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ABSTRACT

This study examined the problem of the lack of understanding of the family's reaction to the psychiatric hospitalization of a family member. A review of the literature indicated that little has been done to increase our knowledge of the family's perception of this event in their lives. It further indicated that these families have needs and concerns resulting from the experience of the psychiatric illness and hospitalization. These needs and concerns were not being addressed by health care workers.

This qualitative study utilized the phenomenological approach. Data were obtained from seven families of patients admitted to a psychiatric hospital for the first time. Two unstructured interviews were conducted with each family during the course of the patient's hospitalization. The content of the interviews included discussion of all aspects of the hospitalization with the families directing the emphasis toward the aspects that were important to them.

The data were analysed using the method of constant comparative analysis. Major categories were developed which reflected the meaning of the hospitalization experience for the families. The categories included acknowledging the hospital as a solution to the problem, reframing past events
to make sense of the present, assimilating the experience into their every-day lives, and questioning the future in relation to the present experience of the illness and the hospitalization. The themes were not found to be discrete, sequential activities but were described as inter-dependent and circular in nature.

The data were discussed in relation to the literature reviewed, with comparisons being drawn between those previous studies and the current one. The implications for nursing practice, education, and research were discussed.
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CHAPTER I
INTRODUCTION TO THE PROBLEM AND PURPOSES

Families of hospitalized patients have long been a focus of interest and concern to health professionals. The episode of illness and the subsequent hospitalization is commonly viewed as a crisis for the family (Parad, 1965; Glasser, 1970; Anthony, 1969). While this view is shared by authors and researchers concerned with both physical and mental illness and treatment, there has been much less attention given to families in the field of psychiatry.

The awareness of physical illness and hospitalization as a crisis has drawn attention to how families respond to illness. A similar viewpoint of families of psychiatric patients is only just emerging. From the initial psychoanalytical view of the parents as an important influence during early childhood, to the current interest in systems theory and its emphasis on structure and process within families, there has been an increasing awareness of the importance of the family in the treatment of the patient.

Early research involving the family and the psychiatric patient has viewed the family as an etiological factor, contributing to the development of symptoms in the
patient. For example, a study by Lidz and Lidz (1949) described the family of the schizophrenic patient as "adverse extra-familial forces that were major factors in molding the misshapen personality" (1949:343). Although the generally accepted notion of the schizophrenigenic mother was later challenged by Caputo, his study (1963) continued to focus on the parents and the role they played in the development of psychotic reactions.

A gradual change in the focus of research has been attributed to the de-institutionalization of patients, development of more therapeutic treatments involving the community and the family, and a concern for high rates of recidivism for patients. Generally, there was an increasing acceptance of the notion that the patient could not be treated in isolation. Psychiatric hospitals and other treatment units began considering "family-oriented" care, based on the assumption that by helping the family, they were helping the patient. In other words, the family came to be viewed as influential in determining the success of the patient's treatment. Studies on recidivism supported the notion that the patient's progress after discharge was dependent upon the family's attitude and concerns (Kreisman & Joy, 1974:50).

The position within the field of psychiatric nursing practice which emphasizes the importance of considering the family is a relatively new one. Joel and Collins (1978) took a different perspective from most authors,
stating: "It is natural for psychiatric nursing to consider individual health and functioning within the context of a person's present family or network of significant relationships" (1978:243). Most other nursing texts noticeably lack this orientation.

Smoyak's review drew attention to this lack, and further stated that "the idea that psychiatric nurses work in a therapeutic way with families is relatively new" (1976:36). She suggested that a lack of theoretical development by nurses was a major factor. As well, recent articles suggested that the family's reaction was not always considered, and specific directions as to how to intervene with families were lacking.

The lack of theoretical development concerning the family seems to be supported by Anderson's (1977) observations. She suggested that the family had its own concerns, anxieties, and needs associated with the hospital experience, including the need for support and information. She observed that the families in her study experienced difficulties in dealing with "the social impact of psychiatric hospitalization and with deciding what information should be shared and with whom" (1977:699). Her observations resulted in the conclusion that it is important to have knowledgeable staff to interact with the family to meet their needs.

A review of more recent literature reveals an emerging acceptance of Anderson's viewpoint. The
development of support groups for the family, such as described by Atwood and Williams (1978) and family-oriented psychiatric units (Tangari and Class, 1977) have resulted from the gradual awareness that the hospitalization does affect the family. However, it is still not a generally accepted or even understood notion in actual practice, since as Harben observed: "most traditional in-patient units include families only as sources of historical information about the identified patient" (1979:282). He went on to say that little had been done to generate substantive data to support interventions.

Research that has focused on the family, has indeed tended to concern itself more with the family's attitudes toward mental illness, than with an identification of their needs. Families were asked in one study, for example, how they felt about the psychiatric hospitalization of a relative, within the context of their attitudes toward the hospital and its personnel. The families indicated that they felt isolated from the hospital and alienated from the patient (Rose, 1959:198).

It has been suggested by other research that the family experiences a variety of reactions to the mentally ill member. Most frequently, authors have identified feelings of guilt, shame, fear, anxiety, anger, even denial directed toward the patient and/or the hospital staff (Lewis and Zeichner, 1960; Hartocoltis, 1965). Reactions such as relief experienced when the patients
were removed from the home were identified less often, although this was suggested in one study (Grad & Sainsbury, 1968) and discussed briefly by other authors (Bray and Bird, 1969). Such research has drawn greater attention to the importance of considering the family during the treatment of the patient.

In summary, the importance of considering the family has evolved from an historical interest to an understanding of the importance of the structure and processes within the family unit. Interest in the family of the psychiatric patient has changed from viewing the family as a cause of illness to viewing it as important in the treatment of the patient. Observations in clinical settings have revealed a lack of knowledge and understanding about the effect of psychiatric hospitalization on the family. Research to this point has focused largely on attitudes, and the feelings and reactions of families have been neglected. If family-oriented treatment centers are to be effective, research must now be concerned with increasing our knowledge and understanding of the impact of the hospitalization on the family.

Although numerous articles describe the inclusion of the family in care, little research has attempted to identify how the family perceives the experience of hospitalization of a relative (Rose, 1959). The requirement for family-oriented nursing care has been identified, but has not been effectively implemented, due to lack of
specific information about the needs of the family.

The importance of considering families of psychiatric patients has thus been supported by the literature. The lack of understanding about the impact of psychiatric hospitalization on the family has been identified as a major factor in the failure to consider the family as clients. It is hoped that this study will address this problem by providing knowledge about the meaning of psychiatric hospitalization to patients' families.

STATEMENT OF THE PROBLEM

It is the aim of this research to address the lack of knowledge and understanding of the family's reaction to the psychiatric hospitalization of a family member. Specifically, the study is concerned with how the family understands and explains this hospitalization episode in their lives.

THE PURPOSES OF THE STUDY

The purposes of the study are:

1) to describe, from the family's point of view, how they experienced all aspects of the first psychiatric hospitalization of a relative, from
the events leading up to admission to the point of discharge.

2) to describe their perceptions of how they dealt with any problems or concerns during the hospitalization.

3) to identify, from the family's point of view, what they need or needed from health care workers during the hospitalization period.

The following terms have been used in the above statements of the problem and purposes of the study, and are defined here as used by the author in this context.

DEFINITION OF TERMS

1) Family for the purposes of this study, a family is the person or persons, relative or non-relative, defined by the patient as being significant to him or her.

2) Experience the reaction to the hospitalization including: concerns about any aspect of the hospitalization; any problems or questions raised by the events of the hospitalization; the meaning given to the events; the emotions felt at the beginning of, during,
and toward the end of the hospitalization; and the effect on the
family's everyday life.

3) Hospitalization first admission of a patient to an
inpatient psychiatric unit, lasting
approximately four to six weeks.

4) Perception the recall of family members of the
experience of hospitalization that
was meaningful to them as verbally
communicated to the researcher.

5) Patient any person eighteen years or older
admitted for the first time to an
adult psychiatric ward. The patient's
role within the family is not con-
sidered a factor in selection, but
will be acknowledged and addressed in
the analysis of data.

INTRODUCTION TO THE METHODOLOGY

This study utilized the principles of qualitative
research and its development was based upon the theor-
etical perspective of phenomenology. Qualitative method-
ology was chosen as appropriate for the purposes of this
study because it was seen to provide a deeper and richer
understanding of human behaviour (Rist 1979:20). From the
phenomenological perspective, the researcher is directed to elicit the subject's understanding of his world (1979:19).

This methodology differs from quantitative research in that it goes beyond objective observation of behaviour and attempts to elicit the individual's perception of the situation being studied. It considers the past experiences and knowledge used by the individual to "make sense" of the environment in order to act within it (Cicourel, 1968:111).

Another major difference is the role of the researcher in the events being studied. The phenomenological perspective recognizes that the research act involving human subjects is a social one--an interaction between the observer and the observed--to which both bring their own perceptions and understanding of the situation (Davis, 1980:187; Rist, 1979:20).

The importance of this perspective within a nursing context was stressed by Davis, who identified a "conceptual fit" between the approaches of clinical nursing--observation, interviewing, interaction and interpersonal relations--and the phenomenological approach (1980:194). Ragucci further defined the goal of the nurse researcher as one of understanding how the client explains the phenomena of health and illness (1972:321). An acceptance of these principles allows the researcher the freedom to develop conceptualizations, rather than be restricted by
pre-formed hypotheses.

The collection of data, therefore, is also different from that of quantitative methodology. As described by Lindemann (1974) who has used this method in her own research, the original study group is chosen as a result of the area of interest of the researcher; further comparison groups may evolve as categories of data emerge. Constant data analysis, simultaneous with data collection, may result in an emerging theory or hypothesis to be tested later (1974:106-107).

ASSUMPTIONS OF THE STUDY

This study is based on the assumption that the family has a variety of responses related to the hospital experience. It is also assumed that the information the family provides about these experiences is an accurate reporting of the meaning of the experience for them.

LIMITATIONS OF THE STUDY

The willingness of the subjects to report in detail to the researcher may have limited the extent of the data and affected the final outcome of the study. Although the role of interviewer as researcher was emphasized, the
participants may have responded to the researcher as nurse: requests for help during the interview sessions did occur. The written information, reinforced prior to the interview, and the site of the interview away from the hospital setting minimized this possibility. When requests for help did occur, they were referred to the appropriate staff on the unit.

The richness of the data obtained was limited by the time constraints of the study. These limitations prevented the use of more extensive data collection methods, such as field observations of the families in the hospital setting.

SUMMARY

This chapter has described the development of the problem and has identified the purposes of the study. The methodology used was discussed and the assumptions and limitations of the study were presented. The next chapter will examine the literature that is relevant to the problem and purposes of the study.
CHAPTER II
REVIEW OF THE LITERATURE

This chapter will present and critically examine research that has been concerned with families of psychiatric patients. The aim of the discussion will be to illustrate the need for the present study as well as to provide a conceptual background to explain the development of the problem and purposes of this study. In doing so, the discussion will focus on three major areas. First, as discussed in Chapter I, much work has been done regarding the impact of physical illness on the family. The applicability of this work to psychiatric illness must be considered since many studies have compared physical and mental illness. Therefore, several studies done in this area will be discussed in order to provide an important contrast to the subsequent review of research on the impact of mental illness.

Second, the group of studies more specifically concerned with psychiatric illness and hospitalization will be presented. Given that the study is utilizing the phenomenological perspective, this writer did not choose a particular theoretical framework by which to view the family of the psychiatric patient. However, it was
necessary to examine the predominant frameworks in the literature, in order to understand and appreciate ways in which families of these patients were viewed in the past. For this reason, the research discussed in the second section of this chapter will be organized within the following theoretical frameworks:

1) psychoanalytic theory, which views the family as an etiological factor;
2) interpersonal theory, which considers the socio­logical perspective of roles and interpersonal relationships;
3) systems theory, which views the patient as part of the larger family system.

Finally, nursing research relevant to the purpose of this study will be discussed. While the studies reported here may fit into one of the above theoretical frameworks, it was felt that the relative lack of nursing research in this area must be highlighted in this way, in order to further illustrate the need for the present study.

COMPARISON OF PHYSICAL AND MENTAL ILLNESSES:
IMPACT ON THE FAMILY

Research focusing on the family of the physically ill patient tended to examine the psychological impact of the illness in two ways: 1) sudden, life-threatening illnesses
such as myocardial infarction, stroke, or impending surgery (De La Mata et al., 1960) were viewed as a crisis for the family and 2) chronic illness such as cystic fibrosis, diabetes, physical disabilities were seen as a stress for the family (Anderson, 1960; Crain et al., 1966; Skipper et al. 1968). Variables such as economic status, role of the patient in the family, the effects of cultural backgrounds, and the severity of the illness were among those examined in these studies.

While most researchers defined a specific illness and examined its effects on the family, others chose to compare physical and mental illness. Interestingly, in reviewing these studies, it was noted that the comparison was most often with chronic illness, for example, tuberculosis (Anthony, 1969) or asthma (Block, 1969). Other researchers noticeably omitted psychiatric patients from their studies. Thus, the conflicting rationales for such inclusion or exclusion of mental illness from research on the impact of illness indicate a need to study this body of research for clarification of its relevance.

Studies which viewed illnesses as stressful situations for families, but excluded psychiatric illness, are exemplified by Hollingshead's (1970) study of the impact of physical illness of a husband or wife on the patient and his or her spouse. Another example is the research of Stember (1977) which looked at the family stress experienced as an adult member was hospitalized.
These two studies will now be examined.

While Hollingshead's study concentrated on the impact of the illness on the hospitalized patient, he also examined the reactions of the spouse to the patient's hospitalization, and in this way his study is similar to Stem- ber's research. Hollingshead categorized the impact of the hospitalization from minimal to catastrophic in 225 families of medical-surgical patients. Using structured interviews and observation, he assessed the families as follows: 32 per cent experienced "minimal" impact (that is, they were judged as coping successfully), 27 per cent experienced moderate impact (they experienced disruption of their initial adjustment to the illness when the patient was hospitalized), 26 per cent experienced extensive impact (there was a major disruption of roles), and 15 per cent of the spouses suffered catastrophic impact (their family functioning and structure were severely affected).

While these categories give some indication of the variations in responses to the illness and hospitalization, the value of the results is questionable, in that there was a lack of clear definition of the means of assessment. A further finding reported in this study was the "strong" relationship between the type and severity of physical disability and the emotional response of the family based on the patient's ability to fulfill his role. Again, this was not clearly defined or identified, and one must assume it was based on an assessment by the
researcher, since it was not made explicit.

Stember's research utilized similar methodology to Hollingshead's. While Hollingshead organized his study from the perspective of role theory, Stember was interested in stress theory, and based her study on the assumption that hospitalization is a stressful event. The variables of unfamiliarity with the hospital environment and lack of previous experience were identified as contributing to that stress. As well, the length of the illness and the family's perception of its severity also affected the amount of stress experienced--two findings that were similar to those in the Hollingshead study. Similarly, both studies reported that the sex of the patient had no effect on the familial stress experienced.

Stember's research appeared to be the stronger study in this area, for two reasons. She clearly defined the variables to be studied and supported her assumptions by reviewing the literature. Furthermore, she addressed the issue of previous illness experiences by considering this variable in the analysis.

Stember identified thirteen variables and obtained data for measurement scales by means of interviews, questionnaires, and chart audits. Three hypotheses were supported: 1) previous hospital experience reduced stress; 2) degree of stress was proportional to the length of time in the same residence; and 3) the degree of severity and duration of illness were directly related to the degree
of stress experienced.

This last variable is of particular interest, in that it was the family's perception of the severity which influenced their stress—a perception not always congruent with the physician's or patient's perception. Stember thus drew attention to the importance of communication among these groups, as well as including them in the "diagnostic and therapeutic processes" (1977:73).

As stated earlier, many studies compared the effects of chronic physical illnesses and mental illness. Two such studies will now be examined.

Anthony's (1969) study of the response patterns of families of psychotic and tuberculosis patients was based on role theory as well as on the framework of systems theory which viewed the illness as a challenge to the family's functioning. While some differences were noted between the two groups of families, generally Anthony's discussion made little distinction. His "unroofing" method of living with the family and doing extensive interviews, was designed to discover "the ways in which different families dealt with the impact of illness, and the changes in organization and function which ensued" (1969:433).

Anthony reported similar reactions for families of both physically and mentally ill patients. Both groups were disrupted by the illness, and the authors noted that the reintegration or disintegration was dependent upon the family's pre-morbid state, their socio-economic level, and
the severity of the patient's illness (1970:56).

In reading this study, one must question the author's rationale for selecting these two particular illnesses. While others linked mental illness to chronic physical illness, thus implying a similar characteristic to the mentally ill, Anthony chose a physical illness which he described as having a strong negative societal reaction, a "fear of contamination" (1970:56). As well, in discussing the results, Anthony emphasized the effects of the psychosis on the family and offered little new information about the different effects of physical and mental illness.

A similar purpose was found in Davis's study, which also was concerned with the organizational patterns in families with a chronically ill adult in the home. Her research was designed to specifically examine the family as it was affected by and adapted to the illness (1980:476).

In her study, Davis compared three conditions: 1) chronic mental illness (not further defined); 2) mental retardation; and 3) physical and/or mental infirmities due to aging. She specifically looked at how the family decided to keep the ill relative at home, how that affected the family and its patterns of adaptation.

As was done in Anthony's study, Davis utilized intensive interviews of the families, but did not include observations of the family. Furthermore, she defined as a
limitation of her study, the fact that the families had to rely on and recall past events and experiences, whereas Anthony viewed his study as strengthened by the process of interacting with the families "at a time of crisis". However, both studies identified the importance of eliciting the family's perceptions of their experiences - their explanations of what they did and why they did it.

A content analysis of the interviews in the Davis study revealed emerging categories, some of which have particular relevance to the area of this study. For example, the process by which families decided on home care was related to their understanding of the meaning and function of hospitalization. They viewed institutional care for chronic patients very negatively; they felt that the institution would fail to meet the patient's needs, or to recognize him or her as a unique individual (1980:47).

Other factors considered important in this study were the severity of the illness and the age and health status of the care-giver. Both of these were similar to Anthony's findings regarding factors that influenced the family's response to illness. Davis, however, went further in considering the impact of social climate and the families' beliefs and values as important influences on the families' decisions to care for the patients at home.

The research reviewed thus far has examined the impact of physical illness on the family or has compared the impact of physical and mental illness. The next
section of this chapter will deal more specifically with families of psychiatric patients. The first studies presented will examine the view that the family is a causal factor in the mental illness.

FAMILIES OF PSYCHIATRIC PATIENTS

Psychoanalytic Theory: Family As An Etiological Factor

Based on the writings of Freud, psychoanalytic theory attempted to show the relationship between mental illness (in particular, schizophrenia) and the family. The family, and the parent in particular, were viewed as etiological factors in an historical sense, and the research was specifically aimed at delineating the variables within the family that had caused mental illness.

In one such study, Lidz and Lidz (1949) examined the case records of 50 schizophrenic patients to determine the effect of specific familial situations on the patient. Their data indicated that the majority (40 out of 50) had been subjected to unstable family environments (1949:343).

The concern with the etiology of schizophrenia resulted in further research by Lidz et al. (1965) in this area. In an extensive study of the intra-familial environment of schizophrenics, the researchers used multiple interviews, home visits, and the diaries of the families. They summarized their findings by describing all
families in the study as disturbed and unable to meet the needs of the children (1965: 27).

Research conducted within the psychoanalytic perspective examined early childhood relationships with parents, the mother in particular, to identify pathologies within the family. Caputo's (1963) research was a further illustration of this school of thought. Using quantitative rating scales to study the parents of schizophrenics, Caputo concluded that both parents "contributed to the so-called schizophrenic" character of the family (1963: 355). The psychoanalytic view of the pathological family, as illustrated by these studies, was defined in a review by Bloch as "a model of linear causality" (1974: 182).

Studies which considered the importance of relationships and role expectations among dyads or triads within the family will be examined in the next section. The emphasis in these studies was not on the pathological nature of these relationships and their ability to produce and sustain symptoms. The researchers instead examined the effect of the illness on specific relationships within the family.

**Interpersonal Theory: Impact of Mental Illness on Family Interactions**

The studies included in this section had a common focus: the family relationships that were affected when a
member became mentally ill. The studies included here all draw attention to the response of one or more of the family members toward the "sick" patient. Such factors as changing expectations, difficulties in accepting the illness, making decisions regarding care of the relative, and shifting of responsibilities were discussed in the context of adapting to the ill member at home. Other studies of the family indicated the effect of hospital admission on family relationships. Most researchers chose to look at specific relationships within the family, most frequently that of the husband and wife.

One of the earliest major works done in this area was undertaken by two sociologists, Clausen and Yarrow, who were concerned with the problems that a wife faced when her husband became mentally ill (1955). Based on the assumption that mental illness was disruptive, these researchers hoped to provide information about 1) the wife's definition of, and ability to cope with the illness; 2) how the illness affected the relationship, and 3) the wife's expectation of the hospital. Through the use of intensive interviews, using interview guides, the researchers attempted to elicit the wives' perceptions of these areas. Major assumptions of the study included notions of the situation as ambiguous, unstable, insecure, and anxiety-producing for the wife.

The results of the study indicated that a) the wives were reluctant to recognize their husband's mental illness
and attempted to explain it physically or situationally; b) most often, it was the family physician who was first contacted; and c) the wives tried to conceal the problem from others, anticipating an unfavourable reaction. Thus, this study called attention to the important variable of the stigma of mental illness.

Important to note when reviewing this and other studies of this time are the parameters of the hospitalization period. During the 1950's the majority of hospitalizations were long-term (that is, lasting several years or more) as indicated by Clausen and Yarrow's referral to monthly interviews during the hospitalization. As well, there were a large number of committed patients in these studies, and much attention was given to this variable. These factors must be kept in mind when relating the findings to present-day situations.

An important contribution to our understanding of the impact of mental illness was made by Fleck's study of the family's experience during psychiatric hospitalization (1965). This study continued to look at the family's role in the development of symptoms, but also considered the impact of the hospitalization on the family.

Drawing upon the data from a larger study by Lidz et al. (1965), Fleck identified resistance by families to the admission of the relative to hospital. The resistance, he felt, was due to the reluctance of the family to recognize the mental illness of the relative, and the feelings of
guilt and failure they experienced when the admission occurred. He further observed that some families needed to exclude the patient from the family unit, because they felt embarrassed or angry. Fleck suggested that such feelings and reactions could be adequately dealt with by a family support group.

Another contribution to this area was made by Lewis and Zeichner (1960) who examined the reactions of families up to the point of the patient's admission to hospital and therefore did not deal with the hospitalization per se. The purposes of their research were to identify: 1) the families' recognition of the mental illness; 2) their attitude toward mental illness; 3) their ways of coping with the illness; and 4) the treatment they sought prior to hospitalization.

While their methodology was not well reported, they did state that based on interviews with the families, the following conclusions could be made: 1) 72 of 109 families interviewed recognized the relative to be mentally ill; 2) attitudes ranged from "sympathetic understanding" to apprehension and guilt; 3) a variety of coping methods were used by families, such as expecting less of the relative, a response reported by 22 of the families.

Although the statistical findings of this study did not always support the notions of predominant reactions and attitudes of families, it did clearly indicate the
need for further study in this area. Lewis and Zeichner brought attention to the importance of considering the family prior to hospitalization, and the implications that this has for the hospitalization period.

A focus of Lewis and Zeichner's research was the attitudes of the family toward mental illness and how these attitudes affected relationships with the patient. Other researchers were also interested in this viewpoint of the family. Rose (1959) studied the attitudes of relatives toward the illness and hospitalization of a relative, the effect of these attitudes on the patient's hospitalization, and the change in attitudes resulting from the hospitalization. Basing his study on the assumption that "the development and maintenance of psychiatric illness is influenced, in part, by emotional ties among family members" (1959: 195), he was concerned with the effect of intrafamilial relationships on prolonging hospitalization.

The families of one hundred patients in a veteran's hospital were interviewed. The average length of hospitalization was nine years. Rose utilized unstructured interviews to elicit the families' feelings about the treatment the patient received, the cause of the illness, and the discharge of the patient to the families' care (1959:196). In discussing his findings, Rose talked of "gleaning" and "inferring" the attitudes as well as doing "informal content analysis" (1959:196) resulting in the
following conclusions: 1) relatives felt positively toward the psychiatric hospital and its treatment of the patient; 2) the majority of relatives welcomed the fact that the hospital had "taken over" the patient; 3) the families wanted more contact with hospital personnel; 4) the families understood little about the treatment the patient received; 5) there was a tendency for the families to deny the "mental" symptoms.

Examination of the results of these studies revealed conflicting statements. Some researchers (Lewis and Zeichner) felt that the majority of families were able to accept the illness of a relative, while others felt that the families tended to deny the "mental symptoms" and explained the illness through physical causes. In some cases, it was deemed necessary to include only first admitted patients (Lewis & Zeichner) or only spouses (Clausen and Yarrow), while other researchers made no distinction at all. The length of admission was also a variable recognized as influential (Rose, 1959) in the degree of re-organization of roles that occurred. Studies focusing on the stigma felt by relatives also indicated varying results. Rose reported that the majority of families reported no such feelings, while others (Fleck, Clausen, and Yarrow) reported feelings of shame and concealment by relatives.

Sociological interest in the variable of "attitude", and its effect on family relationships as represented by
the studies discussed thus far, has been pursued through the use of unstructured interviews of patients' families. However, Freeman (1961) departed from this method and chose to use a structured survey to determine the relationships between the families' attitudes toward 1) etiology, 2) the hospital, 3) normalcy of patients, and 4) responsibility of patients; and the age, education, verbal ability, and social class of the family.

Two interviews were done: one immediately after discharge of the patient, and another a year later, using a fixed choice attitude scale. The researcher concluded that relatives' "enlightened attitudes" toward mental illness were directly related to their level of formal education, but had no relation to social class. Of interest also was his finding that attitudes toward outcomes were associated with duration or number of hospitalizations, a finding similar to Rose's.

Freeman added a note of caution to the reader of his findings—the relationship of variables was weak and further research would be needed in this area (1961: 66). He suggested, however, that efforts to intervene with the family should include consideration of these variables, as well as the variable of severity of the patient's symptoms.

In 1965, Zwerling and Mendelsohn used a similar method to empirically measure the verbal and behavioral reactions of the family to: 1) day hospitalization;
2) family therapy and 3) the patient's illness. By observing and listening to the families, the physicians rated each family as "actively oppositional, passively accepting, or actively accepting" (1965:53).

In reviewing their results, however, the authors made several assumptions and admissions of bias: 1) they viewed the patient as the "scapegoat" of the family; 2) they assumed that the stressful period prior to admission was filled with feelings of guilt and shame and the hospital was viewed as a last resort (1965:62). Zwerling and Mendelsohn rated the families on the second and fourteenth day of hospitalization. They summarized their findings by reporting that: 1) half of the families were rated as "actively accepting", indicating a supportive attitude; and 2) 61 per cent viewed the patient as "ill" rather than "bad" which was interpreted as a negation of the scapegoating concept (1965:55).

While Rose considered the hospitalization period, and Freeman the post-discharge period, Mills (1962) provided data about families with a mentally ill relative at home. Of particular interest is his inclusion in one interview of the relatives' point of view of: 1) the onset of the illness, 2) their relationship with the doctor and the hospital, 3) their attitude toward the patient's illness and treatment, and 4) any difficulties they encountered in caring for the patients at home (1962:5).

In his discussion of data, Mills concluded that
families often denied the illness up to the point of hospitalization, which further supports Rose's arguments. Mills observed that the closer the relationship between family member and patient, the less willing the family member was to view the patient as mentally ill (1962:48), a finding previously considered and supported in the research by Rose.

Research in this area of interpersonal relationships was originally dominated by the sociological perspective (Clausen and Yarrow, 1955; Rose, 1959; Fleck, 1965; Lewis and Zeichner, 1960). These studies were concerned primarily with the effect of mental illness on relationships and vice versa. They looked at ways in which the family dealt with the illness and at the family's attitudes toward and reactions to the treatment the patient received.

The results of these studies indicate similarities as well as contradictions. For example, the ability of the family to accept the "mental symptoms" of the relative varied in several studies (Clausen and Yarrow, 1955; Lewis and Zeichner, 1960). However, the importance of considering the "close ties" among family members was agreed upon (Mills, 1962; Rose, 1959).

The review of the relevant research to this point has highlighted the shift of focus from the family as an historical, etiological factor to the interest in the significant relationships and roles within the family unit. The
next section will examine another orientation in this research: the systems approach to viewing the family.

**Systems Theory: The Effect of Hospitalization on Family Functioning**

While sociological research continued to focus on the variable of specific roles and/or attitudes, a changing viewpoint was emerging in the field of psychiatry as a result of Von Bertalanffy's (1969) development of general systems theory. While it is not the intention or scope of this review to examine general systems theory and its related concepts in great detail, its application to families of psychiatric patients will be considered.

A definition of the family system was provided by Haller, who described it as "a mutually regulatory, natural grouping of persons" (1974:462). It was further developed by Hazzard, who described the family as "an open system reacting to changes in the environment in an attempt to maintain a steady state" (1971:387).

This concept of maintaining a steady state has led many theorists to view the psychiatric symptoms in one family member as a signal of distress or pathology existing in the larger family unit (Bateson, 1961; Speck, 1968; Bowen, 1959). As a result of this thinking, families have been viewed as the unit of treatment, rather than the individual.

The studies reviewed here offer the perspective of
the family as an open system whose goal is to maintain system stability. Attention is focused on reactions of family members to changes or demands from the environment which threaten system stability. The illness and hospitalization of a family member is viewed then as a change which places demands on the system. The interest of researchers is the response of the system to those changes, and the resources available to families to regain system stability and resume effective family functioning. The organization of the following studies thus reflects the intention of the researchers to focus on the responses of the families.

In a two year follow-up study, Grad and Sainsbury (1968) attempted to compare the burden experienced by families of psychiatric patients in a hospital versus a community treatment setting. As well, the researchers wanted to compare the effectiveness of these two facilities in relieving the burdens of families.

The concept of burden is defined in this study as "the effect the patient had on the work, leisure, income and health of the family, on children and on the family's relations with their neighbours" (1972:268). The rating of "none," "some," and "severe" were tabulated to provide an over-all "family-problem" score.

In designing this study, Grad and Sainsbury chose to seek empirical data. They identified the limitations of such a method for their purpose: that many aspects of
family life are not objectively measureable, and that their methods prevented discussion of possible positive effects of the illness and treatment on the family (1972:277). Given these limitations, the study made few conclusive statements, other than the recognition of the financial burdens that all the families faced.

The viewpoint of hospitalization as a "burden" was also explored by Robin et al. in a study designed to compare psychiatric units to psychiatric hospitals. They defined burdens as "problems created by the illness" (1979:35), such as financial difficulties, disruption and interference with social and leisure activities. Their method was similar to Grad and Sainsbury's; they utilized standard interviews by social workers to assess the relatives' attitudes, health, and needs.

The results indicated that there were few differences between the two groups—the "mean number of burdens" was similar. Effects on relatives' health decreased over the study period, as did their "needs" (financial, supportive care, and assistance with housing). Finally, the researchers assessed that the degree of insight of relatives also increased in both groups.

Given that the purpose of this study was to compare a psychiatric unit within a general hospital to a psychiatric hospital, there was little discussion on the specific effects of hospitalization per se on the family. Therefore, it did not provide much new or useful
The importance of conducting research to understand the viewpoint of the family rather than just identify the problem, has been given some attention in recent literature. For example, in 1972, Greenley considered the relationship between the family's desire for the patient's discharge, and the actual time of discharge. Using a variety of research methods—observation, structured interviews with doctors, patients and relatives, and the auditing of charts—the researchers identified a strong relationship between the two variables. More specifically, the families of patients who had brief hospitalizations responded positively to direct inquiry about their desire to have the patient discharged. The author suggested that the families' desire for discharge of the patient was met, even when the psychiatrist did not agree that it was appropriate.

An important point Greenley made in discussing these findings was the need to consider the family and its wishes in the planning of care. Implicit in this statement was the need for health care workers and families to identify each others' goals and perceptions of treatment. In fact, the author encouraged such research to determine "the origins of family desires" (1972:35).

The importance of identifying the problems created by hospitalization was stressed by the studies reviewed in
this section. Organized within the framework of the family as a system, the research recognized the system's attempts to react to and deal with change and to regain a stability in its functioning. A similar perspective was shared by nursing research conducted on families of psychiatric patients. That perspective and the results of the studies, will now be presented.

Nursing Research of the Family of the Psychiatric Patient

As indicated by the research discussed to this point, the major work in the area of families of psychiatric patients was done by sociologists. There has been a marked deficiency of nursing research in this area of nursing, although recently some nurse researchers have begun to focus on the family. Two studies found by this writer to be relevant to the area under study concern the family with a chronically ill member at home and the family of the psychiatric patient about to be discharged.

Davis' study (1980), previously discussed, explored the organizational patterns of the family with a chronically ill adult at home. The data were obtained by means of semi-structured interviews and were concerned primarily with the family's decision-making process regarding keeping the ill relative at home.

The interaction between families and hospital personnel indicated a different focus in Leavitt's (1975) study. Using an unstructured method, the researcher interviewed
the families of first-admission patients. The purpose of her study was primarily to determine the "dominant issues and concerns of the families" regarding the impending discharge of their relative from a psychiatric hospital. During the interviews, she also discussed the family's experience before and during the hospitalization.

Leavitt's interviews discussed the impending discharge by including the areas of: 1) what helped the family; 2) what concerns they had; 3) what they learned about mental illness; and 4) their anticipation of the effects of the homecoming.

The results of the Leavitt study revealed a lack of adequate intervention with families, particularly in the area of preparation for discharge. Most families did not view the hospital as helpful to them, and they maintained their feelings of uncertainty and lack of direction throughout the hospitalization. Such results seemed to clearly indicate the need for a closer examination of needs of the family, and the identification of ways in which staff should intervene to help them.

The two studies discussed in this section were offered as representative of the nursing research that has been done thus far on the family of the psychiatric patient. The results were discussed in terms of the direction they gave for the present study.
This chapter has reviewed relevant research on families of psychiatric patients, in order to provide a background for understanding the development of this study's problem and purposes. Since few studies were found by this researcher which dealt directly with the hospitalization experience, other related areas of research were also reviewed for relevance to this topic.

The research concerning the impact of physical illness was one such area. Illustrative of this group were the two studies by Hollingshead (1976) and Stember (1977), both of whom attempted to empirically measure the impact of "severe" illness on specific family members. The relationship between the severity of illness and its impact was a major focus of both of these studies. Similarly, studies comparing physical and mental illness (Davis, 1980; Anthony, 1969) examined the effect of the illness on the family's functioning.

While these latter studies did offer some new information useful to the present area of study, several issues were unclear. The definition of "mental illness" was unclear in Davis' study, and the grouping of psychosis with tuberculosis in Anthony's study implied a similar societal reaction to both mental and physical illness, an important issue that needs to be clarified.

An overview of the research based on psychoanalytic
theory provided an historical perspective of research with families of psychiatric patients. Concerned mainly with the cause of schizophrenia, studies examined the family for adverse factors which contributed to the development of this particular mental illness.

The research conducted within the sociological perspective was reviewed more extensively since it seemed to provide more relevant information about the effect of mental illness on roles and relationships within the family. It was again apparent, however, that even when the focus was on the families' perceptions of the illness and their methods of explaining and coping with it, the studies concentrated on the illness only up to the point of hospitalization or after discharge. Clausen and Yarrow (1955), for example, presented their findings on the wife's attempts to explain her husband's illness with physical causes. An important contribution made by studies such as this one, however, was their examination of the issue of stigma—an issue which will be useful to consider when discussing the data of this present study.

Other researchers with a similar perspective reviewed other segments of the illness experience. Lewis and Zeichner (1960) considered familial reactions up to the point of hospitalization; Freeman (1961) considered the family after the patient was discharged, and Zwerling and Mendelsohn (1965) chose to consider the family's reaction to day hospitalization. Other studies which were
considered within a general systems theory examined the family as a unit reacting to the illness and hospitalization. Attempts were made to identify "burdens" caused by the experience and the effectiveness of various in-patient facilities at relieving the "burden" experienced by families (Grad and Sainsbury, 1968).

Generally these studies showed a range of results: observations and interviews were used to assess families as "actively accepting" (Zwerling and Mendelsohn, 1965), or as having "sympathetic understanding" (Lewis and Zeichner, 1960) or "enlightened attitudes" (Freeman, 1961). Variables such as level of education, the relationship to the patient, the number and duration of hospitalizations were examined to determine the relationship to the families' attitudes toward the patient.

A few studies did specifically examine the period of hospitalization in relation to the family, although their value may be limited in terms of the era in which they were conducted. For example, Fleck's study of the experience of families of psychiatric patients offered some interesting data about the negative reactions of families to hospitalization—an observation that needs to be clarified in terms of today's trends in treatment and possible changes in the societal reaction to mental illness. Similarly, Rose interviewed families in 1959, in order to determine their attitude toward the illness and
hospitalization and the influence this attitude had on the patient and length of his/her hospitalization.

In conclusion, this review of literature has highlighted a major deficiency in the research of the impact of hospitalization on the family; the meaning of the hospitalization for families has not been elicited. When their perceptions were sought, it was in terms of their attitudes toward mental illness, or their coping methods before or after the hospitalization period. Limited efforts to identify problems and concerns were evident, and were subjected to empirical measurement rather than allowing the families to speak for themselves. A review of nursing research revealed one study (Leavitt, 1975) which focused on the family's perceptions of the discharge phase of the hospitalization. This study clearly took a step toward meeting the deficiency in the research thus far. It is hoped that the present study, with its focus on families' perceptions of other aspects of the hospitalization experience will further add to this knowledge, and thus provide direction for nurses working with families during this time.
CHAPTER III
METHODOLOGY

As outlined in Chapter I, the development of the purposes of this study was guided by the phenomenological perspective. In applying qualitative methodology to the collection and analysis of data, this researcher was guided by the work of other researchers who used this approach: Lindemann (1974), Anderson (1981), Porterfield (1981), and Cicourel (1968).

This chapter will discuss more specifically how the qualitative methodology was utilized in this study. The criteria and method of selecting families will be outlined, the process of simultaneous data collection and analysis will be discussed, and the necessary ethical considerations involving patients' and families' rights will be presented.

SELECTION OF PARTICIPANTS

While this study was concerned with the experience of families of psychiatric patients during hospitalization, it was necessary to delineate the criteria for selection
primarily on the basis of the patients' characteristics, in order to ensure that the situations experienced by the families were similar. For that reason, the criteria for selecting the patients, and subsequently the family, will now be presented and discussed.

Criteria for Selection

Based on the researcher's original interest and experience, it was decided to select the families of adult psychiatric patients. Therefore, eighteen was established as the minimum age for the patient group.

The second criterion for selection was that the hospitalization was the first admission of the patient to a psychiatric inpatient facility. The rationale for such a criterion was to have as homogeneous a group as possible. It was recognized that some families may have had previous similar experiences with other family members, although as much as possible, such families were not included. In cases where such inclusion occurred, the effect of the prior experience was addressed in the interviews and considered in the data analysis.

Third, the period of hospitalization was limited to four to six weeks. Based on the researcher's own clinical experience with such patients, this time period was selected as representative of the average length of stay for this setting. As such, the families of these patients would likely encounter similar events during the hospitalization.
Fourth, the families of the patients were living in the Greater Vancouver area, which made contacts by the researcher feasible and practical. Another criterion was that families were English speaking only.

Finally, the patients were able to give informed consent. Given the nature of the setting, it was felt that it was ethically necessary to include this criterion. Although the patients were not included in the interviews, they were discussed during the interview, therefore their consent was sought.

It is important to note that there was no specific criterion based on the patient's diagnosis since the emphasis was on the hospitalization experience of the family and not the specific illness of the patient. Similarly, there was no specific criterion for identifying family members to be interviewed, other than identification by patients of their significant others. The role of the patient in the family was also not a criterion but was addressed in the analysis of the data.

Selection Procedure

The research was conducted in a twenty bed psychiatric unit in a general hospital in downtown Vancouver and in a university psychiatric unit. Initial contact with the patients was made directly by the researcher, after receiving assurances from the psychiatrist that the patient could give informed consent. The patients were
given a letter of information and asked for permission for the researcher to approach their families.

When a patient gave the researcher written permission for the family to participate, the family was then contacted either in person by the researcher or by letter, given to them by a staff member on the unit. In the latter case the letter, when signed, indicated their permission to be contacted by phone.

In both cases, the researcher made arrangements with the family to interview them in their home. The timing of the initial contact and the first interview varied, depending upon the patient's ability to give informed consent, the frequency of visiting by the family (when the initial contact was made), and the ability of the researcher to contact the patient's psychiatrist.

Description of Selected Families

Although the researcher intended to interview each family as a group, it happened in the majority of cases that interviews were conducted with only one family member. There were several reasons for this: 1) there was only one other family member available for interviews; 2) small children were excluded, at the wishes of the parents; 3) the physical location of various relatives' homes made a single, group interview impossible to arrange. Therefore all persons identified by the patient as "significant other" were not always interviewed. The
persons interviewed, however, had been identified as such by the patient.

The relationships of family members to the patients varied. In two cases the family members were wives. In two other families, members were parents of sons or daughters in their early twenties. One family consisted of several sons and daughters of a patient who was 70 years old, and in another case the family member was the patient's grandmother. One family was Chinese, and the family member who agreed to participate, the patient's sister, did so because she spoke fluent English. Other family members identified by the patient had to be excluded because they spoke no English.

In several families there were children under the age of ten, and they were excluded from the interviews, at the families' requests. Other patients identified family members who had to be excluded for reasons of location or other commitments.

Living arrangements in the families also varied. In four of the families the patient lived with the family member interviewed prior to hospitalization, while in the remaining three families, the patient lived alone, but had regular contacts with the family members. The families interviewed also represented a range of locales and types of accommodation, from apartment living in a densely populated area to homes in various parts of the city and outlying areas.
DATA COLLECTION

Data were collected by means of taped interviews conducted in the families' homes. Two interviews were conducted with each family, one approximately one to two weeks after the patient's admission to hospital, and the second just prior to the patient's discharge. Each interview was approximately one hour in duration.

The interviews were essentially unstructured, although the initial interview was guided by the review of the literature and the work of other researchers (see Appendix B). The content of the second interview was based upon the events that occurred subsequent to the first interview, as well as an analysis of that interview. The use of the interview guide varied among families - in one case in particular, the family spoke so freely that the guide was not used until the second interview.

The purpose of the first interview, then, was to discuss the events leading up to and including admission. As well, the family's initial perceptions of the hospital environment were sought, as were their perceptions of the treatment received by the patient, and the effect of hospitalization on their everyday lives. The purpose of the second interview was to clarify meanings of events described by the family in the first interview, and to gather additional information as necessary.

Given the nature of the methodology as described
previously, the researcher did not attempt to remain detached from the interview process. In fact, the researcher recognized her own subjective reactions and possible assumptions and attempted to clarify them within the research situation. Also, the researcher utilized interview techniques learned in other nursing interviewing situations, which were designed to help the family feel comfortable and safe enough to disclose information to the researcher.

Construction of Accounts

It is important when using this methodology to identify clearly what constitutes "data," and to discuss clearly how the data are "collected." As described in Chapter I, the qualitative methodology used here was not in pursuit of "facts," but rather aimed to describe how the families perceived events in their lives and the meaning they gave to these events.

The process by which the researcher learned from the families involved the construction of accounts. The accounts of the hospitalization experience were thus constructed by the active involvement of both the family members and the researcher. These accounts, thus constructed, become the data of the research.

The construction of the accounts by researcher and families was influenced by many variables, including prior notions and experiences of both. Particularly for the
researcher who has worked in the area under study, it was necessary to identify her own preconceived ideas and assumptions about the effect of hospitalization on the family.

The accounts were also influenced by the families' notions of what was expected of them. For example, one family member stated when first contacted "I don't know how much I can help you. This really hasn't been much of a problem for me." Another family member agreed to participate "because we've all been there," indicating that she understood a student's needs because she herself had been a student.

The degree of confidentiality was an issue with some families which affected how much they were willing to share with the researcher. For example, one family admitted hesitation during the initial contact, but later expressed gratitude for the opportunity to share feelings in complete confidence.

The ability of the researcher to identify words and phrases that might have different meanings for families, was one that developed over time and therefore influenced the quality of the interviews. Consequently, the tendency of the researcher in early interviews to assume shared meanings may have affected those accounts; in subsequent interviews the researcher clarified such words or phrases with the family. Interestingly, this was also an influence for the families, who assumed the researcher "understood,"
because of their view of her as a nurse.

DATA ANALYSIS

As each interview was completed it was transcribed by the researcher. It is a characteristic of this method that constant comparative analysis of the content of each interview be conducted simultaneously with data collection. By using this method, the researcher was able to identify emerging themes and categories, which then influenced subsequent interview content.

The categories thus developed in the analysis were indicative of the frequently occurring themes discussed by the families during the interviews. The themes therefore were areas which were important and meaningful for the families to discuss.

ETHICAL CONSIDERATIONS

The rights of the patients and families were protected in the following ways:

The patients' right to refuse their families' participation was respected by obtaining their written consent first. Competency to give consent was assured by consulting the psychiatrist prior to approaching the patient.
The patients were given explanations of the study and the extent of involvement requested from the families. They were asked to identify their "significant others," who were then approached by the researcher.

The nature of the study and details of their participation were then presented to the families prior to obtaining consent. They were assured verbally and in writing that non-participation would have no effect on the care that they or the patient received. They were also assured that the data obtained during the interviews was confidential, and that no names were used on the tapes or any other record of the study. They were told that the tapes would be erased after the data were analysed and the thesis and any scholarly reports were written.

The status of the interviewer as researcher was reinforced prior to the interview. During the interviews, however, some families requested help from the researcher, and, in one case, a situation was discussed that was judged by the researcher to be life-threatening. The researcher was obligated to notify the staff member involved with this family and/or patient. In anticipation of such an occurrence, permission was sought from families prior to each interview to refer their requests for help to the appropriate health professional.

The families and the patients were informed that there was no risk involved in participating. There were also no financial remunerations. Some families did
benefit, however, in that they found it helpful to discuss their situation with the researcher.

SUMMARY

This chapter has described the methodology used in this study. The criteria for selecting the families and the procedure used to contact the families via the agencies were outlined.

A description of the data collection process included a definition of the purposes and content of the two interviews. The processes of constructing accounts and analysing the data as they related to the method of the study were discussed. Finally, the ethical considerations and the rights of the families were addressed.

The next chapter will present the accounts of the families and the major conceptual categories that were developed from these accounts.
CHAPTER IV
PRESENTATION OF ACCOUNTS

This chapter will present the accounts of the families' experiences of their relatives' hospitalization. The accounts presented will show how families used their common-sense knowledge to "make sense of" the occurring events. The researcher has been guided by the writing of Cicourel, who explains that "the task is to identify what is typical, normal, and routine for the actor in 'preparing' the scene, that is, interpreting what is going on, what happened, as well as what appears strange, unusual, crazy or the like" (1968:111).

The purposes of the study directed the researcher to pursue specific areas in eliciting the families' interpretations of the experience: their perceptions of events occurring prior to and during the hospitalization; the families' methods of dealing with or "making sense of" concerns they experienced as a result of these events; and an identification of what they needed from the hospital personnel during the hospitalization period. An examination of the discussion of these areas has identified major themes or categories which focus on the similarities of experiences among the families.

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The major categories developed from the accounts include the examination of the processes utilized by the families in "making sense" of these events in their lives. Process in this context is meant to convey to the reader the non-linear movement over time of the families as they were dealing with the experience of hospitalization. The following processes have been identified within a framework developed by the researcher to reflect the study's purposes: 1) accepting the hospitalization as a solution to the problem; 2) attaching meaning to the illness and hospitalization; 3) restructuring the past to enhance understanding of the present; 4) assimilating the experience into the daily functioning of their family life; and 5) examining the future and dealing with unknowns. While each of these processes will now be examined individually, they are, in fact, intertwined and not discrete.

THE PROCESS OF ACCEPTING HOSPITALIZATION AS A SOLUTION

In order to understand the decision to seek hospitalization as a source of help or accept it as appropriate, it is necessary to place the hospitalization within the context of events that preceded that decision. Without this it is impossible to appreciate the process by which families came to accept hospitalization as a solution. The
process which culminated in that decision can be described as a sequence of both cognitive and emotional reactions to the patient's behaviour. The sequence identified from the accounts consisted of: a) the growing awareness that something was "wrong" with the patient; b) the efforts made to seek help from other sources; c) the occurrence of an event or new behaviour which resulted in the decision to seek or accept hospitalization. Each of these steps in the process will now be discussed in more detail.

Families described a growing awareness for a long period of time prior to hospitalization—in some cases several years—that something was "wrong," that the patient had "changed." This change was seen as stressful for the family. For example, they described efforts to include him or her in family activities or outings:

F: I didn't think it was normal when, even his father would ask him to come for a weekend or for dinner and right up until the day the dinner was he would say yes, but -

R: He would change his mind? So you feel he was unpredictable?

F: Hm, hm. Well, it got so every one just stopped asking him to go anywhere - even myself, I wouldn't ask him.

Their expectations of "normal" behaviour, and the failure of the patient to conform to normal standards were described in emotional terms. Families identified feelings of anger, disappointment, or impatience. Eventually the families resigned themselves to living with the
patient this way:

R: So there was some real disruption, I guess, in your daily lives, as a result of (patient) being here?

F: I wouldn't exactly call it a disruption, it was rather a - something we felt emotionally, I suppose, without being alert about it; but there is a kind of continuing disappointment when she won't communicate with us at all.

Efforts to seek help other than hospitalization were made, as families began to interpret behaviours as "unusual" or "not normal." Neighbourhood clinics or family doctors were approached but most families described these contacts as brief and unsatisfactory. The timing of the decision to accept hospitalization as a source of help was usually determined by the occurrence of an event, previously not experienced, and described by several families as a "crisis," and by one as a "traumatic episode," indicating that it was an emotionally charged event.

The occurrence of such events thus led the family to redefine behaviour not witnessed before in the patient as "unpredictable," "out of control," or "couldn't be trusted," all of which left the family feeling helpless. The emergence of behaviour perceived as "bizarre" in the schizophrenic patient, the sudden occurrence of a "panic attack" by a depressed daughter, are examples of events or behavioural disturbances which became a crisis for the family and which signaled a need for action:
F: I didn't realize she was having these panic attacks, 'cause I hadn't seen her and they were something completely new to me.

R: So you haven't at all seen her when she's feeling panicky?

F: Only the night that we took her to the hospital.

R: Can you tell me about that?

F: Well, I couldn't settle her down, I mean, it was just very hard to talk to her, she was crying and frightened and we didn't know what—we just didn't know how to help.

In three cases, the hospitalization was precipitated by suicide attempts: in these families this was also a signal that something was wrong. Although the decisions were not the families', they accepted it as appropriate. The families experienced shock and disbelief that the patient would behave in such a way, and relief that he or she had not succeeded in committing suicide. At the same time, however, they had similar feelings regarding the behaviour of the patient prior to the suicide attempt; they felt that something was "not normal".

Hospitalization thus became a way of acknowledging that they could no longer cope, at least not with the crisis that developed immediately before admission. Most families were easily able to state this. They admitted that they could not cope, and also that they were relieved that someone else was taking over. In several cases they were quite insistent that this occur: "I just took the
phone and said, 'Would you send somebody for him. I don't think we can take many more days of this.'"

It was not a decision that was made lightly; hospitals symbolized sickness to the families. Therefore, sending the patient to hospital acknowledged that the patient was sick, and was unable to get well without professional help. Families redefined behaviours as "symptoms" of sickness and expected that the hospital would treat "the problem".

This process of accepting hospitalization as appropriate for the patient has been described as a sequence of events—from a growing awareness that something was wrong to the occurrence of a crisis which resulted in the decision to hospitalize the patient. Families were then faced with interpreting events surrounding the treatment, as well as with examining their own notions of mental illness.

The following discussion will cover the process by which the meaning of mental illness and treatment developed for the families. The importance of prior notions about psychiatric and general hospitals as well as the effects of stigma will also be discussed.

THE MEANING ATTACHED TO ILLNESS AND TREATMENT

The process by which families attached meaning to the
hospitalization involved an integration of many factors: articulating their expectations of what would happen, accepting or rejecting what they observed, and evaluating events that occurred after admission. The process also involved comparing psychiatric hospitals to other hospitals, and then comparing the treatment of physical illness to the treatment of mental illness. Prior notions, based on folklore or actual experience, influenced their expectations as well as their evaluations. Finally, their perception of stigma was a major factor in the process of applying meaning to the illness of their relative. These factors and their inter-relationships will now be discussed.

The comparisons that families made in developing meaning for their present experience were based on prior experience with general hospitals, exposure to psychiatric hospitals through work or personal experience, or assumptions formed from public media sources. One family member who had had prior exposure to medical treatment used these experiences to evaluate his initial contacts with the hospital and its personnel:

P: When a person has a ... goes into a hospital ward um, has an accident in a car, goes into a hospital and they're going to do certain things, there's a punctured lung and there's this and there's that, they take you aside and they say, now this is what the situation is and this is what we're going to do ...
He went on to describe how he wanted and expected this kind of information regarding his relative's situation, and did not receive it.

Several other families identified major differences between physical and psychiatric illnesses and treatment. Because the problem was not a tangible one ("it's not like a broken leg") which has a standard form of treatment, it was more difficult for them to understand the prescribed treatment. As well, there were more questions about their own involvement.

The importance of preconceived notions in defining the meaning of psychiatric illness and treatment became evident when families described their initial reactions to the hospital itself:

F: Like I say, I had always the idea that maybe that is an insane, uh, how do call it? an asylum?
R: Well, its a, such a new experience ..
F: Yeah ... no, it was not like that, the picture I had in my mind, the bars, and the kind of, the whole is locked, you know, so nobody can escape, something like that.

Such notions of psychiatric hospitals resulted in feelings of guilt for having participated in bringing about the hospitalization. The source of guilt in some cases was the actual patient. In one case the patient actually verbalized his blame to the family for having him admitted. In other cases guilt originated in perceived societal
reactions to the mental illness or assumptions about psychiatric illness. In the above example, the family member felt others would share her view of the hospital as an "asylum."

Families, therefore, had difficulty in determining an acceptable meaning of mental illness. They were attempting to apply their understanding of general hospitals, but at the same time were experiencing guilt and embarrassment because it was a psychiatric hospital. They seemed to partially resolve this dilemma by observing and evaluating the patient's progress:

R: The first time you went to visit him, did you expect him to be the same, or ...?

F: I didn't know what to expect, and I was quite pleased in what I found. He seemed quite happy to be there and I was relieved.

These observations contributed to the changing meaning of events. The families experienced relief that "the right decision" had been made. The hospital could be defined as a place that helped those who were "sick."

The importance of the families' perceptions of stigma in developing their meaning of mental illness, became evident when they expressed a need to "keep it to themselves." There was a reluctance to share with neighbours because they would not understand:

F: It wouldn't help W., it wouldn't help me, because they're the type that would make great big darn fuss and nothing behind it; you only talk on these things to people who understand you maybe, or who have some feelings for you.
Similarly, another family described:

R: They're aware that she's in hospital?
F: Yes, and that, like my daughter-in-law says, "Well, I don't know what you say to her. I'm not used to being around something like this." So, that's hard, I wish there was some way that uh, I could tell her, you know, but it's like you have leprosy or something, and I find that happens even with my friends.

R: Have you been able to talk to your friends about it?
F: No. Not at all.
R: They're aware that (patient) is in hospital?
F: No. One of my friends, she sort of has had relatives in psychiatric hospitals too and she knows what it's like, but I've also found that she's putting distance between her and myself.

Questions that outsiders asked the families regarding the patient's absence were generally met with vague responses such as "He's in for tests," presumably because medical treatments were more acceptable. In one case, where an ambulance was required and police were needed to take the patient in to hospital, the family expressed embarrassment that neighbours observed this situation.

The families' perceptions regarding the reactions of others to mental illness affected the kinds of supports they sought. They began defining the situation as one that was dealt with alone, or with selected people. For example, one family member relied on a niece for information, because "she was in the business." Another
was able to confide in co-workers, because she felt they shared a similar background and would therefore understand.

The families' decisions about how freely they could discuss their relative's hospitalization also depended upon their concern for the wishes of the patient, as they (family members) perceived them: "Behind it too, is some question of whether (patient) would want us to talk to other people about it." The effect of such stigma regarding mental illness was embarrassment for families, as well as an increased reliance on close family members only for support.

The process of developing meaning therefore involved evaluating the significance of prior experience and knowledge to the present situation, and evaluating the applicability of prior notions of psychiatric hospitals to their own situation. The impact of the families' experience of stigma on the meaning of hospitalization was also evident. While they might be able to come to accept the hospital as helpful to the patient who was sick, they also came to define it as a "private" experience.

The process of attaching meaning to the illness both influenced and was influenced by the ways in which families examined past events and the perceived importance of these events to the development of the illness. That process of re-examining the past in terms of the meaning of mental illness will now be examined.
RESTRUCTURING THE PAST: THE PROCESS OF UNDERSTANDING

The researcher's interest and the focus of the interviews centered on the period of time covered by the hospitalization episode. In spite of this, most families seemed to have a need to discuss and evaluate, in retrospect, events and interactions between themselves and the patient that occurred prior to the hospitalization and to reconstruct these events in terms of the present experience. The process of understanding involved reframing specific events in the past, and examining their own and the patient's contribution to the development of the problem. Their attempts to understand the illness thus involved an assessment of themselves and the patient, as they shared and continued to share the responsibility for what had occurred. The concept of reframing as used in this context will now be examined.

Reframing: Adding Meaning to Specific Events

. Most families mentioned specific events in the family's history as significant factors, that may have contributed to the patient's illness. Events such as moving, attempting to find a job, or a marriage breakup were examined as possible stresses which could have caused the problem. The ways in which the patient's environment was different from that of others was examined by some families, while others pointed to the differences in the
patient's personality from the norm.

It was not clear how much of this kind of introspection took place during the hospitalization period, but it would seem that it became a major activity, once the patient was in hospital. As one family member put it: "I just sort of let it coast along." There seemed to be a tendency to rationalize the behaviour prior to hospitalization, which subsequently became reframed after admission. This latter attitude is exemplified by the terminology used to describe the patient prior to hospitalization:

R: So you explained that he was having problems?

F: Yeah, well, I, they had known previous to that ... that uh, I was having a problem with him not wanting to go out and ... I guess the whole family were putting quite a bit of pressure on him to find work.

Such behaviour was redefined by families as significant, given the present circumstances.

Families also examined the significance of the patient's personality: the perceived differences compared to other family members, and the behaviours which had been accepted as habits of long-standing duration. The purposes of these discussions ranged from suggesting other possible explanations, to merely describing symptoms noted prior to hospitalization, or explaining the patient's unique response to treatment: "He's never been one to open up and
find things for himself." Similarly, another family described it this way:

R: Can you pinpoint what might be the cause of her behaviour?
F: Her withdrawing from the family?
R: Hm, Hm.
F: ... has always been real quiet and not very outgoing person ...

Another common response by families as they evaluated the past was their redefinition or reframing of previous notions of the patient to fit new views of him or her as being "sick." These differences can be seen through comparisons:

F: I don't understand uh, her problems. They may be associated with things which seem very light to me, but are very serious to her. The fact that she is getting older, for example, she's at an age when other children were out of college, and she's still not, hasn't completed her studies.

Another family compared the patient this way:

F: From time that he was very, very young, he was kind of—not different—but, um, his temperament was different than the two older ones.

As past events were redefined as significant, the effectiveness of the treatment regime in addressing them was also evaluated. Some families encouraged patients to "talk about it." One family member, for example, accepted her physician's statement that the patient should discuss
the past, and in fact agreed that this is what finally helped him:

R: What part of his treatment has helped?

F: Well, the talking. In the beginning he was quite, you know, he didn't want to participate in the group sessions, because he thought--the things--he couldn't tell things.

On the other hand, another family who had a different knowledge base due to professional experience, was not as ready to accept such discussions: "I'm not really interested in getting into our sexual or marital things, or, you know, going into family background. That's not what he's there for."

Families thus agreed or disagreed with the therapy, depending upon how congruent they felt it was with their own evaluation of the problem and their knowledge of what the patient was like. One family discounted the meaning attached to the patient's participation in group therapy because it was out of context: "It wasn't as meaningful as they thought, because they don't know what his home life is and how he is at home."

Several families described the patients as private individuals who did not easily share with others. These families were concerned about the effect of group therapy on their relative. As one family member stated: "I thought they would probably have more individual discussions, to see if they couldn't get to the bottom of
Ambivalence experienced in redefining patient behaviours was evident. While they accepted the behaviours as symptomatic of illness, they also attempted to explain them as just "the patient's personality".

The Process of Self-Evaluation

In the process of redefining the meaning of past events, the families also examined and re-evaluated the importance of their own behaviour. They evaluated the ways they had interacted with the patient, and redefined them as possible contributors to the problem: "I am too lenient with him...I just feel that he and I don't get along very well, and I'm probably a lot of the cause of his problems."

Other families queried the effect of their interactions:

F: We weren't comfortable or very happy with ourselves most of the time and she sort of got the bulk of that. I think that is part of it, although I don't - I was sort of feeling that she had come to terms with that.

The position of being too accepting of the patient and his or her past behaviour was also mentioned. Feelings of remorse were evident that perhaps at the time they were not aware of what they could have done:

F: I would have been happy for him to have got himself where he could get married a while back; he probably never would have gone into this, at the same token I couldn't push him out. I encouraged him to look for work, and do this and that...tried to, but I couldn't say, you got to
get out...So you see, I'm at fault too, I know, but what do you do, how do you handle things?

Similarly, another family examined the patient's past relationships with the family by stating:

F: She, I think, does not feel part of our family. I don't know how that happened, we're not conscious of having treated her differently.

One family member seemed more concerned about her behaviour just prior to hospitalization and her ability to cope. "Mainly at that point it seemed to be both our problem. I certainly at that point wasn't hanging in there too tight either."

Another family member clearly stated that he felt no remorse: "if (patient) had died that night, I would have had a clear conscience about my own part in his latter life, partly because I was doing all I could." This same family, however, related their process of questioning themselves about "whether we could have been more responsive to his pain," indicating that they could have responded to the patient differently, and thus perhaps prevented the suicide attempt.

For the Chinese participant in the study, the issue of responsibility was an important one because of her position as the eldest sibling. The expectation in her family was that she would "look after" the patient who was younger than she, and she had attempted to help him in the past, with little success. She continued to view her relation-
ship to the patient as one of responsibility:

F: I think, you know, he's the youngest in the family, and uh, I think, for the youngest, it depends on the eldest more than I do, because I am the eldest in the family. You know, the mother looks after you, but you have to look after the youngest that follows you.

One family described feeling impatient with their relative's constant complaints of physical ailments in the past and acknowledged during the interview that they had not understood "this kind of illness."

Similarly, several other families described feelings of impatience with the relative's behaviour:

F: You know, he's a big boy, I can't slap him, I can't say, you have to do this and you have to do that. It's entirely up to him. Actually he is a big boy. But I was so upset at times, but I didn't say anything. I stay quiet because, what can I do, I can't do anything.

These reactions to the patient in the past were reframed in terms of what the families now understood to be the significance of the patient's behaviour. The reactions were now viewed as "wrong" or ineffective and families described changing their responses to the patients now that they were in hospital.

This discussion has outlined the process by which families were attempting to understand what was happening in the present by examining what had occurred in the past. They examined events previously taken for granted, and
began to see them as significant factors in the develop-
ment of the patient's illness. They evaluated their
interactions with the patient in the process of redefining
their significance to the development of the illness.
They spent time thinking about the patients' "personality"
and its importance in the development of the illness.

The next section will discuss how the families dealt
with the effect of the hospitalization on their daily
lives. The problems and concerns that arose as a result
of the hospitalization will be presented as the families
perceived them and the process by which they dealt with
these concerns will be examined.

THE PROCESS OF ASSIMILATING THE ILLNESS INTO FAMILY
FUNCTIONING

As the families discussed the process of evaluating
themselves and the patient in terms of the past, they also
were concerned about the effects that this illness and
hospitalization would have on their present family rela-
tionships, and on their interactions with the patient and
the hospital. As a result they experienced new problems
and concerns about dealing with the hospitalization.

The process by which the families were attempting to
deal with the problems and concerns was an integral part
of their efforts to assimilate the experience. The
assimilating process involved several facets: 1) learning to identify necessary role changes and dealing with them; 2) using informal methods for information gathering; 3) comparing their relative to other patients in an attempt to rationalize their beliefs about mental illness; 4) adjusting personal routines to accommodate hospital routines; and 5) making decisions about including or excluding small children from the experience.

Their beliefs about causality and their concerns about their own contributions to the illness created initial feelings of uncertainty about how to approach the patient when visiting. More importantly, many families alluded to queries they had about their role in relation to the patient because this had happened: "How do you be firm with the guy who was always firm with you?" Another family described it as: "Yeah, I suppose now I'm a little nervous about what I do and say to him - I don't treat him like I used to."

Beliefs about and attitudes toward mental illness were evident in the examples cited above: the families felt they had to choose their words carefully when interacting with the patient, because saying the wrong thing may "set it off" again. Role changes were evident as some families began to expect less of the patient in terms of decision-making.

They asked questions about resuming a parent role, or assuming responsibilities normally taken by the patient.
This was evident regardless of the role of the patient as spouse, son/daughter or parent. The solutions to these dilemmas varied, depending upon how the family viewed the patient's ability to make his/her own decisions or accept responsibilities:

F: You have seen very recent evidence that this person is not capable of making decisions, in his own best interests ... at what point did you get to thinking that he is capable of making up his mind in a productive way?

Another family member described her attitude toward her role change in relation to her husband in hospital: "In a way, you know, at that moment, you just have to treat him like small children, you know, you have to keep on, repeating and repeating things."

The families' beliefs about the roles and functions of various health professionals affected their ways of assimilating the experience. When there were questions about their own contribution to the illness, the families considered psychiatrists and others as "experts," professionals who would be able to answer these questions. All families experienced disappointment when such information was not offered. They acknowledged their need for information but were unable to seek it out. They continued to hope that the professional would seek them out. When this did not happen, their efforts to assimilate the experience were hampered:
F: There's never anybody around when you go.

R: In the evenings, when you visit?

F: Right, well I haven't found out anything. I don't know, maybe I've been wrong, maybe I should have just pushed in and asked a whole bunch of things, but I thought maybe they'd, whoever was, would tell me.

R: Do you understand what it is they are trying to do with (patient)?

F: You can't phone and say, how is (patient) today, I really need to know that, because maybe I'm not entitled to know that anymore, nobody's ever said anything to me about that.

The insecurity and self-doubts expressed by this family were shared by other families. Although information gathering was seen as a necessary element of the assimilation process, they lacked the resources to do it.

Assimilating the experience included relating to the hospital environment. They were uncomfortable in the environment, as evidenced by uncertainty and insecurity in approaching the "right person" for information. The discomfort hampered the assimilation of this other, new "culture" into their own.

This response of the families to the psychiatric ward was part of their reaction to its "cultural" aspects. "Culture" is used in this context to emphasize the impact of a totally new setting--a sub-culture of the families' larger culture, which has its own norms of behaviours, its own rules and regulations and its beliefs and attitudes toward mental illness which may be different from those of
the families. Some or all of these aspects were difficulties for them. As one participant described it: "The environment is so separate in the hospital, home and hospital are two different worlds."

Families related the informal ways in which they attempted to understand the "culture" of the psychiatric hospital. They sought information about the rules and regulations, the routines of the ward, the kinds of therapy offered, and then formed opinions about all of these aspects.

One family member described her impression that the "lounge" meant they should spend time with other patients and families: "Well, you saw us in the lounge. No, we go there, 'cause we don't want to be separate from, you know, feel separate from the other people there; we're all kind of in the same boat".

In many cases, the patient became the main source of information about the hospital "culture":

F: I was very interested in knowing what had happened in the hospital, with him, in these group sessions that he hated so much.

R: You never really got a clear idea what they were about?

F: Only from (patient). And nobody told me what they were all about.

For many families this was unsatisfactory, and attempts were made to elicit information from the nursing staff. Other families listened attentively to interactions between
the staff and the patient, and attached meaning to them:

R: Have you asked the doctor that question, how long it will take?

F: No, not really - well, he talked about it yesterday, not that I asked him that question, but it came out in the talk that he had with (patient) while I was there.

In most cases, families expressed dissatisfaction with this method of information gathering, or expressed a wish that it evolve into consistent and frequent contacts with, as one family described it, "someone who has some connection with him." At the same time, however, families did seem to use what information they received as a means of evaluating the "rightness" or "wrongness" of the treatment, and its effectiveness for their relative.

F: I couldn't really say, well it's a great place, I don't really know what - how deeply involved they got in discussion groups, but ... I thought it was just sort of a place where you talked with the other patients there and ate and slept.

From attempts to assimilate the philosophies of the hospital into their own belief systems, conflicts became evident. For example, in one unit the philosophy was to assume that patients can be responsible for making decisions and evaluating each other's progress. Several families expressed concern at this:

F: You can't depend on somebody, you know, most of the people on this ward there is something a little bit wrong in here (pointing to head), you can't depend on the people with something wrong in
Such conflicts in beliefs resulted in increased concern for families about how the patient was being treated. Such concerns made the assimilation of the experience more difficult, adding more questions and doubts which affected their ability to function on a daily basis. A further illustration of the effects of beliefs and attitudes was found in the families' reactions to the patient on pass. The passes added some stress which affected the family's functioning. Time was taken to evaluate the patient's behaviour and appearance:

R: You see a change in him right now?

F: Oh yeah, yeah. I thought he was on Sunday, on the weekend it was very very good, I thought. I was a little apprehensive to start with, but once he came in and started talking, I knew it would be all right.

Beliefs about mental illness also affected the families' evaluation of the seriousness of the illness and their expectation that the hospital would "get to the bottom of the problem." The majority of families viewed the illness as serious, and this view affected the family functioning. One family member stated: "I know it's serious. You know, what will be resolved in one week?" Another family expressed relief that the patient's illness was situationally related and thus was not as serious, indicating that major changes in family functioning would
not be required.

The awareness of the "problem" influenced the assimilation process, as families came to expect long admissions, and they therefore prepared themselves for this period of time. When discharge became imminent earlier than anticipated, the families expressed surprise. For some, there was a lack of readiness and a concern for the patient's ability to function and the family's ability to cope. The lack of readiness was discussed in terms of questions about accommodation and employment. They were also unprepared because of the lack of understanding of what had occurred:

F: Let's suppose they've had - (patient) has been out there for two or three weeks...and they have studied her over this period, and it's decided that she should go home...well, she still comes home a complete mystery.

Two families described close and supportive relationships with the relative's psychiatrist which helped them to feel more comfortable with the experience. They were less concerned about the discharge because they felt they were able to get the information they needed.

Other families mentioned one or two contacts with other staff members that were satisfactory; however, they experienced frustration later when this person was no longer available. Again, they referred to the need for one consistent person to help them deal with the experience—
especially to help them understand the "culture" of the hospital.

Receiving prior notice of discharge was important in terms of its effect on the family's functioning. Most families received some understanding that the hospitalization would last for several weeks or more and so had adjusted somewhat to the absence of the missing member. In the one family where this did not occur and discharge was expected after several days, they experienced confusion and a more immediate concern for their ability to cope:

F: We didn't know from day to day, now if someone had come and said, now look, we're going to keep him for two weeks, it would not only give us a period of time to readjust, and to say, okay, a breathing space, we got two weeks, you know, then we can worry about what's going to happen then.

Families who did have some idea of the length of hospitalization spoke of an improvement in certain areas, now that the patient was "under care." A sense of immediate relief was experienced by most families at the time of admission, but also a recuperation of physical and emotional strength was described. For example, sleeping patterns returned to normal and daily activities were resumed in a more predictable fashion. They further described adjustment to the idea of hospitalization which occurred after an initial period of time: "The first couple of days, you really aren't oriented to what the procedure is all about." Another participant who described a disturbance in concentration and constant thoughts of her
relative in hospital, later described her adjustment:

F: It's not as bad as in the beginning; I didn't know what to do ... I'm doing more things now ... than I did the first two weeks. So, you know I have adjusted to it.

The adjustment described by this family member again emphasized the role changes that occurred as families began to assume some of the responsibilities formerly belonging to the patient. Other families indicated role changes in terms of a relief from responsibility, which they saw as being assumed by the hospital.

Finally, the families spoke of the effect of the hospitalization on their daily lives; that is, they more specifically defined the practical issues and concerns they needed to deal with. Two areas identified as important considerations were financial problems, resulting from the hospitalization, and the responsibility of visiting the patient, resulting in the disruption of the daily routine:

F: I was a little concerned also with expenses, that's one reason I saw the social worker - we're not overly rich.

Another family described it this way:

R: What effect did it have on your every day life? What difference did it make?

F: Well, it really did to me, uh .. because I live so far away, for one, and I felt guilty that I should be in to see him as much as I could. I was going in, once a week, which is a lot for me when I'm working full time and I'm trying to do everything else, and it's mentally exhausting.
A third consideration discussed by several families was the presence of small children in the household. The need to explain the reason for hospitalization to children was affected by the children's age, and by the parents' desire to protect them:

R: Does your daughter understand why her father is in hospital?

F: I don't - no I don't think so, what is really happening, and uh, I'll leave it like that ... she's only seven. So I don't want to go into detail.

This section has discussed the family's efforts to assimilate the hospital experience into their daily lives. The process was described as consisting of many elements: evaluating the patient and deciding how to interact with him/her; dealing with the elements of the hospital culture, and resolving the problems and concerns that arose as a result of the hospitalization. The process was affected by the family's beliefs about mental illness, and the difficulties they experienced in gathering information about the illness and the hospitalization.

The family's efforts to assimilate this experience into their family functioning also had important implications for their considerations of the future. The process by which they attempted to deal with their questions about the future will now be discussed.
EXAMINING THE FUTURE: THE PROCESS OF DEALING WITH UNKOWNNS

As explained previously, the meaning of the present experience of the illness and hospitalization was discussed by the families within the context of evaluating the past and examining the future. While these two themes are presented here separately, it is important to note that for the families they were intertwined, that is, how they evaluated what happened in the past was reflected in their decisions about how the hospitalization could or should change situations in the future.

Three major areas were identified: 1) defining their relationship with the patient in the future; 2) determining the possibility of a cure; and 3) examining the need for separation from the patient. A predominant attitude they expressed, as these issues were raised in the context of what had occurred before, was that "things would be different" in the future. Families had held this as a hope and/or an assumption at the beginning of hospitalization, but expressed disappointment as discharge approached and the changes were not apparent.

Defining Relationships

Several variables were discussed as important to consider in the future relationship with the patient. The issue of who was now responsible for the patient arose as a
result of the changed expectations of the hospitalized patient. Families seemed to have decided that they must be involved, as they questioned the patient's abilities to cope with the future:

R: What about now that he's getting some treatment in the hospital, what do you expect will happen from that?

F: Well, I think this is what worries me the most now, is that I know what the problem is, what kind of future is he going to have? Is he going to be able to find a job and help support himself?

Families also continued to question the impact of their interactions with the patient in the future, assuming that by saying or expecting certain things, "it" will start again:

F: I'm a little nervous about what I do and say to him - I don't treat him like I used to, sort of thing.

R: Because he's been in hospital?

F: Yeah, well you're kind of afraid that they'll fall back into the way they were before and you're not sure if you are the cause of it or not.

The age of the patient was discussed as a significant variable in determining the family's involvement in the patient's future. When patients were in their early twenties, for example, families expressed concern because they were so young and their entire futures were affected.
Several families described a dilemma they felt regarding legal responsibility, firstly because the patient was twenty-one, and secondly because they felt there were legal implications of the patient's suicide attempt.

While some families expected less of the patient in the future, other families felt they would have to give a clear message that change was expected. The families were willing to support the patient after discharge, but expressed less tolerance for disruption of their family functioning:

F: She did talk about coming back.
R: Is that something you think might happen?
F: Hm, hm, Sure. And that would be fine. I don't know, I think that, it's almost that we'd have to put down some guidelines, she'd have to understand that we have our own life.

This indicates the dilemma that many families experienced as they looked toward their future relationship with the patient. They expected less of the patient but at the same wanted things to be different. Their questions about whether the patient was cured were a major factor in determining their expectations in the future.

The Possibility of Cure

Beliefs about mental illness were very evident here, as families discussed how long it would take the patient to
get better, and the possibility of a recurrence. Questions like "will he ever be the same?" and "will he get back to normal?" reflected the feelings of uncertainty experienced. As well, families viewed the problem as serious, and thus felt the patient required more time after hospitalization to "get better."

R: What do you expect will happen after he comes home, will be continue to see Dr. S.?

F: Yeah.

R: Did they talk to you about that?

F: No...I guess he will go more often, in the beginning, you know, until he is completely... rid of his problem.

One family member who queried genetic involvement felt that the patient had the problem for life. Others, who felt the hospitalization had not adequately dealt with the problem, did not expect much change in the future. As one family member described it, "I don't think it was helping him to stay there" and another felt that the change was "for a very short period of time."

The attitude toward the possibility of a recurrence was varied: most families expressed a hope that it would not happen; several expressed a "wait and see" attitude, while several others thought it was possible because they still lacked the knowledge they needed to support the relative in the future.
The Need for Separation

The need to change the environment in some ways was expressed by all families, the degree and type of change depending upon what they believed caused the problem. The accommodation of the patient was a common focal point: "Should he come back to the surroundings that he left? Is he going to go right back to that kind of thing again?" Another family expressed concern that the patient's environment was not changing, therefore the possibility of a recurrence was increased.

The issue of changing the patient's living arrangements was one that was raised by the hospital staff in several cases, and these families had strong opinions about the suggestions the patient was receiving: "I'm worried about this business of him going into a place of his own. He wouldn't be happy in a group, he wouldn't be happy boarding."

Other changes in the environment that had been identified as sources of stress, such as the patient's employment, were still considered important. One family member expressed acceptance of such changes, but also felt strongly that she needed to be included in such planning:

F: It's my future too, right? It's not just my husband, we have to go through it together, and if I don't know what they plan for him, then it's, you know, I can't help him here, if I don't know if he has to go through this or through that, so yeah, I want to be involved.
Such feelings and beliefs about the family's involvement in the patient's future were shared by many families. The need for involvement in decision making about the future was one of the most important of those identified by the families.

SUMMARY

This chapter has presented the families' accounts of their experiences of the first psychiatric hospitalization of a relative. It has been described in terms of processes, developed and organized by the researcher within the framework delineated by the study's purposes. The themes identified as processes thus indicated the dynamic nature of the experience for these families.

The process of accepting hospitalization as a solution was described as an important aspect of the hospital experience which families needed to explore. Events that occurred prior to hospitalization were examined for added meaning, now that the patients were defined as sick, and their behaviours were seen as symptomatic of their illness.

As families attempted to understand the meaning of the illness and its treatment, it became clear that they perceived it as a negative experience in terms of the stigma attached to it. Their process of understanding also
included an examination of their relationship with the patient, both before and during hospitalization. They, therefore, viewed the experience of illness as a shared one, a view they continued to hold about the treatment.

Finally, the effects on the family's functioning were addressed in terms of the problems and concerns the patient's hospitalization caused. Their difficulties in dealing with such concerns on their own were discussed, as were their apprehensions about dealing with the future and its uncertainties.

Throughout the accounts, the families expressed a variety of emotions, from relief that the problem was being dealt with to guilt because they had participated in the admission. Families were able to identify what they needed from health professionals and they were able to distinguish between emotional and informational needs.

This chapter has attempted to present the accounts as they were constructed during the interview process with the families. The next chapter will interpret their significance as they relate to the literature reviewed in Chapter II.
CHAPTER V

DISCUSSION OF ACCOUNTS

In the previous chapter, the families' reactions to the hospitalization of a family member were presented. These reactions will be discussed in relationship to the literature reviewed in Chapter II. The purpose of such a discussion is to illustrate how the present knowledge of the impact of hospitalization on families can be enhanced by eliciting the family's perspective.

The purposes of the study guided the researcher to seek the families' perceptions of all aspects of the hospitalization, their perceptions of problems and concerns and how they dealt with them, and their perceptions of what they needed from health care workers. The discussion of the relationship of the accounts to the literature will therefore pay particular attention to the increased understanding of these areas.

The chapter will follow the organization of the literature reviewed in Chapter II. The areas to be discussed are the impact of physical and mental illness on the family, the psychoanalytic theory of the family as an etiological factor, interpersonal theory of the importance of roles and relationships, and systems theory and the
effect of hospitalization on the family functioning.

IMPACT OF PHYSICAL AND MENTAL ILLNESSES ON THE FAMILY

The review of the research in this area revealed two major categories of illness: illness episodes regarded as a crisis, and chronic illness viewed as on-going stress for the family. Both of these categories seem to apply to this study, but at different phases of the illness experience.

Families described experiencing stress prior to hospitalization. They described the patient's behaviour as "unpredictable," or "disappointing." They then related the emergence of a new event or situation for which they were unprepared. The situation became a crisis, warranting immediate attention by someone outside the family.

Research in this area also revealed a parallel between chronic mental illness and the effect of tuberculosis (Anthony, 1969). The question has been raised whether certain physical illnesses, such as tuberculosis, have a stigma similar to that of mental illness.

The families in this study perceived no such similarity between the experience of mental illness and any physical illness. Although the extent of their experience with physical illnesses may have affected their ability to draw such parallels, it is their perception of these situations which is at issue. These families viewed their
situations as being unique within the health care system. That fact must be considered when evaluating their efforts at dealing with the psychiatric illness and treatment experience.

The research specifically concerning general hospitalizations for physical illness indicated that families' responses and coping patterns were affected by their unfamiliarity with the hospital environment and the type and severity of the illness. The coping patterns of the families in this study were similarly affected.

Families did indeed identify lack of previous experience or exposure to psychiatric hospitals as a factor in their ability to cope. They described their notions of general hospitals, presumably formulated from a variety of sources, and their finding that any such knowledge did not help in the present situation. It was as if the psychiatric hospital were a sub-culture of its own to which few people were exposed, and for which the rules, procedures, and assumptions of the larger culture did not apply. Thus, they experienced confusion and dissonance when exposed to ward routines, regulations, philosophies, and treatments that were different from what they assumed hospitals were like. One family did have a prior exposure to a psychiatric setting because of the hospitalization of another member. This family felt that, as a result, they understood what the patient "was going through", but it did not help them to deal with the second hospitalization, or to feel more
comfortable in the psychiatric hospital setting.

The families' perceptions of severity of illness was an important aspect of the experience for them. They felt that their awareness of stigma affected family functioning. This is a finding similar to Stember's (1977), in that the families' perceptions of severity influenced the amount of stress they experienced.

The differences between the two findings, however, were the factors seen to influence the family's perception of the patient's illness. In Stember's study, she felt it was due to the lack of communication between physician and family. In the present study, families felt that severity of mental illness was less easily and less accurately defined than physical illness, because it was less visible. There were no tangible signs of the illness. The ambiguity of mental illness experienced by all families led them to perceive the patient's situation as "serious," regardless of the particular diagnosis.

It would seem that this ambiguity may be due to their lack of psychiatric knowledge, compared to the more prevalent medical knowledge. In order to help explain the meaning of the patient's illness, families may make erroneous assumptions because they lack the knowledge necessary for and specific to the situation at hand.

In summary, families viewed mental illness and hospitalization as different from physical illness and treatment. At the same time, however, they tried to see the
similarities in order to make sense of the experience. It is important to recognize that such incongruencies may exist in many areas where families are struggling to develop explanations of the various aspects of the hospitalization, and are attempting to deal with the problems and concerns that arise. The perception of the uniqueness of the psychiatric hospital was thus an important aspect of the experience which families identified. They had problems in coping with the experience as a result of this perception.

FAMILIES OF PSYCHIATRIC PATIENTS

Psychoanalytic Theory: Family As an Etiological Factor

While the present study was designed to elicit the family's perception of the hospitalization and as such was not concerned with causal factors in the illness, most families initiated discussion of causality themselves. The question of their own contribution to the development of the illness had a major effect on all aspects of the hospitalization experience.

During the course of the interviews, it became obvious that the families did not share the researcher's view of the hospitalization as a distinct experience, or even a distinct period of time. For them, the hospitalization became one aspect of the illness experience, as did the
events leading up to admission. As a result, this researcher came to understand the families' view of the "illness-hospital experience," rather than to narrowly focus on aspects of the hospitalization as a separate experience.

During the time of the hospitalization, the families examined their familial roles, whether as parents, children, or spouses. They examined their own values and were concerned about the effect of these on their expectations and treatment of the patients. The reviewed literature indicated attempts to identify "specific parental attitudes, traits, or practices" (Bloch, 1974: 182) which caused mental illness. The parents in this study similarly examined their own lives for the laying of blame. Children and spouses also examined their past relationship with the patient, and tried to determine how they could have helped, thus preventing the illness from happening.

A major characteristic of the illness-hospital experience that was clearly described by families was their perception that it was a highly personal one. In other words, they saw themselves as involved with the patient prior to admission, and continued to define the hospitalization as a shared experience. Previous research has not called attention to this important perception.

The search for causal factors, while it included self-examination to a great degree, also included an examination of the patient's personality, implying that
"that's the way he or she is" and thus could not be expected to be any different. This explanation and acceptance of certain behaviours emphasized the families' belief in shared responsibility. They were willing to accept blame, but only to a point. The lack of clarity in their own thinking about this issue of responsibility was evident. It was a sensitive issue, a problem that families had difficulty resolving.

The assumption by families that they had contributed to the patients' problems influenced their expectations of the attention they would receive from hospital staff. This is an area that had not been addressed by previous research. Believing that they were part of the problem, and assuming health professionals shared this belief, families therefore expected to be part of the solution. They also expected to receive information on what they could do differently to prevent the problem from recurring. It was a concern to them when such suggestions and help were not forthcoming. This did not indicate to them that their assumptions had been wrong, only that they had not been confirmed.

The failure of the staff to meet the families' needs for support or denial of perceptions left the families feeling pessimistic about the future. While the expectation of these families of the degree and type of involvement in this setting may be unique, they evidently did have some understanding of the roles of health professionals.
This researcher has questioned why these families subjected themselves to such intensive introspection. Were they using it as way of "making sense" of their experience? It may be that the lack of clear answers from other sources resulted in the families using their past interactions with the patient as a way of explaining the illness. Complex societal forces may also contribute to their views, as may the messages they receive from health professionals.

Several families in this study were not so intensively introspective. They were not preoccupied with accepting blame for contributing to the problem, and thus seemed to expect different results, regardless of whether they were included in the treatment. In one case, a family member had a comfortable relationship with the patient's psychiatrist, whom she trusted to make the patient "better." She accepted her lack of understanding of the treatment. In another case, a family member had professional experience in the field, and therefore utilized her knowledge to explain what was happening. The contrast provided by these families illustrates the importance of considering the source of knowledge and how it is used by families in understanding events. It also highlights the individuality of each family's experience, and thus adds an important dimension to the consideration of families' reactions to hospitalization.

A further contrast to note in this discussion is the effect of cultural backgrounds on one's explanations of the
cause of the problem. For the Chinese family in this study, there was a distinction between mental (meaning "crazy" and "scary") and emotional (meaning struggles with one's conscience for wrong-doings). Since the patient was subjected to a struggle with his conscience, the family believed the patient's own actions were the cause of the problem, and therefore they felt there was little they could have done to change that, other than give advice to act differently. Such cultural variations, while certainly not definitively demonstrated in this study, highlight the importance of clarifying key phrases or terms such as "mental illness" with each family and patient.

This discussion has shown how the issue of causality is an important aspect of the illness-hospitalization experience of families, involving a "looking back" to the past for explanations of present events. The following discussion will examine what has been learned about the effects of these and other aspects of the experience on the family's interactions with others.

**Interpersonal Theory: Impact of Mental Illness on Family Interactions**

The responses of the family to the presence of a mentally ill relative have been researched in some depth. Several factors should be considered when evaluating the effect on the family's interactions with the patient, with each other, and with others outside the family unit. These
factors include difficulties in accepting the illness, changing expectations, making decisions regarding the care of the relative, and shifting responsibilities.

**Difficulties Accepting Illness.** The ability of the family to accept the mental illness was a major variable studied by researchers. The literature contains reports of conflicting results.

Several authors reported that families denied the mental illness as they searched for physical causes to explain the patient's behaviour. While the present study has indicated similar difficulties for some families prior to the hospitalization, these same families began developing an awareness of the patient as "mentally ill" when hospitalization actually occurred. This was shown clearly by their descriptions of the patient as "different" and his or her behaviour as "not normal."

What seemed to be difficult for these families was dealing with the problem of the patient's behaviour. They described difficulties in "taking charge" of the patients for a long period of time, and encouraged the patients to seek help for themselves. This was in contrast to interactions with patients after admission, when families described a more direct and firm approach toward the patient.

Having decided to seek help, families related their efforts to contact psychiatrists or other mental health
professionals or agencies, thus indicating their awareness of the problem as "mental illness." Clausen and Yarrow (1955) indicated that families most often contacted the family physician first, and related this finding to the family's need to define the patient's problem as a physical one. In the present study, in cases where a family physician was contacted, it would seem that it was as much a case of not knowing where else to go as it was an attempt to define the problem as a physical one.

The difficulties they experienced in seeking and receiving this kind of help may have been aggravated by the hospitalization, since it forced the recognition by themselves and others that the patient was sick. Even though behaviours prior to hospitalization were viewed with concern and there was an awareness of the need for psychiatric help, it seems that it was not until the patient was in hospital that the "sick" label was applied. Phrases such as, "now that I know what the problem is" and "now that she's sick," were indicative of a change in the way that families viewed the patients.

There was a concurrent shift in the interactions with the patient. A sense of uneasiness or carefulness developed. The reader is referred to Zwerling and Mendelsohn's (1965) impression that hospitalization is a last resort for the family--an interpretation that could be applied here, because of the "sick" label.
The Perception of Stigma. The initial hesitancy about hospitalization may also be influenced by the family's perception of stigma, in that hospitalization is more difficult to conceal from others. Clausen and Yarrow identified the need for concealment as important to the wives in their study, and it may be an important influence in the present study.

The complexity of the stigma issue and the need for concealment may have had an effect on who was considered "acceptable" to contact for help, without publicly labelling the patient as "mentally ill." The literature reviewed revealed little in terms of responses by families in regard to stigma.

This was an important concern for all families in the present study, affecting all aspects of the hospitalization. As discussed in the previous chapter, families dealt with the problem by becoming selective about with whom to share the information, becoming protective of the patient, and in some cases developing closer familial relationships as they began to rely on each other to preserve their privacy. They excluded outsiders who would not understand, or who were perceived as having negative ideas about mental illness.

The notion of increased sensitivity by families to such attitudes in others was also a finding in Davis' (1980) study. She observed that families responded with anger when they perceived any evidence of stigma. Such
sensitivity was evident in the families' accounts. Rather than an angry reaction, however, they seemed to accept the fact the stigma existed and attempted to protect themselves and the patient from it.

The perception of stigma, therefore, provides an important understanding of the impact of the hospitalization on the families' daily lives. The family's ability to deal with the mental illness of the patient was affected greatly by their impressions of the stigma associated with the illness. The issue of stigma was an important one which affected their interactions with the other family members, friends, neighbours, and co-workers.

Making Decisions Regarding the Care of the Patient. Relinquishing of responsibility for care to the hospital was an important factor, according to one study reviewed (Rose, 1959). In the present study, however, the relief from on-going worry reflected the families' beliefs that the hospital was the "right place" for the relative to be, regardless of their evaluation of specific aspects of treatment or the hospital environment.

This finding is similar to that reported by Rose (1959), who also found positive attitudes toward the hospital. His respondents, though, related the relinquishing of responsibility to the acceptance of "authorities" who had taken over and "relieved them of the burden" of caring for the patient (1959: 198).
In reviewing Rose's study, one notes that these same respondents tended to deny the "mental symptoms" of the patients, and seemed to use the hospital to exclude the patient from the family unit and thus maintain denial of the psychiatric illness. Such exclusion would certainly be easier during the time of Rose's study, when the average length of stay was nine years. Families in the present study perceived the hospitalization as appropriate as they developed awareness that the patient had psychiatric problems. The institutional nature of psychiatric treatment during the time of Rose's study is a significant variable to consider when comparing his findings to the present study.

Families in the present study may have perceived psychiatric hospitals, particularly psychiatric units within general hospitals, as representing shorter hospitalizations. The parallels with general hospitals in terms of the actual setting may facilitate this perception. It may have an effect on the family's response to the patient's admission, as well as the amount of contact and degree of involvement they experienced with the patient. Further research is needed to assess whether the location of the psychiatric unit in a general hospital influences the families' experience of psychiatric illness.

The observation by other researchers (Fleck, 1965) that families felt guilty about the patient's hospitalization is consistent with the findings of this
study. The degree to which families experienced this guilt seemed related to the role they played in getting the patient admitted and the degree of responsibility they accepted for causing the problem.

The guilt feelings experienced affected the initial interactions with the patient. Families described a watchfulness or attentiveness toward the patient's actions and conversation. They felt relieved and more comfortable when they observed that the patient was "relaxed" and "all right," and that he or she did not appear upset about the hospitalization. In two cases, however, the patients expressed ambivalence and this increased the guilt feelings for the families.

A further observation made in the literature was that families felt a sense of failure when hospitalization occurred (Fleck, 1965). This finding was not clearly supported by the present study. While the families acknowledged that they were no longer able to cope, their overwhelming feeling seemed to be relief that the "professionals" were available and were now dealing with the problem. It was particularly evident in families who had been living with "the problem" for an extended period of time, and who experienced relief when their family functioning returned to "normal."

**Changing Expectations.** Several researchers mentioned that families changed their expectations of the patients.
This was seen as a coping mechanism used to deal with the problem (Lewis and Zeichner, 1970). Such variables as "enlightened attitudes" and "degree of acceptance" of the patient were also examined and related to the number of previous hospitalizations or to the social class of the family.

The present study revealed that what families expect of the patient is a more important variable than has been indicated by the literature. They began to expect less of the patient, particularly in terms of the future, but also continued to question the appropriateness of doing so. Relationships such as "attitudes" and "social class" were not as important to consider, in the families' views, as previous researchers have thought.

This section has described how various factors, such as difficulties accepting the mental illness prior to hospitalization and the stigma associated with mental illness, were important aspects of the experience. They resulted in problems and concerns for the families in regard to their interactions with the patient and with others. Families identified feelings of guilt as well as relief, indicating a need for support and understanding from the staff. The following discussion will examine what has been learned about the effect of the experience on the family's functioning.
Given that the present study's purposes were to determine the meaning of hospitalization to the family and to identify problems and concerns they experienced, it was expected that this body of literature would focus more on the family system's reactions to stress and its attempts to respond to it to maintain system stability. The research reviewed within this framework was therefore examined for an understanding of how the hospitalization, as a new and stressful experience, affected family functioning.

The concept of "burden" was a major focus of several of these studies, the assumption being that a mentally ill relative places burdens upon the family, and the tasks were to identify and deal with these burdens. Within the systems framework, burdens can be interpreted as demands placed upon the system.

The present study indicated that this concept is too narrow a focus to describe the stress on the family system. The families did not relate the effect on their lives in this sense only. They responded to the researcher's queries about problems, concerns, and effect on every-day lives by relating the questions they had formulated in their minds, and which were discussed in other sections of this chapter: What caused the problem? What have I done to contribute to the problem? What does the future hold?

Events such as the admission process, visiting practices, and patient passes were reviewed as potentially
difficult episodes or stressful events for families. As they described their response to these events, it became obvious that meanings were influenced by their emotional reactions to the illness, by their understanding of the meaning of mental illness, and by their concern about their responsibility.

The findings that aspects of daily life were affected, aspects such as household routine, social and leisure life, income and family employment (Grad and Sainsbury, 1968: 271) were presented in two studies reviewed. Some of these findings are supported by the present study in that disruptions of normal routines were described by families both prior to and during hospitalization of the patient.

Effects on daily routines and normal activities seemed to receive less attention or were perceived as less important to the families. They spent more time talking about the effect on their own emotional health and their ability to deal with their emotional reactions to the illness.

The need for supportive care was assessed in one study. In the present study, such a concept was interpreted by the families as their need for "someone to talk to." As one family explained: "Even if they don't have the answers, it would help if they would listen." They had great difficulties in dealing with the lack of contacts with staff, the absence of inclusion in treatment, and the seeming lack of recognition or understanding that they
would continue their close involvement with the patient during hospitalization.

The need for more information about mental illness and the treatment the patients received in psychiatric hospitals was identified in the literature. This was supported in the present study. Lack of information concerning many aspects of the illness and the hospitalization was cited as a hindrance in their ability to deal with the situation, which then left the families feeling helpless and directionless.

Although all families described great difficulties in dealing with these concerns, they seemed to adopt a passive stance. They were unable to deal with this concern by initiating contacts, or by asking questions to determine who was "in charge." It seemed to be a feature of these families that they "never got around to it," although it was a major concern. They either perceived themselves as inadequate--unable to ask the right questions--or they relied on their notions of the roles of health professionals as informants about the patient's illness, and assumed that eventually they would be approached.

Although not stated clearly by families in this or other studies, it is also possible that the presence of guilt feelings affected their ability initially to interact with staff or psychiatric nurses. Further research would be needed to clarify the important elements of the staff-family interaction in such a setting.
When help from staff was not forthcoming, families utilized other methods to gather information. They gave meaning to events they observed or conversations they heard, they relied on relatives for support, or as most families described it, they tried to be patient, waiting for their relative to get better. It became clear that events, situations or even characteristics of a psychiatric hospitalization that health professionals take for granted take on great significance for families.

The concept of a "sub-culture" was offered by this researcher as a conceptualization of the difficulties experienced by families in assimilating the various aspects of the hospitalization into their own world. A heightened awareness was identified as a method of gathering new information about this "subculture." They utilized whatever was available to them to do this: what they saw and what they heard, during chance encounters with patients and staff.

In presenting the accounts in the previous chapter, it was clear that families had notions about their own involvement in the situation, the kinds of treatment they expected, and their expectations for the future. In all these areas, they wanted "expert" opinion to either refute or support their "lay" notions, as well as to provide additional information not readily available to non-professionals.

Families identified the need to be acknowledged as
relatives who were involved in the treatment of the patient. The need to feel comfortable within the hospital environment was identified as a factor that influenced their reactions and their ability to assimilate the experience into family functioning. Being able to identify a consistent person who would spend time with them, having some privacy for visiting their relative, and having contact with other families for the purpose of mutual support were factors identified as important in the adaptation to the stressful environment.

Most families stated that family meetings with staff would have been helpful to them in understanding the experience, a finding that supports Fleck's (1965) discussion of the benefit of family groups. They wanted the opportunity to share their views about what had happened, and to share their perceptions of the patient at home with the staff caring for their relative. They wanted to give their interpretations of what was happening to the patient while he was in the hospital, and they wanted an opportunity to ask questions.

The issue of control by families over aspects of the hospitalization was addressed in one study (Greenly, 1972) in relation to the timing of the patient's discharge. The author concluded that families did have control over the discharge.

In the present study, it is noted that families do indeed have an opinion about the discharge. However, while
most families discussed the discharge in terms of a concern that the patient was not ready, they seemed unwilling, or perceived themselves as unable, to affect that decision. As in all other aspects of the hospitalization, when families experienced concerns or confusion, they were unable to initiate the contact with staff to alleviate these concerns. The impression given in Greenly's study of the power of the family to influence decisions is not substantiated by the family's accounts; they instead experienced feelings of powerlessness and resignation. Family functioning was severely affected by the lack of internal support systems available to handle present and future stresses.

This presentation has offered some support for previous research in terms of the effects of hospitalization on family functioning. The discussion has, however, moved beyond those findings, to identify in more depth and detail the needs of the families as a result of the experience. It has thus emphasized what families felt they needed from health care workers. The next section will also discuss the needs of families, as the findings of previous nursing research are examined.

Nursing Research of the Family of the Psychiatric Patient

A significant contribution to the area under study was found in Leavitt's (1975) study of the discharge phase of the hospitalization and its effect on the family. For
this reason, and also because it is taken as representative of nursing research in the area, its relationship to the present study will now be discussed.

Leavitt also examined and reported that families experienced major disruptions in their lives prior to hospitalization. The families in the present study did not describe it this way. They distinguished the on-going behaviour (something they attempted to adapt to) from the specific crisis event which precipitated the admission. It became a multi-dimensional decision-making process with characteristics of ambivalence and rationalization. Our understanding of this decision-making process must include an appreciation of the family's need to maintain its functioning as long as possible with the resources it has.

A further finding in Leavitt's study was the identification by families of "uncontrollable variables" as causes of the mental illness. In the present study, the self-examination by family members was much more evident, and became a pervasive theme for them throughout the experience. This is not to say other variables were not considered. For these families "other" variables were given less importance in terms of contributing to the problem. One might argue that self blame would be a more important question for a parent of a patient. The present study, however, indicated similar reactions for family members in various roles.

The families in Leavitt's study identified
"interaction with others" within the hospital setting as helpful to the patient. Again, the families in the present study perceived such therapy with ambivalent feelings, and if the family's involvement was not addressed in treatment, then the group therapy for the patient was seen to be of limited value.

Since the focus of Leavitt's research was the imminent discharge of the patient, she presented much data on the impact of this aspect of hospitalization on the families. It was described as a crisis, with families experiencing feelings of turmoil and uncertainty about the patient's future. These findings are well supported by the families' accounts in the present study. As well, these families expressed pessimism or apprehension about the future because they had not learned how they could provide on-going support to the patient.

The criteria for discharge in Leavitt's study were seen to be those of the staff, and not those of the family. The author has suggested that families acquiesced to the staff decision because they hoped that discharge meant the patient was cured. While the families in the present study did not openly disagree with the discharge, they did seem to experience feelings that the problem was not over. They did not seem to accept the patient as "cured," but expressed a "wait and see" attitude which implied that they would expect less of the patient in the future. The presence of such an attitude, however, cannot
be viewed in isolation; for these families it was considered within the context of the entire experience and was influenced by the families' beliefs about mental illness, and the effect of their experiences on changing or confirming those beliefs.

It was not possible to identify at which point the discharge became a concern for families. For some, it became a question they raised very soon after admission. Again, it was not a straightforward issue consisting of debates about the timing of discharge. Rather, it became a focal point of the whole evaluation process in terms of "is this going to make a difference?" It elicited sensitive discussions of feelings by families, all of whom felt it was important for them to understand "what was going on." While they could resign themselves to being excluded from the patient while he was in hospital, they all perceived the discharge as an important event that affected both their own and the patient's future. Thus, the impact of hospitalization did not end when the patient was discharged.

This discussion has focused on the perceptions and needs of the family during a specific phase of the hospitalization: the discharge. It has further provided information about the relationship of those needs to other aspects of the hospitalization.
SUMMARY

The findings of previous research were shown to be corroborated by this study's presentation of the family's perspective. The hospitalization was described as an integral part of the illness experience. The issue of stigma was shown to be an important one for families, as was the issue of causality. Both of these areas were highlighted as a result of this study. The effect on the family's interactions with others and on the family's daily functioning were other areas in which the present study offered new insights.

The accounts of the families in this study therefore have significant implications for nursing practice, education, and research. Those implications, as well as the conclusions of the study, will be discussed in the next chapter.
CHAPTER VI
SUMMARY, CONCLUSIONS, IMPLICATIONS FOR NURSING

SUMMARY

This qualitative study was designed to elicit the family's perspective on their experience of the first psychiatric hospitalization of a relative. Utilizing a phenomenological perspective, the study focused on the meaning that the participants gave to events that occurred prior to and during the hospitalization.

Unstructured interviews were conducted with family members in their homes during the patient's hospitalization period. The interviews were the forum by which the participants constructed accounts of their experiences. They explained how they interpreted events, how they made sense of unfamiliar events or surroundings, and they identified their needs and concerns and discussed how they coped with them. They described their emotional reactions to the experience, and they displayed their cognitive efforts to understand the patients.

The purpose of the study was not to test a hypothesis or construct a theory of families' responses to mental illness. Rather, the aim of this research was to
increase understanding of what the experience was like for those families involved, by allowing them to speak for themselves and share their interpretation of the meaning of events. The data thus obtained cannot, therefore, be replicated. They can, however, be used to increase awareness of the importance of the family's perspective.

The participants' accounts were presented in detail in Chapter IV, and discussed in relation to the literature in Chapter V. The findings will be briefly summarized here:

The processes by which families dealt with various aspects of the hospitalization experience were identified. The process of acknowledging hospitalization as a solution to a problem was discussed in terms of how families gradually changed their interpretation of the patient's behaviour. The process by which they reframed past events to make sense of the present was presented in terms of their acknowledgement of the patient as sick, and in terms of their opinion that they had in some way contributed to the development of the illness. Their efforts to assimilate new and strange environments and customs were described as they experienced psychiatric hospitalization as "different" from other hospitalizations and "medical" treatments. Finally, the process by which they dealt with their concerns about the future was discussed within the context of their expectations and their coping methods.

The discussion of processes thus highlighted the
dynamic and complex nature of the experience for these families. While the processes were presented individually, the reader has been cautioned that they were in no way discrete or sequential; for these families, each process influenced the other. Incongruencies were noted between processes, while thinking and feeling aspects were also discussed as intertwined elements of the overall process of "making sense" of the illness and the hospital experience.

CONCLUSIONS

The data obtained in this study represent the families' perspective of the hospitalization experience, and reveal a complex inter-play of processes. Conclusions that may be drawn from this presentation will now be discussed.

Families view the psychiatric hospitalization as different from general hospitalization, and therefore have fewer resources to call upon when dealing with the mental illness of a relative. They feel affected by what happens to the patient. Therefore, it is important to acknowledge the presence of families in the treatment of patients, and to listen to them as they identify their needs.

The stigma attached to mental illness by society is a major issue for families. It affects their interactions
with others outside the family unit, and thus severely restricts the support they can use to deal with the situation.

Families experience a variety of emotions in response to various aspects of the hospitalization, from guilt at the time of admission to relief that the patient is being helped to apprehension about the future. They need help to understand and deal with these reactions.

Families do not have the resources to deal with the "culture" of the psychiatric hospital on their own. They may be unable to be assertive, to directly voice their concerns, or to ask that their needs be met. Thus, their inability to initiate contacts with staff does not mean they have no need of such contact.

Families need information. They need to know more about current perspectives on mental illness and the effects of their relationship with the patient. They need to understand the implications of the illness for their own and for the patient's future. Families have their own notions of what mental illness is. They rely on those notions to explain what is happening to their relative. At the same time, however, they assume that the hospital will either confirm or deny these notions.

The question of causality of the illness is an important one for families. They examine their own lives, in the past and in the present, and are often too ready to accept blame for what has happened to their relative. It
also affects their perceptions of the future and results in feelings of apprehension for themselves and the patient.

When given the opportunity and when asked about their concerns, families are able to articulate what is important to them about this experience—i.e., their emotional response, their needs and concerns, the impact on their lives.

IMPLICATIONS FOR NURSING PRACTICE

The aim of this study was to increase understanding of the family's experience of hospitalization in order to provide better nursing care to families. The findings of the study suggest several directives for nursing practice.

The meaning of "mental illness" has been discussed in terms of the family's notions of causality, treatment, and its implications for the future. What has become obvious is that each family has its own understanding of "mental illness" which influences how the family deals with this episode in their lives. It is important, then, for nurses interacting with these families to become aware of the family's definition, and to avoid assuming shared meaning. Kleinman (1978) advocates the eliciting of the client's "explanatory model" in order to understand how it governs their behaviour.
The changing orientation regarding the concept "mental illness" in the field of nursing is reflected in the discussion by Wilson and Kneisl (1979), who advocate an awareness of the social, cultural, and interpersonal factors that affect how behaviour is judged (1979:5). The findings of this study indicate, however, that public opinion about mental illness is not changing as quickly as professional views.

Families blame themselves, regardless of the messages given to them by health professionals. Nurses must be sensitive to this process of families examining their own behaviour. They must be ready to anticipate questions about such causality and they must be aware of the indirect messages they give to families when interacting with them.

The concept of stigma has proven to be an important one for the participants in this study. Nurses must be aware of this added stress experienced by families, and the restrictive effect it has on their ability to elicit support from others. The need to support families, therefore becomes an important function of the nurse since she usually has the most frequent contacts with them.

The importance of a comprehensive orientation to the psychiatric ward has been identified by the participants of the study who did not understand the rules or the philosophies of treatment. As a result, they could not accept some therapeutic strategies and were left feeling
concerned that their relative had not been helped. Such concern could be alleviated if efforts were made at the beginning of the hospitalization to explain treatment rationales to families and allow them to voice their concerns.

The participants in this study were able to identify their need for information. This has implications for the type and content of family groups that may be instituted. The need for such a group is clear; however, it is important to distinguish, as these families have done, between their needs for information and their needs for emotional support. The ability of families to provide emotional support to each other is also an important factor to consider in designing family groups.

The need for information, coupled with the still prevalent effects of stigma, has important implications for psychiatric nurses working in a variety of settings. The need to educate the public, to disseminate information about mental illness is an important function of nurses, working in either the community or the hospital setting, who have contact with groups in the community.

The findings of this study also have implications for nursing administration. The feeling of isolation described by families and their wish to have a "contact" person or a consistent person to approach, are important considerations in designing "family-oriented" psychiatric units.

The focus of nursing on families as clients implies
that if nursing is to consider the meeting of these family needs, then resources must be budgeted for that purpose. Staff time is required to develop and participate in family groups, for example, as one forum for continuing work with families.

The importance of giving support and guidance to families regarding the future has been defined. They must be given the opportunity to ask questions and to discuss their expectations and plans for the future. These participants have asked for information regarding what they should do differently. Their questions should be answered as honestly and completely as possible. The need for follow-up care for patients has been recognized. The need for follow-up support for families has been neglected.

Finally, it is of overall importance for nurses to acknowledge the family: to recognize that the family is involved in, and affected by, what is happening to the patient. It is necessary to communicate such recognition to families, to create a climate in which they feel they can ask questions or admit their concerns.

IMPLICATIONS FOR NURSING EDUCATION

The importance of considering families as clients is a notion that should be developed within nursing
curricula. A focus on the needs of families of psychiatric patients has been shown by the literature and by the findings of this study to be an important one. Such a focus would require the development of specific skills by nurses, as well as exposure to the various theoretical frameworks of the family.

Skills in assessing family needs should be a focus of family-oriented nursing curricula. The development of skills in interacting with families in groups should also be an objective. Curricula should also focus on hospital-based psychiatric care as a part of an integrated system, so that the needs of the family prior to and after discharge are recognized.

An understanding should be developed of the forces which create attitudes of stigma toward mental illness, so that the nurse becomes aware of her role in changing attitudes and learns to deal with the effects of stigma on the family.

IMPLICATIONS FOR NURSING RESEARCH

The findings of this study have highlighted the need for further research in the area of the family of the psychiatric patient. Subsequent studies would benefit from more intensive data gathering methods. The richness of the data as presented here could be enhanced by the use
of participant-observation, as well as interviews prior to admission and after discharge. This would help to develop a more complete understanding of the meaning of the illness experience for families.

The difficulties created by feelings of stigma were noted in this study. It would be useful to determine in future research the extent to which experiences within the hospital would be effective in changing or at least influencing these negative experiences for families.

The need for family groups has been suggested in this study. Families have expressed a need for support, information, and contact with others to share their experiences. The appropriateness of a group situation to meet these needs should be addressed in future research. This study has highlighted the fact that families can indeed speak for themselves. They are able to define their needs, and can judge what has helped to meet those needs. Therefore, future studies should consider family evaluation of programs that may be designed for their benefit.

The inclusion of a Chinese family in the present study has indicated cultural variations in the meaning of mental illness and in terms of the role of the family. Comparative studies among ethnic groups would enhance our appreciation of the importance of cultural background in giving meaning to mental illness and treatment.

This study has illustrated the importance of understanding the meaning of the psychiatric hospitalization to
families. It is hoped that further research in this area will increase knowledge of the family's reactions to this experience, and thereby help nurses to more effectively treat the family as well as the patient.
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APPENDIX A

INFORMATION AND CONSENT FORMS
Patient's Information and Consent Form

My name is Linda Rose. I am a registered nurse and am presently studying for a Master's degree at the University of British Columbia. I am interested in learning how nurses can help families like yours with any concerns they might have while you are in hospital. For that purpose, I would like to talk to your family about any concerns they might have.

I would like your permission to ask your family to participate. If you agree, I will meet with them twice while you are in hospital. If your family is agreeable, the interviews will be tape-recorded, but your name or your family's name will not be used anywhere on the tapes. The tapes will be kept confidential, and made available only to myself and my thesis advisors and the participating family members. The tapes will be erased after this has been done and my thesis has been written. No names will be used in my thesis.

A refusal will have no effect on the treatment received by you or your relatives. You are free to withdraw your consent at any time.

There are no financial benefits to participating in the study, but is hoped that what I learn from the families I talk to will help families in the future.
If you agree, your family will receive a similar information form asking them to agree to talk to me.

____________________

I understand the nature of this study and give my consent for my family to participate.

Date:__________________

Patient's Signature:__________________________
Dear

I am a registered nurse, and am also a student at the University of British Columbia, working on my master's degree in nursing. From my experience in psychiatric nursing and my reading, I have found that nurses know little about how families feel when a relative is hospitalized in a psychiatric unit.

I feel it is important for nurses to consider the whole family and I am interested in learning about how families feel about having a relative in hospital, as well as any other feelings that they consider important. If nurses have this knowledge, it is hoped that they will then be able to work better to meet your needs as well as those of your relative.

If you would like to help me by talking about your experience, and would like further information, please sign this form and give it to one of the staff.

This does not mean that you have agreed to participate, only that you have agreed to being contacted by me by telephone to discuss the study.

Yours truly,

Linda Rose

Relatives' Signatures: ______________________

Phone Number: ______________________
Families' Information and Consent Form

My name is Linda Rose. I am a registered nurse, and am presently studying for a master's degree in nursing at the University of British Columbia. I am interested in learning about how nurses can help families who have a relative admitted to a psychiatric hospital. Little is known about how families feel about this experience. Talking to you about your reactions to the hospitalization of your relative would help to increase that knowledge.

If you are willing to help me learn more about the concerns that families like yours have while your relative is in hospital, I would like to talk to you about it. I will interview you twice, in your home.

If you agree, the interviews will be tape-recorded. The tapes will be kept confidential, and will be heard only by myself and my thesis advisors. After I have studied them to identify concerns and experiences of the families, the tapes will be erased. Your names will not be mentioned anywhere on the tapes or in the report.

You should only participate if you would like to. A refusal will have no effect on the treatment received by you or your relative. You are free to withdraw from the study at any time; you may also refuse to answer any of the questions during the interview.
There are no financial benefits to you in participating in this study. Although there is no guaranteed benefit for you, it is hoped that what we learn will help families in the future who are in a similar situation. Some families may find it helpful to share their experiences with someone if they have not had an opportunity to do so.

If you agree to participate, please sign this form and I will arrange an interview time with you.

If you have any further questions, please feel free to ask me.

I understand the nature of this study and agree to participate.

Date:______________________________

Signature(s):________________________
APPENDIX B

INTERVIEW GUIDES
SAMPLE QUESTIONS FOR INTERVIEWS
(adapted from: Harbin (1979), Leavitt
(1975, Anderson (1977), Kleinman (1978))

1. How did you react when (your relative) was admitted to hospital?

2. What do you think brought about the hospitalization?

3. What treatment do you expect (your relative) to receive?

4. Do you have any concerns or questions about the hospitalization that you would like to talk about?

5. How often have you visited (your relative)? What did you expect from the visits?

6. How involved would you like to be in what is happening with (your relative)?

7. If (your relative) came home on pass, what do you think would happen?

8. Which areas of your everyday life have been affected?

(your relative) - name of patient.