (up to 30¢ per day) or a maximum of 105 tokens weekly (up to \$2.10 weekly), plus up to 5 tokens daily for cigarettes @ 1 token per cigarette. After that week, their earnings will be as indicated on the table below (figures to be totalled Monday through Sunday of previous week).

T A B L E

<u>Percentage</u>	<u>0 - 60</u> <u>Phase I</u>	<u>60-70</u> <u>Phase II</u>	<u>70-80</u> <u>Phase III</u>	<u>Over 80</u> <u>Phase IV</u>
80 - 100%	2.10	2.50	3.50	4.50
70 - 79%	1.70	2.10	3.00	-
60 - 69%	1.40	1.70	2.00	-
50 - 59%	1.00	1.20	1.50	-
40 - 49%	.70	.80	1.00	-
30 - 39%	.30	.40	.50	-
0 - 29%	-	-	-	-

To move up to Phase II, a person must obtain a net total of 60% or better of his possible maximum for 2 consecutive weeks. On the Monday on which a person is promoted to Phase II, he will be given a sum of money which is equal to the amount stipulated in the Table below for persons in Phase II whose percentage falls in the same category as that of the person promoted. This money must last the entire week. In addition, persons who smoke will be able to exchange tokens for cigarettes up to a maximum of 5 tokens per day (35 per week) at one token per cigarette.

Phase II

During this phase, tokens will be paid out once daily only between 17:15 and 18:00 hours. Persons will continue to work at jobs around the hospital, attend groups, school, C.T., etc. On this phase persons will not have to exchange tokens for money directly, but their earnings will depend on their net earnings of the previous week (including those for whom this is their first week in Phase II indicated in the following table. This amount is payable on Monday between 17:15 and 18:00 hours. In addition, persons who smoke will be able to exchange tokens for cigarettes up to a maximum of 10 per day @ 1 token per cigarette independent of their previous weeks earnings.

To move up to Phase III, a person must obtain a net total of 70% or better of his possible maximum for 2 consecutive weeks. On the Monday on which a person is promoted to Phase III, he will be given a sum which is equal to the amount stipulated in the Table for persons in Phase III whose percentage falls in the same category as that of the person promoted. The money must last the entire week. On the morning of his first day in Phase III, he will also be given a bonus of 30 tokens to tide him over the first day.

Those demoted to Phase I will, however, receive no lump sum on the Monday, but will be eligible that day to exchange tokens for money on the basis of their previous weeks earnings as outlined in Phase I. Persons who are demoted will also not be eligible for day or week-end passes the week of their demotion.

Phase III

During this phase, tokens will be paid out once a week only, on Mondays between 17:15 and 18:00 hours. Persons on this phase will have the privilege of taking higher paid jobs, (i.e. those on which people can earn \$3.00 or more per week) such as Skills, the Pallet Shop, car wash. Persons on these jobs will be paid directly and will keep all their income. Those persons in other activities such as school, upgrading, groups, office or other work around the hospital are also eligible for higher income as indicated in the above table.

In addition, persons who smoke will be able to exchange tokens for cigarettes up to a maximum of 15 per day @ 1 token per cigarette independent of their previous weeks percentage earnings.

To move up to Phase IV, a person must obtain a net total of 80% or better of his possible maximum for 2 consecutive weeks.

On the Monday on which they are promoted to Phase IV, persons will be given a sum of money which is equal to the amount stipulated in the Table above for persons in Phase IV whose percentage falls in the same category as that of the person promoted.

They will also be given a supply of tokens equal to their net earnings of the previous week. Both the money and the tokens must last the entire week.

Those demoted to Phase II, however, will, on the day of their demotion be paid according to the schedule outlined for Phase II, for their previous week's percentage. On the morning of his first day in Phase IV a person will also be given a bonus of 30 tokens to tide them over the first day. Persons who are demoted will also not be eligible for day or week-end passes the week of their demotion.

Phase IV

During this phase people will no longer be on the token system in that they will not actually be paid tokens or required to pay for any privileges. Behaviour, however, will continue to be recorded so that we can determine whether the responsible behaviour has been maintained. Persons working on the same jobs as outlined in Phase III will continue to be paid directly and will keep all of their income. Those persons in other activities such as school, upgrading, groups, office or other work are also eligible for higher income as indicated in the above Table.

In addition, persons who smoke will be able to exchange tokens for cigarettes up to a maximum of 15 tokens per day @ 1 token per cigarette independent of their previous weeks percentage earnings. Persons on Phase IV only, may, if they wish, take a half carton (5 packages) of cigarettes (20's) and receive one dollar less in cash.

Those who are demoted to Phase III, however, on the day of their demotion be paid according to the schedule outlined for Phase III for their previous week's percentage. They will also be given a quantity of tokens equal to their net earnings of the previous week. If this is less than 200 tokens they will be paid the number of tokens they actually earn daily. Both money and tokens must last the full week. Persons who are demoted will not be eligible for day or week-end passes the week of their demotion.

Phase IV (Cont'd)

Persons in Phase IV will be required, within three weeks of their promotion, to submit a discharge plan which will be evaluated in separate group meetings, first by patients and then by staff. This plan will discuss such matters as where the patient is going to live or how he plans to find a place to live, the job or training program he will be going to, or how he plans to seek employment, kinds of social activities and hobbies he plans to engage in, the nature of any problems he foresees and how he plans to deal with them etc. The purpose of this is to give patients an opportunity to participate more fully in planning their own future.

Additional Information

In each phase those persons who fall below the required minimum for entry into the phase for 1 week will be demoted one phase. Persons who quit a high-pay high-prestige job in Phases III or IV without adequate reason and without giving notice will have no income or job for a period of one week and then will be required to take a lower paying job (\$2.50 maximum) for a period of 3 weeks before they will again be eligible for a higher paying job. They will not be demoted a phase, however, unless their token earnings fall below the required minimum for 1 week as above.

In general, for the week in which a person is promoted or demoted, he will receive money in accordance with the schedule outlined for the Phase into which he is moving, not in accordance with the schedule for the Phase he was in during the previous week.

Gifts of cigarettes and money will be given to the recipient at the end of the first week in which they earn the minimum net number of tokens for the Phase on which they are located. Persons in Phase I or observation must earn 50% of their tokens in order to be awarded their gifts. In the event this doesn't occur, the gift (or a fresher replacement in the case of cigarettes) will be awarded upon transfer or discharge.

Persons presently in jobs which pay more money than they should be earning in view of their past token earnings will be permitted to retain their present job if they perform at the level stipulated above for that job.

Prizes

For persons on Phase I to III cash prizes will be awarded weekly as follows:

Highest net earning percentage	\$2.00
Second highest net earning percentage	1.50
Third highest net earning percentage	1.00

The minimum percentage required to win one of these awards is sixty (60). In addition, the person who shows the greatest improvement in percentage from the previous week will be awarded \$1.00. The minimum improvement required to qualify for this award is 15%. Persons who earned 10% or less during the previous week are not eligible to qualify for the improvement award. Persons who have been demoted one phase are not eligible for any of these prizes in their first week in the lower phase. Persons are only eligible to win one prize in a given week.

Ombudsman

The staff on this ward are well trained, conscientious persons who are working in this kind of setting because they have both the knowledge and the desire to be of assistance to you. It is possible, however, that even such people may, because they are human, make the occasional mistake. To ensure that such infrequent events have no detrimental effect on any resident one staff member will be elected Ombudsman by the patients for a period of one month. Elections will be held monthly and an Ombudsman may succeed himself. It will be the duty of this staff member to investigate any complaints by residents that they have been unfairly treated e.g. they have been fined when their behaviour did not warrant it, they have not been awarded tokens they feel they have earned, they have been treated with unnecessary disrespect by staff etc. Complaints must be submitted in writing (with the Ombudsman's assistance if necessary) within 24 hours of the time the Ombudsman comes on (or is on) duty following the incident. A Deputy Ombudsman will also be selected to deal with any case which may involve the Ombudsman himself as staff member, or if the Ombudsman is away for 48 hours or more. The Ombudsman will, if in his opinion the resident's complaint is justified will award compensation in the form of tokens at his discretion. Other forms of compensation may be awarded if the matter is discussed and approved at a staff meeting. If, on investigation the Ombudsman feels that the complaint was unjustified the resident will be fined 20 tokens. This is purely to deter trivial and unjustified complaints not realistic ones.

GENERAL RULES

58.

A. EARNINGS

I. Getting Up in the Morning:

1. All persons will use alarm clocks to awaken. Staff will not get anyone up.
2. Persons may sleep in on weekends @ 5 tokens per hour and provided they are up and dressed by 1000 hours they are still eligible for their grooming tokens. Sleeping in on weekdays will cost 5 tokens per half hour plus loss of grooming tokens.
3. Beds must be made before breakfast. Staff will check between 7:40 and 7:50 hours. 1 Token to be awarded after breakfast.
4. Dining room doors will not be opened until 7:50 hours. Persons must arrive between 7:50 and 8:00 hours to earn their tokens and to get their breakfast.
5. Grooming tokens to be paid as patient leaves dining room along with tokens for table manners, bedmaking if earned as follows:

(a) Bed making	1 token
(b) On time for breakfast	1 token
(c) Grooming	
1) teeth brushed	1 token
2) clean shaven and hair combed	1 token
3) no body odor-wash hands and face	1 token
4) clothes clean and pressed	1 token
5) clean fingernails	1 token
6) bathing or showering	1 token
7) changing underwear and socks	1 token
8) shoes well shined	<u>1 token</u>

Total Maximum

10 tokens

If at any point during the day when the patient should be well groomed and isn't a fine equal to the number of above categories where the patient is deficient but not exceeding the number earned in the morning will be assessed.

6. Persons will be assigned one period for washing and drying their clothes each week. Twenty-five (25) tokens can be earned each week for these two activities. All clothes which are not permanent press must be ironed and shown to the staff in order to qualify for the tokens.
7. Persons will earn 10 tokens for attending training class in ironing clothes if the staff member responsible feels that the person is cooperating and learning something.

II. Meal Time

1. Appropriate eating habits one half token up to a maximum of two for the following behaviours. If one half or one and a half tokens are earned zero and one token respectively are to be awarded.

a) using appropriate utensils	$\frac{1}{2}$ token
b) eating without excessive noise	$\frac{1}{2}$ token
c) eating without excessive spillings	$\frac{1}{2}$ token
d) eating without other inappropriate behaviours (excessive reaching, etc.)	$\frac{1}{2}$ token

Total maximum 2 tokens

2. Meals unless otherwise specified in the individual's program cost as follows:

Breakfast	5 tokens
Lunch	10 tokens
Dinner	10 tokens

These are to be paid before entering the dining room.

3. In order to obtain a meal a person must arrive within 10 minutes of the time the dining room doors open unless he has a good excuse for being late.

Breakfast	7:50 hours
Lunch	11:50 hours
Dinner	16:50 hours

4. All persons must remain in the dining room at least 15 minutes per meal in order to earn their tokens for table manner.
5. Tokens (or 2 cigarettes if requested) for table manners will be paid as a person is leaving the dining room.

III. Work, School, Groups, Etc.

1. Ward workers will do tasks as assigned at the stipulated times.
2. Tokens earned and fines incurred on jobs outside ward, school, groups, O.T., etc. will be phoned to the ward and staff and recorded by them.
3. Payment of these tokens which have not yet been received will take place between 1715 hours and 1800 hours.
4. Certain jobs which have high income potential will be regarded as privileges to be earned by patients who have high net earnings (earnings minus fines).
5. A person who quits his job without good reason will not be able to earn any funds for the next week and will be demoted to a lower job for at least 3 weeks. This will also include persons who as a result of self-inflicted injury are unable to work.

III. Work, School, Groups, Etc. (Cont'd)

6. Persons will not be given the privilege of working at a high paying job such as Skills, car wash, etc. in the future unless they have been promoted to at least Phase III. If they are demoted to a place below phase III they also lose the privilege of working at a high paying job.

IV. Current Affairs

Persons will also earn 5 tokens for attending the once weekly current affairs discussion group to which they are assigned. Bonus tokens for participation up to a maximum of 10 per time will also be awarded at the discretion of the staff.

Officers in current affairs clubs will be paid as follows:

President:	10 tokens per week
Secretary:	5 tokens per week

A bonus of 10 tokens for each officer in those weeks that the average participation earnings of the members is 6 or more.

Officers will be rotated once per month.

V. Homework

Persons will earn tokens for reading the daily paper @ 2 tokens for 5 minutes up to a maximum of 15 minutes (6 tokens). They will also earn 2 tokens per question correctly answered up to a maximum of 3 questions (6 tokens). Except under special circumstances this should be completed between 16:30 and 18:30 hours.

VI. Exercises

If their program so specifies persons may earn up to 10 tokens each day for participating in the group exercises. Except under special circumstances, this should be completed between 16:30 and 18:30 hours.

VII. Individual Programs

Persons will also be able to earn additional tokens as specified in their individual programs.

B. EXPENDITURES

I. Passes

1. Grounds passes cost 5 tokens per day and can be obtained any time between 8:05 and 17:00 provided there is no reason for which one should not be issued.
2. Evening passes cost 10 tokens per day and can be obtained any time between 19:00 and 20:30 hours provided there is no reason for which one should not be issued. Persons must return by 21:00 hours unless they have special permission to remain out later than this.
3. A pass for downtown Selkirk costs 20 tokens and can be obtained any time between 19:00 and 20:00 hours. Staff must be told where the person is going. If the person is not found to be there and does not have a legitimate reason for not being there a fine of 30 tokens will be assessed.
4. Patients must inform staff if they wish a pass for the next day the night before. A daily pass costs 35 tokens. A TWO DAY week-end therefore costs 70 tokens (30 tokens if a person leaves the night before). In addition, persons must have earned certain percentages the previous week as follows:

one day pass	50 percent or better
two day pass	67 percent or better
two day plus Friday evening	80 percent or better

Passes will not be issued before 1600 hours Friday evening or before 3:30 hours on Saturdays although exceptions can be made occasionally in individual cases. Persons on pass must return by 21:00 hours on the day they are scheduled to return or be subject to a fine of 10 tokens per hour up until 24:00 hours of that day. If a person is going to arrive after 21:00 hours he must phone the hospital to inform the staff, otherwise an additional 70 tokens will be assessed for each day or portion thereof they remain away. At 24:00 hours each day an additional 70 tokens will be imposed.

5. Persons on pass will earn 10 tokens per day for every full day they are away and no inappropriate behaviour is reported.
6. Persons wishing to go outside of Selkirk on pass must be able to demonstrate they have adequate means of transportation, i.e. bus fare or a ride. Hitch-hiking is not acceptable and persons caught doing it will be fined 20 tokens.

7. Open Door Club

Persons in groups wanting to go to the Open Door Club with groups will be charged 15 tokens. In addition the fines assessed (whether paid in tokens or time out) on the 3 days prior to the proposed visit must not exceed the following amounts:

Phase I	75
II	50
III	25

II. Television

1. Television set will be on each day from 18:00 hours to 23:30 hours.
2. Radio, T.V. and record player time will be purchased @ 3 tokens per hour or part thereof each, except for news broadcasts for which persons will be paid 3 tokens per $\frac{1}{2}$ hour if they remain for the entire $\frac{1}{2}$ hour.

Television Channel 7	18:30 - 19:00 hours	23:00 - 23:30 hours
Channel 6	18:30 - 19:30 hours	23:00 - 23:30 hours

or other times at the discretion of staff. News programs must be on between 18:30 and 19:30 hours. Each activity will be done in a specified area, and the volume must be such as not to disturb others. Certain programs will be specified as free programs. These will be indicated on the bulletin board.

3. In case of a dispute regarding which program to watch the majority will rule. In case of a tie a staff member will flip a coin. If there are two persons, the person who arrived first will decide the program until that particular program is over.

III. Purchasing Cigaretts and Money

1. Tokens can be exchanged for cigarettes at 1 token per cigarette up to a maximum as stipulated in the program. For those in Phase I tokens may also be exchanged for 2¢ each as outlined above.
2. If a person on Phase I wishes, and has the required number of tokens, he may exchange up to seven (7) times his daily number of tokens for money once a week at the designated time (17:45 to 18:00 hours). In no instance, however, can a person obtain more than seven (7) times his daily income in a given week. If the person does not wish to spend all the money he obtains with tokens he can have the ward staff save it for him, but he can only draw from his savings once a week. Persons on Phases II to IV will be paid once weekly on Monday between 16:30 and 18:30 hours

IV. Additional Expenditures

Sleeping In, Sending to canteen, appointments, outings and phone calls may be purchased for the amounts specified in the following table.

- V. Individualized reinforcers will cost the amounts specified in individual programs.

REINFORCERSGeneral ReinforcersTokens

1. radio	3/hr. or part thereof
2. television	3/hr. or part thereof
3. record player	3/hr. or part thereof
4. grounds pass	5
5. breakfast	5) second helpings at
6. lunch	10) any meal cost an
7. dinner	10) additional 5 tokens
8. evening pass - from 6:30 - 9 p.m. till 10:30 unless special	10
9. downtown when 6:30 - 9 p.m.	20
10. daily pass weekend = 2 days (70 tokens) if begins Friday night, 10 extra tokens (80 tokens)	35
11. sleeping in weekends	5 per hour
12. sending to canteen	5 per time
13. appointments, doctor, chaplain, psychologist, social workers, etc.	10 per visit
14. cigarettes, maximum value stipulated in program	1 each
15. exchange of tokens for money 1 token = 2¢ - maximum value stipulated in program	
16. special outings of 4 hours or less total duration - including open door club (time leave hospital to time returned)	15 per time
17. special outings of more than 4 hours duration	35 per time
18. use of direct line to Winnipeg (maximum of 2 - 10 minute calls per person per week unless special circumstances except as decided by staff)	10 per call

Category II (Cont'd)

6. Manipulative behaviour (excessive crying, threats, etc. burning cigarettes, telling staff members differing versions of events for personal gain or to avoid fines, approaching more than one staff member for a request when one staff member has already refused it (see Ombudsman) 20 each time
7. (a) picking up cigarette butts 20 each time
- (b) throwing butts on the floor 20 each time
- (c) smoking in the dorm:
Any evidence that smoking has been going on in the dorm will result in all persons resident in the dorm being fined whether they are there or not. It's up to you to stop people from smoking. 20 each time
8. Going into the residence area (which is bounded by the walls of the corridor leading from the sitting area) of the opposite sex without special permission. 20 each time
9. Sleeping on the ward or in the sitting room 20 each time
10. Time Out Rules
- (a) Talking to staff member, other residents, etc. or taking cigarettes, food or other privileges without permission. 20 each time
- (b) Lying down in time out (except after 21:30 hrs.) 20 each time
- (c) Leaving time out without permission 20 each time
11. Appearing in Sitting Area in Night Attire 20 each time

Category III

1. Other token offences (stealing, including mere possession of other people's tokens), manipulating them from other residents or staff, etc. 50 each time
2. Trading or selling personal possessions without staff permission 50 each time

Category IV

1. Consumption of Liquor. The fines to be levied at the discretion of the staff according to person's legal status and state of intoxication up to a maximum of 200 tokens.
2. Destructive behaviour (this includes throwing furniture, cigarette butts on carpet or any attempt to break things, not slamming doors, etc. which will be fined at the same level as yelling or swearing 100 each time
3. Fighting with or hitting staff or patients if injury is inflicted. 100 each time
200 each time
4. Homosexual behaviour or seriously inappropriate behaviour towards opposite sex 100 each time
5. Self mutilating or destructive behaviour. 200 each time

Additional Rules

If the injury to any person is serious, or if any attack involves the use of any weapon, the matter is to be reported to the police immediately. Patients will be subject to criminal prosecution for such behaviour just like any other citizen.

Other fines to be levied at the discretion of the staff.

If a particular offence can be committed more than once on a particular occasion such as swearing, lying, or fighting, where this is feasible the patient should be warned before the additional fine is levied. When a second or additional fine is levied on one occasion, the total fine is the sum of all fines levied.

If a person has in his program an individualized system for any of the above offences, the individual program takes precedence over the general one.

E. TIME OUT RULES

1. Persons will go into the time out area when they do not have enough tokens to pay a fine for violating a rule, or immediately for certain types of offences or persons on certain types of programs. The title of the room comes from the fact that the person is required to take time out from earning and/or enjoying various social or other reinforcements.
2. (a) Persons who do not have enough tokens to pay a fine will go into time out during their leisure period (including noon hour but not including sleep period 23:00 to 07:00 hours), up until 23:00 hours each day or until the fine is paid off with each hour of time equal to ten tokens. (Payment must be made in multiples of 10 - no fractions of hours will be served).
 - (b) If the offense falls in categories 1 to 3 (see fines) and the total fine is less than 60 tokens, and if the person is not on a special program involving immediate time out, credit will be extended until after tokens have been dispensed at 17:45 to 18:00 hours. Persons on Phases III and IV may also pay fines out of credit on tokens already earned but which are normally not paid out until the following Monday.
 - (c) If the total fine falls between 60 and 150 tokens and does not include an offense in category IV and the person does not have the tokens to cover all of it, he must go immediately to time out and serve an amount of time which in combination with any tokens he may have paid is equivalent to one-half (50%) of the magnitude of the fine. He may then come out and earn tokens for activities.
3. Persons in time out whose offences do not include one in category IV or whose total fine is less than 150 tokens will normally be allowed out during the day to participate in their usual activities and earn the usual number of tokens which they may then apply towards their fine (for those whose fine falls between 60 and 150 tokens, they must first pay off, in tokens or in time one-half of the fine). They must re-enter the time out area when their daily activity is over or at 16:30 hours at the latest. They may buy meals at the regular price if they wish - otherwise a liquid diet (with the required number of calories will be available at no charge. All meals will be eaten in the time out area.
4. Persons whose offence falls in category IV (see fines) or who have incurred a total fine of 150 tokens or more will be required to go immediately to the D12 or D10 seclusion room until their total fine has been paid off. Time spent between 23:00 and 07:00 hours will not be counted but will nevertheless be spent in time out.
5. While in the time out area persons must not lie down, must not leave until told to be a staff member, must not engage with any staff member or resident in conversation and must not receive any cigarettes, food or other privilege from staff members or resident. Failure to comply with these regulations will result in additional hours of time out.

6. Some persons may be placed on programs which require immediate removal to DL2 for any offense, if it is felt to be in their best long-term interest.
7. Except under special circumstances to be determined at a staff meeting, no person will put in more than 48 consecutive hours of time out (32 hours of formal time out).

KAS BEHAVIOR INVENTORIES
S FORMS

By Martin M. Katz

	25				
Study	Form	Hospital	Subject	Period	Rater

Name of subject _____

Date _____

Interviewer _____

Please wait for instructions before beginning.

	Today or during the past few weeks				
	1 have not had this complaint	2 bothers me a little	3 bothers me quite a bit	4 bothers me almost all the time	
					<u>Card 01</u>
1. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 19
2. Pains in the heart or chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 20
3. Heart pounding or racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 21
4. Trouble getting your breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
5. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
6. Nausea, vomiting or upset stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
7. Loose bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
8. Twitching of the face or body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
9. Faintness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27
10. Hot or cold spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 28
11. Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 29
12. Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 30
13. Pains in the lower part of your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 31
14. Difficulty in swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 32
15. Skin eruptions or rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 33
16. Soreness of your muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 34
17. Nervousness and shakiness under pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 35
18. Difficulty in falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 36
19. Sudden fright for no apparent reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 37

		Today or during the past few weeks				
		1	2	3	4	
		have not had this complaint	bothers me a little	bothers me quite a bit	bothers me almost all the time	
20.	Bad dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 38
21.	Blaming yourself for things you did or failed to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 39
22.	Feeling generally worried or fretful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 40
23.	Feeling blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 41
24.	Being easily moved to tears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 42
25.	A need to do things very slowly in order to be sure you were doing them right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 43
26.	Feeling like you have to do the same thing over and over again like touching, counting, handwashing, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 44
27.	Unusual fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 45
28.	Thoughts or impulses which you don't like keep pushing themselves into your mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 46
29.	Your "feelings" being easily hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 47
30.	Feeling that people were watching or talking about you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 48
31.	Preferring to be alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 49
32.	Feeling lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 50
33.	Feeling like you have to ask others what you should do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 51
34.	People being unsympathetic with your need for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 52
35.	Feeling easily annoyed or irritated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 53
36.	Severe temper outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 54
37.	Feeling critical of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 55

	Today or during the past few weeks				
	1 have not had this complaint	2 bothers me a little	3 bothers me quite a bit	4 bothers me almost all the time	
38. Frequently took medicine to make you feel better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 56
39. Difficulty in speaking when you were excited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 57
40. Feeling you were not functioning as well as you could, feeling blocked or unable to get things done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 58
41. Having an impulse to commit a violent or destructive act, for example, desire to set a fire, stab, beat or kill someone, mutilate an animal, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 59
42. Blurring of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 60
43. Feeling thirsty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 61
44. Pains in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 62
45. Loss of strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 63
46. Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 64
47. Pain in belly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 65
48. Feeling hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 66
49. Getting tired easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 67
50. Feeling sleepy much of the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 68
51. Keyed up and jittery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 69
52. Having no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 70
53. Having trouble keeping your mind on what you were doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 71
54. Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 72
55. Having strange sexual ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 73

KAS FORM S2

	1 am not doing	2 am doing some	3 am doing regularly	0 does not apply	
1. Help with household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 74
2. Visit friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 75
3. Visit relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 76
4. Entertain friends at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 77
5. Dress and take care of myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 78
6. Help with the family budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 79
7. Remember to do important things on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 80
					<u>Card 02</u>
8. Get along with family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 19
9. Go to parties and other social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 20
10. Get along with neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 21
11. Help with family shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
12. Help in the care and training of children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
13. Go to church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
14. Take up hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
15. Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
16. Support the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27

KAS FORM S3

	1 did not expect to be doing	2 expected to be doing some	3 expected to be doing regularly	0 does not apply	
1. Help with household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 28
2. Visit friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 29
3. Visit relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 30
4. Entertain friends at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 31
5. Dress and take care of myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 32
6. Help with the family budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 33
7. Remember to do important things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 34
8. Get along with family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 35
9. Go to parties and other social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 36
10. Get along with neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 37
11. Help with family shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 38
12. Help in the care and training of children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 39
13. Go to church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 40
14. Take up hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 41
15. Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 42
16. Support the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 43

KAS FORM RS4

	1 frequently	2 some- times	3 practically never	0 does not apply	
1. Work in and around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 44
2. Work in the garden or yard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 45
3. Work on some hobby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 46
4. Listen to the radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 47
5. Watch television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 48
6. Write letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 49
7. Go to the movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 50
8. Attend lectures, theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 51
9. Attend club, lodge, other meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 52
10. Shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 53
11. Take part in community or church work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 54
12. Bowl or other sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 55
13. Play cards or other table games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 56
14. Take rides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 57
15. Visit friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 58
16. Entertain friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 59
17. Sew, crochet or knit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 60
18. Read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 61
19. Go to the library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 62
20. Just sit and think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 63
21. Take courses at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 64
22. Go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 65
23. Other (what?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 66

KAS FORM S5

	1 satisfied with what I do here	2 would like to do more of this	3 would like to do less	0 does not apply	
1. Work in and around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 67
2. Work in the garden or yard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 68
3. Work on some hobby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 69
4. Listen to the radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 70
5. Watch television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 71
6. Write letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 72
7. Go to the movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 73
8. Attend lectures, theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 74
9. Attend club, lodge, other meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 75
10. Shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 76
11. Take part in community or church work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 77
12. Bowl or other sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 78
13. Play cards or other table games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 79
14. Take rides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 80
					<u>Card 03</u>
15. Visit friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 19
16. Entertain friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 20
17. Sew, crochet or knit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 21
18. Read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
19. Go to the library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
20. Just sit and think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
21. Take courses at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
22. Go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
23. Other (what?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27

KAS BEHAVIOR INVENTORIES
R FORMS

By Martin M. Katz

	24				
Study	Form	Hospital	Subject	Period	Rater

Name of subject _____

Name of respondent _____

Respondent's relationship to the subject _____

Date _____

Interviewer _____

Please wait for instructions before beginning.

	1 almost never	2 some- times	3 often	4 almost always	
1. Has trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Card 01</u> col. 19
2. Gets very self critical, starts to blame himself for things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 20
3. Cries easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 21
4. Feels lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
5. Acts as if he has no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
6. Is restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
7. Has periods where he can't stop moving or doing something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
8. Just sits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
9. Acts as if he doesn't have much energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27
10. Looks worn out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 28
11. Feelings get hurt easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 29
12. Feels that people don't care about him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 30
13. Does the same thing over and over again without reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 31
14. Passes out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 32
15. Gets very sad, blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 33
16. Tries too hard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 34
17. Needs to do things very slowly to do them right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 35
18. Has strange fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 36
19. Afraid something terrible is going to happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 37
20. Gets nervous easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 38
21. Jittery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 39

	1 almost never	2 some- times	3 often	4 almost always	
22. Worries or frets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 40
23. Gets sudden fright for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 41
24. Has bad dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 42
25. Acts as if he sees people or things that aren't there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 43
26. Does strange things without reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 44
27. Attempts suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 45
28. Gets angry and breaks things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 46
29. Talks to himself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 47
30. Acts as if he has no control over his emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 48
31. Laughs or cries at strange times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 49
32. Has mood changes without reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 50
33. Has temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 51
34. Gets very excited for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 52
35. Gets very happy for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 53
36. Acts as if he doesn't care about other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 54
37. Thinks only of himself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 55
38. Shows his feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 56
39. Generous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 57
40. Thinks people are talking about him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 58
41. Complains of headaches, stomach trouble, other physical ailments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 59

	1 almost never	2 some- times	3 often	4 almost always	
--	----------------------	---------------------	------------	-----------------------	--

- | | | | | | | |
|----------------|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------|
| 42. | Bossy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 60 |
| 43. | Acts as if he's suspicious of people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 61 |
| 44. | Argues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 62 |
| 45. | Gets into fights with people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 63 |
| 46. | Is cooperative | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 64 |
| 47. | Does the opposite of what he is asked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 65 |
| 48. | Stubborn | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 66 |
| 49. | Answers when talked to | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 67 |
| 50. | Curses at people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 68 |
| 51. | Deliberately upsets routine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 69 |
| 52. | Resentful | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 70 |
| 53. | Envious of other people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 71 |
| 54. | Friendly | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 72 |
| 55. | Gets annoyed easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 73 |
| 56. | Critical of other people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 74 |
| 57. | Pleasant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 75 |
| 58. | Gets along well with people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 76 |
| 59. | Lies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 77 |
| 60. | Gets into trouble with law | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 78 |
| 61. | Gets drunk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 79 |
| 62. | Is dependable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 80 |
| <u>Card 02</u> | | | | | | |
| 63. | Is responsible | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 19 |
| 64. | Argues (talks) back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 20 |
| 65. | Obedient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 21 |

	1 almost never	2 some- times	3 often	4 almost always	
66. Shows good judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
67. Stays away from people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
68. Takes drugs other than recom- mended by hospital or clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
69. Shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
70. Quiet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
71. Prefers to be alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27
72. Needs a lot of attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 28
73. Behavior is childish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 29
74. Acts helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 30
75. Is independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 31

PART II

1. Moves about very slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 32
2. Moves about in a hurried way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 33
3. Clumsy; keeps bumping into things or dropping things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 34
4. Very quick to react to some- thing you say or do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 35
5. Very slow to react	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 36
6. Gets into peculiar positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 37
7. Makes peculiar movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 38
8. Hands tremble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 39
9. Will stay in one position for a long period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 40
10. Loses track of day, month, or year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 41
11. Forgets his address or other places he knows well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 42

	1 almost never	2 some- times	3 often	4 almost always	
12. Remembers the names of people he knows well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 43
13. Acts as if he doesn't know where he is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 44
14. Remembers important things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 45
15. Acts as if he's confused about things; in a daze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 46
16. Acts as if he can't get certain thoughts out of his mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 47
17. Acts as if he can't concentrate on one thing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 48
18. Acts as if he can't make decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 49
19. Talks without making sense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 50
20. Hard to understand his words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 51
21. Speaks clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 52
22. Refuses to speak at all for periods of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 53
23. Speaks so low you cannot hear him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 54
24. Speaks very loudly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 55
25. Shouts or yells for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 56
26. Speaks very fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 57
27. Speaks very slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 58
28. Acts as if he wants to speak but can't	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 59
29. Keeps repeating the same idea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 60
30. Keeps changing from one subject to another for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 61
31. Talks too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 62

	1 almost never	2 some- times	3 often	4 almost always	
32. Says that people are talking about him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 63
33. Says that people are trying to make him do or think things he doesn't want to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 64
34. Talks as if he committed the worst sins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 65
35. Talks about how angry he is at certain people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 66
36. Talks about people or things he's very afraid of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 67
37. Threatens to injure certain people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 68
38. Threatens to tell people off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 69
39. Says he is afraid that he will injure somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 70
40. Says he is afraid that he will not be able to control himself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 71
41. Talks about strange things that are going on inside his body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 72
42. Says how bad or useless he is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 73
43. Brags about how good he is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 74
44. Says the same thing over and over again	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 75
45. Complains about people and things in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 76
46. Talks about big plans he has for the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 77
47. Says or acts as if people are after him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 78
48. Says that something terrible is going to happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 79
49. Believes in strange things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 80

	1 almost never	2 some- times	3 often	4 almost always
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Card 03

- | | | | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------|
| 50. Talks about suicide | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 19 |
| 51. Talks about strange sexual ideas | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 20 |
| 52. Gives advice without being asked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | col. 21 |

KAS FORM R2

	1 is not doing	2 is doing some	3 is doing regularly	0 does not apply	
1. Helps with household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
2. Visits his friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
3. Visits his relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
4. Entertains friends at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
5. Dresses and takes care of himself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
6. Helps with the family budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27
7. Remembers to do important things on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 28
8. Gets along with family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 29
9. Goes to parties and other social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 30
10. Gets along with neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 31
11. Helps with family shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 32
12. Helps in the care and training of children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 33
13. Goes to church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 34
14. Takes up hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 35
15. Works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 36
16. Supports the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 37

KAS FORM R3

	1 did not expect him to be doing	2 expected him to be doing some	3 expected him to be doing regularly	0 does not apply	
1. Helps with household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 38
2. Visits his friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 39
3. Visits his relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 40
4. Entertains friends at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 41
5. Dresses and takes care of himself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 42
6. Helps with the family budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 43
7. Remembers to do important things on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 44
8. Gets along with family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 45
9. Goes to parties and other social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 46
10. Gets along with neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 47
11. Helps with family shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 48
12. Helps in the care and training of children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 49
13. Goes to church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 50
14. Takes up hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 51
15. Works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 52
16. Supports the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 53

KAS FORM RS4

	1 frequently	2 sometimes	3 practically never	0 does not apply	
1. Work in and around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 54
2. Work in the garden or yard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 55
3. Work on some hobby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 56
4. Listen to the radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 57
5. Watch television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 58
6. Write letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 59
7. Go to the movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 60
8. Attend lectures, theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 61
9. Attend club, lodge, other meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 62
10. Shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 63
11. Take part in community or church work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 64
12. Bowl or other sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 65
13. Play cards or other table games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 66
14. Take rides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 67
15. Visit friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 68
16. Entertain friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 69
17. Sew, crochet or knit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 70

	1 frequently	2 sometimes	3 practically never	0 does not apply	
18. Read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 71
19. Go to the library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 72
20. Just sit and think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 73
21. Take courses at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 74
22. Go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 75
23. Other (what?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 76

KAS FORM R5

	1 satisfied with what he does here	2 would like to see him do more of this	3 would like to see him do less	0 does not apply	
1. Work in and around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 77
2. Work in the garden or yard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 78
3. Work on some hobby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 79
4. Listen to the radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 80
<u>Card 04</u>					
5. Watch television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 19
6. Write letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 20
7. Go to the movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 21
8. Attend lectures, theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 22
9. Attend club, lodge, other meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 23
10. Shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 24
11. Take part in community or church work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 25
12. Bowl or other sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 26
13. Play cards or other table games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 27
14. Take rides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 28
15. Visit friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 29
16. Entertain friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 30
17. Sew, crochet or knit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 31
18. Read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 32

	1 satisfied with what he does here	2 would like to see him do more of this	3 would like to see him do less	0 does not apply	
19. Go to the library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 33
20. Just sit and think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 34
21. Take courses at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 35
22. Go to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 36
23. Other (what?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	col. 37

APPENDIX C

EMPLOYMENT:

1. How many hours have you put in at work during the last two weeks?

1	2	3	4
8 or less hours a week	9-16 hours a week	17-32 hours a week	33 or more hours a week

2. How often in the last month has your work been criticized by someone in a position superior to yourself?

1	2	3	4
once or less	twice	3-4 times	5 or more times

3. What is your present average monthly income
- from work
- ?

1	2	3	4
less than \$150	\$150-\$349	\$350-\$599	\$600 or more

4. What proportion of the time since your discharge on _____ have you been working full-time?

1	2	3	4
None	1-25%	26-65%	66% or more

5. What proportion of the time since your discharge on _____ have you been working part-time?

1	2	3	4
None	1-25%	26-65%	66% or more

6. Are you presently taking any job-related or academic courses?
-
- If so, how many hours a week do you spend attending and preparing for your courses?

1	2	3	4
one - three	four-seven	8 - 14	15 or more

HOUSEWORK AND FAMILY CARE:

1. How much time, on the average, do you spend
- daily
- cleaning the house and doing laundry, cooking, etc.?

1	2	3	4
20 minutes or less	21 minutes to an hour	1 - 3 hours	more than 3 hours

HOUSEWORK AND FAMILY CARE (continued):

2. How often, in the past month, has your housework been criticized?

1	2	3	4
once or less	2 times	3-4 times	5 or more times

RELATIONSHIP WITH FAMILY:

1. How often do you have serious arguments with one or both of your parents?

1	2	3	4
once a week or more	2-3 times a month	once a month	less than once a month

2. About how often do you and your husband/wife argue about such things as budget, friends, child-care, home management, and recreation?

1	2	3	4
once a day or more	2-6 times a week	1-3 times a week	less than once a week

SOCIAL LIFE:

1. About how many people do you consider to be your close friends?

1	2	3	4
None	one	two or three	four or more

2. About how often do you go to social affairs or other entertainment? (eg. parties, movies, etc.)

1	2	3	4
once a week or more	1-3 times a month	once every 2 or 3 months	2 or 3 times a year or less.