

6-6-1978

Assessment of the Needs of the Families of the Hospitalized Mentally III

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<https://doi.org/10.15760/etd.2747>

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ASSESSMENT OF THE NEEDS OF THE FAMILIES
OF THE HOSPITALIZED MENTALLY ILL

by

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A practicum submitted in partial fulfillment of
the requirements for the degree of

MASTER OF SOCIAL WORK

Portland State University
1978

TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

The advisor approves the research practicum of
Jean Pelosi Audette and Phyllis J. Jossey presented on
June 6, 1978.



Barbara Friesen
Research Advisor

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CHAPTER I

INTRODUCTION

Increasingly, in mental health literature and theory the role of the family in treatment is being reassessed and emphasized. This emphasis involves family participation in treatment rather than peripheral consultation with family members for gaining information about a client or patient. It implies direct involvement of the family in the therapeutic process regardless of whom is designated as the identified patient or client. Family members participate along with the patient in treatment; in fact the entire family is seen as the patient or client system. Emphasis is placed upon analysis and examination of the dynamics of family interactions.

Included in this recent resurgence of interest in family involvement in treatment is greater consideration of the family in the treatment of the mentally disturbed individual. At the present time mental health professionals are exploring alternatives to traditional hospitalization and the role of the family both in therapy and as a support system for the patient is becoming increasingly recognized. William Doll comments upon the crucial need to consider the

needs of the family as well as the patient in the therapeutic process, especially in the community setting.

The failure to monitor family-patient conditions at home and to provide institutional mechanisms for support and relief may cripple the community movement. In fact if ... the family crises are severe enough, the trend toward community care may have to be reversed and permanently replaced by institutional care. (Doll, 1976)

The above mentioned emphasis in family treatment is, for the most part, reflected in literature on family therapy and alternative mental health delivery systems. Professionals are recognizing the importance of utilizing all family members in treatment and are striving to develop theoretical orientations and practice methods based upon providing a greater role for families in the treatment process. Implementation is often hampered by the setting and structure of the institution where the treatment is carried out. This is true for treatment in a psychiatric hospital, especially a large state mental institution.

The more traditional treatment method, hospitalization, separates the disturbed individual from his family. It further enhances that person's isolation. Alternative treatment approaches would help ease this isolation and separation, but the need for support services for the family becomes even greater under these conditions.

This study is basically concerned with the problems faced by families of hospitalized mental patients. Under

the current system of treating disturbed individuals, family members often take part in the decision to hospitalize. Not only must the decision be made, but procedure, costs and conditions for hospitalization must be reckoned with, often by the family of the patient. Thus not only are family members dealing with the practical aspects of the decision, but also the emotional trauma and separation issues of institutionalizing a family member.

Support systems and information sources are crucial at this time. Other issues such as concerns and questions about the emotional difficulties that the family member is experiencing and the role of the entire family in the problems that the patient is experiencing are problem areas which the family often deals with. There are many issues which a family may be facing due to mental illness and subsequent hospitalization, but an exclusion from services and treatment isolates the family members. They do not know how to help or cope and do not receive the opportunity to learn how to change family patterns which might contribute to the individual member's dysfunction.

Changes such as psychiatric hospitalization often represent a crisis for not only the individual involved but his entire family system. Families must deal with various issues regarding mental illness and hospitalization. Whether the family receives adequate help and support from the mental health delivery system yet remains a question.

PURPOSE

The purpose of this study was to assess the special needs of the families of hospitalized mental patients. The study focused upon the time prior to and including the decision to hospitalize a mentally ill family member. Particularly, the researchers wished to examine the stresses that the family encountered in attempting to deal with a disturbed member as well as their concerns regarding psychiatric hospitalization and the effect which it had upon the family.

Another important focus of the study was to look at the advice, information and support which the family received at this time. The issues examined in the research were: Where did the family members seek help and support; from whom and where they received it; and were they satisfied with the services they received? The researchers were interested in finding out what questions family members had concerning hospitalization, medication, the nature of the patient's difficulties and in ascertaining which factors may have prevented them from seeking advice, information or support. In addition, information about any changes which the family members perceived as a result of the patient's illness and subsequent hospitalization were documented. We also explored possible concerns which they

may have had regarding their own part in the patient's difficulties.

The major areas which the research addresses are:

1) the kinds of services which the families of hospitalized mental patients were receiving; 2) their level of satisfaction with those services; 3) other needs which they perceived themselves as having.

ORGANIZATION OF THE STUDY

Following the introduction are definitions of some of the terms and assumptions which were part of this study. The review of the literature follows that with an overview of crisis theory and family diagnostic theory. Literature and research dealing with the reactions of families to mental illness are also reviewed. Finally, a discussion of alternative approaches to treatment of the mentally ill with a brief outline of the development of mental health services in the United States concludes the chapter.

The next chapter includes the methodology employed in the study, inclusive of the general design, setting, population and sample, collection of the data, questionnaire, and the pilot test. An analysis of the data collected and interpretation of that data follows. Conclusions and recommendations based upon the findings are presented in the final chapter.

DEFINITIONS

Several terms are used throughout the study which are defined here as follows:

Admission Status: 1) Court Committed - After a judicial hearing, an individual found mentally ill beyond a reasonable doubt is committed, by the presiding judge, to the State Mental Health Division for no more than 180 days, after which time recertification may occur. The legal criteria for court commitment include that an individual be: a) dangerous to himself or others; b) unable to provide for his basic needs and is not receiving such care as is necessary for his health and safety. (ORS 426.005(2)(a), (b))

2) Voluntary Commitment - It is an admission status to Dammasch State Hospital whereby an individual agrees to self-admit himself to the institution as a patient.

There are other involuntary commitment statuses which were excluded from this study population.

Family: For the purposes of uniformity in this study, we defined family as the person(s) living with the patient at the time of hospitalization, related either by blood or marriage. Our contact with the family involved an interview with one member of the patient's family who is at least eighteen years of age.

First Admission: This term refers to the first admission of a patient to Dammasch State Hospital. It does not include admissions to other inpatient psychiatric institutions.

Needs Assessment: It is an attempt to enumerate the needs of a particular population and identify the difference between what services are being offered and what should be provided. The means which was utilized to implement this needs assessment was a field survey.

Readmission: This term refers to any repeated admission of an individual to Dammasch State Hospital.

Tri-County Area: This refers to the geographic boundaries encompassing Multnomah, Washington and Clackamas counties in Oregon.

ASSUMPTIONS

There are several assumptions underlying this study which are based upon our orientations toward this particular area and the theoretical orientations reflected in the review of the literature regarding crisis and family diagnostic theory.

- the time prior to and including the decision to hospitalize a disturbed individual is a time of crisis and stress for his family.

- the family of a hospitalized psychiatric patient has certain needs surrounding the emotional difficulties and hospitalization of a family member.

- some of the needs of families of the hospitalized mentally ill are not being met and a gap exists between the services being offered to them and the services which they need.

- the family members need to be questioned to determine their own specific needs and whether they are being met.

- family members have a right to receive certain information and services when a member is disturbed or hospitalized.

- mental health professionals' increased understanding of the stresses, concerns and questions which family members have should lead towards providing services to better meet the needs of this particular group and may prevent further family breakdown or dysfunction.

CHAPTER II

INTRODUCTION TO THE REVIEW OF THE LITERATURE

The purpose of the review of the literature is to describe the research which is relevant to the study; that is, the family's experience of coping with mental illness and psychiatric hospitalization of a family member. The review is organized into four sections which are as follows:

1) Crisis theory, with specific examples of mental illness and psychiatric hospitalization as a time of crisis. The stages experienced in a crisis are explored, as well as the factors which influence how families experience an event as stress versus a crisis. Included is a discussion of how people cope with crises and how, with timely intervention, they can make therapeutic changes.

2) Family diagnostic theory as an alternate approach to diagnosis and treatment of emotional problems. The development, as well as the current practice of family therapy is outlined. Explanations of the goals and assumptions in family therapy are given, and finally, a list of the benefits of family therapy are contrasted with the drawbacks of hospitalization of a family member.

3) A description of how society in general, and

family members in particular react to mental illness. The reaction of family members in accepting mental illness in the family are compared with those facing the death or dying of a family member.

4) Alternatives to traditional treatment with a review of the history of mental health services in the United States and an overview of alternative programs of psychiatric services. Included is a selective review of alternative programs describing such services as halfway houses, foster care, community lodges, and cooperative apartments. This is followed by an examination of home treatment and day treatment services.

CRISIS THEORY

Psychiatric hospitalization is generally thought of as being the last resort in a search for immediate help for one experiencing emotional difficulties. The period of time up to and including the act of hospitalization is often stressful and for some, may be experienced as a crisis. In this section, crisis theory and how it relates to psychiatric hospitalization will be discussed. The definition and characteristics of a crisis will be described, as well as how people react and the stages they go through in time of crisis. Research on how people view events as stress or crisis will be examined, along with the characteristics of crisis-prone and crisis-resistant families. Finally, we will discuss how people deal with stress, why they are motivated to use help and to change in a time of crisis, and what the professional can do to improve family functioning.

The term crisis is used to refer to both an event and a period of time, and consequently results in some confusion. Reuben Hill in "Social Stresses on the Family" (1958), looks at a crisis as a stressor or crisis-provoking event and defines it as "a situation for which the family has had little or no prior preparation and must therefore be viewed as problematic." On the other hand, Bernard Bloom's (1965)

concept of crisis refers to a period of time " ... when an individual finds himself unable to deal effectively with an emergency problem." Phyllis Silverman (1966) says a crisis can be either the specific event or the moment of turning in the "critical transition" of one's life. She prefers the term "critical transition" over crisis because it includes both the disequilibrating event and the moment of turning. In the discussion of crisis theory, the more inclusive concept of crisis will be used, with designation made whether referring to an event or a period of time.

A time of crisis does not continue indefinitely, according to Gerald Caplan (1961). The person in crisis seeks some solution to restore equilibrium, usually within one to six weeks of onset. The solution may lead to higher, lower, or the same level of functioning as prior to the crisis event.

People experiencing a crisis event and trying to restore equilibrium go through predictable phases. Silverman labels the phases "stages in a critical transition." The first stage is the "period of impact", when the full and direct effect of the initial stress is experienced. In this stage the person seems stunned and unable to come to grips with what has occurred, and his field of attention is restricted. Time orientation is to the immediate present. The second stage is the "period of recoil", when the person

becomes aware of what has happened, and feels turmoil as he realizes changes have taken place. In this stage, the person's first overt expression of emotions occur. The time orientation is to the past. The final stage is the "period of recovery", when the person feels that stress has passed. He reintegrates the new situation with past adjustments, and develops new functioning roles. The time orientation is the past, present, and future. As stated earlier, the solutions found during this stage may be at a higher, lower, or the same level of functioning as prior to the period of impact.

These stages of a "critical transition" may, for some family members and patients, apply to the period of time up to and including psychiatric hospitalization. The period of impact is when the family member's behavior is viewed as so dysfunctional that the family can no longer accommodate him. The family is aware of the person's severe difficulties, yet unable to accept the reality of it. Denial is a likely defense at this stage and so, for some, the first awareness of dysfunctional behavior may be when hospitalization is sought. In families where the family member's problems came on gradually, this stage may be less acute. The period of recoil is when the family sees that the dysfunctional behavior is real or that it has worsened to the point that something must be done. The period of

recovery is when they develop new ways of coping and integrate the new situation with their past life experiences. It is the severe change in the family member's behavior that must be integrated with their previous thoughts and feelings about the person, and so is independent of hospitalization. They may begin integrating the experience before or after hospitalization, depending upon when they realize and accept the fact that his behavior changed.

Gerald Caplan (1964) sees a time of crisis experienced in "phases" of increasing levels of tension. In the first stage the initial rise in tension is experienced and the usual problem-solving mechanisms are called into play. When the problems are not solved by the usual mechanisms and the problem stimulus continues, there is a further rise in tension which marks the second phase. The level of tension continues to rise, and in the third phase the person turns to "emergency problem-solving mechanisms." He may try one or more of several approaches: a) create new methods to solve the problem; b) re-define the problem so that it is within his problem-solving experience; c) give up current goals and define new ones; or d) use a "trial and error" approach to problem-solving. The problem may be solved by one of these approaches, in which case the tension level would decline. Otherwise, the fourth and final phase occurs, which is a continued rise in tension with possible

"major disorganization" resulting. In disorganization, he may try to release inner tension, or again take on the task of attempting to solve the problem. Caplan is referring to the experience of individuals in his description of crisis phases, but we believe that similar phases would occur in a close family unit.

Reuben Hill discovered reaction patterns people go through in time of crisis which are closely related to Silverman's stages. He calls it the "roller coaster" effect, which he outlines as:

crisis → disorganization → recovery → reorganization

In the initial phase, when the crisis event happens, they may not realize the full impact. Then, as they realize what has happened, they experience a downward slump in organization, roles are played with less enthusiasm, resentments are smothered or expressed, and conflicts are expressed or converted into tensions. As the situation begins improving, new routines are arrived at, and agreements about the future are reached.

From Hill's description one can see that even though people experience similar feelings and patterns in disorganization and recovery, the way they handle their experiences may be different. Some smother resentments, others express them, some convert conflicts into tension, others voice them. Hill stated:

Inter-family activities vary as a result of crisis. Some families withdraw from all activities until the "shame" is over and become more than ever closed systems. Others become quite outgoing in their open-window policy during the troubled period.

Even though people generally go through stages in restoring equilibrium, there is much room for individual differences. Some may be more open in expressing their difficulties, others want to keep to themselves; some may spend a longer time in the disorganization phase, others may quickly move toward recovery. In short, some may experience a severe crisis which immobilizes them; others may experience the same event as stress or as a problem.

The term stress, like crisis, is used to refer to different concepts. Lydia Rapoport (1965a) defines stress as a burden and says it is used to denote three different phenomenon: a) an event or situation; b) the way an individual responds to a stressful event; and c) the relation of the stimulus, the person's reaction to it, and the events to which it leads. Hill uses the term stressor and crisis-provoking event interchangeably, and says the only difference between whether an event is a stressor or a crisis is in the meaning the family makes of the event. Cumming and Cumming (1962) contrast a crisis with a problem:

... a problem does not have to challenge the assumptive state ..., it can be solved by the use of new combinations of available ego sets ... Problem solution strengthens the ego by introducing new organization of old sets and by the practice it provides....

Crisis, on the other hand,
... requires the learning of new sets and
their integration into the ego, or the re-
organization of the ego, following the
loss of old sets.

Lydia Rapoport in "The State of Crisis" (1965a) says that people respond to hazardous events as a threat, a loss, or a challenge depending upon how they view the event and their own ability to problem-solve. The stressful event, which is new in the person's life experience requires a novel solution. Some see the problem as a challenge, meet it with energy, and are able to develop solutions to the problem. Others see the problem as a threat to fundamental, instinctual needs or to their sense of integrity, and respond with anxiety. Those experiencing the problem of actual loss or deprivation feel depressed. When the hazardous event is experienced as loss or a threat, it continues unresolved and becomes a crisis.

Reuben Hill, who found several variables related to why families experience stress differently, shares Rapoport's view.

No crisis-precipitating event is the same for any given family.... Clearly, the stressor event must be seen as a variable rather than as a constant in family crisis research.... Stressors become crisis in line with the definition the family makes of the event.

It is this intervening variable, the meaning or definition of the event, which is required to transform a stressor event into a crisis. Hill outlined an equation for how

a stressor event becomes a crisis:

A (the event)-----interacting with B (the family's crisis-meeting resources)-----
interacting with C (the definition the family makes of the event)-----produces
X (the crisis).

Hill found that the meaning of the stressor event is influenced by whether it is intra-family or extra-family caused. He state, "If the blame for the stressor can be placed outside the family, the stress may solidify rather than disorganize the family." An example of an extra-family stressor event is a family forced to leave their home due to flooding in their area. They will likely be unified and supportive of each other in the loss of their home and in relocating. Intra-family events tend to disorganize the family because it reflects poorly on the family's internal adequacy. A delinquent child is an example of an intra-family stressor event. The child reflects poorly on his parents' child-rearing abilities and consequently some parents look for extra-family stressor events in order to shift the blame, e.g., they claim the child's behavior is non-delinquent and that social agencies are just causing trouble. The same is true with mental illness and psychiatric hospitalization. It is an intra-family stressor event, yet some families try to find cause outside the family because it makes it easier to accept.

From the above discussion one would expect a crisis-prone individual or family to be one who experiences a

stressor event as a loss or threat for which the cause is within the family, and one who has limited ability to problem solve. Hill mentions other variables as contributing to crisis-prone families.

Crisis proneness is in effect the phenomenon of experiencing stressor events with greater frequency and greater severity and defining these more frequently as crises. In other words, crisis-prone families appear to be more vulnerable to stressor events ..., and more likely because of meager crisis-meeting resources and failure to have learned, from past experience with crisis, to define these events as crisis-provoking.

Hill says the explanation for crisis-proneness lies primarily with how the family defines the meaning of the event and their crisis-meeting resources, yet he also brings in factors of frequency and severity of stressor events. A possible conclusion, then, is that a family faced with mild stress on an infrequent basis is more crisis-resistant than one who meets severe stress often. Another deduction is that a family becomes crisis-resistant by being frequently severely stressed, learning from their experiences, and developing crisis-meeting resources. It would seem that a family experiencing occasional stress and learning ways to deal with it will be better able to withstand future, more severe stress and consequently, reduce their crisis-proneness. Phyllis Silverman lists other factors which affect how a "critical transition" is experienced and thereby, the amount of work required in making the transition:

1) Suddenness of onset of the event or crisis; 2) amount of loss to the individual; 3) how much his life is touched by the situation; and 4) whether it requires total, partial, temporary, or permanent change. The amount of loss and how much one's life is touched by the situation is related to what Hill calls "the meaning of the event." Suddenness of onset and the amount of change required are, like frequency and severity, relative factors in crisis-proneness. Experiencing many sudden and severe stresses that require a great deal of change is certainly more difficult than infrequent, mild, somewhat expected stress that requires little adjustment. One is constant turmoil, the other the usual ups and downs. A summary of the factors influencing whether an event is experienced as stress or a crisis is: Families, who may have many or few problem-solving resources encounter stressor events, which may be severe or mild, frequent or rare, sudden or expected, require much or little change, and the families define the meaning of events in ways of threat, loss, or challenge.

Developing crisis meeting resources is therefore one way families can prepare themselves to handle stress. What are crises-meeting resources and what does a crisis-resistant family look like? Robert Angell (1965) found that crisis-meeting resources in Depression Era families are family integration and family adaptability. He defines

family integration as "bonds of coherence and unity running through family life, of which common interests, affection, and a sense of economic interdependence are perhaps the most prominent." Family adaptability is the "family's capacity to meet obstacles and shift courses as a family." Cavan and Ranck (1938) also studied Depression Era families and found crisis-resistant families are unified in family objectives and ideals, subordinate their personal ambitions to family goals, and find their interests satisfied within the family group. Earl Koos in Families in Trouble (1946) studied low-income families in the 1940's and found that even though all were financially pinched, some experienced it with more difficulty. Those families who found it less troublesome had an agreed upon family role structure and goals, accepted definition of the good of the family, and provision for the interests of family members within the home. In the descriptions by Cavan and Ranck, and Koos, a family is crisis-resistant as long as there is no change in their role structure, goals, ideals, and common interests. How would they accommodate a family member experiencing emotional difficulties? The important factor in handling stress is that of adaptability mentioned by Angell. The family must allow for change and make appropriate adaptations.

Knowing that a family is integrated and adaptable

suggests that they will be more able to deal with stress before it becomes a crisis. It does not tell how they will deal with it or how those doing crisis intervention can be most useful to those having difficulties handling a crisis. Lydia Rapoport (1965a) addresses the issue of how people deal with stress or crisis.

In general, the patterns of responses for an individual or family necessary for healthy crisis resolution may be described as follows: 1) the correct cognitive perception of the situation, which is furthered by seeking new knowledge and by keeping the problem in consciousness; 2) management of affect through awareness of feelings and appropriate verbalization leading toward tension discharge and mastery; 3) development of patterns of seeking and using help with actual tasks and feelings by using interpersonal and institutional resources.

This approach to crisis-resolution involves gathering and analyzing information, talking about feelings, and seeking and using other resources. It is a problem-solving approach which may require extra-family resources.

Regardless of whether families are able to resolve their crisis, they may need professional help. They will restore equilibrium whether or not they receive therapeutic intervention, but it may be at a lower level of functioning. According to Katharine Baldwin (1968), a person trying to cope with stress is motivated to use help. "Timely intervention" may prevent a lower level of functioning; that is, maladaptive responses, psychological disequilibrium, or

conversion into somatic symptoms. Lydia Rapoport (1965a) is more optimistic that intervention may bring about a higher level of functioning. The crisis event may be linked to old threats to instinctual needs and reactivate unresolved unconscious conflicts. This may add burden to the present crisis, yet may be a chance, especially with therapeutic intervention, to resolve some of the old conflicts.

Howard Parad (1965) is in agreement with Baldwin and Rapoport in his summary of crisis theory. He sees those in a crisis as vulnerable to further breakdown because their "internal equilibrium is off balance" and their "psychological resources over taxed." At this time they are challenged to develop new solutions to the present problems, as well as to the old problems which the current stress may have reactivated. The crisis event provides a new opportunity to deal with these old problems. Those in a crisis state with a composite of new and old problems are usually,

... more ready for, and amenable to, interventive help if it is offered at the right time and at the right place; that is, during the throes of crisis before rigid defenses and related maladaptive solutions have become consolidated by the ego.

Minimal intervention at this time can produce maximum results in a short period of time.

It is apparent that in a time of crisis people are vulnerable. They experience old conflicts related to the

current problem, and are looking for a solution to restore equilibrium. They will make changes and are especially ready to receive therapeutic intervention. Lydia Rapoport (1965a) sums it up well:

... the person or family in crisis becomes more susceptible to the influence of "significant others" in the environment. Moreover, the degree of activity of the helping person does not have to be high.

Some of the activities or techniques used with a person experiencing a crisis differ from the more traditional casework approaches. In comparing psychoanalytic with preventive casework, Parad says preventive casework is more active than passive, more outreaching than reflective. Regression is discouraged rather than encouraged so that transference does not follow. The initial interview must be therapeutic rather than purely information-seeking. The goal is to prevent maladaptive responses such as excessive denial, guilt, anxiety, and unhealthy regression; and to encourage and support family members in mobilizing and using their ego capacities.

Specific intervention tasks Parad discusses are: 1) Helping the client develop a conscious awareness of the problem; 2) helping him meet specific needs in the first interview and reducing his guilt and tension; 3) offering positive hope and support so he will engage in constructive efforts instead of giving up; and 4) accompanying him in using resources if he is incapable. Lydia Rapoport (1965b)

offers similar suggestions from her study of families of premature babies: 1) Keep families focused on the crisis and help them gain a conscious grasp of it; 2) help them with doubts of adequacy, guilt, and self-blame; 3) help them work through grief and mourning in relation to feelings of loss and emptiness stimulated by the separation; 4) help them work through the crisis in the "here and now" and as it relates to earlier conflicts as it rises to awareness; 5) offer information and education about the particular problem, which in her study was child development and child care; and 6) create a bridge of community resources, by referral and acting as advocate with agencies where the client experiences communication failure.

Timely intervention is beneficial regardless of how people experience stress. Families undergoing the stress of a family member experiencing emotional difficulties will go through predictable stages in realizing and accepting the change in behavior and in integrating the experience. Families can benefit from support services during this stressful time regardless of their problem-solving abilities. The families who seem self-sufficient and uninterested in offers to help may be the most vulnerable. They will resolve the crisis on their own, but it may be in a maladaptive manner. In order to promote healthy family functioning, the professional needs to be aware of the needs of families of psychiatric patients, their various ways of experiencing stress, and how to engage them in helping services, if appropriate.

FAMILY DIAGNOSTIC THEORY

The period of time up to and including hospitalization was examined in the discussion of crisis theory. Hospitalization of a family member is one of many ways to approach and treat emotional problems. Another way is to look at the family as a unit and to see problems within the unit as family problems rather than individual. This diagnostic approach to mental illness is used in family therapy and is a rather recent addition to the treatment methodologies. In this section we will look at family diagnostic theory as it relates to psychiatric hospitalization of a family member. We will discuss how the family orientation to psychiatric treatment got started and the factors that contributed to its rather late development. An overview of the family therapy orientation and some of the assumptions therapists make in their work with families will be presented, as well as a description of the different ways families attempt to deal with conflict and when they decide to seek help. We will briefly look at the practice of family therapy, why therapists work with all the family members together, and how the focus shifts from an individual to the family as a unit. Finally, the drawbacks of hospitalizing one family member will be contrasted with the benefits of treating the family unit together.

The family movement had its beginning in the 1950's in research on schizophrenic patients and their families. The approach was new because it involved studying patients and their families as a unit, rather than as individuals. At the time, this was a radical shift in treatment orientation and several factors increased people's difficulty in accepting it.

One major barrier to family therapy, according to Murray Bowen (1975), was the psychoanalytic principle to protect the privacy of the patient-therapist relationship and to prevent contamination of the transference by contact with the patient's relatives. Psychiatric hospitals carried out this principle by having one person (often a psychiatrist) to treat the patient and another (usually a social worker) to work with the relatives. Seeing families together was accepted only because it was in the context of research. Though it is more acceptable to see families together today, some psychiatric hospitals still employ the model of separate personnel to deal with the patient and his relatives.

Explanations about the causes of mental illness also contribute to people's reluctance to accept family therapy. Bowen (1976) outlines several explanations of mental illness causation which were generally accepted before family theory was known, and are still the basis for some therapies currently. Two of the ideas of causation which were among the

most widely received seemed to be especially contrary to family theory. Maternal deprivation, which is presumed to mean inadequate nurturing at an early age, is a cause of mental illness which fits for many clinical cases. However, it does not account for the large number of "normal" people who have been exposed to more severe maternal deprivation than those who were labeled "sick". Maternal deprivation as a cause of mental illness discouraged family intervention for two reasons: 1) It was too late to help because the deprivation was experienced during a critical period which had passed; and 2) the mothering figure was inadequate and would be of no therapeutic benefit. A second belief of causation is that of a single traumatic event in the past. Again, this may have explained some clinical cases, but it did not account for people who suffered trauma but did not develop symptoms. The emphasis in the traumatic event is on the past, and so, for people using it as a therapy basis, family therapy, which is oriented to the "here and now", would not be appropriate.

These were some of the factors which delayed the growth of family therapy. By the 1960's much of the opposition was overcome and it started gaining popularity. Over the past few years, theory has expanded as people have written about their experiences in working with families. We will discuss this theory as we look at therapists'

assumptions about working with families, how families handle conflict, and when they seek help.

James Framo (1976) says that family therapists assume that the person brought in for help is the representative or symptom-bearer for the family. According to Nathan Ackerman (1970), the "identified patient" is either the scapegoat for the pathology of the family or a stand-in for a more disturbed member. Donald Langsley and David Kaplan (1968) outline similar assumptions about working with families. They assume one of three things about the illness or symptoms: 1) The symptoms of a family member are in part an expression of family conflicts; 2) the individual is being scapegoated and is expressing the upset of the entire family or of another member; or 3) the "... adaptation and equilibrium of any given family member depends upon reasonable stability within the family as a social unit." When the whole family is upset, it may be that the individual who is expressing symptoms is more susceptible to stress than the other family members.

The common thread in all these assumptions is that individual symptoms are an indication of family conflict. Families, like individuals, will attempt to restore equilibrium when faced with stress. They may use a range of methods to cope with stress and restore a steady state, and consequently, families express their problems in different ways. Alfred Messer (1970) described some of

these methods which he labels "family homeostatic mechanisms."

1) Scapegoating: This is labeling one person the cause of all the trouble in the family. The family controls conflict by assigning it all to one person. Sometimes family members offer themselves as scapegoats in order to reduce conflict, e.g., "It's all my fault, I just can't control my temper."

2) Formation of defensive alliances or coalitions: This is joining forces with another, usually during an argument. In families, alliances may be equally divided or all against one.

3) Withdrawal of affect: The family stops emotional communication and the conflicts remain unresolved. The family continues the motions of family functioning, but there is no meaningful emotional contact among them. A variation of this method is when they communicate indirectly through other family members.

4) Designate one member as family healer: Someone in the family or close to the family who the family respects acts as a "go-between." He contacts dissenting parties to arrange a truce or reconciliation. This person may be the one who convinces the family to seek help and the therapist can use this person to promote family cooperation.

5) Loosening the family unit: Family members deal with conflict by finding emotional satisfaction with people outside the family. The family members are on good terms

when they are in contact with each other, but do not look to each other for emotional satisfaction. They get along with each other better than those using "withdrawal of affect."

6) Repetitive fighting: Families discharge tension by verbal and/or physical battles. This method does not lead to conflict resolution, but it may temporarily relieve tension and hostility.

7) Resignation or compromise: Family members give up their needs for assertion, affection, or emotional expression because of another member's conflicting needs. For example, if father rules the family with an iron hand, mother may put aside her domination needs in order to maintain harmony in the family. Her needs may come out in less direct ways, such as sabotage, unless she can truly resign her needs.

8) Family myth: The family invokes a belief about the family in order to deal with conflict. It is a statement of what the family will not allow and is intended to keep conflict from arising. An example of a family myth is that the family cannot survive if any member leaves it. As long as no one challenges the myth, conflict will not arise.

9) Reaction formation: The family represses and transforms traumatic ideas into opposites. In families where breakup is impending, they may present themselves as

overly harmonious and united. They impose a rule against expressing negative feelings and instead present an "all is well" picture.

All of these ways of handling conflict work to some degree for families using them. Some, like "withdrawal of affect" and "repetitive fighting", may be an immediate means of coping, yet maintain conflict in the long run. Others, such as using a "family healer" or "loosening the family unit", may bring more long-term conflict resolution. Though these methods may not bring emotional satisfaction, they may keep the family together and functioning, and decrease the urgency for outside intervention. Outsiders may find some of these methods of family functioning an intolerable way to live, yet families have their own criteria for deciding when to seek help.

According to Framo (1970), behaviors which outsiders may see as symptoms are only defined as symptoms by the family if they threaten the integrity of the family and the family's ability to maintain a steady state.

In general, the recognition and specificity of the symptom depends on what the family system does or does not allow, and families usually seek help only when the system is hurting, that is, when someone in the family is expressing antisystem symptoms ... No matter how bizarre or dangerous a symptom is, on the other hand, if it does not have a system function it is simply not acknowledged, although neighbors, school, or the police may force the family to do something.

An illustration of this point is parents whose response to their child accused of car-theft is "it is only a childish prank."

John Bell (1975) concurs with Framo that families not only decide if and when they need help, but they also determine what they want to change once they are in therapy.

... behavior which appears pathological or deviant to a professional person may not be a matter of concern to the family. Thus the family would not orient itself to modifying the symptomatic behavior; their value-orientation would direct their concern to other problems than those of seeming import to the therapist.

The therapist should be reluctant to make assumptions about what the family wants to change, and in many cases, who they want to change.

Many families have their own ideas about what will occur in therapy. Even though they may have agreed to seek help as a family unit, they may expect the therapist to change one person, rather than the family system. Most family therapists insist on seeing the family together so that they can determine what changes each family member wants and to take the focus from the "sick one". Framo (1976) says,

Unless the whole family is observed interacting together, it is very difficult to tell what the symptoms mean and who or what needs changing ... Family diagnostic evaluations were proposed as the best way to determine what really produced the manifest symptoms in one or more family members, and indeed,

whether there is a "patient" as such. Some behaviors are labeled by the family as mental illness which to outsiders are clearly not abnormal, and may even be adaptive. Other behaviors which are clearly disordered or dangerous from a psychiatric or social adjustment point of view, are denied, blocked out, or minimized by the family.

By seeing the whole family together, the therapist not only gathers information about each member's view of the problems in the family and assesses the presence of underlying issues, but he also will explain how the problems in the family really are evidence of difficulties between people rather than one person's problems. Virginia Satir (1964) believes that the words one uses in referring to the person showing symptoms is important in moving the family away from singling out one person as the problem. She says the therapist should use labels like the "identified patient" rather than the family's label of "the sick one", "the different one", or "the one who is to blame", in order to move the "identified patient" out of the problem role.

As intervention proceeds, the focus of conflict and disturbance usually shifts from one member to another since other members often have problems, too, according to Ackerman (1970). Don Jackson (1970) would agree with Ackerman that the focus of conflict shifts, but he sees it shifting to transactions between people rather than from one person's problems to another. By saying that this

person or that person or the whole family is sick, the focus is kept on an individual orientation. Jackson feels it is more helpful to look at the family interactions than to "seek the villains".

The approach of looking at the family as the unit of conflict and pain, rather than the individual is contrary to the way many emotional problems are treated. Individual psychotherapy and removal of the individual from the family are still commonly used in treatment of those with emotional difficulties. Langsley, et al. (1970) discuss some of the drawbacks of this approach.

The removal of an individual from his family to a hospital is more likely to complicate than aid the situation. It removes one member from a family, permits extrusion and scapegoating and avoids the family problem which may have precipitated the crisis. This action denies that the family can be helped to solve its own problems.

Many family therapists share the opinion that the removal of one family member may complicate or worsen the situation. When a person is removed from the family, the family may, in its attempts to maintain homeostatis, either develop new roles and behavior patterns which exclude the patient, or allow the patient to be part of the family if he will maintain the "sick" role. Satir (1964) reports observations of how families respond to individual treatment of a family member. Some interfere with, try to become a part of, or sabotage the treatment of the "sick" member.

Often a hospitalized family member will worsen or regress after a visit from the family. Her third observation was that many times another family member will develop symptoms as the patient gets better. All of these observations reinforce the view that families operate as a system; that is, if there is a change in one part, another part changes in response in order to maintain equilibrium.

Satir's observations also show that families are a part of the patient's treatment even if they are excluded from direct involvement by the therapist. It seems a waste not to try, through family therapy, to direct the ready and available energy of the family so that they can make constructive changes and become a supportive unit. Some of the benefits of using the family approach to treatment, according to Framo (1976), are: 1) It helps the family members to take responsibility for the process in which they share; 2) it helps the "scapegoated" family member not to feel that everything is dumped on him; and 3) it helps keep the family together and working on problems.

We have listed many possible benefits from using a family orientation to treatment, such as lessening the burden of the identified patient, keeping the family together, and getting the family to work on improving their patterns of interaction. The point that seems of great importance

is that of helping the family to be its own best resource in time of difficulty. It seems likely that with help in reducing stress, improving interactions, and learning to be supportive; in short, directing energy in a positive way, that family members could be of more help to each other.

FAMILY REACTIONS TO MENTAL ILLNESS

In the discussion of crisis theory a description of how people react differently in a stressful time depending upon the stressor event and the meaning it has to them was given. We showed that if it is experienced as a crisis, people's responses will follow fairly predictable patterns. This section will focus specifically on mental illness as the stressor and how family members react. First, the way society in general responds to mental illness, the functions their responses serve, and how their response influences family reactions will be examined. Then family members' responses to mental illness will be described and compared with the reactions of people facing the death or dying of a family member.

Cumming and Cumming (1957) studied the beliefs and attitudes of the public toward mental illness in the early 1950's. They found that "society" reacts in a pattern of denial, isolation, and insulation from the mentally ill and that this "isolation pattern" serves several functions for society. They found that the first response of people is to deny that there is anything wrong with the disturbed person's behavior. When the disturbing behavior is increased to the point that denial is no longer possible, then they move toward social and physical isolation of the deviant.

This usually means "putting the person away" in the hospital and is rationalized on the basis that hospitalization will get the person the help he needs. Finally, people insulate themselves from the problem by denying that the "isolated deviant" is a problem any longer. They rationalize that he is taken care of and that there is nothing more that they can do.

These reactions are based on the fact that people are fearful of the mentally ill. The "isolation pattern" directly serves the purpose of allaying people's fears by removing the deviant from society. Other functions of isolation are: 1) "The maintenance of the integration of the community as a predictable and normative social system"; 2) the preservation of the expectation that members of society will act out their roles in an orderly and understandable way; 3) relief of guilt about societal responsibility to the mentally ill ("we hospitalized him and there is nothing more we can do"); and 4) attempting to get the person help and to restore him to a state of health. Isolation also has the effect of large losses to the community of personnel who could be productive even though they are labeled "ill". Furthermore, the patient is isolated from everyday societal expectations and compromises, and will experience additional difficulty in trying to reintegrate in the societal system.

The family members of mentally ill individuals also react to mental illness in patterns of fear, denial, and isolation. They often have mixed emotions and are unable to be supportive of each other or of the disturbed member. Robert Albert (1960) studied the breakdown in interactions between the mental patient and his family. His analysis showed that the disruption in interactions occur in stages of progressive dysfunction. In the first stage, the patient and his family become aware that their interactions require more effort and are more unpleasant than in the past. The family members view the individual as different and he begins to doubt himself. The first stage is characterized by the following features: a) Increased anxiety in all family members; b) increased defensiveness and rigidity in all family members, which serves to heighten their self-esteem and reduce guilt; c) increased "narcissistic" needs and fewer ways to satisfy the needs; d) limited family interactions because they are dissatisfying; e) efforts at interaction are more desperate and tense and viewed as demanding special effort; and f) they see each other as "problem-carriers" and are unable to problem-solve.

In stage two, the family patterns of behavior continue to change and are acknowledged as new patterns. Family members feel a sense of loss and helplessness since their values and ways of behaving do not solve the problem.

Family members usually respond to the feelings of loss and helplessness in one of three ways. They may resign themselves to the situation and feel tired and unenthusiastic; they may feel increased aggression to return to the old family patterns; or they may withdraw from the family, denying responsibilities and feelings, and not play out their roles. In the final stage, the disturbed individual is isolated and openly referred to as needing special consideration. The family members separate themselves from the individual and are ready for him to be hospitalized or otherwise removed from the family at this point.

The final stage in Albert's findings, that of isolation of the disturbed individual, is similar to the isolation pattern response Cumming and Cumming found in the "general public". Evidence of these findings are obvious in the numbers of psychiatric patients who no longer have interested "significant others". From analyzing Albert's stages in interaction, it would seem that if family intervention was made in the first stage, when the family is still trying to interact in their usual patterns, that the isolation pattern may be avoided.

The denial response found by Cumming and Cumming was also discovered by Clausen and Yarrow (1955) in their study of the impact of mental illness on the family. They interviewed the wives of 33 hospitalized patients and specifically looked at their initial reactions to the problem

behavior and the process whereby their perceptions of their husbands changed from that of being "well" or "normal" to "sick". They found that the wives were generally resistant to recognizing their husband's problems and chose to deny the problems as long as possible. The women's individual needs and values determined when they defined the behavior as a problem. It was usually seen as a problem when one of three situations occurred: 1) When his behavior upset the status quo; 2) when she could no longer manage him; or 3) when she could no longer explain his behavior.

Even after recognizing that the behavior was a "problem", many wives did not see it as mental illness. They viewed the problems as: a) Physical; b) "character", i.e., he is acting "weak" or lacks will-power and self-discipline; or c) environmental, that is, he is just upset about an external stimulus, such as the loss of a job. Those who did define the problems as emotional alternated between being "understanding" and "judgmental" of the individual. The researchers compared the reactions of wives of those diagnosed psychotics with those diagnosed psychoneurotics and found that psychoneurotics were more often seen as emotionally disturbed than psychotics, even though the wives of psychotics reported more disturbing behavior.

During the early period many wives recalled feeling

uneasy and confused, and were uncertain of how seriously to take their husbands' problems. However, after the initial confusion, they tried to resolve their uncertainties and make some change in the situation. Their attempts to change the situation most often meant redefining their husband's problems in one of three ways: 1) They started seeing the problems as mental illness and reacted with varying degrees of acceptance and blame; 2) they looked for situational and momentary explanations for the behavior, rather than attempting to understand the overall pattern of behavior; or 3) they offered various explanations for the pattern of behavior, but continued to deny mental illness.

Clausen and Yarrow discovered many factors which contributed to the wives' (spouses') difficulties in accepting their husbands' (patients') behavior as mental illness. One, the patients behavior fluctuated between being acceptable and problematic. Because the disturbing behavior was not persistent and was often followed by acceptable behavior, the spouses were uncertain whether it was really a problem. Two, the problem behavior was often an exaggeration of the patient's day-to-day behavior and the spouses adapted to it until it became too disturbing. Three, the patients denied that they had problems and refused to seek psychiatric help. The spouses wanted to comply with the

patients' wishes and so tried to deny the problems also. Four, friends and relatives often discounted the spouses' concerns and assured them that the patients' behavior was "normal". Fifth, spouses were reluctant to admit mental illness because it caused them to question themselves and look at their roles in the upset. Finally, there are many social supports for maintaining "normality", and conversely, many social consequences of admitting mental illness. The social consequences feared were: a) "Psychological stigma" which is the belief that people will talk about the family and refer to the individual as "crazy" and out of control; b) social discrimination which would result in the patient losing his job, the children being rejected at school, and the spouse excluded by friends; and c) loss of social status which, more specifically, refers to a ruined family name or reputation.

Clausen and Yarrow conclude that their findings are not surprising considering what is known about the psychology of perception.

The findings on the perceptions of mental illness by the wives of patients are in line with general findings in studies of perception. Behavior which is unfamiliar and incongruent and unlikely in terms of current expectations and needs will not be readily recognized, and stressful or threatening stimuli will tend to be misperceived or perceived with difficulty or delay.

A slightly different view of the family members' reaction to mental illness was reported by Raymond, Slaby,

and Lieb in The Healing Alliance (1975). Like Cumming and Cumming, and Clausen and Yarrow, they talk about the denial reaction, but reported it as only one of the many stages family members go through in accepting the mental illness of an individual. The first response is "an intermittent sense of uneasiness and momentary puzzlement." They make comparisons between the previous and present behaviors of the individual and try to make him see the "unreasonableness" of his behavior. The family members use the defense of suppression at this point; that is, a conscious attempt to exclude what they know seems wrong. An example of this is to write off the individual's behavior as a "phase". If his problems then subside, they are reassured that their uneasiness was unwarranted.

If the behavior persists, the second response of attempting to gain reassurance usually occurs. The family members try to find confirmation that the problem is not serious. They are fearful that mental health professionals will not reassure them, but rather will judge the whole family the cause of the person's problems. Consequently, any reassurance received, especially from mental health professionals, would be highly regarded because it confirms what they want to hear. However, it would not necessarily satisfy them or curb their need for further reassurance. One way they may reassure themselves is by likening the

upset person to famous creative people who were also emotionally unstable. This is an example of wishful thinking that things will turn out well for the individual even though he is "ill". Another predictable behavior of the family member at this stage is that they search for explanations for the individual's problems in circumstances and surroundings, rather than in the individual or the family relationships. This is similar to the finding in crisis theory that it is easier to accept and deal with an extra-family, rather than intra-family stressor event. It is also in line with Clausen and Yarrow's finding that spouses define problems as environmental, rather than mental illness.

Raymond, et al., state:

It is much easier for anyone to account for a family member's problem through outer circumstances such as overwork or financial problems than to examine one's own feelings or one's part in a troubled relationship.

The third response, if reassurance does not alleviate the uneasiness, is an attempt to minimize the symptoms or deny that an "illness" is present. They respond to only "surface communications" because they want to avoid the responsibility that comes with open recognition of another's distress and the guilt over what role they may have played in the distress. By denying the problem, the family members do not demonstrate understanding to the upset person and may thereby exacerbate his disturbing behavior.

When the family members are no longer able to deny the problems, they feel resentment and anger, and may blame the individual for his behavior. Fear and hopelessness often underlie the anger. The family members may be confused about how to best deal with the individual's behavior. Should they overlook his problems or expect him to conform? Because of their uneasiness about how to handle the problem, as well as doubts about the security of the family relationships, the "sick one" is blamed and becomes an outsider.

Next, the family members may question their own role in the situation and feel "guilt, remorse, shame, and grief." They no longer feel confident and may distrust their perceptions, instincts, and judgments. Those who believe that the person's "cure" depends entirely on the therapist feel that they are useless in treatment and may even feel they are regarded as bad for the person. An individual, rather than family approach to treatment confirms their feelings.

After the family members have openly recognized the problem and taken steps to get help, they may feel a sense of relief. However, they may also feel confused about the patient's diagnosis, and the changes he makes in therapy, and consequently may urge him, directly or indirectly, to go back to being his "old self." By using a family therapy approach, this confusion and counter-therapy influence may

be avoided.

The final stage is when the family members accept the reality of the situation and try to help the individual get better. This phase is similar to Silverman's recoil stage and Hill's recovery stage, where the person has recovered from the initial effects of the crisis and is mobilized to change. Moreover, like the stages in a crisis, the family members may go through all the reaction stages in a short time, or they may spend a longer time in some stages, and less time in others.

Raymond, et al., have likened family members' reactions to mental illness to the stages people go through in accepting death. According to Elizabeth Kubler-Ross (1969), the dying person and his family go through similar predictable stages in accepting the reality of death. The reaction in the first stage of accepting death is denial and isolation. The family members seek help and reassurance that the person's illness is not terminal. When denial is no longer possible, they feel anger, envy, and guilt. They feel anger with the doctor who diagnosed the illness and are envious that they cannot be the ones to provide care for the patient. They review the past opportunities to do things for the patient and feel guilty that they did not do more. In the third stage, they try to bargain for an extension on life by promising to do certain things in exchange for more time.

There is acceptance of death in this stage but with the condition that they decide the time. In the fourth stage, the anger and attempts to bargain are replaced by feelings of loss and depression. Expressions of sorrow and grief are made as a way to prepare for final separation. The final stage is acceptance of the reality of final separation and death. Anger, envy, and depression, which have been expressed, are absent from this final stage. Though the struggle is over in the final stage, it is not a feeling of resignation or giving up, but rather of peacefulness.

The stages people go through in accepting death, which Kubler-Ross identified, are indeed similar to those Raymond, et al., reported in family members' acceptance of mental illness. According to Raymond, et al.:

It is not surprising to find so many similarities between the reaction of a family to mental illness and to impending death. Both involve a loss; one may be temporary, the other final. In some cases of severe chronic psychiatric disturbances, such as chronic undifferentiated schizophrenia, there is indeed a sort of death in life. A patient may never return to function at his previous level, and family and friends may need to adjust to a chronic condition and progressive deterioration.

There are situations, such as that described by Raymond, et al., where "cure" of mental illness may be temporary or where the person continues to worsen over the years. Because of this reality, it is not realistic to use alleviation of symptoms as the only criteria in selection

of the treatment approach. Otherwise, some people may not receive any treatment at all once they were labeled "chronic". Family intervention, like other treatment approaches, cannot promise the removal of symptoms in every case, but it can be helpful even where "cure" does not seem possible. From the discussion in this section, family intervention seems helpful in the following ways: a) To help the family to accept the reality of problems in the family and to work on making changes together; b) to change family interaction patterns before the identified patient becomes isolated from the family. By keeping him a part of the family he may have less problems trying to fit in later; and c) to allow family members to express feelings of loss, even if temporary, so that positive emotions can emerge and they can help each other, as well as the disturbed individual. By openly expressing feelings about the person's difficulties and the loss, the family members may be more willing to keep him in the family.

ALTERNATIVES TO TRADITIONAL TREATMENT

The origins of public care for the mentally disturbed can be traced to the development of state hospitals for psychiatric patients. Care prior to that time consisted of private facilities for those who could afford such services and a variety of make-shift programs for those who could not. The latter included offering contracts for a fixed fee to provide care for an individual in a private home (usually for the enrichment of the provider) and lodging the mentally ill in prisons and poorhouses. During the early days of the state hospital movement, many of these facilities were imitative of the private psychiatric hospitals of the time, providing humane and moral treatment for the disturbed. (Bloom, 1975)

However, by the late nineteenth century the treatment in state mental institutions had seriously declined. They were drab, overcrowded and understaffed. In addition, the state hospitals were fast becoming filled with foreign-born persons. Admissions soared, with the immigrant and often destitute patient accounting for that increase. (Williams and Ozarin, 1967)

At the same time the state hospitals were increasing in admissions and deteriorating in treatment, the "moral" treatment approach to mental illness was abandoned largely

due to overcrowded conditions, overtaxed budgets and a lack of sympathy for the psychiatric patient, likely to be an immigrant, poor and from the slums of the large eastern cities.

The early part of the twentieth century did see some progressive steps taken in psychiatric treatment. Beginning in 1902, psychiatric wards were opened in general hospitals, social work programs were developed in psychiatric care, and some outpatient and aftercare services were originated. The development of the mental hygiene movement in 1909 helped to forge ties between the community and the often isolated state hospitals. A step towards providing follow-up care and transitional care for the released mental patient was the entrance and growth of social work in psychiatric care. In 1906 the first professional social worker in an American mental institution was hired by the Manhattan and Islip State Hospitals in New York. (Williams and Ozarin, 1967)

Dr. Adolf Meyer (1866-1950) was one of the early pioneers in the aftercare movement. He advocated not only community treatment and rehabilitation of mental patients, but also urged the examination of what factors in the community itself helped to produce mental problems (Williams and Ozarin, 1967)

Concurrent with the rise of professional psychiatry in the United States came the continued decline and deterioration of the state hospital system. Through the years of

the Second World War and the early fifties, the patient population continued to rise in the state institutions and for the most part these facilities had "... lapsed into vast storehouses for some of the most disabled and miserable people in the country." (Bloom, 1975) However, during the early 1950's several important developments occurred which were to add new dimensions to the possibilities of providing community based care as an alternative to institutionalization as well as improved hospital based care.

The first was the development of psychoactive drugs for treating the mentally ill. The use of such drugs as reserpine and chlorpromazine was effective in subduing some of the erratic and bizarre behavior of the patients as well as reducing their own anxiety and discomfort. Many patients were able to return to their own homes and communities sooner than before by continued use of these drugs. (Bloom, 1975)

A second development was the origin of the idea of providing a therapeutic community within the hospital. Various research and demonstration projects were funded to examine such issues as social interaction in hospitals between staff and patients, milieu therapy and sociopsychological factors in treatment. A major study in 1954 related patient's symptoms to the informal organization of the hospital itself, suggesting that the structure of the

institution hindered treatment success. (Williams and Ozarin, 1967)

A final development was the decentralization of state hospitals according to geographic boundaries (i.e., where the patient had lived prior to hospitalization). Previously, patients had been grouped according to the type of disorder they were labeled as having. Grouping patients according to geographic locations was an important step in providing a link between the state hospital and the community which it served. It paved the way to provide community based aftercare and transitional services for the released patient and helped end the isolation of patients by the severity and type of their disorder. (Bloom, 1975)

With greater numbers of patients being released after shorter periods of time from the state hospitals, the need for community based services grew. With the creation of the National Institute of Mental Health in 1946, the basis for federal intervention in mental health services was begun. The United States Congress appropriated funds to analyze and evaluate the social and economic problems associated with mental illness under the Mental Health Study Act in 1956. The Joint Commission on Mental Illness was established to perform this task. In 1961 it presented its findings and conclusions in Action for Mental Health. Its major findings and recommendations included:

(1) immediate and intensive care for acutely disturbed mental patients in out-patient community mental health clinics created at the rate of one clinic per 50,000 population, in-patient psychiatric units located in every general hospital with 100 or more beds and intensive psychiatric treatment centers of no more than 1000 beds each (to be developed by converting existing state hospitals, (2) improved care of chronic mental patients in other converted state mental hospitals, again involving no more than 1000 beds, (3) improved and expanded aftercare, partial hospitalization and rehabilitation services, (4) expanded mental health education to inform the public about psychological disorders and to reduce the public's tendency to reject the mentally ill. (Bloom, 1975)

Response to the Commission's report was in the form of Congressional legislation authorizing up to \$150,000,000 to finance the construction of community mental health centers throughout the nation. The Community Mental Health Centers Act of 1963 provided for a strong role for the federal government in financing mental health services. The 1965 amendment to that Act appropriated additional funding for the staffing of the centers. (Williams and Ozarin, 1967) But in a broader sense, it represented a commitment on the national level to community based rather than institutional services for the mentally ill, as an alternative to traditional service delivery.

However, the resultant "deinstitutionalization" movement in mental health services has spawned some unanticipated problems among which is the greater burden placed upon the families of disturbed individuals who are treated in

outpatient settings without entering hospitals or are able to be released after short periods of time in institutions. Their abilities to cope with the disturbed family member have sometimes not been considered in the recent thrust towards deinstitutionalization and alternative treatment. The family's skill in dealing with these changes is being found to be important in the successful functioning of alternative programs.

A study was undertaken to attempt to determine the importance of the family environment for a patient's continuation in a day treatment program as DuBois Day Treatment Center in Stamford, Connecticut. The subjects were 150 severely disturbed patients admitted to the day treatment program and 219 of their relatives. Family members were interviewed when the patient was referred to the program. Those exhibiting considerable emotional turmoil were referred to the research project. Both the family members and the patient became involved in a verbal therapy group in which they each explained what brought them to the Center. Contact continued with these family members to attempt to determine whether there were significant factors in the family which related to continuing in treatment. The highest level of continuance in the treatment program was found to be among those who were able to recognize a certain amount of maladjustment in their family unit. The

treatment team also recognized through this study the importance of inclusion of the family in the intake process to evaluate the stress that the family was experiencing and the attitude toward the identified patient. Further implications were that family members should be included in treatment planning and goals for therapy as well as providing special orientation for the family to the Clinic, its settings and functions. Various treatment approaches should be utilized in dealing with family members which insure not only continued participation of the patient, but also help improve family functioning and deal with the stress that the family is facing. The study concludes that without such measures to deal with families continuation and hope for success with the patient would be limited. (Donovan, 1977)

In another study on the effects of deinstitutionalization on families, William Doll discusses the severe emotional and social strain which is placed upon families who are experiencing the effects of deinstitutionalization. Though often the disturbed family member is accepted physically in the home, often there is a social rejection or isolation of the disturbed family member within the family itself. He cites the importance of including the family members in the treatment plan and the need to help them cope with the day-to-day immediate living problems of a disturbed relative. Doll states that: "Increasing numbers of families are being forced into dangerously untenable situations either

because of poor planning ... or because of legitimate fiscal and administrative needs have been given priority over the equally legitimate, albeit less visible, needs of the patients and their families." (Doll, 1977)

Findings indicate that families generally exhibited little shame or avoidance of the mentally ill and found reassuring their willingness to participate in treatment. He warns that failure to pay attention to the family-patient condition and provide institutional support could have disastrous effects upon the community care movement and other alternative to traditional psychiatric hospitalization. (Doll, 1977)

The above articles help illustrate the importance of the family in the success of an alternative treatment program for the mentally ill. Therefore, in light of research conducted on alternatives to institutionalization, it is important that the role of the family and of "significant others" of the patient be remembered in formulating and carrying out treatment plans and providing support services. The following are descriptions of programs which are representative of alternatives to traditional inpatient hospitalization.

Friedman, Rolfe and Perry describe a treatment approach which provides for the treatment of psychiatric patients in their own home. In 1957 a Psychiatric Home

Treatment Service was established at Boston State Hospital. In an effort to avoid hospitalization for disturbed individuals, a program was developed whereby a team consisting of a psychiatrist and a social worker visited individuals experiencing emotional difficulties in their own homes with their families. Referrals for the program were received through other community agencies, clergy, physicians, informal sources, and self-referral. All were deemed to be traditional candidates for in-patient hospitalization.

After a joint interview with the patient and his/her family, the social worker interviewed the family alone while the psychiatrist interviewed the patient. All were then united to discuss a working plan for treatment. Attention was given to social pressures (financial, legal, etc.) as well as the patient's presenting difficulties. The treatment usually included drugs, out-patient services, and frequent visits by the team. When hospitalization was required, the team helped to prepare the family and the patient for that experience. It was found that: "Much confusion and stress can be generated around hospitalization." Often transportation and support services were arranged to help alleviate that stress. The social worker often helped the family deal with anxieties regarding hospitalization and other serious social consequences such as child care, home-maker services and financial assistance. As a result of

this approach consultation with all concerned and the basis of a working relationship with the patient and family was formed which could later be utilized for therapeutic change.

This program was designed not only as an alternative to hospitalization, but also served as a support service for families when institutionalization became necessary. Of the individuals who were seen through this program, 60% did not require hospitalization while 40% were eventually treated in an institution.

Another alternative to traditional hospitalization was one which involved a program whereby mothers were admitted to the hospital along with their children. Henry Grunebaum and Justin Weiss describe this unique treatment program designed for young mothers who were suffering from severe post-partum depression requiring hospitalization. Instead of separating the women from their babies and providing traditional therapy, treatment revolved around joint admission of mother and child. Joint placement was made under three considerations: (1) The responsibility of the hospital; (2) the therapeutic needs of the mother; and (3) the effects of a disturbed mother upon the child. The decision to bring the child into the hospital was always concurred with by the patient without coercion. It was an integral part of the program that the patient's family be included in the planning and discussion of the treatment plan.

A program which was aimed at avoiding hospitalization for mentally disturbed individuals was experimentally initiated in Louisville, Kentucky in 1961. The program consisted of three groups, an experimental group in which diagnosed schizophrenics remained at home, on drugs and under public health nursing care; and two control groups, one consisting of patients who remained at home receiving placebos and public health care and one group who were hospitalized in a state institution. The results of this experimental program showed that after thirty months three-quarters of the experimental group could be maintained in their own homes, and were at a significantly higher level of functioning than the members of either of the control groups. However, after the experimental program was discontinued, the level of functioning dropped to one that was not significantly higher than the other two groups.

The success of the home care and drugs program was attributed to two factors: (1) Drugs were taken to the home by nurses who urged family members to supervise the patient's taking of the medication. (2) Nurses went out systematically to the home. Patients and relatives did not have to assume the initiative in treatment.

The nurses interacted with the family and gave them emotional support and practical problem solving guidance. It was found that taking the program to the patients and

their families was essential.

... the most important finding of the study was that chronic schizophrenics, in order to remain successfully in the community, must have continuous supervision and medication. They and their families must receive social services and psychological support to alleviate the all too familiar pattern of personal and family disorganization. (Davis, et al., 1973)

Other alternatives exist which, though not preventing initial hospitalization, seek to move the released patient into the community after a shorter period of hospitalization and offer support services to prevent recidivism. Some have been utilized, though, as a primary alternative to hospitalization. Traditional programs in this area include partial hospitalization, halfway houses, group homes and cooperative living arrangements. Included here is a selective sampling of several programs which provide innovative treatment plans and support services to the mentally disturbed individual and his/her family.

Categorization of the programs is difficult due to the wide and varied nature of the services offered. In attempting to systematically present the alternatives available, the services are divided into those offering residential alternatives to hospitalization and those that provide treatment without residential services.

The residential programs vary from those offering comprehensive treatment in a live-in setting to those

offering some support and supervision in the individual's daily living situation. The following represent alternative living arrangements to in-patient hospitalization.

Halfway Houses:

The formal development of halfway houses is a relatively recent occurrence, though informal arrangements have probably existed. Allusions to "halfway houses" rarely exist in the literature prior to the mid-fifties. In 1957, it was estimated that there were just three halfway houses in the United States. By 1967 the numbers appear to have increased to over 100 and indications were that they would continue to rise rapidly with the shifting of emphasis to community based treatment. (Raush and Raush, 1968) Raush points out in his study of halfway houses, that because of their relatively recent origins, there is little legal clarity regarding their standards, operating procedures, or restrictions. In some ways this is advantageous, allowing for innovation and experimentation, but consequently also leads to problems in zoning, staffing, licensing and other matters of legal responsibility.

Despite the wide variety of halfway house programs, there are certain common factors of form and purpose which these programs share. Raush suggests the following as a guiding definition for a halfway house:

- a) The residents have recognized psychiatric problems;

- b) The halfway house is not usually on hospital grounds;
- c) It is, if only temporarily, the primary residence of the persons living there;
- d) Presumably the residents do not remain permanently.

(Raush and Raush, 1968)

The above represents some generalized criteria for facilities to be recognized as halfway houses. As specific houses are examined the diversity of the programs becomes readily apparent. The single thread that seems to bind them is that the halfway house resident is "brought into closer relation with the pattern of living in ordinary communities." (Raush and Raush, 1968)

Some of the earliest halfway houses, though not labeled as such, were rural facilities founded by non-professionals with humanistic rather than psychiatric orientation. Gould Farm in Massachusetts (1913), Spring Lake Ranch in Vermont (1932), and Meadowlark Homestead in Kansas (1951) are examples of this type of early facility. The prototype of the modern urban halfway house is considered to be Rutland Corner House which was founded in 1954. (Raush and Raush, 1968) Several examples typical of modern halfway houses are as follows:

Gill reports on an innovative halfway house program in San Antonio, Texas which provides an alternative to hospitalization as well as post-hospital support for ex-

psychiatric patients. The house is staffed by a married couple who serve as resource persons to the residents. Residents either are employed in the community or are pursuing vocational training. In addition they are expected to assume assigned household responsibilities and are given personal liberty to come and go from the house within curfew limits. Treatment offered here is minimal and is usually sought outside the facility. In a follow-up study of 91 residents one year after leaving, it was found that: 16 were living independently and had been employed for ten months; 57 were living independently and had been employed for two months or more; and 18 had been readmitted to the hospital. (Gill, 1967)

A descriptive study of the halfway house system in Vermont reveals that the program, like San Antonio's, stresses educational and job training objectives for its residents. However, it offers these programs within the houses themselves rather than utilizing community services. The rural locations often necessitate this structure. The houses are staffed predominantly by non-professionals and here, too, treatment services are minimal and generally secured outside the house itself. (Huessey, 1969)

Overview evaluations of halfway houses have focused upon specific types of programs. Wilder cites two distinct styles of halfway houses; nurturing and high expectation.

The nurturing recognizes the "illness" of the resident and the staff assumes much responsibility for everyday chores with expectation lowered to accommodate the limitations of the residents. The high expectations house emphasizes the health of the tenants and forces them to assume responsibility for the running of the house. The authors of this study cite as high expectations model, Overing House, Bronx, N. Y. In a follow-up study done six months after a group of residents had left the program, it was found that 41% of the women and 50% of the men were living independently. In addition, another group of residents was able to return to living with their families who had benefited from the House's program of allowing intermittent stays at home for the residents as well as counseling and family therapy to ease the transition to the return home. (Wilder, 1968)

Finally, Harold Raush, who has done extensive research about halfway houses, took a critical look at their overall performance as an alternative for psychiatric patients. He evaluated the role of the halfway house in terms of its importance in the rehabilitation of the ex-mental patient. Twenty-six statistical reports evaluating halfway houses around the country were examined. Collectively compiling the results of those reports, he found that 80% of the residents of the houses studied readjusted to community

living and that overall rehospitalization rates were significantly lower after residence in a halfway house. (Rog and Raush, 1975)

In describing the value and uniqueness of the halfway house, Rothwell compares and contrasts various aspects of the halfway house to a mental hospital. He cites positive aspects of the house as being; lack of medical supervision, small size, relative anonymity for the residents and simple administrative structure. He contends that hospitals, by the nature of the system which they operate in and its effects as a major institution, cannot be reformed or reorganized to provide the distinct service that the halfway house offers. (Rothwell, 1963)

Foster Care:

An alternative to hospitalization which is not as widely used at the present time but deserves mention is foster care for mental patients. Though primarily used prior to the development of psychotropic drugs and at times for custodial purposes alone, some of its more progressive aspects suggest contemporary uses as an alternative to traditional hospitalization.

The foster care program was designed for two distinct classes of patients, those who required "continuous care" and those who were making therapeutic progress and were not ready to be released for independent living. (Crutcher,

1949) The former refers to patients who had spent a lifetime in institutions but through placement in family living situation had responded and shown improvement. The service to the latter category of patients acted as a therapeutic measure to provide the link between hospitalization and return to the community and often their own families. The author discusses various reasons why an individual would not be able to return to their own home, but would be able to make a satisfactory transition in a family care setting.

When such a patient is placed with a family in a community where he finds the security and protection that he would in his own home, but without the emotional complications, often he is able to work out his own adjustment. (Crutcher, 1949)

Matching the family to the patient's therapeutic needs was considered vital, as was providing intensive casework for the patient, foster family, and the patient's own family. The data derived from the study of this program was encouraging. Of 100 state hospital patients placed in the therapeutic foster care situations (Springfield State Hospital, Maryland), 88 had been able to remain outside the hospital. Sixty-five of that group became self-supporting and were able to be discharged from all supervision.

(Crutcher, 1949)

Community Lodge:

Fairweather describes the gradual process of taking the results of an evaluative study and transforming them into a

functioning program offering an alternative to hospitalization. His original research toward the community lodge model began in 1958. The original research divided released patients into two groups, those who would utilize traditional outpatient clinics and those who would stay in a community dormitory (lodge) where a work and living situation was provided for them. Gradually, supervision of the lodge group evolved to the point where all everyday living needs were managed by the group itself. The ex-patients eventually became autonomous and self-supporting. After a 40 month follow-up period it was found that the median employment time over a six month period for the lodge members was 72% while for those in the traditional treatment approach it was 0%. Other benefits, such as dramatically reduced program costs and improvement in patient morale and perception of themselves, were significant. Thus, the basic premise of the lodge program is providing community group living under supportive conditions with intensive professional supervision gradually allowing the residents to assume responsibility for their own living needs and operations. (Fairweather, 1974)

Cooperative Apartment:

The cooperative apartment alternative is an outgrowth of the halfway house movement. Usually, it involves a group of former patients living together in an apartment receiving

a minimum amount of supervision. Often daily contact is maintained with a non-professional with less frequent supervision provided by mental health professionals. (Hodgman, 1966; and Chien and Cole, 1973) The goal underlying the cooperative living alternative is to provide a transitional arrangement for the former patient facilitating his/her return to the community from an institutional setting.

Hodgman and Stein describe a cooperative apartment in Brookline, Massachusetts. The residents function without live-in supervision and the supervision they do receive is provided by a semi-monthly visit from a state hospital social worker and a psychiatric social worker from a mental health center. Crises are handled by telephone communication with either of these social workers. This living situation provides for a time of transition without the stigma of hospitalization. It closely approximates an independent living arrangement and helps the ex-patient deal with everyday living responsibilities with minimal supervision. (Hodgman and Stein, 1966)

Another cooperative living arrangement for former patients was established by Boston State Hospital. Landlords act as a support group for newly released mental patients in the community. This approach utilizes an informal helping system for daily supervision. As in the Brookline apartment arrangement, the tenants meet on a

weekly basis with a team of mental health professionals, who are also available for twenty-four hour telephone contact, if necessary. The degree of satisfaction on the part of the clients and landlords has been high. After five years, the results of an evaluation revealed that 82% of the former patients in this program had successfully remained in the community. In addition to the latter benefits, it was also found that the costs were significantly lower than hospitalization and less expensive than other alternatives such as halfway houses, nursing homes, group homes and foster care.

Treatment Programs:

The following is a sample of alternative treatment programs to traditional hospitalization. They represent programs which do not offer residential services to clients but operate exclusively to provide therapeutic services. Some may provide emergency in-patient services but only on a short-term crisis situation.

Day Treatment:

Day treatment is another relatively new service developed to provide treatment to improve the emotional functioning of the released psychiatric patient. Glasscote outlines the goals of day treatment as the following:

- 1) As an alternative to inpatient treatment.
- 2) As a transitional facility.

- 3) As a locus for intermediate-term rehabilitation of persons who have social and vocational deficits resulting from or related to mental illness.
- 4) As a service for patients so seriously impaired that, but for the support and maintenance of the day program, long-term hospitalization would be required.

(Glasscote, 1969)

The day treatment program is described as a transitional program facilitating the patient's return to the general community from the institutional setting of a psychiatric hospital. Two other uses of the day treatment facility were found to be rehabilitation and maintenance of the long-term patient. The service allows for rehabilitation of individuals who because of prolonged hospitalization exhibit poor employment and educational records and need extensive retraining to obtain vocational skills for adequate employment. The second category of patients refers to those who due to long histories of mental illness and the dependencies fostered by long periods of hospitalization show little hope of ever attaining independent living. The day treatment programs offer intensive support, maintenance, and supervision to help this individual avoid permanent hospitalization.

Glasscote offers an extensive survey of various day treatment facilities across the country. He describes twelve facilities and their programs, including each

center's physical facility, staff, referral and treatment procedures, characteristics of the patients, treatment philosophy and programs, transportation, relationships with other agencies, financing, and future plans. (Glasscote, 1969)

Home Treatment:

Psychiatric home treatment is one of the most recent alternatives to inpatient hospitalization. On the basis of pilot studies conducted in the late fifties at Boston State Hospital and Boston Psychopathic Hospital it was found that patients who eventually were hospitalized for mental disorders had little or no access to evaluation and treatment prior to hospitalization. As a result the National Institute of Mental Health awarded a grant to Boston State Hospital to provide for an experimental program in psychiatric home treatment. (Weiner, et al., 1967)

By 1962, after several modifications in the program and services offered, the experimental Home Service Project became an on-going psychiatric service offered through Boston State Hospital, The philosophy and aims of the Home Service are: 1) To provide psychiatric evaluation (and treatment when needed) to patients suffering from serious mental illness who are unable, or unmotivated to obtain help at an outpatient facility; 2) to determine the efficacy and feasibility of treatment in the home as an alternative to

hospitalization; 3) to offer both consultation and seminars to community caregivers to enhance their knowledge of and ability to help emotionally disturbed patients; 4) to provide training in community psychiatry for residents and other mental health professionals. (Weiner, et al., 1967)

The Service operates on the principles of community psychiatry and crisis intervention. Referrals are accepted from anyone in the community, with the focus upon prompt evaluation and treatment by an interdisciplinary team of mental health professionals, who visit the individual and family in their own home. The family is involved in the evaluation and treatment process and whenever feasible avoidance of hospitalization is a high priority. Therapy is usually geared towards a short-term (less than six months) goal-oriented program. Following intervention or referral to another community caregiver, the Home Service remains in contact with the patient or agency to provide continued support or consultation. (Weiner, et al., 1967)

Another home treatment program based upon a similar model was established at the Colorado Psychiatric Hospital. In this project a clinical team treated 180 patients considered acutely in need of psychiatric hospitalization, on an outpatient basis. A control group of 150 patients was routinely hospitalized. In 33 of 36 of the original cases psychiatric hospitalization was avoided. Family

crisis therapy was utilized by the treatment team, consisting of a psychiatrist, social worker and nurse, and was considered to be more economical and less stigmatizing than traditional hospitalization. (Flomenhaft, et al., 1969)

Treatment aims were: To help restore confidence in the family's ability to cope with their own problems, to help them deal with external and internal stresses within the family, which were often represented by the family member who is hospitalized. Specific techniques which the Family Treatment Team used were: 1) Family oriented interviews; 2) twenty-four hour availability; 3) home visits; 4) drugs; 5) holding bed in the emergency room; and 6) post crisis contacts.

CHAPTER III

METHODOLOGY

In this chapter, the research methodology is discussed beginning with an explanation of the research design. It is followed by a description of the setting, population, sample and sample selection, collection of the data, the questionnaire, and the pilot test.

RESEARCH DESIGN

In the search of the literature, it was found that little research had been done in the area of the experience of mental illness and psychiatric hospitalization from the point of view of the patient's family members, but rather has been from the patient's standpoint. As a result, this exploratory study was formulated in order to determine the needs of families of psychiatric patients during the time up to and including hospitalization. A secondary reason the exploratory design was selected was to identify areas for further research on this subject.

SETTING

Dammasch State Hospital is one of three state institutions for the mentally ill in Oregon. It is located approximately 18 miles south of Portland, in Clackamas County, and serves a six county area. Three of the counties in the catchment area, Multnomah, Clackamas, and Washington, encompass the largest metropolitan area in the state, and comprise 95% of DSH admissions. The other three counties, Columbia, Clatsop, and Tillamook, are less populated and account for 5% of DSH admissions. In-patient mental health services in the metropolitan area are also provided by four private general hospitals with psychiatric wards (Providence, Portland Adventist, Woodland Park, and Holladay Park), one private psychiatric hospital (Cedar Hills), and one university teaching facility (University Hospital and Crisis Unit).

The size of the DSH population averages about 392 patients, with a census range of 361 to 460 patients. About 66% are admitted to the hospital on a voluntary basis, while 34% enter involuntarily. Forty-five days is the average length of stay in the hospital of those patients who are not permanent residents (permanent residency is defined as one year or longer of continuous hospital stay).

POPULATION

The original population was defined as all the family members residing in the Tri-county area who were living with Dammasch State Hospital (DSH) psychiatric patients at the time up to and including their admission to DSH. The geographic area limitation of the population was established because the data was to be collected by in-home interviews and the six county area served by DSH was beyond the travel capability of the researchers. The Tri-county area was selected for two reasons: 1) The largest percentage of the population reside in the three county area; and 2) it was feasible to arrange and conduct home interviews within this area.

The size of the population was difficult to determine from hospital census information. The hospital social service department kept daily data on who entered the hospital, whether each was first or re-admission, and the admittance status, i.e., voluntary, court-commitment, or emergency hold. These records did not indicate where or with whom the patient was living, but we were able to cross-reference the information with the patient's admission card, which indicated the patient's living arrangements, including the relationship of those with whom he lived. The information reported on the admission card was usually obtained from

the patient during the admission procedure and was sometimes inaccurate for such reasons as faulty memory, concealment, and ease in reporting, e.g., patients who did not have a permanent address often gave the address of a relative even though they were not living at the address.

Using the cross-reference system, which was time consuming and of questionable accuracy, a list was compiled for the month of November of patients living with family members at the point of hospital admission, living in the Tri-county area, first and later admissions, and voluntary and court-committed (emergency hold was excluded because they leave the hospital if they do not become voluntary or court-committed status within five days). Forty-five first admissions and 42 re-admissions were found for the month of November.

Based on the above information, the population was re-defined as all family members residing in the Tri-county area who were living with DSH psychiatric patients during the time up to and including their first admission to DSH. We were more interested in the needs of families of patients admitted for the first time because we suspected that if there were any differences in first and later admissions, the needs would be of greater quantity and acuteness in first admission families.

The population was re-defined after the pilot test

because so few referrals were received for the test (one referral in three weeks). The population was expanded to include first and re-admissions. The final definition of the population was all family members residing in the Tri-county area who were living with DSH psychiatric patients at the time up to and including their admission to DSH.

SAMPLE AND SAMPLE SELECTION

The size of the sample was originally limited by three factors: 1) The use of interviews as the data-collecting instrument; 2) the number of interviewers; and 3) the time constraints of the study. Twenty-five families was established as the sample size objective.

Several considerations went into the decision to select the sample from the DSH admissions for one month, rather than selecting them randomly until we reached a total of 25 families. The major consideration was the fact that the hospital does not compile separate data regarding patients who live with families, so there was not a central list of the population from which families could be selected randomly. The second possibility considered was to have each social worker refer every fifth family from their individual caseloads of admissions. This idea was discarded because it seemed complicated for the social workers, and more likely to result in confusion and inaccuracies. It was the aim of the researchers to cause the least disruption of the social workers'

procedures. Other considerations in deciding against random selections were: 1) The small population size; 2) the anticipation of refusal of families to participate in the study; and 3) the time constraints of the study. Given the small population size and probability that some percentage of people would refuse to participate in the study, we anticipated that random selection would cause the study to extend beyond our time limits. It seemed that using one month of admissions instead of random selection would prevent the drawbacks of losing the cooperation of DSH personnel and prolonging the study, and still allow for the collection of data.

In order to maintain privacy rights, the people who were selected for interviews were first told by their hospital social worker and then asked to give written consent, if they were willing to participate in the study. The researchers therefore received from the hospital social workers referrals for the study in the form of signed consent forms. The researchers then contacted the family members and arranged appointments to interview them in their homes. After the interview the consent forms were destroyed in order to maintain confidentiality. To control for the effect of time on people's report of their needs, we originally asked to receive the signed consent forms from the family members within two weeks of the hospital admission. This time constraint proved to add to the difficulties in getting the

sample size and was later discarded.

The problems in getting referrals for the sample and the amendments made in response were many. Initially, the lack of referrals seemed a direct result of a temporary change in admissions policy. One week after the study began, a temporary policy of sending court-committed patients to Oregon State Hospital (OSH) was instituted because the DSH census was too high. This practice lasted approximately three weeks, and during this time voluntary patients were carefully screened and referred elsewhere, if possible. Consequently, there were few admissions to DSH. This unforeseen change in policy and resulting lack of referrals caused an amendment in the initial selection procedure of taking referrals for one month only. At that point, which was one month after the study began, the time limitation was changed to continue taking referrals until the sample size of 25 was reached.

In order to determine to what extent the temporary admissions policy had affected the size of the population, we compiled a list of the patients living with family members prior to DSH admission who were admitted beginning January 16 and ending February 15, 1978 (the first month of the study). Using the cross-reference system, we found a total of fifty (50) new and re-admitted patients in the Tri-county area admitted during the month who reported for

purposes of the admissions card that they were living with family members. There were fewer admission (compared to 87 in November), but this factor did not account for only two referrals received during the first month of the study.

A meeting with the social workers was set so that the researchers could inform them of the data compiled for the first month of the study and to determine the obstacles in obtaining referrals. Responses to the information presented were: 1) The data over-represented the number of patients who were living with relatives; 2) some families refused to participate in the study; 3) job pressures sometimes resulted in forgetting to ask families about participating in the study; and 4) the "within two weeks of admission" time limit is confining and some of the social workers wanted to refer families of patients admitted before the study began. The first three responses were expected problems in the study, yet beyond our control and influence. The last request was possible, so it was decided to drop the two week time limit on receiving referrals in hopes of receiving a larger sample. This change allowed the social workers to make referrals from their entire caseloads, rather than limiting it to new admissions. Some social workers reviewed their caseloads and referred families of patients admitted as far back as six months; others continued with new admissions only; and a few did not make any referrals at all.

By this stage, the restrictions on the number of admissions, the length of time between admission and referral, and the one month time period in which referrals would be accepted were all discarded. The only criteria for referrals were that family members had lived with the patient prior to DSH admission, and resided in the Tri-county area. Nonetheless, the number of referrals remained low. Based on the feedback and comments received from the social workers and the social service director, some of the reasons for the lack of referrals were: 1) Families refused to participate in the study; 2) the study was a low priority in relation to other social work job responsibilities; and 3) the changes in the definition of the population and procedures for selecting the sample resulted in confusion in determining appropriate referrals. There were likely other unknown factors which contributed to the low number of referrals. After three months we terminated the study with a sample size of 14. There were a total of 17 referrals made, but two could not be contacted and one refused to participate, so the total families interviewed was 14.

COLLECTION OF DATA

The data was collected by face-to-face interviews with family members of the patients. Each of the researchers conducted seven interviews, which took place in the homes of

the respondents. The interviews lasted approximately one hour, with the length ranging from 30 minutes to two hours.

A three page questionnaire was used as an interview guide (see Appendix). The questionnaire provided a means to standardize both the interview questions and the recording of answers. Some of the questions were open-ended and respondents were allowed to elaborate on them if desired. Explanations of questions were provided, as needed. In all cases only one questionnaire form was used per family. When more than one family member was responding to the interview questions, one family member always made the largest number of responses. In those cases the demographic information recorded was that of the principal respondent.

QUESTIONNAIRE

In the exploration of research related to the area of study, the researchers did not find an instrument appropriate to survey the needs of families of psychiatric patients. Therefore, a questionnaire suitable for the purpose was designed based on the needs mentioned in the literature, as well as our own assumptions about family needs.

The questionnaire was divided into two main sections consisting of the demographic information (questions 1-13), and the survey of needs (questions 14-27). The demographic questions covered two areas: 1) Specific information about the respondent (questions 1-9); and 2) information about the

current and past hospitalization (questions 10-13). The demographic information was collected in order to compare response with survey data.

The survey of needs was organized into three parts: 1) Information; 2) advice; and 3) support. The first question (#14) was open-ended and was used as an introduction to discussing needs. It was followed by questions 15-18 regarding the need for information about hospitalization, medication, and the nature of the patient's problems. Each question included not only an indication of the need for information, but also how information was obtained.

The second part of the survey of needs (questions 19-22) asked about the need for advice regarding interacting with the patient, managing losses, and talking with family members. As in the section on information, questions were asked about how advice was obtained.

The third part of the survey dealt with the need for support and was introduced by an open-ended question (#23) as a transition to discussing personal thoughts and feelings about the patient's difficulties. Question 24 addressed the respondent's thoughts and feelings about the patient's problems and question 25 asked about how support was obtained.

The last two questions did not fit into the category of needing information, advice, or support. Question 26

asked about the need for protection and question 27 surveyed the reasons why the respondent may have been prevented from seeking information, advice, and support.

These questions generally seemed to cover the areas of possible special needs. It was hoped that with the provision of open-ended questions, "other" categories, and flexible interviewing and reporting, that needs not anticipated by the researchers would also be found.

PILOT TEST

A pilot test was initiated in order to test the feasibility of the questionnaire and to locate possible problems in administering it. The test began in December, 1977 and referrals from three of the thirteen social workers were requested for the test. After three weeks the test was terminated with only one referral. Results of the pilot test indicated possible difficulty in getting referrals, so the researchers decided to review the limitations set on the population. The population was expanded to include first and later admissions.

The questionnaire proved to be a workable instrument, both in the asking of questions and recording of answers, with the one family interviewed in the test. No changes were made in the questionnaire after the pilot test.

CHAPTER IV

RESULTS AND DISCUSSION

The results and discussion of the data are presented in three parts: 1) The demographic data results; 2) the survey of needs results; and 3) the statistical analysis of the data.

I. DEMOGRAPHIC DATA

The following is a description of the results of the demographic section of the questionnaire. Ten of the 14 respondents were parents of the patients, four were spouses, eight were male, six were female, and ten had children living at home. The ages of the respondents ranged between 21 and 65 years (see Table I), with 64% between ages 36 and 55.

TABLE I
AGE OF RESPONDENTS

n=14

Age	Frequency	Percent*
21-25	1	7.1
26-30	1	7.1
36-40	3	21.4
41-45	3	21.4
51-55	3	21.4
61-65	1	7.1
Over 65	2	14.2
Total	14	99.7

*Does not equal 100% due to rounding of figures.

Four respondents did not report their income level either because they did not know their income or they refused to answer. The income level of the remaining ten ranged between \$5,000 and \$25,000 (see Table II). Half of the ten were in the \$5,000 to \$10,000 range.

TABLE II
INCOME LEVEL OF RESPONDENTS

n=14

Income	Frequency	Percent
Under \$5,000	0	0
\$5,000 - \$10,000	5	36
\$10,001 - \$15,000	2	14
\$15,001 - \$20,000	2	14
\$20,001 - 25,000	1	8
Over \$25,000	0	0
Did not know	2	14
Refused to answer	2	14
Total	14	100

All of the respondents had lived in the Tri-county area for at least four months, with the majority (79%) in the area for more than five years (see Table III).

TABLE III

LENGTH OF TIME IN THE AREA

n=14

Time	Frequency	Percent
4-6 months	1	7
7-12 months	0	0
1-2 years	2	14
3-5 years	0	0
More than 5 years	11	79
Total	14	100

Ten of the patients were voluntarily committed to Damasch State Hospital (DSH), while four were of involuntary status at the time of the interview. Twelve respondents said they were involved in the decision to hospitalize the patient, while two felt they were not part of the decision. Twelve also said that the current hospitalization was their first experience with having a family member hospitalized for emotional difficulties.

II. SURVEY OF NEEDS

All participants responded to the first open-ended question about their biggest concern when they realized the person was having difficulties. Some offered more than one

comment or question. The range of responses included:

- 1) "How will I get him feeling better?";
- 2) "I cannot communicate with her.";
- 3) "I wonder if she will be OK.";
- 4) "What is the right kind of help for her?";
- 5) "How long will she be hospitalized, what will it cost, and how am I going to pay?";
- 6) "When will he be out of the hospital?";
- 7) "Is he on drugs?";
- 8) "How do I get help for him?";
- 9) "How will I get him hospitalized?";
- 10) "We cannot help him and he is suffering.";
- 11) "He is spoiling our family life.";
- 12) "How do I treat him so he will get well?";
- 13) "I'm concerned that he cannot hold a job and support himself.";
- 14) "I'm concerned about his fantasy world.";
- 15) "How do I get her to realize that she needs help?"

Questions About Hospitalization

The first area which concerned the needs and questions which family members had was regarding hospitalization. All of the respondents in the study had at least one question or concern about hospitalization. The majority of those who had a question tended to rely upon either the doctors or social workers at DSH for answers. A few also relied upon court personnel for information about commitment or admission procedure.

TABLE IV a

QUESTIONS ABOUT HOSPITALIZATION

n=14

Question	Asked	Did Not	
		Ask	Total
a) Does he need hospitalization?	7	1	8
b) How long will he be hospitalized?	9	0	9
c) What is the procedure for admission?	7	0	7
d) How much does hospitalization cost?	6	0	6
e) What if I cannot afford hospitalization?	2	0	2

TABLE IV b

CURRENTLY WANTS INFORMATION

n=14

Question	Asked	Did Not	
		Ask	Total
a) Does he need hospitalization?	0	1	1
b) How long will he be hospitalized?	4	0	4
c) What is the procedure for admission?	0	0	0
d) How much does hospitalization cost?	2	0	2
e) What if I cannot afford hospitalization?	0	0	0

Table IVa represents the questions which the respondents had concerning the need for hospitalization. The "Asked" column represents the total number of people who had a particular question and asked about it. The "Did Not Ask" column represents those who had the question but, for various reasons, did not ask anyone. For example, out of 14

respondents seven recalled asking a question about whether a family member needed hospitalization, one thought of the question but did not ask it, for a total of eight people acknowledging having this question. The "Total" figures in Table IVa represent the number of respondents who had the question either before or during the interview.

Table IVb illustrates those who expressed a desire for more information about a particular question concerning hospitalization to the interviewer. Under the column heading "Asked" is the number of respondents who had already asked this particular question but still wanted more information in this area. Those who "Did Not Ask" represent the number of individuals who prior to the interview had not thought of asking this question but acknowledged now wanting the information. It also includes those who had wanted information prior to the interview but did not ask for it. Among the reasons given for not asking by these respondents were: "I didn't know who to ask; I thought they would just tell me the information; I felt that no one would be able to answer my question." The same reasons for not asking were repeated for all other questions in this interview.

The "Total" figures in Table IVb represent all those families who still desired some information on that specific question. For example, of the seven individuals in the "Asked" column of Table IVa responding to the first question,

none of these, as reflected in the first column of Table IVb, felt that they wanted further information. This is inclusive of those who indicated they wanted information before the interview and those who desired the information after talking to the interviewer.

Questions About Medication

The respondents reported that eleven of the patients take medication, two do not, and one respondent did not know. Thirteen of the respondents had some questions about medication. Table Va represents only those who answered affirmatively to the questions and therefore does not total 13. The difference between 14 and the totals represents those who did not have questions in those particular areas. For example, the first question in Table Va shows that ten of the 14 respondents wanted information about how the medication affects the patient. Therefore, four did not want the information. Of the ten people who wanted information, eight asked and two did not.

TABLE V a

QUESTIONS ABOUT MEDICATION

n=13

<u>Question</u>	<u>Asked</u>	<u>Did Not Ask</u>	<u>Total</u>
a) How does the medication affect him?	8	2	10
b) Will he always need to take medication?	5	3	8
c) What are the effects of medication?	3	1	4

TABLE V b
CURRENTLY WANTS INFORMATION

n=13

Question	Asked	Did Not Ask	Total
a) How does the medication affect him?	2	2	4
b) Will he always need to take medication?	1	3	4
c) What are the effects of medication?	0	1	1

Table Vb totals show how many, out of those who wanted the information, have not obtained it. By comparing the totals of Table Va with the totals of Table Vb one can obtain the number of respondents who were satisfied that their questions had been answered. For example, the total for Question a in Table Va shows that ten people had questions about how the medication affects him, four still need the information (from Question a total, Table Vb), so six people were satisfied that their questions had been answered. Of the four who still wanted information, two had asked and two had not.

Family members who did seek information about medication most frequently asked the doctors and social workers at DSH.

Respondents also had questions about medication which were not specified in the questionnaire. "Other" questions and comments included: 1) "The effects of the medication seem adverse; should the medication be changed?"; 2) "Why

is the patient not prescribed medication?"; 3) "Does the doctor know about the patient's previous medication?"; 4) "I want information about megavitamins and want to know if it will help the patient."; 5) "Will medication help at all?"; and 6) "How do I deal with the patient's delusions?"

The Nature of the Family Member's Difficulties

This section deals with questions concerning the respondent's perceptions about the nature of his family member's difficulties. Of the total number of participants in the study, all 14 of them had questions in this area. Those who had questions tended to rely almost exclusively upon the doctors at DSH to answer those questions. A few indicated that they turned to the social workers at the hospital for answers.

TABLE VI a

INFORMATION ABOUT FAMILY MEMBER'S DIFFICULTIES

n=14

Question	Asked	Did Not Ask	Total
a) Are his difficulties a hereditary illness?	3	1	4
b) Are his difficulties a contagious illness?	1	0	1
c) Are his difficulties a curable illness?	8	1	9
d) How long will treatment take?	7	3	10
e) How long until he feels good again?	3	2	5

TABLE VI b
CURRENTLY WANTS INFORMATION

n=14

Question	Asked	Did Not Ask	Total
a) Are his difficulties a hereditary illness?	2	1	3
b) Are his difficulties a contagious illness?	0	0	0
c) Are his difficulties a curable illness?	4	1	5
d) How long will treatment take?	4	3	7
e) How long until he feels good again?	3	3	6

In Table VIa the greatest number of those asking questions were concerned with how long treatment would take. Nearly half of those who were concerned with the question did not ask. Among those who did ask, four still wanted more information or were not satisfied with the answers they received (Table VIa "Asked" column). An additional three respondents wanted information though they either did not ask or thought of the question prior to the interview.

Another major concern to family members was whether the patient's difficulties were curable. Nine out of the total 14 respondents had concerns in this area. Five also wanted more information about this question.

In requesting "other" questions which the family members had about the nature of the patient's difficulties, the following responses were elicited: "How will his mental illness affect a younger child in our home? How can I find

out all that is going on in treatment?"

Advice About How to Interact with the Patient

Ten of the 14 respondents wanted advice on how to interact with the patient. Eight wanted advice about how to interact with the patient while he was in the hospital and six wanted advice about interaction with the patient at home (see Table VIIa). Four respondents did not want any advice, so some of the eight who wanted advice when in the hospital also wanted advice when at home. Table VIIb shows the number of respondents who still want advice. The difference in the totals of Tables VIIa and VIIb shows the number of respondents who were satisfied that they had received advice. The respondents generally turned to the DSH doctors for the advice in this area.

TABLE VII a

ADVICE ON HOW TO INTERACT WITH PATIENT

n=10

Question	Asked	Did Not	
		Ask	Total
a) While he was in the hospital	6	2	8
b) While he was at home	4	2	6

TABLE VII b

CURRENTLY WANTS ADVICE

n=10

Question	Asked	Did Not	
		Ask	Total
a) While he was in the hospital	3	2	5
b) While he was at home	4	2	6

Advice About Reported Losses

The next area concerned possible losses which the family members reported experiencing due to the difficulties which another member was going through. A total of four individuals recalled experiencing loss due to the patient's illness. The response options which the researchers presented were: a) Loss of income, b) loss of housekeeper, and c) loss of child caretaker. One of the four respondents indicated loss of income. All four had experienced loss of a housekeeper and three had lost the primary child caretaker in the family.

All of the respondents to this question were male spouses. None of the parents of the hospitalized patients indicated any of the enumerated losses.

When inquiring as to whether these individuals who experienced loss had received help or advice on how to manage these changes, two said that they had wanted advice or help and had asked for it. One was not satisfied with the information and assistance he received and still wanted more. Both of these respondents had turned to community social service agencies for help or information in this area.

Advice About Talking with Other Family Members

Only four respondents wanted advice about how to talk with other family members about hospitalization and matters

relating to the patient (see Table VIIIa). All of those who asked for advice in this area reported that they did not receive it; therefore, the totals in Table VIIIa and VIIIb were the same. The respondents generally sought advice about talking with family members from nurses at DSH.

TABLE VIII a

ADVICE ABOUT TALKING WITH FAMILY MEMBERS

n=4

Question	Asked	Did Not Ask	Total
a) What to tell them about _____			
a) What to tell them about going to the hospital	1	1	2
b) What to tell them about having emotional difficulties	2	2	4
c) What to tell them to expect of _____	1	0	1
d) What to tell them about how to act around him	1	0	1
e) What to tell them about when he will feel better again	1	0	1

TABLE VIII b

CURRENTLY WANTS ADVICE

n=4

Question	Asked	Did Not Ask	Total
a) What to tell them about going to the hospital	1	1	2
b) What to tell them about having emotional difficulties	2	2	4
c) What to tell them to expect of _____	1	0	1
d) What to tell them about how to act around him	1	0	1
e) What to tell them about when he will feel better again	1	0	1

The researchers utilized an open-ended question to help shift the focus of the interview from informational questions to those which concerned the respondents' feelings and concerns about their family members' emotional difficulties. The question which was asked was: Did you have some concerns about your part in the emotional upset? What were they?

Five of the respondents indicated that they wondered about what they themselves had to do with their family member's emotional difficulties. Others thought about what they should or could have done differently: "Did I spend enough time with him? Did I show favoritism to the other children? Should I have let him grow up sooner?" One respondent seemed to summarize this feeling by saying: "I have been thinking about all the 'If only' questions."

Other family members expressed guilt about the patients' emotional difficulties. "I nagged him too much." "We are to blame because we did not protect him from society." "I feel so guilty because of what I may have done to cause this." "I must have done something wrong to cause this because I am his parent."

Some of the parents expressed concerns as to whether this would also happen to their other children, while others expressed puzzlement because all their other children had been raised the same way and did not seem to have the

problems that the patient did. A total of eight of the respondents felt some concern about their own part in the emotional difficulties that the family member was facing. Of these eight, seven were parents of the hospitalized individual and one was a spouse.

Thoughts and Feelings About the Patient's Difficulties

Ten people answered affirmatively to the statement about their thoughts and feelings about the patient, his difficulties, and their part in the upset. Figures for Table IX total more than ten because some of the respondents indicated agreement with more than one statement. All respondents who indicated that they had thoughts and feelings similar to those described in the statements said they talked with someone about it. They all reported that they did not feel a further need to talk. Five people talked with the clergy and family members about their thoughts and feelings, three turned to professional people in the community, and two talked with family members, clergy, and professional people. One "other" response was given to this question. It was an expression of concern about how the children would accept the situation, rather than thoughts or feelings about the patient or self.

TABLE IX

THOUGHTS AND FEELINGS ABOUT PATIENT'S DIFFICULTIES

n=10

Statement	Frequency	Percentage* of Affirmative Responses (n=16)
a) He is behaving this way to get even with me	5	31
b) He is having difficulty because he was bad and is receiving his punishment	0	0
c) I must have done something wrong and caused it in some way	5	31
d) He will never be the same and I'll just have to learn to live with this	6	37
Total	16	99

*Does not equal 100% due
to rounding of figures.

Need for Protection

The researchers were interested in finding out whether family members felt that they needed protection at any time. Of the 14 respondents, eight felt that they did need protection at some point, while six felt that they did not need protection. An analysis of which respondents indicated they felt that they needed protection appears in the section examining relationships between the demographic data and the responses to other questions.

Reasons Prevented from Seeking Advice, Information or Support

The final question concerned whether the respondent felt prevented from seeking information, advice or support. A total of nine respondents reported feeling in some way

prevented from seeking these services.

TABLE X
FEELING PREVENTED FROM SEEKING ADVICE,
INFORMATION OR SUPPORT

n=9

Reasons	Frequency	Percentage of Affirmative Responses (n=20)
a) I did not want it	1	5
b) I did not know where to get it	4	20
c) I did not have money to obtain it	4	20
d) I asked and did not under- stand the answer	2	10
e) I asked questions and they were not answered	5	25
f) Other reasons	4	20
Total	20	100

Table X illustrates the reasons given for feeling prevented from seeking information, advice, or support, with the frequency representing the numbers of respondents who reported that reason for feeling prevented from seeking advice, information or support. The percentage figure in Table X represents the per cent of responses which each particular reason represents out of the total number of responses given. Of the nine respondents who answered the question affirmatively, some gave more than one reason for feeling prevented. There was a total of 19 responses given by the nine respondents. Thus, one individual agreed with the first reason given ("I did not want it"), and that represents 5% of the total responses given. Notable is the

fact that the most frequently given reason was that the individual asked a particular question and felt that it was not answered.

"Other" reasons which were offered by the respondents were: "It took all my energy and initiative to get my daughter admitted and nothing was left to get them to answer other questions." "There was not enough time to ask and the personnel didn't take time to explain." "I was reluctant to ask because I felt that they didn't know the answers." "I couldn't afford the treatment." "I felt little support from the mental health people."

III. DATA ANALYSIS

In analyzing the data, the researchers were interested in testing for significant relationships which might occur between some of the demographic characteristics of the respondents and their answers to some of the questions which were presented to them. Ten separate tests of relationship were computed on the data. They were the following: Needing protection/having children at home; needing protection/relationship of the respondent to the patient; needing protection/patient's admission status; experiencing losses/having children at home; experiencing losses/respondent's relationship to the patient; prevented from seeking information/respondent's relationship to the patient; prevented

from seeking advice/patient's admission status; prevented from seeking advice/age of the respondent; respondent's concern about own part in the patient's difficulties/relationship to the patient; respondent's relationship to the patient/asking for advice on how to interact with the patient.

The test employed to determine the existence of a significant relationship between two variables was the chi square test. Results of these tests are as follows.

Testing the relationship between having children and feeling a need for protection was carried out because the researchers felt that a family having children at home might feel a greater need for protection. However, it was found that no significant relationship existed between these two variables ($\chi^2 = .013$, 1 df, NS).

Investigating a possible relationship between the admission status of the patient and the family members reporting that they felt a need for protection yielded similar results. It was felt that family members who had a relative committed through court procedure might report feeling a greater need for protection. However, no significant relationship existed between these two factors in this study ($\chi^2 = .129$, 1 df, NS).

The two variables which approached a statistically significant relationship were the family members feeling a

need for protection compared to the respondent's relationship to the patient.

TABLE XI

FAMILY RELATIONSHIP BY FEELING NEED FOR PROTECTION

	Relationship to Patient		Total
	Spouse	Parent	
Felt needed protection	1	7	8
Did not feel needed protection	3	3	6
Total	4	10	14

Testing for a relationship at .10 level of significance with a relationship existing when $\chi^2 \geq 2.70$ with 1 df, the test produced the following results: There was no statistically significant relationship but $\chi^2 = 2.41$. This was an outcome which was very close to demonstrating a significant relationship between these two factors. It suggests a possible relationship may exist with a greater likelihood of a parent feeling a need for protection from the patient than a spouse would.

Examining the data collected on those who had experienced losses due to a family member's hospitalization and emotional difficulties, the researchers felt that a relationship might exist between that response and the relationship of the respondent to the patient.

TABLE XII
FAMILY RELATIONSHIP BY EXPERIENCING LOSSES

	Relationship to Patient		Total
	Spouse	Parent	
Experienced losses	4	0	4
Did not experience losses	0	10	10
Total	4	10	14

Testing for a relationship, the researchers found that there was a statistically significant relationship between the respondent's relationship to the patient and experiencing losses upon hospitalization ($X^2 = 14.62$, 1 df $\alpha = .05$). The researchers recognize that the responses which were offered tend to be more likely the sort of loss that a spouse would report experiencing (such as loss of income, child caretaker, etc.). However, the existence of the relationship also illustrates the needs of family members regarding actual losses which they report experiencing due to emotional difficulties and hospitalization.

Testing for a relationship between having children at home and reporting experiencing losses did not yield any significant results ($X^2 = .24$, 1 df, NS), though the researchers felt that families with children at home might report these losses significantly more often than families with childless homes. Having children at home was not a significant factor in reporting experiencing losses.

The next set of tests dealt with the possible relationships of three separate variables to respondents' feeling prevented from seeking advice, information and support. None of the three tests demonstrated statistically significant relationships between the variables. In comparing admission status of the patient to the respondent feeling prevented from seeking advice, information and support, the researchers thought those families whose members had been court committed might be more likely to feel prevented. Five relatives of voluntary patients felt prevented and one did not. Upon testing, there was not a significant relationship found between these two variables ($\chi^2 = .70$, 1 df, NS).

Similar results were obtained for the comparison between respondents' relationship to the patients and feeling prevented from seeking advice, information and support. No significant relationship was found ($\chi^2 = .70$, 1df, NS).

The final test in this area was to test for a relationship between the age of the family member and feeling prevented from seeking advice, information and support. The researchers felt that a relationship might exist between the age of a family member and whether that respondent felt inhibited about gaining things that they felt they needed. Especially, the researchers were interested in whether the young or the old were particularly feeling prevented from seeking these services. The breakdown of the data is as follows:

TABLE XIII

AGE OF RESPONDENT BY FEELING PREVENTED
FROM SEEKING ADVICE, ETC.

	Age: 21-40	41-55	Over 55	Total
Felt prevented	3	4	1	8
Did not feel prevented	2	2	2	6
Total	5	6	3	14

There was no significant relationship between age and the respondent reporting feeling prevented from seeking advice, information and support ($\chi^2 = 92, 2 \text{ df}, \text{NS}$). Age does not appear to be a factor in reported feelings of being prevented from seeking help, based upon our study sample.

The researchers questioned whether a relationship existed between asking for advice on how to interact with the patient and the respondent's relationship to the patient. It was thought that parents might be more likely to request help in dealing with the disturbed family member.

TABLE XIV

FAMILY RELATIONSHIP BY ASKING FOR ADVICE
ON HOW TO INTERACT WITH THE PATIENT

	Relationship		Total
	Spouse	Parent	
Sought advice on how to interact	2	8	10
Did not seek advice on how to interact	2	2	4
Total	4	10	14

The results of the testing revealed that there was a significant relationship between the relationship of the respondent to asking for advice on how to interact with the disturbed family member ($\chi^2 = 3.24, 1 \text{ df}, \alpha = .10$). For the participants in this study there was a relationship between these two variables.

The final chi square test which was performed on the collected data involved these two factors: Relationship of the respondent to the patient and concern about the respondent's own part in the emotional upset of the patient. The researchers suspected that there might be a significant relationship, with parents being more likely to be concerned about the role they played in their family member's emotional upset.

TABLE XI

FAMILY RELATIONSHIP BY CONCERN ABOUT
OWN PART IN EMOTIONAL UPSET

	Relationship		Total
	Spouse	Parent	
Felt concern about own part in the emotional upset of family member	1	7	8
Did not feel concern about own part in the emotional upset of family member	3	3	6
Total	4	10	14

Testing revealed that there was a significant relationship between the familial relationship of the respondent to the patient and whether the individual reported concern

over their own part in the emotional problems of the family member ($\chi^2 = 6.76$, 1 df, $\alpha = .05$). Therefore, within the group of family members interviewed in this study, there was a significant relationship between being a parent and reporting concern over their own part in the emotional upset of a family member.

In conclusion, the test that was employed to determine whether a relationship existed between two variables was the chi square test for significance. The power of other tests is greater but the restraints caused by the size of this study made chi square the appropriate choice. Thus, the relationships which were tested for apply specifically to this study and cannot be interpreted to apply to any population of psychiatric patients and their families. In addition, the small study size severely limits the likelihood of finding the existence of statistically significant relationships, which would account for the lack of related variables found in the testing and limits the conclusions which may be drawn from the collected data.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Based upon the data which we have presented and analyzed in the preceding chapter, the researchers present conclusions which have been drawn from that information and analysis. However, the conclusions which were reached are restricted in their scope and significance by the size and limitations of the study. These conclusions cannot be applied to the population which the researchers wished to focus upon due to the small size of the study and the lack of random selection of the participants. They only apply to the group of family members which were interviewed by the researchers. It is with consideration of these limitations that the researchers present the following conclusions and recommendations.

People indicated that they had needs in all the areas covered in the questionnaire. Almost all of the respondents wanted some information in the areas of hospitalization,

medication, and the nature of the patient's difficulties. Over 70% of the family members expressed the need for advice on how to interact with the patient and the need to talk with someone about their thoughts and feelings about the patient's difficulties. Less than a third of the participants indicated a need for advice about talking with family members about hospitalization and matters relating to the patient, and the same number reported experiencing losses due to the patient's difficulties.

People in the study generally turned to the doctors and social workers at Dammasch State Hospital (DSH) for information and advice. A few sought advice from social service workers in the community and nurses at DSH. Interestingly, of those who talked with people about their thoughts and feelings about the patient's difficulties, half of them talked with informal sources only, i.e., family members and clergy.

People were more willing to seek answers to questions concerning specific information areas, such as hospitalization and medication. They also tended to be satisfied that their questions were answered in these areas.

Regarding hospitalization and medication, the respondents in almost all cases asked the questions which they had and reported satisfaction with the information received. A possible explanation for their willingness to ask

questions in this area is the perceived appropriateness of requesting information in such concrete areas as hospitalization and medication. These are less threatening questions to ask and people are more likely to receive direct answers to such questions. Another possible explanation is that it was necessary to obtain answers for questions in these areas, especially hospitalization, in order to have the family member admitted to DSH.

In the less concrete areas, such as wanting knowledge about the nature of the family member's difficulties, advice on how to interact with a family member experiencing emotional difficulties, and advice on how to talk to other members of the family concerning the emotional difficulties of the patient, people reported a higher rate of wanting further information than they did in the more concrete areas. A possible reason for this might be that such questions reflect more personal uncertainties, doubts and feelings which might be more threatening to ask about than the more concrete information areas. Also, it was not mandatory to obtain answers to these questions in order to get services for the patient.

Reasons for respondents' dissatisfaction or still wanting more information might be that they were seeking definitive answers to questions for which there were no definite answers. It is also a possibility that they were

seeking support and reassurance when requesting information in these areas. Their level of dissatisfaction with answers may indicate that their needs were not met in terms of support and advice.

People who reported that they were not satisfied with their answers were not necessarily denied answers. They may have been unable to listen to, understand, or remember the information or advice due to their stressed state. Another possible explanation for why they did not feel satisfied that their questions were answered is that in receiving information or advice, other questions were raised which they did not ask.

People who want information and advice did not necessarily seek it. Some wanted information or advice and did not ask for it because they expected to be offered information or advice if it was something they "should" know. Other reasons given for not asking were that they did not know where to obtain help, or the questions did not occur to them until they were mentioned by the researchers.

The most common concern identified by the respondents was that they wanted to help the family member, but did not know what to do.

The experience of feeling guilty or to blame for emotional difficulties was more often reported by parents of patients than spouses.

Male spouses of patients were more likely to report experiencing losses due to hospitalization than were parents of patients.

Parents of patients were more likely to seek advice on how to interact with the patient than were spouses.

RECOMMENDATIONS

The researchers recommend the following:

1) That hospital and community mental health personnel offer information and advice in the areas covered in the questionnaire. It cannot be assumed that family members do not want or need information just because they do not ask for it.

2) That hospital and community mental health personnel should expect that some family members may need their questions answered more than once or may need some information repeated. Families may need to go over some information or advice several times before they are able to integrate it.

3) That because hospital doctors and social workers are often the main source of information and advice to family members, these personnel can expect that family members' prior knowledge of hospitalization and mental illness is limited.

4) That hospital and community mental health personnel should be aware that family members experience greater

difficulties in asking questions relating to their feelings and concerns about their family member's emotional difficulties than more specific questions, such as hospitalization and medication. They may need support and encouragement to discuss these more personal areas and in some cases, it may be support that they are seeking through their requests for information.

5) That special efforts be made to assure that family members be included in treatment planning and the treatment process. The most common concern voiced by family members was that they wanted to be of help, but did not know what to do.

6) Further research be undertaken in this area utilizing a random sample, upon which valid interpretations about the population could be based.

7) Further research be done comparing the needs of family members of first time admitted patients with re-admitted patients.

8) Further research be done to look at post-hospitalization needs of family members. This study would enlarge the information base in which services to families are provided.

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APPENDIX

QUESTIONNAIRE

- 1) What is your relationship to the patient?
 a) spouse
 b) child
 c) parent
 d) sibling
 e) Grandparent
 f) aunt
 g) uncle
 h) other _____ (specify)
- 2) What is your age?
 a) under 21
 b) 21-25
 c) 26-30
 d) 31-35
 e) 36-40
 f) 41-45
 g) 46-50
 h) 51-55
 i) 56-60
 j) 61-65
 k) over 65
- 3) Sex
 a) male
 b) female
- 4) What is your approximate income?
 a) under \$5,000.
 b) \$5,000.--\$10,000.
 c) \$10,001.--\$15,000.
 d) \$15,001.--\$20,000.
 e) \$20,001.--\$25,000.
 f) over \$25,000.
- 5) Do you have any children living at home?
 a) yes
 b) no
- 6) What are their ages?
 a) 0-5
 b) 6-12
 c) 13-17
 d) 18 or over
- 7) Do you have any children living out of your home?
 a) yes
 b) no
- 8) What are their ages?
 a) 0-5
 b) 6-12
 c) 13-17
 d) 18 or over
- 9) How long have you lived in the tri-county area?
 a) less than 1 month
 b) 1-3 months
 c) 4-6 months
 d) 7-12 months
 e) 1-2 years
 f) 3-5 years
 g) more than 5 years
- 10) What is the patient's admission status?
 a) voluntary
 b) court--committed
 c) other _____ (specify)
- 11) Were you involved in the decision to hospitalize?
 a) yes
 b) no
- 12) Is this your first experience with having a family member hospitalized for emotional difficulties?
 a) yes
 b) no
- 13) Specify relationship to interviewee of other family member(s) hospitalized.
 a) self
 b) spouse
 c) child
 d) parent
 e) grandparent
 f) aunt
 g) uncle
 h) mother-in-law
 i) father-in-law
 j) daughter-in-law
 k) son-in-law
 l) other _____ (specify)

14) Often people in a time of trouble like this have many concerns. What was your biggest concern when you realized that _____ was having difficulties?

15) Family members of people in an emotional crisis often have questions about hospitalization, medication, and the nature of the difficulties. Did you receive information about the following questions on hospitalization?

	Wanted to know	Asked	Who/Where	Wants info.
a) does he need hospitalization				
b) how long will he be hospitalized				
c) what is the procedure for admission to the hospital				
d) how much does hospitalization cost				
e) what do I do if I cannot afford hospitalization				
f) other questions in this area (specify)				
g) no questions in this area				

16) Does the patient take medication?
 a) yes
 b) no

17) Did you receive information about the following questions on medication?

	Wanted to know	Asked	Who/Where	Wants info.
a) how does the medication effect him				
b) will he always need to take medication				
c) what are the effects of medication				
d) other questions in this area (specify)				
e) no questions in this area				

18) Did you receive information about the following questions on the nature of _____'s difficulties?

	Wanted to know	Asked	Who/Where	Wants info.
a) are _____'s difficulties an illness that is hereditary				
b) are _____'s difficulties an illness that is contagious				
c) are _____'s difficulties an illness that is curable				
d) how long will treatment take				
e) how long will it be before _____ feels good again				
f) other questions in this area (specify)				
g) no questions in this area				

19) Sometimes people faced with a situation such as yours need advice on how to handle certain situations. Did you receive advice on how to interact with _____ while he is emotionally upset?

	Wanted to know	Asked	Who/Where	Wants info.
a) yes, while he is in the hospital				
b) yes when he was at home				
c) no				

20) Did _____'s difficulties bring about changes for you such as:

- a) loss of income
- b) loss of housekeeper
- c) loss of child caretaker
- d) other _____ (specify)
- e) none

21) Did you receive advice on how to manage any of the above changes?

	Wanted to know	Asked	Who/Where	Wants advice
a) yes				
b) no				

22) Did you receive advice on talking with other family members about any of the following matters?

	Wanted to know	Asked	Who/Where	Want.ad
a) what to tell them about _____ going to the hospital				
b) what to tell them about _____ having emotional difficulties				
c) what to tell them to expect of _____				
d) what to tell them how to act around him/her				
e) what to tell them about when he will feel better again				
f) other (specify)				
g) none				

23) Often people in this kind of situation have concerns about themselves or what they could have done. Did you have some concerns about your part in the emotional upset? What were they?

24) The following are examples of what some people have expressed about how they thought or felt about the patient and his/her difficulties. Did you have any similar thoughts or feelings?

- a) he/she is behaving this way to get even with me
- b) he/she is having difficulty because he was bad and is receiving his punishment
- c) I must have done something wrong and caused it in some way
- d) he/she will never be the same and I'll just have to learn to live with this
- e) I do not remember my thoughts or feelings about it
- f) other _____
- g) none

25) Did you talk with anyone about your thoughts or feelings?

	Wanted to know	Asked	Who/Where	Wants info.
a) yes				
b) no				

- 26) Did you feel that you, your family, or the patient needed protection from _____?
- yes
 - no
 - undecided
 - yes, but didn't know where to get it
- 27) Did any of the following prevent you from seeking information, advice, or someone with whom to discuss your feelings?
- I did not want it
 - I did not know where to get it
 - I did not have money to obtain it
 - The person got better and I did not feel I needed it
 - I asked and did not understand the answer
 - I asked questions and they were not answered
 - I was reluctant to ask because _____
 - other _____
 - none

Abbreviations:

Dr.P - psychiatrist
 Psy. - psychologist
 SW - social worker
 PN - psychiatric nurse
 PA - psychiatric aide
 Rec. - receptionist
 FP - family physician
 Pol. - police
 CP - clergy person
 T - teacher
 Nur. - nurse
 Fri. - friend
 Nei - neighbor
 Rel. - relative