THE INTERPRETATION OF STRESS IN RELATION TO FAMILIES OF HOSPITALISED MENTAL PATIENTS

An Exploratory Analysis of a Sample
of Mentally Ill Patients and Their Closest Relatives
Crease Clinic, Vancouver, 1962-63

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ABSTRACT

The complexities of man's current social universe permit little opportunity for him to function in a social environment that is undergoing constant change, without experiencing stress. Those who are unable to adapt or adjust to the stresses of modern living fall prey to the ravages of mental illness. Changing professional perspectives and the research of social scientists, are re-awakening professional eyes to the significance of the patient in relation to his social environment. The experience of mental illness and all it's ramifications are also the experience of those who shared in a reciprocal role relationship to the patient. Isolation - the remedy of old - today is a lost cause. For social work, current theories of social dynamics promise to add a new dimension, by which to understand the social structure of the mentally ill person and those who interact with him. The new theory requires inspection and testing. This thesis is an attempt to examine some of the clinical applications of a theory that might well have great consequences for social casework.

Social role theory is reviewed as background, and the concepts of role and stress are explored in relation to the family, when one of it's members becomes mentally ill and requires hospitalisation. To examine clinically the effects of hospitalisation on family and patient, using role concepts, a small group of families was selected and studied. Structured interviews were used to elicit both descriptive details and feelings about the family, as well as the meaning and effect of hospitalisation. The sample group was drawn from both female and male sections of the Crease Clinic of Psychological Medicine; and, where possible, both the patient and a reciprocal (close relative) were interviewed. The questions were directed particularly to roles and relationships before and after admission.

The study reveals that patients and their reciprocals experienced stress in two phases: (a) when the patient is mentally ill, but living at home and (b) when the patient has been hospitalised. In the former, stress centres around changes in perception and performance in an effort to continue functioning, in spite of the maladaptive roles of the mentally ill family member. In the latter, stress centres around the absence of the family member, whose absence displaces role and relationships upon which the social structure of the family network is highly dependent. The study also reveals that hospitalisation is relieving for both patient and reciprocals, and in some cases leads to the resumption of certain roles discarded during the presence of the mentally ill member at home.

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THE INTERPRETATION OF STRESS IN RELATION TO FAMILIES OF HOSPITALISED MENTAL PATIENTS

CHAPTER I - ROLE CONCEPTS RELEVANT TO SOCIAL WORK

The Problem - General

> " The socio-cultural revolution that characterises our time has spurred mistrust and fear among the nations, altered the face of family life, and unsettled established patterns of individual, family, and community. No piece of earth, no person, no community is immune. Human beings and human relations have been plunged into a state of turbulence, while the machine surges far ahead of man's wisdom concerning himself. The shrinking of space and the cramped intimacy of people living in clashing cultures calls for new understanding, a new vision of the relations of man to man and man to society." [1]

Ackerman's statement of contemporary world crisis, is one of many appearing more frequently in social scientific literature. Terms and phrases such as 'anomie', 'affluent society', 'the organisation man', 'mass society', 'the decline of the west', are becoming all too familiar. They give expression to the intricate complexities of mid-century life and problems. Even the issues of present day mental health reflect the turbulence of the kind of society of which we are a part. Mental illness is no longer the concern of the sick individual, but involves the entire structure of the community, immunity from the problems of mental illness is an unreality. The human devastation of mental illness and it's incalculable damage to family life and the welfare of the community, have in recent years stimulated public interest in the urgency of the problem. This interest has been expressed in allotments of public moeny for research and training in the field of mental health. Because of the frequency of mental illness, the societal

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1 Ackerman, Nathan W. (M.D.) The Psychodynamics of Family Life Basic Books Inc. New York, 1958, Page 3.

attitude towards it has changed, definitions have changed, and the perception and treatment of mentally ill persons have changed. Today we are striving away from the approach of considering what goes on psychically within one person, and moving in the direction of considering what happens between a person and his environment and what is distorted in the social processes of that environment. This new direction is expressed in the writings of Reusch who says

> "Today we conceive of the individual as a living organism whose social relations are combined into a complex organisation, whose inner world of experience is closely related to his social operations, and whose soma materially makes possible his various activities." [1]

This thesis is a part of that general trend in mental health to move into that reality which serves to see the mentally ill patient, his conflicts, problems and dynamic way of life as an integer of his social environment and his interaction with the components of that social environment of which he remains a part.

The Problem - Specific

This thesis is an exploratory attempt to investigate and analyse the social effects of the hospitalisation of mentally ill persons, using the concept of stress as a theoretical frame of reference. It will specifically examine the ways in which the character and quality of family roles and relationships are affected by the illness and hospitalisation of a member of a family. It attempts in a broad perspective to integrate two highly relevant principles arousing considerable thought in the fields of social

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1 Reusch, Jurgen Toward a Unified Theory of Human Behaviour ed. Grinker, Roy R. Basic Books, New York, 1956, page xi.

work, psychology and psychiatry - the renewed principles of family, and the new social role theory. This together with the strategic importance of mental illness in western society established primarily the relevance of the study.

The pattern of social relationships within any one family is a dynamic one, and the subtle changes may be continually occurring, especially in what may be described as the emotional toning of relationships. However, in order to study more realistically the effects of illness and hospitalisation on a family it is necessary to examine data from a static viewpoint in time. Such an abstraction often obscures the dynamic quality of family relationships, and it is the belief of the writer that the very content and quality of social role theory offers a structural framework which gives expression to the dynamic aspects of relationship.

Rose in a study of relatives' attitudes and mental hospitalisation makes special note of the scant consideration in literature given to the attitudes of relatives, he states:

> "Observations by those who work with relatives of patients have increasingly suggested that these attitudes may be a factor in maintaining the illness and prolonging the hospitalisation. When a psychiatric patient is hospitalised, his relatives develope distinct attitudes towards the illness and the hospital." [1]

It was the problem of these attitudes which led to the study undertaken by Rose who postulated that ...

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1 Rose, Charles L. "Relatives' Attitudes and Mental Hospitalisation" Mental Hygiene, April 1959, Volume 43, No. 2, Page 194.

> "The removal of the ill member through hospitalisation brings about further attitude changes distinct from those which were apparent when the ill member resided at home." [1]

He studied the attitude of relatives that were associated with prolonged hospitalisation, and his analysis points to the fact that there were very distinct attitudes in relation to hospitalisation. This thesis is equally concerned with relatives, more specifically family members' attitudes towards hospitalisation.

A question that frequently emerges as to how well we are applying the current theories of social role and relationships to mental patients in mental hospitals, or whether we are still thinking in the old terms of the individual in isolation. As Murphy and Cottell have said:

> "When clinical psychiatry appeared as an entity, in the hands of Emil Kraepelin; the disease was inside the patient, just as an ulcer or a tumor was inside him; ... with Freud the phenomena of transference began to make embarrassingly clear that two persons were involved in every symptom and in every step towards cure, the analyst serving as temporary surrogate for the persons who were or are the physosocial reality of the patient; and with Sullivan the conception of a disease inside the person, carried around by him intact from one situation to another was frankly abandoned, with a clear recognition that all we really see and deal with is a career line of interactions between individuals; and ... if this be so, it is the relationships, not the individuals that become our concern." [2]

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1 Ibid. Page 195.

2 Murphy, Gardiner and Cottell, Elizabeth The Contributions of Harry Stack Sullivan, ed. Mullahy, Patrick, Hermitage House, New York, 1952, Page 162.

This thesis is one of many attempts to find a way of applying social role theory to mental patients and their effected family, and move away from the rather limited and conservative approach of thinking in terms of the individual in isolation. None of us lives his life alone, not even the patient.

Upon admission the patient enters a new and unfamiliar world. How does the mental hospital environment differ from the home environment? It is evident that no matter how well organised the hospital may be, the environment is an abnormal one compared to that which the patient is familiar. The first thing that happens to a patient is that he loses temporarily his liberty, he sees barred windows, and his personal sentimental emotionally valued objects are taken away. Though these may be eventually restored, the initial impact is great. The patient cannot immediately structure the hospital environment. There is a loss of identity, and the patient becomes as often do his relatives, where their contributions is minimised in the treatment of mentally ill patients, one of many. Kaplan and Wolf observe that

> "There is from the beginning, a loss of identity; our patient becomes one of many." [1]

and in their study of "The Role of the Family" in relation to hospitalisation find that there is

> "a direct relationship between the patient's acceptance of or resistance to loss of identity and his reaction to his family." [2]

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1 Kaplan, Arthur and Wolf, Lois "The Role of the Family in Relationship to the Institutionalisation of Mental Patients" Mental Hygiene, October 1954, Volume XXXVIII, No. 4, Page 637

2 Ibid. Page 637

The inference is quite clear, hospitalisation effects the patient and the family. This thesis is primarily concerned with this problem. In a paper by Bentner and Brauch they affirm the current view that relatives are crucial to the patient's illness and treatment. They also observe that scant attention has been afforded the question of relatives in literature.

> "Whether one enjoys facing it or not, the problem is there and it is more than a question of public relations or personal discomfiture. It is a demonstrable fact, a problem crucial to the patients' illness and to the treatment of it. And while the literature has accorded it this recognition, it also has afforded it scant discussion." [1]

Other reports have emphasised the importance of the family's attitude, for theraupeutic as well as for administrative reasons. For instance Kaplan and Wolf[2] see the family as the patients sole remaining link with the outside world - and one which must be studied if the patient is to be helped to return to that world. There appears to be little doubt that the co-operation of family and relatives is fundamental in working with patients, as there is little doubt that hospitalisation poses problems - stress for the patient and his family. Improvement and deterioration in a patient's condition often seems to hinge directly on relationships with family and relatives, their attitudes towards illness and hospitalisation, the changes and adjustments that are made by the patient and his family, and finally the stress which they all experience in many areas of functioning as a result of hospitalisation.

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1 Bentner Karl R. (M.D.) and Brauch, Russell, "The Psychiatrist and the Patient's Relatives", The Psychiatric Quarterly, January 1959, Volume 33, No. 1, Page 1.

2 Ibid. Page 636, Kaplan, Arthur and Wolf, Lois.

Social Work and Role Theory

.. In recent years the development of a body of knowledge within the field of social work, promises to open up a new chapter of practice and understanding for the professional social worker, engaged in social casework at mental hospitals. The social worker in mental hospitals has for some time been primarily concerned with the family of mentally ill patients. Today he is still concerned, and the new knowledge promises to make him more concerned in the future.

Like most new knowledge it comes in a highly abstract and theoretical form, and it's eventual integration will depend on it's application and usefulness in practice, initially determined through social research. In it's present form the theory is better known as 'Social Role Theory'. It remains generally untested and therefore of limited practical value, however many social workers have attempted to apply aspects of the theory and indicate that it has proven useful in social diagnosis, and found to be an aid to casework. Vesper [1] makes use of role theory in her treatment of marital conflict which she interprets as "marital role reversal". Similarly McCoy [2] translates aspects of role theory in relation to the problems of foster parenthood, and provides a useful definition of the role of foster parent.

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1 Vesper, Sue "Casework Aimed at Supporting Marital Role Reversal", Social Casework June 1962, Volume XLIII, No. 6.

2 McCoy, Jacqueline "The Application of the Role Concept to Foster Parenthood", Social Casework May 1962, Volume XLIII, No. 5.

McCann in his treatise on social role theory and professional responsibility deals very explicitly with the question of social work and social role theory.

> "Our interest in new theoretical formulations is fostered by our professional orientation which is both scientifically and philosophically rooted. Our professional aspirations clearly indicate, however, that we have a definite responsibility to examine new theories critically in the hope that they might strengthen any work and facilitate the realisation of our goals." [1]

Social role theory extends a new and revitalising modus opporandi, for social caseworkers, it establishes a theoretical apparatus which is socially oriented and makes it possible to move away from the limiting procedure of personal diagnosis. It provides a framework for studying the dynamic patterns of social stimulation and response, and the dynamic structure and quality of an individual and his social environment. Sabin says of role theory

> " Role theory attempts to conceptualise complex behaviour at a high level of abstraction. The theory attempts to show the interaction between the individual and his environment by linking psychological, social and cultural phenomenon. Role theory encompasses concepts of the internal organisation of the individual, his needs, his responses, and his aspirations. It also encompasses the environmental forces that affect his behaviour. According to the theory the person is acted upon by the environment and at the same time is changing the environment." [2]

In a sense role theory is not that new to social work, for social workers have been constantly involved with the problem of the individual and his environment, physical and social.

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1 McCann, Charles W. "Social Role Theory and Professional Responsibility", The Social Worker, June 1961, Volume 29, No.3, p.16.

2 Sabin Theodore R. "Role Theory" Handbook of Social Psychology Volume I Theory and Method Gardiner, Lindzey, Ed. Addison Wesley Publishing Co. Inc. Caimbridge Mass. 1954, Page 225.

Inadvertantly or not they work in practically every problem solving situation, with a person's relationships, his roles and his reciprocals directly or indirectly. However, the approach has been determined by the influences of psycho-analytic theory, which misses much that is truly social. Bowers, sensitive to the impact of social role theory on social work writes

> "There is a change coming about in social work, a good and healthy change, a going back to social work's original emphasis on the family and on the crucial social roles that exist within this primary group and primary environment." [1]

The primary group refers to the individual and his family. The work of the curriculum study gives particular prominence to social role theory, and it's significance for social work, since the goal of social work is considered to enhance social functioning wherever the need for such enhancement is either socially or individually perceived. The content of social role theory is perhaps more than sufficiently summarised in the definition of social casework as reported by Boehm.

> "Social casework can be defined as a method of social work which intervenes in the physo-social aspects of a person's life to improve, restore, maintain, enhance his social functioning by improving his role performance. Interaction occurs when the person, or members of his group or his community, realise that his role performance is hampered or threatened. The intervention takes place through a professional relationship between the worker and other individuals whose interaction with the person affects his role performance. Since social functioning is the product of interaction among intrapsychic, somatic and social factors, social caseworkers involves assessing the internal and social forces which impair or threaten the person's role performance and helping him to find

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1 Bowers, Swithern, "The Future of Social Work", The Social Worker, January 1960, Page 36.

> "and use the somatic, psychic and social resources at his disposal to eliminate or reduce malfunction and to enhance functioning in social roles. " [1]

Boehm defines social functioning as

> " the sum of the individuals activities in interaction with other individuals and situations in the environment." [2]

The Conceptual Framework

One of the important concepts explicit in social role theory is the concept of stress. Theoretically it has been found useful in examining and understanding more fully the nature of certain types of conflict where this concept is the outcome of role interactions, perceptions and performance. Because the concept of stress is so interrelated with the concepts of role, let us deal with the question of role.

The Concept of Social Role

The concept of social role is derived mainly from the fields of social psychology, sociology and social anthropology, where considerable attention has been given to role in the functional analysis of primitive societies. For the purposes of this study the concept of role is used to describe individual behaviour as determined by the interaction of the individual (somatic and psychological) and social factors.

The concept is a dynamic one in the sense that change in one of the factors produces change in other factors. Social

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1 Boehm, Werner W. "The Social Casework Method in Social Work Education", Council on Social Work Education Volume X, New York 1959, Page 44 - 45.

2 Ibid. Page 94.

roles are activities and tasks which an individual is expected to perform and are patterned and prescribed by social norms such as custom, tradition and convention. Social roles as do social relationships, have a manifest and latent content. It is the manifest content which is of importance to social work and to this thesis, the latent content is the field of psychiatry and psychology, it's use to social work is only so far as providing an appreciation of the manifest content. The concept of social role has a number of components, expertly documented by Boehm in report of the curriculum study. Though we are not immediately occupied with a study of these components, they bear an important relationship to the concept of stress, and so require brief examination.

Range

This refers specifically to the socially accepted ways of satisfying needs.

Role Perception

This is the manner in which a role is viewed by an individual performing the role, or by a reciprocal person. Personality, class, culture, values will determine an individual's perception of roles.

Interrelatedness of Roles

This component refers to the repercussions and effects of change in performance on one role upon the performance of the other roles.

Role Network

This component combines the concepts of role interrelatedness and role reciprocity and provides a view of the client as an interacting unit in a system of roles. It refers to all the client's social relationships.

Reciprocity

Reciprocity refers to an individual who stands in a relationship to another individual.

Role Performance Modifications

This refers to changes in role behaviour which may result from new perceptions of the role, assumption of new roles, or change in role expectations.

It can clearly be seen from the description of social role that it has definite value in providing social analysts an understanding of an individuals functioning in his role network, and any changes that may come about in that network.

The Concept of Stress

For the purposes of this thesis the major interest lies in the concept of stress. It is intended to accomplish in exploration of the effects of hospitalisation, the task of identifying stress, analysing stress, and examining those factors which make for stress in the light of social role theory.

The term stress is familiar in many different fields of scientific and medical endeavour. Intellectually the concept gives the picture of an object subjected to overloading pressure. When the pressure becomes greater than the object can contend with,

something significantly happens to the object, it may break, become weakened, of no further use, or of limited use. Expanding this idea to include human beings, the picture remains the same except that the object becomes a person, the pressure, that which is exerted from within a person, and without a person by his social environment. Bernard defines stress as

> "a situation involving threat; and we break it down into three component elements:
> (1) the stress factor, which threatens
> (2) the value which is being threatened, and
> (3) the reactions, individual and collective, to the threat." [1]

The concept is quite clearly related to the concept of role and may be thought of as any situation which produces a threat to the performance of a social role or roles. The concept is not, however, congruent with the concept of anxiety, which refers more typically to the stress reaction. Boehm adds

> "that stress factors may originate in either realm of the interactional field social or individual: that they may not be consciously perceived, but manifested in the individual's response to them and therefore detected only through changes in the role performance." [2]

The concept of stress includes certain essential components:-

Stress Factors

Stress factors are threats which arise within the individual or from the environment, within his network of roles or the social system. From the viewpoint of social work it is those threats from the social environment that are the concern

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1 Bernard, Jessie, Social Problems at Midcentury, Holt, Rinehart and Winston, New York, 1957. Page 70.

2 Boehm, Werner W. Ibid. Page 107.

of social workers. Any pattern of maladapted role functioning in the nature of impairment will provide yet a secondary source of stress.

In considering the component, stress factors, the question arises as to whether this component can be measured. In social casework some value is often assigned arbitrarily to stress factors, and they are frequently seen as severe, great, mild. Obviously these value connotations are highly subjective in spite of the fact that they may be correlated with the individual's ego strengths, individuality, and personality. Bernard postulates about the measurability of stress

> "When we speak of stress factors as greater or less at one time as contrasted with those of another time, we imply that the threats can be measured ... Actually, however, threat may be thought of as having degrees which may be measured in terms of probability, both objective and subjective." [1]

This thesis is particulary concerned with the problem of measurability and hopefully intends to explore the possibility of measurement.

Value Threatened

Bernard considers that life, health, property, privilege, freedom, security, status, self-respect, opportunity, future prospects - all as related to one's own self, to one's loved ones, or to one's group, or to all three are values that may be threatened. Conceivably a threat to any value of significance to the individual may produce stress. The value may have varied significance to the individual, however it is the subjective value that determines to some extent, the degree of reaction. It is the meaning of the

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1 Bernard, Jessie. Ibid. Page 74.

value to the person which is of consequence, threat to a particular value held by two individuals may have different consequences for each of them.

Reaction to Stress

Responses made by the individual with the goal of maintaining the level of social functioning which existed prior to the occurence of stress, is what is meant by reaction to stress. Most human behaviour which expresses itself in terms of role performance consists of reactions to stress, and is an attempt biologically-psychologically-socially to attain social symbiosis which might involve re-establishing a previous level of functioning, or attaining a new level of functioning which is satisfactory either individually or socially by adapting to stress situations. Some types of reaction may or may not lead to problems depending on the manner in which the stress is alleviated or eliminated.

The Social Environment

In any analysis of stress, the question of social environment is a focal issue. The social environment comprises of the individual's social situation. By social situation is meant those persons who form part of an individual's role network, and refers to individuals in the group of which he is a member, and with whom he interacts fairly intensively. Reference groups are similarly important and refers to those persons with whom an individual identifies. Their importance lies in the fact that an individual's values, standards and aspirations will be determined by the reference group. Social resources and material goods which

are needed for effective role performance constitute part of the social environment. Other relevant components would be societal ideologies, economic, political, physical and finally the stratification peculiar to a society of which one individual is a member.

The Total Situation

Some reference needs be made to the total situation which in terms of social role theory would be viewed more typically as the social environment. This thesis focuses attention on stress factors relating to the hospitalisation of mentally ill persons, that is, the removal of a person who is considered to be mentally ill from his customary social situation to a social situation of a particular type. Relative to the patient or reciprocal, social situation may be thought of as being synonomous with the term social environment.

The hospital community of Essondale of which Crease Clinic is a part, is viewed as a self-sufficient and self-integrating unit despite the difficulties of it's space time margins. It is a patterned and patterning system with functions and components. Theoretically it appears to satisfy the sociological criteria customarily used for establishing the status of social organisations, complexes and groups, described by Young it

> "(1) occupies a territorial area
> (2) is characterised by common interests and
> (3) common patterns of social and economic relations;
> (4) derives a common bond of solidarity from the conditions of it's abode;
> (5) has a constellation of social institutions; (school, recreational centre, shops, church etc.) and
> (6) is subject to some degree of group control." [1]

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1 Young, Pauline V. Scientific Social Surveys and Research 3rd Edition, Prentice-Hall, Englewood Cliffs, J.J. Page 471.

The hospital environment in many respects has characteristics which are adequately expressed by Aitken, when he refers to the ship as a community, since an

> "extraordinary feeling of kinship, of unity, of solidarity far closer and more binding than that of nations or cities or villages was swiftly uniting the travellers; the ship was making them a community." [1]

In terms of theory then, Essondale would be accorded the status of community. Clinically, however, it is viewed more as a part of the thereaupeutic mileau of the hospital. It's various social institutions are there by specific design, and to be understood as thereaupeutic instruments complementing and supplementing the treatment patients receive within the walls of each hospital unit. This view establishes Essondale as more typically a social institution, meeting the classification criteria discussed by Young in her chapter titled "A Study of Social Institutions." [2]

For purposes of this thesis, the writer prefers to compromise with the difficulties involved in classifying the social environment of the hospital, and therefore views Essondale as both community and social institution. As a social institution it is a function of the communities surrounding it, and as a community it has a high degree of interdependence with those communities surrounding it. As a social institution it is part of the total situation of patient and reciprocals. They are aware of it's existence. They may never directly have any involvement with the

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1 Aitken, Conrad, Blue Voyage, Charles Scribner's Sons, New York, 1927, Page 33.

2 Young, Pauline V. Ibid.

institution, but indirectly they contribute to it financially, politically, and socially. As a community it may be regarded to be somewhat removed from the total situation of patient and reciprocal.

Situationally, whatever cultural status is assigned, the fact is that the freedom permitted both patient and reciprocal at Crease Clinic by way of weekend leave, day privileges, frequent visiting, it is the opinion of the writer that the patient is never really removed from the total situation when he is hospitalised since he enters a community or social institution which in many ways is a model of the larger community in which he functioned prior to his illness and hospitalisation, but probably better structured and more highly organised. For both patient and family it means theoretically extending or broadening the social environment, and in a sense they have to contend with two social situations temporarily. The real issue on discharge, is not so much that the patient returns to the total situation, since he was always a part of it, but that he re-adapts and re-adjusts himself to that part of the total situation with which he was familiar prior to his illness and hospitalisation.

It is useful to remember that the individual is constantly reacting and adjusting or adapting to a complex and dynamic total situation which is relative to himself.

Significance of the Study for Social Work

It has been stated that social role theory is new to the field of social work generally. Any new theory requires that

it be subjected to testing and experimentation if it is to be adopted for use as a method in the problem solving process. Regensburg expresses this viewpoint when she writes

> "The framework is not to be viewed as a final product; much of it will undoubtedly be reformulated as experimental work proceeds. The choice of this particular concept of social functioning and of other concepts which logically precede and follow it, is a matter for thorough testing and research. ... Granted that there will be much floundering and trial and error while further study and research proceed. I suggest that even so the gains of social casework practice can be great." [1]

This thesis is an attempt to experiment with an aspect of social role theory, it is a pioneer study which has as it's aim, the purpose of making a contribution in discovering the usefulness of a small component of social role theory, and fulfilling the responsibilities of a professional social worker in relation to new theories.

Schlesinger in his thesis on "Social Casework in the Mental Hospital" writes that

> "When the patient enters hospital, relatives are frequently more confused and upset than he is. They may have needless fears that the patient is being 'put away for life' or may need help to face the fact that the patient will remain ill for an extended period. They feel responsible for the patient's breakdown, and may be affected by guilt feelings about committing the patient to hospital; or they may show relief at getting rid of the responsibility of caring for the patient ... All these feelings and attitudes have a disrupting influence on the patient and the effective functioning of the family." [2]

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1 Regensburg, Jeanette "The Curriculum Study: Implications for the Practice of Social Casework" Social Casework January 1960

2 Schlesinger, Ernest Social Casework in the Mental Hospital Master of Social Work Thesis, University of British Columbia, 1953 Page 2.

This thesis by virtue of it's focus, will be re-examining some of the problems mentioned by Schlesinger in the light of social role theory, and hopefully add yet another dimension by which to understand the causes and origins of problems caused through hospitalisation. For if it can be proven that fear, confusion, guilt feelings and other problems - responses to stress, are related to a network of inter-dependent and interrelated social factors, the study has important significance for social work, and inevitably enable social workers in the practical field to be of greater value in helping the patient and reciprocals.

This study furthermore, aims at discovering ways in relation to social work theory of;

(a) helping caseworkers understand, identify and assess certain behavioural phenomena as perceived through an individual's role performance, role functioning and role relationships. The behavioural phenomena which is of interest is that associated with the admission of an individual to a mental hospital of a particular kind.

(b) helping to explain and understand certain structural changes in social role functioning, certain types of responses, following the admission of an individual to a mental hospital.

Scope of Thesis

The thesis is intended to focus attention on what happens to the significant network of roles and role relationships in a family, when one of the members is displaced from the network.

To do this the concept of stress has been chosen as the criterion of examination and analysis. By taking a look at role functioning, it is expected that it will be possible to identify significant areas of stress, the degree of stress, resulting from the displacement of a family member from his social network. Furthermore it is intended to attempt to explain what happens to the hospitalised member, and his reciprocals in terms of role functioning, when he is displaced from his customary social situation.

Hypotheses

For purposes of most experimentation and research, a model of operation requires at the outset, a framework of assumptions which will focus the whole nature of the research into stress and hospitalisation. For the purpose of establishing a hypothetical framework, the following assumptions in relation to the area of interest have been set up.

Assumption 1

When a member of a family unit is displaced [1] from his network of roles and relationships with reciprocals which make up his social network, a threat is produced and results in stress. Displacement in this context will be identified as a stress factor. Rose observes that

> "When a psychiatric patient is hospitalised his relatives develope distinct attitudes toward the illness and hospital ... With hospitalisation, these attitudes become more explicit, and are elaborated to include attitudes toward the hospital treatment program and the hospital's responsibility in the custody and care of the patient." [2]

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1 The term displacement is used by the writer to refer to the removal of an individual from his usual physical and social environment.

2 Rose, Charles L. Ibid. Page 194

Assumption 2

That the individual patient and his family reciprocals reacts to this stress or threat brought about through displacement, by changing, adjusting and withdrawing from roles and role relationships. The reaction to stress may be positive or negative.

Assumption 3

That displacement bringing about new roles and relationships for the hospitalised family member produces stress for the family reciprocals, as well as for the patient.

Assumption 4

That displacement to a social environment of a particular kind - the hospital community, is both stressful to the patient and his family reciprocals.

Restating the major focus of the thesis, it may be said therefore that it is primarily concerned with stress - the nature of stress, the reactions to stress, the pattern of reactions, in what way stress may be interpreted, analysed, measured, and in what way the concept may be utilised in treatment.

Setting of The Study

The Crease Clinic of Psychological medicine has been selected as the setting of the study, because of a combination of factors.

Firstly, as an institution for the care and treatment of mentally ill patients, it is in some degree a compromise between the Provincial Mental Hospital and the day clinic. It therefore assumes the position of a half-way type of treatment institution.

Secondly, it is an institution where prevention of more serious mental illness through early treatment is the aim. It serves more the needs of the acutely ill than the chronically ill, as well as the needs of emotional disorders. The policy manual of the Provincial Mental Hospital and Crease Clinic states

> "... the function of Crease Clinic is to treat acute cases of mental and emotional disorders." [1]

and lists the following types of mental patients acceptable for admission.

> "1. early psychosis
> 2. psychoneurotics
> 3. psychosomatic disabilities
> 4. all psychotics, except those of long standing duration and those demonstrating marked deterioration and having a poor prognosis." [2]

Thirdly, the period of hospitalisation is relatively short

> "Persons who are considered suitable for admission are those who will respond to treatment in a period less than four months and who can then return to the community ... It is to be noted that the average period of treatment is about two months." [3]

At the time the study was being conducted, the period of treatment was approximately five to seven weeks.

Fourthly, Crease Clinic is more open than Provincial Mental Health Hospital and the patients tend to require somewhat less supervision, and are granted much more freedom and many more privileges than patients institutionalised at Provincial Mental Health.

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1 Policy Manual, Provincial Mental Health Services, Provincial Mental Hospital and Crease Clinic, Page 32.

2 Ibid. Page 33.

3 Ibid. Page 32.

Fifthly, because of the type of patient admitted to Crease Clinic, they are more amenable and suitable for interviews of the type used in this study.

Geographically, the Crease Clinic of Psychological Medicine is situated adjacent to the buildings making up the units of the Provincial Mental Hospital. The clinic is part of the administrative organisation of the larger hospital, although it functions seperately as a treatment unit. The hospital community is called 'Essondale' and is located in a rural area approximately twenty miles from downtown Vancouver. Essondale includes, apart from the hospital units, residential units for staff, a post office, store, Credit Union, two cafes, recreational and community centre, farm, and is set amid well kept parkland. Crease Clinic itself has a library, hairdresser, and recreational therapy unit.

Crease Clinic was established in 1948 under the terms of the "Clinics of Psychological Medicine Act", and officially opened in November 1949. The West wing of the building housing male patients and the East wing female patients. To each ward is assigned a psychiatrist, social worker, psychologist, occupational therapist, and a team of psychiatric nurses.

CHAPTER II - METHODOLOGY APPLIED TO THE CASES

Case Study Method

Young introduces her chapter on "The Use of Case Data in Social Research" with a quotation from Charles H. Cooley, who states that:

> "Case study deepens our perception and gives us a clearer insight into life .. It gets at behaviour directly and not by any indirect and abstract approach." [1]

In designing a research experiment, which intends utilising an abstract theory such as social role theory, the experimenter must naturally give serious consideration to the question of what method of social research is best suited for the particular kind of material that is to be handled. In this study we are exploring and analysing a process, which is highly dynamic, we are also examining a set of social units. We are studying interrelationships of one unit to another, at a particular moment in time. For this kind of data, Young considers the case study method most useful.

> "... through the case method the social researcher attempts to see the variety of factors within the social unit as an integrated whole." [2]

As a method it is most useful in research exploring a variety of factors, where the researcher is working with a limited number of cases and working alone. The case study makes no attempt to change the condition of the client or that of the treatment; the client is observed in a clinical setting. The particular research design used in this study is infused with this quality.

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1 Young, Pauline V. (PhD) Scientific Social Surveys and Research Prentice Hall Inc. Englewood Cliffs, N.J. 1956, Page 229

2 Ibid. Page 229.

Social work is primarily concerned with social behaviour in relation to the social environment. In dealing with such subjective situations, the question of bias and objectivity frequently emerge. We are aware that the appearance of the interviewer and the way the interview was conducted will influence the responses obtained from an individual. It is known that when there is interaction between pairs of people changes in mind may result from persuasion. In a setting such as a mental hospital, the mood, treatment, amount of disorganisation and nature of the illness will determine the sort of responses a person makes when he is asked questions. While it is possible to control many of these hindering facets in the service of objectivity, it may not be entirely possible to limit their effects on the results of the experiment, however, a knowledge of them is imperative in the final analysis.

In investigating social behaviour the research tools are somewhat limited, it may be necessary to borrow the tools of other sciences. In social work we are doing this constantly. Argyle expresses this view in his book "Methods of Studying Social Behaviour" and goes on to state

> "The student of social behaviour has two measuring instruments ... These two are the different kinds of interview and questionaire, and the techniques of controlled observation." [1]

The measuring instrument used in this thesis study is the interview.

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1 Argyle, Michael The Scientific Study of Social Behaviour Methner & Co. Ltd., London 1957, Page 14.

The Interview

It is indeed impossible to conceive of any better instrument to use in conducting this research, other than the interview. In essence it is largely the topic of the thesis which determines the type of instrument to be used in research. To investigate the material discussed in Chapter I it is essential to have face to face contacts. The quotation from Gordon Allport introducing the chapter on "The Interview as a Tool in Field Exploration" by Young adequately expresses this theme.

> "If we want to know how people feel, what they experience, and what they remember, what their emotions and motives are ... why not ask them." [1]

What people feel about themselves and others, what they experience and what their emotions are in relation to social roles is precisely the theme of this thesis.

In the research conducted for this thesis use has been made of an interview format which is in fact a combination of types of interview design. Use has been made of the standardised interview, and

> "questions are presented with exactly the same wording and in the same order." [2]

The reason for standardisation is to ensure that all individuals are replying to the same question since

> "Differences in question order can also influence the meaning and implications of a given question." [3]

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1 Young, Pauline V. Ibid. Page 205

2 Selltiz, Claire. Jahoda, Marie. Deutsch, Marbou. Cook, Stuart W. Research Methods in Social Relations, Henry Holt & Co. 1960, Page 255.

3 Ibid. Page 255.

In conducting the research use has been made of "open-ended" questions, which are designed to permit the person being interviewed the opportunity to answer in his own terms and in his own frame of reference. Selltiz, Deutsch and others consider that the distinguishing characteristic of open-ended questions is

> "that they merely raise an issue but do not provide or suggest any structure for the respondent's reply." [1]

The general type of interview used in this research study might well be classified in terms of "the focused interview" so designated by Merton and his associates. They indicate that this type of interview is differentiated from other types of interview in that

> "(1) it takes place with persons known to have been involved in a particular concrete situation;
> (2) it refers to situations which have been analysed prior to the interview;
> (3) it proceeds on the basis of an interview guide which outlines the major areas or enquiry and the hypotheses which locate pertinence of data to be secured in the interview;
> (4) it is focused on the subjective experiences, attitudes and emotional responses regarding the particular concrete situations under study." [2]

From the point of view of this study the advantage of the focused interview allows the interviewer

> "to explore reasons and motives, to probe further in directions that were unanticipated." [3]

Together with some of the other aspects make it the most practical research instrument for conducting this thesis study, in terms of the data to be handled.

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1 Ibid. Page 257.

2 Merton, Ralph R. "The Focused Interview" American Journal of Sociology, Volume LI, May 1946, Page 541 - 542.

3 Ibid. Selltiz, Deutsch and others. Page 264.

The Interview Format

Relying primarily on the theoretical hypotheses as a foundation for developing an interview schedule, questions were initially formulated using the terminology of social role theory, and phrased in technical language. Since we were investigating two social units, one comprising of the individual placed in a particular social environment, and the other, comprising of an individual's reciprocal, functioning mainly in a different social environment, two interview formats would be required, oriented to the social situation relative to each social unit. Despite the construction of two differing interview formats the procedure used in designing them remained the same.

As described in Chapter I, the concept of stress in social role theory bears a direct relation to the concept of social role and it's component parts. The study of stress requires that we also study social role. The interview format gives expression to this principle, and starts with questions intended to provide a background of information about roles, role expectations, role perceptions, role performance and range. A comparison of both formats in relation to the above components would then be expected to provide information concerning the interrelatedness of roles in respect of patient and his reciprocals.

Since role functioning involves interaction between an individual and reciprocals with inter-dependant roles, relationship, and feeling, a series of questions were designed to elicit responses that would give some appreciation of these three factors.

For example in the 'Interview Format for Interviews with Patients' the following questions were asked.

> "13. Can you describe your relationship with your wife/husband?
> 9. What did you feel about leaving your family?
> 6. In your opinion, what are your feelings about the things you do at home?" [1]

Then finally there were those questions which would provide data about the patient and the reciprocals adjustments and adaptations or lack of them, to the environment, feelings about change and the new situation generally. For example in the 'Interview Format for Interviews with Reciprocals', the questions asked were:

> "6. Can you explain the sort of changes that were necessary in your way of life ... as a result of your wife's/husband's admission to Crease Clinic?
> 5. What is your view of what happened to the things you did ... when your wife/husband was admitted to Crease Clinic?
> 23. What are your feelings about your contacts with the hospital staff?" [2]

It was to be expected that in responding to some of the questions the patient and his reciprocals would be able to verbalise some of the stresses experienced as a result of hospitalisation, and where appropriate questions were inserted for this purpose. However, it was also accepted that in many areas of functioning neither patient or family member might be aware of stress. This would come from an analysis of role functioning, and strongly support the need to ask questions which provide data about the patient's functioning as well as the functioning of each family

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1 Appendix A_1.

2 Appendix A_2.

member.

When the two interview formats were completed one for the patient, and one for the reciprocal, but phrased in professional terminology, the writer set about translating each question into more useable and simple language. This proved extremely difficult and made manageable partly through experimentation with four subjects, all having experience of hospitalisation in a mental institution themselves. Following experimentation the interview format was further analysed and restructured in the light of the results obtained. For example, the initial format asked the question

> "What were your roles prior to your wife's/husband's hospitalisation?" [1]

After translating 'role' in terms of useable language the question asked

> "(a) Could you describe the jobs you did at home before your wife/husband entered Crease Clinic?
> (b) Could you also describe your social activities before your wife/husband entered Crease Clinic?" [2]

Following experimentation and in the light of experience and the results obtained while engaged in experimentation, it became necessary to change the question to

> "1. Before your wife/husband entered Crease Clinic, can you describe the things you did
> (a) at home
> (b) in the community
> (c) socially. " [3]

Obviously the question of semantics is extremely important in the design of an interview format, and can quite considerably pose as a very limiting and impedimental factor in research, using

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1 Appendix A_1.

2 The above is a sample of the questions contained in the experimental format for interviews with reciprocals. The experimental format has not been included in the Appendix.

3 Appendix A_2.

the method adopted in this study. It is essential that where the question of semantics arises, that experimentation be done with a fairly large sample, before entering the actual research experiment. In this study it was not practical to use a large sample for preliminary exploration. In view of the fact that the problem of semantics proved so interesting, the writer inserted a few questions asking for definitions of terms commonly used by social workers, involved with a client's roles.

Sampling

One of the advantages of the case study method is that it permits the use of a small sample, In the research area of this thesis a small sample was used. The rationale behind sampling lies in the acceptance of the reality factor that to study some phenomenon in detail would involve such a mass of data as to render the task of analysing almost impossible. A sample, as the name suggests, is a representative of a larger whole, and an essential part of all scientific procedure. Young says a sampling is

> "One of the most important as well as the most difficult problems in social research." [1]

It's importance lies chiefly in that it makes far easier management of social research projects and has the quality when used in statistical research of facilitating measurement of results and when applied constructively it acts as a controlling agent of bias.

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1 Young, Pauline V. Ibid. Page 301.

At the outset of the thesis, the writer's intention was to make use of purposive samples. Selltiz, Deutsch and others write

> "The basic assumption behind purposive sampling is that with good judgement and an appropriate strategy one can hand-pick the cases to be handled in the sample and thus develope samples that are satisfactory in relation to one's needs." [1]

In practice, the sampling though partly purposive tended to fall generally within the non-probability sampling category, due mainly to a variety of limiting factors imposed on the research by the experimental environment. From time to time the writer had to resort to accidental sampling. Selltiz, Deutsch and others consider that

> "In accidental sampling, one simply reaches out and takes the cases that fall to hand." [2]

The sample in it's final form comprised of nine cases - four from the female and five from the male sections of the Crease Clinic of Psychological Medicine respectively. Cases were intended to be selected according to certain predetermined criteria decided on by the writer as being essential for the purpose of conducting research in terms of the focus of the study undertaken. However, due to circumstances over which the writer had no control, only four cases actually satisfied the requirements of selection criteria, so that the sample is not considered representative, and therefore stands as one of the many limitations of the study. The sample in it's final composition represented 12.8% of the patient population, but this has no real significance. The other limitations of the sample and study are also apparant.

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1 Selltiz, Deusch and others. Ibid. Page 520.

2 Selltiz, Deusch and others. Ibid. Page 516.

As a result of renovations, and a shortage of medical staff, the patient population at Crease Clinic had been substantially reduced at the time of conducting the research. The female ward East 2, normally serving the needs of an average thirty-six patients monthly, had eighteen patients. One complete ward on the male side of the clinic was closed for renovations. Furthermore many of the patients who might have qualified in terms of the criteria for selection of cases were incapacitated through treatment, or too grossly disturbed, suffering memory impairment as a result of electro-convulsive therapy, or in the process of being discharged before satisfactory arrangements could be made to interview them.

Selection Criteria

1. Since the study is family oriented all patients selected had to be married and living with their spouses prior to hospitalisation, and the parent of children or of a child who were living at home.

This criterion was determined in large measure by the natural focus of the study, and the set of hypotheses developed for the thesis.

2. The current admission was to be the patient's first admission to a mental hospital. This requirement was selected for the obvious reason that the first admission to a mental hospital would be expected to have an important impact on the patient and family. Such an impact would tend to highlight areas of stress in relation to displacement, and enable the researcher to investigate stress more easily. Role functioning and feelings were

considered to be somewhat differently affected at the first admission than would be the case with re-admissions.

It was not possible, however, to rigidly apply this requirement, due to the fact that the patient population was so small, and the number of patients well enough to become involved in research interviews, yet suitable in terms of the selection criteria was even smaller.

3. That the patient should have been in hospital for a period exceeding two weeks. This would allow the family time to react to the displacement of the patient from the home, and become acquainted with the hospital environment.

4. That the patient be well enough to handle a research interview without experiencing too much difficulty, as well as have a fairly intact memory.

Since the interview deals quite substantially with pre-hospitalised roles and role relationships, it was important that the patient be able to give a fair description of his roles and role network in response to questions asked by the interviewer. Furthermore, as the interview involves a two-way communication it's success would depend on the ability of the patient to communicate verbally.

5. That the patient customarily resides in the Lower Fraser Valley-Vancouver region, and would include any other area falling within a radius of 35 miles from the hospital community of Essondale. This criterion would serve to facilitate interviews with family, and also permit the researcher to assess how family members perceive the hospital community. In only two instances

was this requirement wavered, when patients were scarce. One patient came from Chilliwack and the other from Edmonton.

The Study Method

As a necessary preliminary, permission to conduct the research was obtained of the clinical director of Crease Clinic. The scope and purpose of the research was then tabled in a memorandum by the clinical director, and passed to the unit directors. The memorandum set out briefly the criteria of selection, and asked for co-operation in referring patients for use in the research. Discussions were similarly held with the casework supervisor of the social service department, and the writer set out in a memorandum, the focus of the study, and the criterion to be used in the selection of patients for interviews, and the number of patients required by the writer to constitute the sample. This information was then passed to social workers in each of the respective wards of Crease Clinic. In discussion with the supervisor it was decided that workers would discuss the matter with ward doctors and refer cases to the supervisor, who would then refer them to the researcher. After a period of approximately six weeks it was found that this arrangement was not proving effective, and the researcher decided to list all new admissions from January of patients meeting the criteria of selection. The supervisor would then discuss cases at the unit meeting, appearing suitable for referral to the researcher, specifically chosen in the list. This arrangement did not prove entirely successful either, and the researcher decided to have direct contact with ward doctors in order to obtain referrals.

Initially it was arranged that the ward doctor would briefly discuss referral with the patient, and gain his or her approval. The ward social worker would then outline the purpose and nature of the research to the selected patient. This procedure was considered necessary to allay any fears that the patient might have about the interviews and the research. It was also considered a useful procedure in that the patient would be adequately prepared for the interview situation, and thus minimise the amount of time that would normally be spent in the process of introduction and establishing rapport. In each case, the patient was to be asked whether he approved of interviews with a member of his family. This last procedure was not however, carried out, and the interviewer was required to discuss this matter at the conclusion of the interview. Only in one case did the patient resist the idea of interviews with a relative or member of the family. The arrangements for the doctor and social worker to see the patient prior to the interview worked out reasonably well for the first four cases referred, but the practice was not maintained and in the last six cases the interviewer was required to discuss very briefly the reason why the patient had been referred, and for what purpose.

Originally, all interviews with patient and relative were scheduled to take place at the clinic, however this was not possible for an assortment of reasons.

(a) On the days when the interviewer would be available at Crease Clinic - Wednesday, and Friday afternoons, it was not convenient for the family to visit.

(b) Extra responsibilities, and lack of transportation made it inconvenient for family members to visit except on Sundays.

(c) When an interview was possible with a family member during visiting hours, no office was available for use by the researcher.

(d) The patient was discharged very shortly after the interview, and family members did not wish to travel "all that way" now that the patient was home.

Therefore, in the case of five referrals, interviews with the family reciprocal took place in their homes. In the case of two referrals where the patient had been discharged fairly soon after his or her interview, the patient showed reluctance to let the interview with the reciprocal proceed without sitting in.

Initially contact with the patient's reciprocal was to be made by the ward social worker, this was done in four out of ten of the cases referred. In respect of the remaining six cases, this was not done, and the interviewer made the contact with the reciprocals himself. The reason for this is probably attributable to the fact that these six cases had at no stage of hospitalisation been referred to the social service department, or been picked up by the social worker assigned to the respective wards in which the patient had been placed. All contacts with reciprocals were made over the telephone, and the purpose of the research communicated to them as with the patient. Over the telephone arrangements were also made for an interview.

Prior to each interview with the patient, the interviewer met the patient on the ward and engaged in light conversation while

conducting the patient to the interview room. The reason for this procedure was to lessen any anxiety which the patient might be experiencing about the research interview, set him at ease, and enable both researcher and patient the opportunity of adjusting to each other. In the case of the reciprocals, the interviewer engaged in light conversation, and then casually led the conversation in the direction of the research. In two instances, and rather in the spirit of an experiment, the ward was contacted and asked if a nurse would escort the patient to the interviewing room. Interestingly, there was a noticeable difference in the initial stage of the relationship, the patients escorted by the nurses to the interview room, tended to be less at ease, seemed uncomfortable in their chairs, tense and cautious. For the first five minutes they appeared somewhat lost and apprehensive. This situation changed quite radically ten minutes after they entered the office.

In each interview, the researcher introduced the focus of the interview, briefly summarised the purpose of the research, and the reason why the research was being conducted. Each respondent was informed that no names would appear and that the information provided by him or her was not intended for hospital use. The introduction used was structured in a guide attached to the interview format, and was the same for each interview whether with patient or reciprocal. The respondent was told that the format was a guide and would be referred to during the interview. Should the respondent wish to ask any question in relation to the questions put to him in the interview, he or she should feel free to ask. Few questions were actually asked by respondents, those that were, were requests for clarification of the meaning of the question,

or requests that the researcher repeat the question. In only one instance, in the interview with Mr. M. - a patient's husband, after he had answered three questions, were questions asked about the interviewer's position and status in relation to the hospital. When questions asked were for clarification, the interviewer gave a standard example of what was meant by the question.

In the preliminary process of formulating method, it was anticipated that the writer would be permitted to conduct all interviews with patients and reciprocals. This assumption was based on the fact due to the small size of the sample and the use of a standardised interview schedule, the interviewer should be the same for all interviews so as to limit the amount of bias in the research. However, in the case of two interviews with patients, Mr. C. and Mr. R., the supervisor felt that the workers had a very good relationship with the patient, and considered at the time it inadvisable to involve these patients in an interview with anyone other than their social workers, as it might lead to some confusion. The writer did not oppose this suggestion more particularly as he was given full opportunity to explain the focus and purpose of the thesis to the social workers, discuss the nature of the questions structured in the interview format. Furthermore the use of an interview format in conducting the interview would tend to eliminate the bias of the interviewer. However, the involvement of additional interviewers represents an additional variable and potential limitation.

Besides the preliminary contacts with the patient and reciprocal, during the process of the interview, the writer used

consistently communication intended to lend support to the person being interviewed, and gain his or her co-operation. For example the individual was asked to help with the study, the writer was sympathetic in those situations which were and had been stressful. When individuals wondered whether they were giving the right information, the writer responded by saying that "what you are telling me is invaluable", "it sure is important". At the end of the interview, the individual was asked by the writer "Are there any comments you would like to make?", "Is there anything else you would like to say in relation to the questions you have been asked?" The patient or reciprocal was then thanked for their co-operation and help. In all the interviews the respondents thanked the writer, and hoped that the information would be of help, four respondents offered further help, and two respondents said that they were pleased the writer had come, that it was "nice to have someone they could talk to".

Generally the interviews were from sixty minutes to seventy five minutes in duration, and covered fairly adequately the full range of questions. Finally in view of the horizontal character of the research method, the writer obtained recordings of the patient's history, compiled by the ward psychiatrist to provide for the vertical dimension. This was done in view of the rationale underlying social role theory, as well as to facilitate analysis of the data obtained by the writer in terms of physical and psychological functioning.

Limitations of the Study

Throughout this chapter frequent reference has been made to the question of limitations. That these limitations seriously hindered the research has been fairly well established. In most instances, they rendered criteria ineffective; they required unqualified changes in method; they minimised the significance of the sample because the final sample had to be made up of cases not meeting selection criteria, thereby making it highly unrepresentative.

Finally some point should be made about the setting. Presently, Crease Clinic suffers from an acute shortage of offices and interviewing rooms. In many departments, offices are shared, and the chance of obtaining an office in which to conduct an interview is a matter of 'pure luck'. On three occasions patients had to be kept waiting, and on four occasions the time of the interview had to be changed. Such problems as these can detract from the value of the research and may in the broadest sense be a measure of the institution's interest in research generally.

Recording

Since the major portion of the study depended highly on the interview, the question of recording was extremely important. The use of a fairly well structured interview format somewhat aided recording in the interviews. Each question in the format is numbered so that responses could be numerically tabulated. In most instances the recording is in verbatim form, except in the interviews conducted by someone other than the writer. Recordings of the interviews appear in the index of the thesis.

CHAPTER III

ROLE AND STRESS: PRIOR TO AND DURING HOSPITALISATION

The following chapter presents a descriptive analysis of the data obtained in interviews with both the patients and a reciprocal family member - the spouse. No attempt is made to use the whole body of material obtained and only those responses which are felt to be of significance in terms of the study have been selected for presentation.

Initially the writer discusses the roles as perceived and performed by the patient and his reciprocals prior to and after the admission of the patient to mental hospital. So that areas of stress can more easily be identified, an exposition follows of the attitudes to role adjustment, and adaptations made by all members of the family to displacement. [1]

In order to dilute the tendency of the study to somewhat ignore the broader social network of interrelationships with people other than the family, the matter of relatives and friends are briefly referred to in relation to mental illness and hospitalisation.

Throughout this chapter and the following chapter, reference will be made to Chart 1. The chart is a summary of those factors felt to have a bearing on the study and includes information extracted from hospital files pertaining to the patient and the family members. Each family has been designated a case number (1 - 9) and an alphabetical letter. Reference will either be made to the alphabetical letter (eg. Mrs. F.) or case number (eg. Case 1). To facilitate presentation, cases will be discussed individually, or in groups, whichever is the most convenient in terms of the data being referred to.

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1 See Chapter I, Page 21, Footnote 1.

Pt.	Age	Diagnosis	Date of Adm.	Treatment	No. of Prev. Adm.	Occupation	Marital Reciprocal	Other Family Reciprocals	Residential Area	Social Serv. active.	Date of Interview.
Mrs. F. Case1	27	Catatonic Schizophrenic Reaction	Mar.10 1963. Cert.	E.C.T., Chemo Therapy	2	Housewife	Husband (army sargeant)	four sons (5-9 yrs.)	Camp Shile, Manitoba	No	Patient April 1963
Mrs. M. Case 2	43	Psychoneurotic in an emotionally unstable personality.	Mar.29 1963 Vol.	Insulin, Chemo therapy group psycho-therapy	2	Housewife	Husband (labourer)	3 sons 1 daughter (son aged 4 at home)	Burnaby	No	Patient April 1963
Mrs. D. Case 3	31	Neurotic Depressive Reaction	April 10th, 1963 Vol.	E.C.T. Chemo Therapy	1	Housewife	Husband (school teacher)	1 daughter 2 sons (7 months - 8 years)	Chilliwack	No	Patient April 1963 Reciprocal April 1963
Mrs. S. Case 4	43	Chronic Undifferentiated Schizophrenic Reaction	March 28, 1963. Cert.	E.C.T., Chemo Therapy	2	Housewife	Husband (Delivery van driver)	2 sons aged 9 & 6 years	Vancouver	No	Patient April 1963
Mr.B Case 5	24	Depressive Reaction in Schizoid Unstable Personality	March 1st, 1963 Vol.	E.C.T., chem and group psycho-therapy	0	Drifter-unemployed 12 months	wife separated	2 daughters (3 months & 1 year)	Burnaby	Yes (Intake)	Patient April 1963
Mr. Ch. Case 6	52	Psychotic Depressive Reaction	Feb. 19th, 1963 vol.	E.C.T.	0	Unemployed 6 months	Wife (saleswoman)	3 sons 1 daughter (9-19 yrs.)	New Westmin-ster	Yes	Patient April 1963 Reciprocal
Mr. R. Case 7	44	Paranoid Schizophrenic	March 22nd, 1963 Vol.	E.C.T., chemo therapy	0	Unemployed 6 months	Wife (housewife)	1 daughter 2 sons (5-11 years)	Port Kells	No	Patient April 8, 1963 Reciprocal April 26, 1963
Mr. C. Case 8	40	Chronic Brain Syndrome Post Traumatic Personality Disorder	Feb. 21st, 1963 Cert.	Chemo Therapy	0	Unemployed 16 months	Wife (housewife)	3 sons 1 daughter (8-16 yrs.)	Richmond	No	Patient April 1963 Reciprocal
Mr. E. Case 9	37	Sociopathic-Sexual Deviation Homosexual. Depressive Neurotic Reaction	March 10th, 1963. Vol.	Group psycho-individual-Recreational Occupational Therapy	0	Shoe Salesman	Wife (Carting clerk)	1 son 2 daughters (10 - 15 yrs.)	Vancouver	No	Patient April 1963 Reciprocal

CHART I

DEFINITION OF ROLES

Roles Prior to Hospitalisation

The Role of Married Woman with Children In the Home

Of the eight women interviewed, four of which were hospitalized patients, the tendency was to generalize the components of a particular role using a common descriptive word - "housework". With the exception of Mrs. E. (case 9) who described her role in the home thus:

> "The same things I've always done, perhaps more crankier than usual. Working, looking after kids, taking care of everyday living." [1]

The remaining seven women, added a brief description containing the following common elements: cleaning, washing, cooking food, looking after children, shopping at least once a week.

Mrs. C. who has an invalid husband added to these:

> "Looking after husband, seeing that he changed his clothes, washed, went to bed and awoke at the right time." [2]

Mrs. R. who lives in a typically rural area added:

> "attending to the animals, milking the goats, feeding the fowls." [3]

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1 Excerpt from Case 9, interview with reciprocal, response to question 3(a). Appendix.

2 Excerpt from Case 8, interview with reciprocal, response to question 3(a). Appendix.

3 Excerpt from Case 7, interview with reciprocal, response to question 3(a). Appendix.

In the interviews with husbands whether reciprocals or patients, the same pattern was repeated, they generalized the components of the woman's role, and in five of the seven interviews gave brief descriptions which corresponded exactly with the descriptions applied by their wives. Of the remaining two, it was not possible to interview the wife of one patient, and in the case of Mr. E. he supplied a description of his wife's role which she had not given in the interview with her.

> "She does everything, the dishes, ironing, washing, cooking, making clothes for the family, shopping, the entire gamut. Looking after the children." [1]

which corresponds highly with the descriptions given by seven of the female informants.

Socially

Socially there was not a great deal of variation in the socially oriented roles of female respondents. All eight reported contact with a neighbour or friend, four had an additional social activity. Mrs. Ch. curling, Mrs. R. piano lessons, Mrs. S. walking with sons, Mrs. C. bowling. Of the remaining four, one reported no other activities, while the other three reported at least two or more activities.

Mrs. M. "attending church and women's circle, playing cards, drives with friends".

Mrs. F. "dances, dinners, playing cards".

Mrs. E. "dancing lessons, the Diabetic Association". (in which she holds the position of Secretary/Treasurer)

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1 Excerpt from Case 9, interview with patient, response to question 3. Appendix.

Where husbands were describing the roles of their wives, there was parity of description. For example in the case of Mrs. M. she described her social life thus:

> "I spent a lot of time with Mrs. Ms., stayed there on weekends. Went to church on Sundays, in the morning had coffee with one of two neighbours, watched T.V. in the evening, sit in the corner reading to stop thinking. Played cards on the weekend with Mrs. Ms., and went for drives with her. Went to a church women's circle." [1]

Mr. M. described his wife's social activities thus:

> "She spent weekends with Mrs. Ms., watched T.V., went to church, was always visiting two neighbour friends, reading, went to ladies church circle." [2]

The Role of Married Men with Children In the Home

Two of the seven respondents gave no actual description of their role in the home, a further two gave a very brief description, and the remaining three descriptions were in more detail.

> "Tell Edna (wife) the right way of going about life as I understand it. If she had listened to me there would be no need for her to go (to hospital). I do my own sandwiches, make my own breakfast, take wife a cup of tea in bed in the mornings, get my own cup of tea at night. When my wife was at Mrs. Ms.'s made my own supper. Mrs.M. was against it. I washed up the dishes, washed the floors, washed the kitchen floor. When I came home from work spent most of my time with my son. On weekends I was with him most of the time. She (wife) couldn't stand him (son) around." [3]

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1 Excerpt from Case 2, interview with patient, response to question 2. Appendix.

2 Excerpt from Case 2, interview with reciprocal, response to question 3(b). Appendix.

3 Excerpt from Case 2, interview with reciprocal, response to question 3. Appendix B.

Mrs. M. in her description of her husband's role in the home, gave a response which correlates with Mr. M.'s description of his role.

> "He eats supper, washes up, makes his own sandwiches, washes floors, and washes the kitchen floor. Cares for son and plays with him in the garden, messes around in the basement. Made his own breakfast, when I was away made his own meals." [1]

Mr. D. described his home activities:

> "I help with the dishes, most of the time I spend working on another house. I put my daughter to bed. I discipline children when I see the situation. I do anything I am asked to do. Sometimes I do a bit too much to the frustration of my wife. Spend a lot of time reading." [2]

Mrs. D. in less detail showed a degree of parity in her description of her husband's activities in the home.

> "He helps with the dishes, baby-sits, spends a lot of time building a new house. Spends a lot of time reading." [3]

Mr. E.'s description of his role activities correlated with Mrs. E.'s description.

> "Upkeep the gardening, washed dishes occassionally, take wife shopping. General disciplinarian for family. With the children in the evening, while my wife is at work. I talk to the children and play with them. I will clean the chesterfield and rugs." [4]

Mrs. E.'s description of husband's activities in the home.

> "Washes the dishes, works in the garden, disciplines the children, listens to records, spends time with the children. Cleans the rugs, takes me shopping." [5]

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1 Excerpt from Case 2, interview with patient, response to question 3. Appendix B.

2 Excerpt from Case 3, interview with reciprocal, response to question 3. Appendix B.

3 Excerpt from Case 3, interview with patient, response to question 3. Appendix B.

4 Excerpt from Case 9, interview with patient, response to question 1. Appendix B.

5 Excerpt from Case 9, interview with reciprocal, response to question 3. Appendix B.

Socially

Seven out of seven of the men interviewed reported no social life of any account. They visited a friend or friends only occasionally. Responses to questions about the social life of husband tended to correlate completely without exception.

Mr. D. stated that he did do enough socially.

Mr. M. stated that his social life had changed in the last four months.

Mr. E. explained that he was not able to lead a fuller social life because his wife worked at nights.

The Role of Children [1]

In the Home

Case 1

Mrs. F. has four sons ranging in age from 4 years to 8 years. Three sons go to school, and the youngest attends kindergarden. The 7 year old son attends a Child Guidance Clinic. The two eldest boys make their own beds, and when home, keep an eye on the youngest. The three eldest sons attend swimming classes, take part in cubs, and they all play with friends. They play with their trains and ping pong. They help wash the dishes.

Case 2

The M. family have one child aged 4 years living at home. Mrs. M. has three other children by a former marriage. One is adopted and the remaining two are in the Navy.

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1 See responses to question 3, interviews with reciprocals. See responses to question 4, interviews with patients. Appendix B.

Mrs. M. reports that he plays with toys, and the neighbour's children. He spends a considerable amount of time at the home of Mrs. Ms. (a friend). Mr. M. added to this discription that his son goes for walks with him, and plays with him in the garden.

Case 3

The D. family have three children ranging in age from 7 months to 8 years. One child is at school. They do not have many friends. They play together. Mrs. D. takes the eldest son to the library. Mr. D. added that the son builds models, reads, and the daughter plays with cats.

Case 4

The S. family have two sons aged 6 years and 9 years. Both attend school. They dry dishes, tidy up clothes, learn carpentry in the basement. They play with friends a lot. One son is a cub.

Case 5

The B. family have two children. Mr. B. could give no description of the activities.

Case 6

The Ch. family have four children ranging in age from 9 years to 19 years. Mr. Ch. related that the eldest son works, the others attend school. They have few friends, belong to no groups or clubs. They help in the home, with dishes, cooking.

They do not go out much. Mr. Ch. added to his wife's description:

> "Children look after their own rooms; watch T.V. a great deal of the time." [1]

Case 7

The R. family have three children ranging in age from 5 years to 11 years. The daughter aged 11 years is mentally retarded due to emotional stress, and was a patient at the Burnaby Children's Clinic. Two of the children attend school. Mrs. R. stated that the eldest daughter takes music lessons, clears the table. They all make their own beds, help feed the animals. The two sons feed their pet rabbits, help clean the floor, and burn papers. They do not have many friends to play with. They play together. Mrs. R. explained that in the past six months the children have not been allowed friends by father (patient). Mr. R. gave a full description of the activities of the children.

> Girl - "helps with dishes, and the housework, helps feed the rabbits, plays with friends - school friends, visits with them and they visit with her. I'm afraid I made it pretty tough on them when I quit my job." [2]
>
> Boy - "tries to be helpful, pretty good little kid - same as older sister, has friends." [2]
>
> Youngest - "exceptionally sociable. I think he takes after his mother, always playing around the barn, looks after his rabbits, asks me if he can help, usually works with me." [2]

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1 Excerpt from Case 6, interview with patient, response to question 4. Appendix B.

2 Excerpt from Case 7, interview with patient, response to question 4. Appendix B.

Case 8

The C. family have four children ranging in age from 8 years to 16 years. They all attend school. Mrs. C. says:

> "the two eldest boys go fishing, hunting, the second eldest plays golf. The two older boys take turns washing the dishes, they tidy their rooms. Made it a necessity, figured they should have done it a long time before, but mother-in-law interfered." [1]

Mr. C. in response to questions about the children said:

> "They do help with domestic chores, they're always out of the house." [2]

Case 9

The E. family have three children with ages ranging from 10 years to 15 years. All attend school. Mr. E. stated that:

> "The children do nothing in the home, they don't help mother. They have a great many friends, the eldest goes to dance parties, is a scout. The older daughter goes to girl friend's parties and is a Pioneer. The younger daughter spends a lot of time at home with daddy." [3]

Mrs. E. just felt they were good children.

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1 Excerpt from Case 8. Interview with reciprocal, response to question 3. Appendix B.

2 Excerpt from Case 8. Interview with patient, response to question 4. Appendix B.

3 Excerpt from Case 9. Interview with patient, response to question 4. Appendix B.

Discussion

Case 1

In relation to the role activities described by Mrs. F., prior to hospitalisation she thought that she should mend her ways in cooking, keep herself smart, make things easier at home. She felt she was too strict with the children and too hard on her husband. Socially she explained she has only two or three friends, and has trouble keeping them. They never come to the house, because she keeps things too clean. The reason for this was the fact that her husband, a sergeant in the army, was always inspecting houses, and she felt obliged to keep up appearances to set an example, and lest he found something wrong. The inference may be drawn that Mrs. F. has some confusion in her role of housewife due to her confused perception of her husband's role.

Mrs. F. stated that she started working as a Nurses Aide a month prior to her hospitalisation, because of financial problems. She worked from 6 a.m. to 3 p.m. Her husband assumed the maternal activities of seeing the children got ready for school, and the domestic activities of cooking breakfast and cleaning up afterwards. Arrangements were made with a woman to care for the youngest child. Mr. F. expressed his disapproval of Mrs. F. working, fearing that the pressure of work and her domestic, marital, and maternal roles would lead to mental illness.

Generally Mrs. F. gave evidence of being quite satisfied with the role performance of her husband and children, but felt that the children should spend more time on their homework, and that her husband being more educated that she, should help them with

their homework. The inference is that there is in this area a problem of role expectation. Neither the children or husband are performing in terms of Mrs. F.'s role expectations.

In relation to Case 1, and in terms of the descriptions of roles, and comments made in relation to role functioning, the following stress areas are identifiable prior to hospitalisation.

1. The stress of Mrs. F.'s cleaning activities carried out in her role of housekeeper. At night when her husband was at home she carried on cleaning, until her husband stopped her. She says now that she is in hospital she feels "glad to get away from cleaning."[1] Her role performance was stressful to her and her husband.
2. The stress of lack of finances to meet bills. Mrs. F. felt lack of finances prevented social life.[2] Mrs. F. responded to the stress created by the financial problem, by assuming an additional role, which we assume created stress for her husband and herself. For she explains that her breakdown "could have been due to the strain of working." [3]

Case 4

Mrs. S. is the wife of a Polish immigrant. She states that he was an alcoholic until he started a job with the Sun eight months ago. She says that she is treated like a servant and that

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1 Excerpt from Case 1, response to question 12, interview with patient. Appendix B.

2 Excerpt from Case 1, response to question 2, interview with patient. Appendix B.

3 Excerpt from Case 1, response to question 24, interview with patient. Appendix B.

this is because Polish men treat their wives in this fashion. She feels treated like a servant because of the manner in which he talks to her. He is constantly cranky.

> "I am not contented at home, I hate the way he talks to me. I'm treated as a servant." [1]

There is quite clearly a conflict of role expectation for Mrs. S.'s responses infer that her husband's role functioning is not considered appropriate in terms of her perception, and furthermore she is in conflict with his perception of her role in the family. Consequently the conflict has led to stress. Mrs. S. tried to adapt to the stress by abandoning her role, however,

> "They reunited three months ago because she had no other place to go, not because she wanted to. She came back on his condition that she must obey orders. Since the reunion she has been upset and hearing voices." [2]

It may be inferred therefore that there is severe marital stress, which Mrs. S. tried to resolve through role abandonment, this proved unsuccessful and eventually led to the development of symptoms. Mrs. S.'s role descriptions tell us of her very limited social network.

> "As to her social and recreational life, she says that she could be happy but that her husband won't let her, that anything she undertakes he makes sneering remarks about and is very critical." [3]

Thus her reciprocal is acting in such a way that he is impairing Mrs. S.'s role functioning.

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1 Excerpt from Case 4, interview with patient, response to question 6. Appendix B.

2 Ward Notes, Mrs. S. Case 4. Appendix C.

3 Ward Notes, Mrs. S. Case 4, page 2. Appendix C.

Case 2

Mrs. M.'s expectation and perception of her husband's role and relationship is the cause of stress for her.

> "I would like my husband to sit and talk, give understanding, comfort. He sits in the kitchen reading sexy books. I am ashamed of him, he's nothing but a ditch digger." [1]

Concerning her performance of domestic, marital roles Mrs. M. said that:

> "I got very bored and it made me bitter. I wanted to go out but couldn't, when I went out it was with Mrs. Ms., but her way of life is different to mine. I refuse to go to my husband's club. I like people, but I couldn't drive myself to go. I don't like housework but had to be tidy. This got on my husband's nerves, but I did the housework nevertheless. I didn't want to go out with my husband, he makes me feel so embarrassed." [2]

Mr. M. is not satisfied with either his wife's domestic, maternal, marital role functioning in the relationship she has with him. Mr. M. is in conflict because his wife does not perform according to his expectations. Because of the stress and dysfunction of role interelationships, Mr. M. no longer feels in a position to continue his socially oriented roles. He has for the four months prior to hospitalisation, given up roles in the social environment and taken on additional roles in the home which he feels are essentially ones which his wife should perform. Essentially then the stress is related to marital, maternal and domestic performance relationships, which have in turn impaired social roles, and created more stress.

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1 Excerpt from Case 2, interview with patient, response to question 5. Appendix B.

2 Excerpt from Case 2, interview with patient, response to question 6. Appendix B.

Case 3

Mrs. D. felt her role performance and relationships were very different when she was mentally ill.

> "While sick, I was dissatisfied with everything, everything was a tremendous effort, went to bed and cried ... still went visiting ... the family didn't mean anything." [1]

Initially in describing her roles at home and socially she tended to give descriptions at period before her pregnancy and illness - 16 months ago. When she had a fairly broad role network.

> "I went to the Women's Institute Sewing Circle, P.T.A., attended meetings of the horticultural and Alpine Club once a month. Visited frequently." [2]

The onset of pregnancy and later mental illness. While there is no substantial evidence to suggest that the illness may have been caused through stress engendered by role transition, it remains an unproved possibility. It is true however, that Mrs. M. had a very active broad role network, and a wide range of socially accepted ways of meeting her needs, she also says that:

> "Pregnancy last year stopped me from doing all these things." [3]

From this it could therefore be inferred in terms of social role theory, that Mrs. M. was in a state of rolessness. This could conceivably have caused stress.

Mr. D. expressed satisfaction with his role functioning and the roles of all other members of the family. He explained that he likes his work as a teacher, has a social life that is

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1 Excerpt from Case 3, interview with patient, response to question 6. Appendix B.

2 Excerpt from Case 3, interview with patient, response to question 2. Appendix B.

3 Excerpt from Case 3, interview with patient, response to question 2. Appendix B.

enough for himself, and was generally happy to be doing things together with others in the family. Mrs. D. expressed the same theme.

Case 6

From the responses obtained in interviews with Mr. and Mrs. Ch. it was strongly evident that there was no general discrepancy in family role perceptions. However, it was most apparent that Mr. Ch.'s role expectations for himself were creating considerable stress. Since the collapse of his plumbing business in Calgary, and Mr. Ch.'s migration to New Westminster to escape his debts, he has not been in employment. He feels extremely badly that he cannot provide for his family. Mrs. Ch. has had to find employment as a sales woman in order to cope with some of the economic needs of the family. Thereby displacing Mr. Ch. as "breadwinner". She is unhappy and misses her former life in Calgary, and therefore is in a state of rolelessness.

The children are also unhappy, and have had problems at school, due to the difference in educational programs between Alberta and British Columbia. Socially they have not been able to develope a satisfactory role network in New Westminster in any way comparable to the role network they had in Calgary.

> "They have not met friends, and want to return to Calgary." [1]

Like mother they are in a state of rolelessness.

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1 Excerpt from Case 6, interview with reciprocal, response to question 3. Appendix B.

In practically all the responses about role functioning prior to hospitalisation, Mr. and Mrs. Ch. talked about what they and the children did at home and socially while in Calgary. It is clear that in the family's interaction with the present social environment they are experiencing considerable stress. The family finances which are poor are a source of stress. School for the children is also a source of stress. The stress situation is adequately expressed in Mrs. Ch.'s statement that

> "We don't go out, my husband's business fell apart, we have financial worries. It has an effect on the children. We have all had to give up a lot. My husband has had to give up work. I am very dissatisfied with things." [1]

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1 Excerpt from Case 6. Interview with reciprocal, response to question 4. Appendix B.

Case 7

The social roles of Mr. R.'s reciprocals in the family have largely been determined by Mr. R.'s periods of illness. Mrs. R. states that her husband's illness has been evident for seven years. The family have learnt consequently to adapt to those periods when he has been disturbed at home. Despite their ability to adapt their social life and roles to his periods of illness and reasonably healthy functioning, Mrs. R. finds the situation stressful.

> "When my husband was ill, it was pretty awful, he could be dangerous, he argued all the time. When he went into a depression he would drink, become violent, destroy the house." [1]

> "Visiting neighbours stopped last September. All winter long I saw nobody, he objected to my going out, now he is in hospital things are back to normal, and I have retained contacts with neighbours and friends." [2]

The situation was slightly different with the children, and Mr. R. let them see only certain people.

Mrs. R. reacted to the stress caused by her husband's most recent pathological functioning and behaviour by leaving him. This made things stressful for him, and when he saw his wife he said that he would go to Crease Clinic if she returned home.

Of Mr. R.'s role functioning, Mrs. R. feels that he has not been a father to the children, and is incapable of taking care of himself without her help.

> "My husband can't do anything alone, he can't function without me - it's unnatural, but I have got used to it." [3]

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1 Excerpt from Case 7, interview with reciprocal, response to question 4. Appendix B.

2 Excerpt from Case 7, interview with reciprocal, response to question 3. Appendix B.

3 Excerpt from Case 7, interview with reciprocal, response to question 21. Appendix B.

In this case the major area of stress is in relation to the adaptations family members have to make when Mr. R. (patient) becomes disturbed at home. It can only be postulated that Mrs. R.'s assumption of some of her husband's roles at home, have created stress for him, and stress for her, although she gives no conclusive evidence that this is the case.

Case 8

Mr. C. has a long history of hospitalisation following a serious accident in the winter of 1962. He was discharged as an invalid in December 1962 from Shaughnessy Hospital. Mrs. C. maintains that she has adapted to her husband's condition, and only sought his admission to Crease Clinic following stress caused when

> "he became aggressive towards his wife so that she had to call in neighbours to quiet him down." [1]

Since his accident and it's physical and mental consequences Mr. C.'s range and social network have become seriously limited and impaired. He has not been able to meet the expectations of his role as father, breadwinner, husband, nor gain any measure of independence in his functioning. He was until his hospitalisation completely dependant on the family. Mr. C.'s response to format question 5 was inappropriate

> "nil, not thought about it - as long as I don't get trouble." [2]

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1 Ward Notes, Mr. C. Case 8. Appendix C.

2 Excerpt from Case 8, interview with patient, response to question 5. Appendix B.

However he was able to verbalize his feelings about his social role situation.

> "I'm never satisfied, I would like to do machine work, repair work, spend more time with the children. Have more social life. I had a lot of friends in Richmond. It would be easier for my parents if we moved." [1]

Mr. C. would appear from this response to have some perception of his role functioning.

The C. family live with Mr. C.'s mother and stepfather. Mrs. C. does not have a good relationship with her mother-in-law, and resents both, living with them, though circumstances dictates that they must, and mother-in-law's interference in family relationships.

Concerning Mrs. C.'s roles, and her assumption of new ones in the family - nurse to husband, father as well as mother to the children, she does not appear to be experiencing stress in these roles, since circumstances dictate that she must adapt, which she appears to have done. She continues to maintain her socially oriented roles,

> "I went out more often - it was a form of escape to get to someone I could talk to - it was the only thing that kept me going." [2]

The inference may be made however, that the new roles she was required to assume, together with her customary roles were stressful, but that this stress was somewhat relieved by the range of

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1 Excerpt from Case 8, interview with patient, response to question 6. Appendix B.

2 Excerpt from Case 8. Interview with reciprocal, response to question 6. Appendix B.

her role activities. She may be said therefore to have established at that point in time a symbiotic role network.

Identifying therefore possible areas of stress it may be stated that Mr. C. finds his social role impairment stressful, and Mrs. C. finds her role functioning in relation to her mother-in-law stressful.

Case 9

Mrs. E.'s social and family role functioning is determined in part by her working role - counting clerk on night shift. When her husband Mr. E. is at home in the evening, she is working. The husband-wife role relationship is therefore somewhat impaired. Any stress is defended against by the fact that both marital partners want more money. Mrs. E.'s socially oriented roles are also impaired by her working role, but she does not appear to be having any stress.

> "I was doing just what I wanted to be doing, wish we had more money." [1]

In the case of Mr. E., he is dissatisfied with his working role, social role, and marital role, which he correctly perceives is related to the need for more money, and his wife's working role.

> "He would like to obtain a more satisfactory and more financially rewarding employment so that his wife could quit work and therefore the lonely evenings at home would be avoided which have contributed to the release of this mechanism. (excessive drinking and homosexuality)" [2]

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1 Case 9, excerpt from interview with reciprocal, response to question 4. Appendix B.

2 Discharge Synopsis, Case 9. Mr. E. Appendix C.

His perception of his wife's role, and her present role performance in relation to himself are therefore a source of stress. His own social role is impaired because of Mrs. E.'s working role. This has produced stress which eventually has sought release in pathological behaviour which is stressful to his wife because his drinking is considered by her to be inappropriate and threatens her relationship with him, and is stressful to him, as it threatens his marriage.

Mr. E. is quite satisfied with his wife's role performance in all other areas of family functioning. She meets his expectations of her maternal and homemaker roles. Parental roles in relation to the children appear to be satisfactory, from the perceptions of Mr. and Mrs. E.

THE PROBLEMS OF HOSPITALISATION

Affects on Role Performance - Adaptations

In the interviews with reciprocals, they all reported that there was no alteration in their social and home roles, or those of family members. Mrs. C. said there was

> "Just as much responsibility, perhaps more when he was home. It was a relief." [1]

Mrs. Ch. said there were no changes, as did Mr. D., Mrs. R. and Mr. M. Mrs. E. explained that

> "the children don't know (about Mr. E.'s admission to Crease Clinic) we all took it as a matter of course, it had to be. I carried on as before, except that I had to do all the worrying myself - controlling the kids. I got a driver's license as a necessity." [2]

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1 Case 6. Interview with reciprocal, response to question 5.

2 Case 9. Interview with reciprocal, response to question 5.

However, their initial responses were somewhat modified by a slightly differently worded question. Where there were very small children, not of school age, environmental changes were necessary and the social network of the child altered, establishing new relationships for the child, with an undoubted change in the social and family roles and relationship within the nuclear family unit. In the case of Mrs. D. and Mrs. M. not only were they displaced from the family network, but so were one of their children. Where there were older children, attending school and requiring some supervision, arrangements were either made with a friend to look after them until the patient's reciprocal returned from work, or for a relative to live with the family, thereby assuming some of the maternal and domestic roles formerly performed by the hospitalised patient. In the case of Mrs. D. Case 3

> "Nothing altered, I took on extra responsibilities (cooking) and did a minimum of everything. I loved the kids more than usual. I did everything that had to be done, reserved my strength, spent a little less time working on the new house, continued my social life. The baby went to my mothers in New Westminster and the younger son is with a neighbour until I get home from work." [1]

and Mrs. F. Case 1

> "My husband had to take time off from work to look after the children until my mother-in-law arrived from Vancouver. It's working well." [2]

Temporarily Mr. F. had to give up a role, and take on more family and home roles, that was usual, until his mother arrived.

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1 Case 3. Interview with reciprocal, response to question 6 and 7. Appendix B.

2 Case 1. Interview with patient, response to question 7. Appendix B.

In the case of Mr. M., immediately prior to Mrs. M.'s admission to Crease Clinic, she made arrangements for her four year old son to live at home, and spend the day with a neighbour. Mr. M. finding the extra responsibility too stressful made alternate arrangements shortly after his wife's hospitalisation, for the child to live with Mrs. Ms., a friend. This unburdened Mr. M. of a home role he found impossible to cope with, as well as all his other roles.

Mrs. E. was fortunate in the sense that any family changes or changes in role functioning were anticipated because of her husband's planning prior to his admission to Crease clinic. Changes largely affected their role performance. She was required to modify her working role, by adjusting working nights from six to two a week. Mr. E.'s son was required to assume his father's gardening role,"on orders from father."

> "My wife's social life stopped, and any spare time she had she comes out to see me - three or four times a week." [1]

Mrs. E. vaguely described that

> "all members of the family had to take on extra responsibilities and they all had to watch money closer." [2]

This was necessary as the family were required to live on social assistance, while Mr. E. was in hospital and not working, and Mrs. E. was working only two nights a week. Mr. E. made all the arrangements with Social Welfare prior to his hospitalisation.

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1 Case 9. Interview with patient, response to question 8. Appendix B.

2 Case 9. Interview with reciprocal, response to question 7. Appendix B.

Any adjustments to role functions took place easily and without stress.

Mrs. Ch. felt there were no significant changes, it meant extra responsibility in decision making, but she had become adjusted to this function, performed by her husband in his role as father, and head of the family, until he became mentally ill four months prior to admission. Since, Mrs. Ch. has a very full range of roles, in relation to her home, family, and employer, she was only able to visit her husband on her day off and Sunday.

It is significant however, that the eldest son began work shortly after his father's hospitalisation. It may be inferred therefore, that as a result of the stress engendered from economic factors, which attributed to father's mental illness, he reacted to the situation - threat of no money, clothes, food, by assuming a working role. Mr. Ch.'s perception of his family roles, now that he is in hospital is expressive of the stress he is experiencing over his displacement from the family network. He says that he feels it is:

> "Not a pleasing thing to think about, I feel it is very hard on my wife. I don't like to think of my son selling shoes. But there is nothing I can do." [1]

The eldest son's working role is not therefore in congruence with father's expectations.

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1 Case 6. Interview with patient, response to question 8. Appendix B.

Mr. C. or the family were not significantly affected in their range of role functions, neither was the family role network significantly affected. It would seem adequate to explain this as a consequence of the family's familiarity with hospitalisation. Mrs. C. says that

> "We were not affected, as we have had the same thing for ten months. The children are not fully aware how father actually is, they don't understand. When he was home he used to get mad at the children, used to say they broke his tools, so I would think they were relieved he returned to hospital." [1]

It will be seen from this description and previous reference to Mrs. C.'s attitude to her husband's hospitalisation, that role interelationships with reciprocals in the family role network, were stressful to the reciprocals. Consequently, hospitalisation as it proved to be in this situation, was stress relieving for the reciprocals in the nuclear family unit. The release of stress, would suggestively not require any change in role functioning, except release Mrs. C. of the responsibilities of nursing role in relation to dependant, invalided husband.

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1 Case 8. Interview with reciprocal, response to question 9. Appendix B.

PATIENT PERCEPTION, ATTITUDES IN RELATION TO RECIPROCALS

ROLE PERFORMANCE, AT HOME, SOCIALLY

Referring specifically to eight selected cases, four of the patients (three males and one female) were satisfied with arrangements at home. In the case of Mr. E. Case 9, he still retained, despite his absence from home a measure of control. Of the nine cases it was the only case, which suggested to the writer the concept of the invisible father, which will be discussed in the fourth chapter.

> "I phoned my wife every day, the family put off any decisions, signing of cheques, until discussing it with me and obtaining my approval, if the children wanted to do something they phoned me at the hospital. For example when my wife refused permission for my son to take some records to school it was necessary to phone me first." [1]

In the remaining four cases (three female and one male) the three female patients were satisfied with arrangements but with some reservations. Mrs. D.

> "I am happy about the baby being with my mother-in-law, but not too happy about my husband looking after the children, after he has had a whole day at work." [2]

Mrs. F. has a bad relationship with her mother-in-law, who is taking care of the home and children

> "but grateful that she is there." [3]

Mrs. M. feels quite satisfied about the domestic roles that her husband is now performing, but ...

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1 Case 9. Interview with patient, response to question 7.

2 Case 3. Interview with patient, response to question 8.

3 Case 1. Interview with patient, response to question 8.

Appendix B.

> "I object to the arrangements he has made for my son, because he refused to cope with the child. He does take care of the child in the weekend." [1]

One patient, Mr. Ch. made no comment, but implied that he was not happy about arrangements, because of the hardships his hospitalisation imposed on the family. [2]

LEAVING THE FAMILY - DISPLACEMENT

THE PATIENT

Case 1

Hospitalisation for Mrs. F. did not immediately mean being displaced from the family network. She was en route to Vancouver to join her mother, who had written to request that she come to Vancouver, because her step-father had suffered a heart attack. Her husband was very opposed to the idea and "very hurt" that she wished to leave the family. When she left Edmonton on the bus she became very distressed.

> "I was crying half the way - I felt lonely - I didn't want to leave the family, but mother sent a ticket. Mother and I are not too close - I went against my will." [3]

She misses the family, and worries about the condition at home

> "but glad to get away from cleaning." [4]

When she see's children visiting on the ward she cries and feels very sad. This seems to indicate that Mrs.F. is missing her maternal role in relation to her children.

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1 Case 2. Interview with patient, response to question 8.

2 Case 6. Interview with patient, response to question 8.

3 Case 1. Interview with patient, response to question 9.

4 Case 1. Interview with patient, response to question 10.

Appendix B.

Case 2 Patient

Mrs. M. was glad to get away from her husband and son.

"I was glad to leave my husband ... home. I have no feelings about son, he gets on my nerves." [1]

This response accurately sums up Mrs. M.'s feelings about displacement from the family network of role relationships. She does not miss anything. She was admitted voluntarily to the hospital, she has no relatives of any import, and would appear to have sought refuge and "escape" from the stress of her marital, maternal, and domestic roles, and relationships.

Case 2 Reciprocal

Mrs. M.'s re-admission to Crease Clinic made Mr. M.

"a frustrated housewife." [2]

he was not happy about her re-admission and feels that her problem is

"a problem a person can fight by themselves." [3]

In a sense he considered that since this was her third admission it was a matter of "the same old routine". He tended to agree it was an "escape" for his wife, from reality.

Case 3 Patient

Mrs. D. admitted herself voluntarily to Crease Clinic and appeared to be aware of her illness. She states that:

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1 Case 2. Interview with patient, response to question 9.

2 Case 2. Interview with reciprocal, response to question 8.

3 Case 2. Interview with reciprocal, response to question 15(a). Appendix B.

> "I had to leave home, I was doing a terrible lot of damage to my husband. I was too sick to worry about what leaving the family meant." [1]

This is Mrs. D.'s second admission, and she described the clinic as a shelter. She was relieved to be back in hospital because she realized she was failing in her role performance at home. She is

> "eager to go home, start in again with the family. I can give more to the children now that I am cheerful." [2]

Case 3 Reciprocal

We have already seen that the family roles on Mrs. D.'s re-admission were not radically changed. There was no particular stress evidenced in the network due to hospitalisation. Her husband compensated for her, and in Mr. D.'s opinion satisfactorily. Nevertheless, the children missed their mother. Perhaps more in the area of relationship than in role performance, was the situation stressful.

> "I was bored, making time. It was lonelier for me. Inconvenience of extra domestic chores and the feeling of inefficiency bothered me - I didn't remedy it." [3]

It is reasonably obvious that Mr. D. did not resent his wife's admission, but we can see from the above response that her displacement interferred with the interrelatedness of their roles, and placed Mr. D. in a state of rolelessness in relation to his wife. This was stressful as were the inconvenience of the domestic

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1 Case 3. Interview with patient, response to question 9.

2 Case 3. Interview with patient, response to question 28.

3 Case 3. Interview with reciprocal, response to question 9.

Appendix B.

"housewife" roles he was required to assume. It is interesting to note that he became more loving towards his children. The inference may be made that this was compensation for temporary loss of his wife.

Case 4 Patient

Mrs. S. was certified to Crease Clinic. She did not give any idea what her feelings might be about displacement in those questions designed to ellicit such a response. Instead she described her husband's meanness and the consistent manner in which he referred to her as insane. Things that she did, which she now misses were:

> "I miss looking after the home, miss my children, I love my children. It was a long time before I had children and they mean a lot to me." [1]

Displacement, however, appears to have threatened her relationship to her children and her maternal and domestic roles. Just immediately prior to the interview with Mrs. S. the nurse remarked that she was always trying to get weekend leave or day leave to see her children. Her responses generally suggested that displacement from the role relationship she has with her children has been stressful.

Case 5 Patient

Mr. B.'s responses to questions pertaining to displacement from family through hospitalisation were irrelevant in terms of this study, since he has been seperated from his wife for some

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1 Case 4. Interview with patient, response to question 12. Appendix B.

months prior to hospitalisation. Generally he was relieved to be in hospital, and aware of his inability to provide a background of stable and satisfactory role relationships in a family situation.

Case 7 Patient

> Mr. R.'s feelings about leaving the family were that he "felt lonesome and sorry not to be there (home) to help them." [1]

he misses "all the work around the house." He misses the home environment, and his network of role relationships in that environment, however at the time of admission he felt

> "confident and relieved." [2]

Mr. R. expressed concern that his wife might visit a neighbour ..

> "She has men in when her husband is away, not that I think she'd get involved but ..." [3]

Throughout the interview with Mr. R. he was constantly expressing concern about his wife and family, their hardships and welfare. He says he felt the family

> "were shoving me off ... wanted to see me better." [4]

Together with these illustrative examples, many of his responses to questions conclusively indicated that despite his voluntary admission, displacement from the network of family role relationships was stressful.

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1 Case 7. Interview with patient, response to question 9.

2 Case 7. Interview with patient, response to question 25.

3 Case 7. Interview with patient, response to question 26.

4 Case 7. Interview with patient, response to question 10. Appendix B.

Case 7 Reciprocal

Mrs. R. did not express any feelings that she was finding her husband's displacement from the home stressful. She expresses relief, for it has enabled her and the children to resume their social relationships and roles with the neighbourhood community which were cut off when Mr. R. became ill six months before his admission to Crease Clinic. Her fear is rather that he will be returned to the family role network before he is well again.

> "He might take a notion I put him in hospital and come back and hurt me. He threatened my life when I asked him to see a doctor." [1]

It will be remembered that in the section of this chapter dealing with role definitions, Mrs. R. carried most of her family roles, as well as most of her husband's. Hospitalisation would tend therefore to be less stressful in such a situation.

Case 6 Patient

Due to the effects of electro-convulsive therapy Mr. Ch. cannot remember his feelings about leaving the family. He misses not being able to do anything about his affairs, and this is presumed to mean that he misses his employment role, for his history [2] indicates that he has regarded his working role as the most important in the complex of his social roles.

He states that his hospitalisation is very hard on his wife, which in a sense may be realistic, however the interviewer states that Mrs. Ch. was relieved to have her husband admitted. He misses being without his family and the lack of privacy.

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1 Case 7. Interview with reciprocal, response to question 15(b)

2 Ward Notes. Case 6 Mr. Ch. page 1. Appendix C.

The interviewer who conducted the interview with Mr. Ch. and who has had previous contact with a reciprocal other than his wife reported that his father was

> "continually worried about being a failure as a father." [1]

Mr. Ch. expresses the theme that he has failed his family, made it hard for them.

> "When business started to go down hill the patient borrowed against the children's education policies and lost them, for which he now regrets. He says his children are his life, he has set great store by their future and he has now ruined it for them." [2]

While there is no directive proof, the character of Mr. Ch.'s responses appear to suggest that displacement has further threatened his role as father to his children, and a consequential source of stress for him in hospital.

Case 6 Reciprocal

Mrs. Ch. apparently responded to her husband's displacement but compensated in her role functioning.

> "I felt kind of lost, but I was so busy I didn't worry about it. I missed his presence in the home, but you have to make the most of things." [3]

The whole family miss him, and the eldest son did not want to say goodbye to his father. Mrs. Ch. felt that her husband did the right thing, and felt relieved from the stress of his presence and illness, while at home for four months.

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1 Case 6. Social Worker's comments at end of interview with patient. Appendix B.

2 Ward Notes. Case 6 Mr. Ch. page 1. Appendix C.

3 Case 6. Interview with reciprocal, response to question 17. Appendix B.

Case 8 Patient

Mr. C. was certified to the Crease Clinic

"he minds being away from the family." [1]

and felt that the children

"felt upset for a while. No daddy around."[2]

He doesn't know why he is at the clinic, and would rather be at home. He constantly talked about working with tools. It was felt that Mr. C. in view of his illness was not cognisant of displacement factors, and that one type of nursing had been replaced by another type of nursing.

Case 8 Reciprocal

Mrs. C. has in fact been fully conditioned to displacement factors as a result of her husband's long periods of hospitalisation since his accident. She says in fact that her husband's return to hospital

> "didn't affect my feelings, he gets proper care and attention. He hasspent a whole year in hospital - and has not been a husband or a father for a long time." [3]

Case 9 Patient

Mr. E. was a voluntary patient, who spent a week planning for himself and the family before admission. He is an effimate individual, with problems of homosexuality. It is in the light of these facts that displacement should be understood. Perhaps Mr. E.'s role situation is best expressed in his own words.

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1 Case 8. Interview with patient, response to question 9.

2 Case 8. Interview with patient, response to question 15.

3 Case 8. Interview with reciprocal, response to question 17. Appendix B.

> "At home I am the court of last resort. I feel that I am the father in the house." [1]

In terms of Mr. E.'s personality and the structure of his role interrelationships with family reciprocals, he attaches considerable value to his role as father in the home. Displacement from the family network with it's consequential implications could therefore pose as a threatening factor, producing stress. To somewhat alleviate the threat, Mr. E. continued to control and vicariously interrelate with members of the family, by arranging to function in the role of father, though actually removed from the home environment in person. This he did by

> "Phoning my wife every day, the family put off any decisions, signing of cheques, until discussing it with me and obtaining my approval, if the children wanted to do something they phoned me at the hospital. For example when my wife refused permission for my son to take some records to school, it was necessary to phone me first." [2]

Furthermore it would appear that he considered that were the children to know he was at Crease Clinic, their perception of him might be changed, and so damage the image of father. Consequently the children

> "don't know I am at Crease Clinic, but they know I am in hospital." [3]

In relation to his wife, he explained that this was the

> "first time in twenty years that I have been away from home. It went against all general principles to discuss my problem with my wife (who is not aware of it except her husband's drinking). I felt I had to come. If I didn't my family would break up. I was unhappy about

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1 Case 9. Interview with patient, response to question 6.

2 Case 9. Interview with patient, response to question 7.

3 Case 9. Interview with patient, response to question 16.

Appendix B.

> "leaving my family - you can't feel nothing when you leave them. But it was necessary to yield to the inevitable." [1]

Mr. E. mentioned that he missed a "goodnight kiss". Displacement evidently was threatening to Mr. E.'s social and family role relationships.

Case 9 Reciprocal

Mrs. E. supported her husband's plans to enter Crease Clinic. She missed her husband, which she describes by stating

> "I disliked being alone, living alone, but I adjusted to his absence." [2]

> "home needs a man to keep it going." [3]

While Mr. E. was in hospital, Mrs. E. appeared to be experiencing the stress resulting from his displacement from the family network of role relationships. She visited her husband at least three or four times a week, and in her responses seems to suggest that stress was attributable to the absence of a husband to interact with her role of wife. In this sense she was experiencing a degree of rolelessness.

THE PATIENT AND THE HOSPITAL

Seven of the nine patients, constituting the sample of this research, expressed positive attitudes towards the hospital. Mr. E. thought that it was

> "the most marvellous place in the world. The longer I am here, the better it seems. The people are wonderful.

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1 Case 9. Interview with patient, response to question 9.

2 Case 9. Interview with reciprocal, response to question 6.

3 Case 9. Interview with reciprocal, response to question 15(c). Appendix B.

> "It gives a sense of well-being. I expected a great deal more restriction. Before I was ill-informed, the hospital needs more publicity. People's thinking out of line, they see it as a 'nut house', but the majority are capable." 1

On admission he experienced a sense of relief, with some fear of what was to come in the way of treatment.[2]

Mr. R. felt that

> "the staff were pretty reasonable and very considerate. (The clinic) is an awful lot better than St. Marys in Montreal - here we are kept more occupied." 3

and on admission he was confident and relieved.

Despite the fact that Mr. B. thought it was more like a jail, he was surprised with the clinic and was relieved to be there.

Mrs. F. found the staff easy to get on with, and said that she didn"t mind the clinic, was treated well and enjoyed lots of freedom. 4

Mrs. D. thinks the clinic is a wonderful place and has the finest regard for the hospital.

Mrs. M. relates that

> "It is a very nice place, I like it and I am happier here (than at home)." 5

The remaining two patients expressed a number of negative feelings to the clinic. Mr. Ch. considered that the

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1 Case 9. Interview with patient, response to question 21.

2 Case 9. Interview with patient, response to question 25.

3 Case 7. Interview with patient, response to question 21.

4 Case 1. Interview with patient, response to question 21.

5 Case 2. Interview with patient, response to question 20.

Appendix B.

thought of being in

> "this kind of institution bothered me. The lack of privacy. I dislike having to ask the nurse to get my personal belongings." [1]

to which he added that

> "the clinic tries very hard, but can only do so much." [2]

Mrs. S. is not able to appreciate the clinic, because of the intensity with which she misses her home and children. She has been refrained from leaving the clinic against medical advice on two occassions. At the time of the interview she related that she was glad she did not leave.

Adjustments to the Clinic [3]

Those patients who had had previous experience in the clinic as patients, had little trouble adapting themselves to the routine and their new roles. Mrs. F. took a week and a half to adjust, Mrs. M. a week and initially resisted attempts to encourage her to mix socially with others. Mrs. S. and Mrs. D. said that they just fitted in.

The remaining five patients, all first admissions to Crease Clinic had little problem adapting to the hospital environment, with the exception of Mr. Ch. who expressed negative attitudes to the clinic. From the point of view of time, Mr. E. adjusted in two days, Mr. R. - four days, Mr. Ch. - two weeks, Mr. B. - one week.

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1 Case 6. Interview with patient, response to question 20.

2 Case 6. Interview with patient, response to question 21.

3 All Cases. Interview with patient, responses to question 19. Appendix B.

Four patients considered visiting hours [1] to be adequate, three patients expressed no judgements, mentioned their visitors. Two of this group of three patients reside at a distance from the hospital. One patient, Mrs. S. expressed the opinion that she found visiting in a room full of people disturbing.

THE RECIPROCAL AND THE HOSPITAL

Worries about the Hospital [2]

Four of the five reciprocals expressed no worries about the hospital (Mr. D., Mrs. Ch., Mrs. C., Mrs. E.). One reciprocal (Mrs. R.) was concerned that the hospital might let her husband return home mentally disturbed. Another reciprocal, Mr. M. was hostile towards the hospital

> "The hospital should administer reverse treatment instead of soft treatment, it only encourages her to stay there, and prevents her from facing up to her responsibilities." [3]

Weekend Leaves, Visiting Hours, Day Privileges [4]

All six reciprocals were satisfied with visiting hours and day privileges. In the case of weekend leaves, all six reciprocals thought they were satisfactory, however, Mrs. E. felt that the family should be prepared for the first weekend. Mrs. C. that the weekend should not be too long, Mrs. R., that in her case

> "they let him come home too soon. He was very difficult, buried the money." [5]

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1 All Cases. Interview with patient, responses to question 16.

2 All Cases. Interview with reciprocal, response to question 15b.

3 Case 2. Interview with reciprocal, response to question 15b.

4 All Cases. Interview with reciprocals, response to question 22.

5 Case 6. Interview with reciprocal, response to question 22.

Mr. M. felt that in some cases weekend leave was good, as it helped patients reintegrate into their community. Mr. D. felt less removed from his wife as a consequence of weekend leaves.

Contact With Hospital Staff [1]

Five of the six reciprocals related that they were satisfied with contacts with hospital staff. One reciprocal Mrs. R., who has no-one to discuss her problems with, other than neighbours, which she considers is a bad practice in a small community, would have liked more contact with the doctor, and someone to talk to at the hospital.

Mental Illness and Hospitalisation

Five of the six reciprocals related that the problems, worries, and changes in the family had occurred before hospitalisation, at the onset of mental illness. Mrs. Ch. considered that

> "the family problems and worries were more in connection with my husband's illness." [2]

Mrs. C. stated that the situation had changed at home some months after her husband's first hospitalisation, following his accident. Mr. D. related that the problems experienced by the family, and any worries they had had were more evident after his wife became mentally ill, prior to her first hospitalisation, similarly in the case of Mrs. R.

The remaining reciprocal felt that there were no problems or changes in respect of her husband's hospitalisation as he had

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1 All Cases. Interview with reciprocal, response to question 23.

2 Case 6. Interview with reciprocal, response to question 19. Appendix B.

taken care of most arrangements for the family, one week prior to his admission to Crease Clinic.

Relatives and Hospitalisation

In the nine cases studied for this research, relatives played no part in hospitalisation. Five of the cases reported that they had no relatives of significance residing within reachable distance. Mr. E. has a brother, but he is not of importance to the family structure. Mrs. C. was the only reciprocal to relate that relatives played a significant role in the family network. This was partly due to the fact that the C. family reside in the home of the patient's mother.

> "My mother-in-law caused a rumpus when my husband was admitted. I arranged all the details of admission, and told my mother-in-law an hour before he was to leave for the clinic. During that hour she spoke to him, and really upset him." [1]

Where relatives were available they played more of an important role after hospitalisation, by taking on some of the responsibilities of maintaining the family as in the case of Mrs. F., or of assuming care for one of the children, as in the case of Mrs. D.

Friends and Hospitalisation

Case 2

Mrs. M. had up until her re-admission to the clinic only one friend of significance. This particular friend had approached the psychiatrist and ...

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1 Case 8. Interview with reciprocal, response to question 21. Appendix B.

"pleaded with him to let my wife remain at home and fight it out." [1]

Mr. M.'s friends were "shocked" to hear that his wife had been re-hospitalised. Generally, friends had played a more significant role in the pre-admission stage. When Mrs. M. arranged for neighbours to care for her son during the day, and in the post-admission phase, when one friend had offered to have Mr. M.'s son live with her during the week.

Case 3

Mr. D. described their circle of friends as

"sympathetic, understanding, and very supportive." [2]

They phoned to offer to care for the children, invited the family to meals, and promised to visit Mrs. D. on her return from hospital.

Case 4

Mrs. S. related that

"the wives in the block where she lives stick together and blamed her husband for her admission." [3]

In this case it is realistic to infer that they were supportive to Mrs. S.

Case 5

Mr. B. said that his friends were probably not aware of the fact that he was in hospital.

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1 Case 2. Interview with reciprocal, response to question 13.

2 Case 3. Interview with reciprocal, response to question 13.

3 Case 4. Interview with reciprocal, response to question 27. Appendix B.

Case 6

The Ch. family have only two friends in Vancouver, and encouraged Mr. Ch. to seek psychiatric help.

Case 7

Mrs. R. related that most of her friends knew about her husband's illness, and felt that his hospitalisation was the best thing, since many of them had had trouble with him.

> "My friends help me with the animals, do repair jobs in the house, babysit when I go to the hospital." [1]

Case 8

Mrs. C. had found that her friends were very supportive and agreed that her husband should be admitted to Crease Clinic.

Case 9

The E. family kept Mr. E.'s admission to Crease Clinic a secret, and to some extent this created a value problem for Mrs. E. It would appear that it was largely Mr. E.'s decision to keep his hospitalisation a secret. Mrs. E. says that

> "no-one knew where he (husband) was, they knew he was in hospital, but that is all. I hated being caught up with lies." [2]

Mrs. E. went on later in the interview to explain that

> "Most people are narrow minded, I was reluctant to tell people, they always talk about it." [3]

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1 Case 7. Interview with reciprocal, response to question 14.

2 Case 9. Interview with reciprocal, response to question 15.

3 Case 9. Interview with reciprocal, response to question 28.

Appendix B.

Mr. E. on the other hand, felt that telling friends of his actual whereabouts would depress his wife. Furthermore his action is best explained in terms of his response to a question asking what he felt about the hospital.

> "Stress made me seek help, I ruled out everything else. I don't care shat people think. People's thinking is out of line. They see it as a nut house. But the majority of patients here are capable." [1]

Displacement therefore threatened the role Mr. E. maintained in relation to his friends, and his reaction to the stress engendered by the threat was to avoid making his actual whereabouts known to his network of friends.

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1 Case 9. Interview with patient, response to question 21. Appendix B.

CHAPTER IV - CLINICAL APPLICATION OF ROLE AND STRESS

In the previous chapter, where appropriate, an attempt was made to interpret some of the data described. In this chapter the major emphasis has been focused on analysis and interpretation of the data described in Chapter III.

Despite the limitations of the study and the size of the sample, there appears to be a considerable amount of information available for analysis and interpretation, however, the sample does not allow conclusive generalisations, but it does permit speculation, and it remains the task of another interested researcher to subject the assumptions and interpretations to further testing.

After a discussion of selected material the hypothesis was re-examined, and where not applicable in terms of the findings, reformulated.

The writer also attempts to measure stress using a continuum scale. One set of continuum scales measures stress for the patient, and another for the reciprocal. The scale is rather primitive. Stress in terms of the measurement used appears to be fairly consistently distributed, in the case of reciprocals. For patients it is subject to a considerable amount of variation. In five out of the six cases subjected to measurement the degree of stress experienced by the patient was not very different in degree to the stress experienced by the reciprocal.

Finally, some suggestions are made about areas requiring further study.

Role As a Determinant of Stress

It is clear to the writer, and adequately confirmed in the responses obtained from the patient's conjugal reciprocals that the problems, worries and changes which confronted the family network of roles and relationships developed at the onset of the patient's illness, sometime before actual admission to a mental hospital. This is understandable within the framework of social role theory. The development of mental symptoms will undoubtedly find expression in the character of an individual's role performance and role relationship in relation to those reciprocals comprising his social network. They will be perceived by the reciprocals as being different, and demand that some adaptation be made.

This essentially requires that those reciprocals affected by the changes in a patient's role functioning adjust their perceptions and expectations in relation to themselves and to the patient. Such an adjustment will be difficult for the average person, especially when he has grown accustomed to interact over a period of time with an individual in a particular way, and discovers that the customary way leads to dissatisfaction and conflict. This discovery creates stress for the reciprocal, and may produce a variety of different reactions.

In this study it would appear that the reciprocals made adaptations in order to sustain a relationship with the patient, but it is clear that these adaptations were not considered satisfactory and generally proved to be stressful. So that when the patient was finally hospitalised, reciprocals felt relieved.

In cases 7 and 8 where this was particularly noticeable, the reciprocals reverted to their previous mode of social functioning.

In similar fashion the potential patient who discovers that he is unable to function in relation to the functioning of the healthy or unhealthy reciprocal, is confronted by a stressful situation. If he is aware of his maladaptive functioning, he may use his previous functioning as a reference of comparability and develop feelings of inadequacy, which in verbalized expression might include such remarks as - "I have let you down", "As a father I have failed you", "Why don't you leave me and marry someone else", "I'm no good to you", as occurred in cases 3, 7, and 8. If he is unaware of his maladaptive functioning he may find it impossible to continue to interact with his role reciprocals, experience further stress, thereby leading to further role pathology, and react by escaping, becoming destructive, violent and withdrawn, as in the cases 2, 5, 6 and 8. Where patients have at least some awareness, both processes may operate.

There may be instances where the potential patient, in the period prior to the onset of mental illness was functioning healthily but was subjected to a considerable degree of stress for a long period. Naturally, the ability of the potential patient to adopt and adjust by suppressing patterns of healthy functioning and the stress that results from doing so, in the interest of values, and a relationship that may have emotional significance, will be determined by relevant bio-psycho-social components.

Following from the data available in Chapter III, it appears that after a period of time, the stress of adapting to an

unhealthy reciprocal, may lead to stress and finally mental illness. There is some evidence to suggest a chain reaction of threat, stress, adaptation, [1] repeated all in respect of one role, with important ramifications for other roles because of the current concept of the interrelatedness of roles. [2]

For instance, a husband who is not performing his role according to the expectations and perceptions of the potential patient; may cause the potential patient to feel that her role of wife is threatened. She may adjust to the stress therefrom, by adapting her role to her husband's pattern of role functioning. The consequences of this adjustment and adaptation may lead to impairment in other roles, thereby threatening her role position and relationship in respect to them, i.e. she may find her roles of neighbour, mother, homemaker threatened, and experience new areas of stress. She may react to the stress and make adjustments and adaptations that lead to a state of rolelessness, by withdrawing from some of the roles important to her role network and functioning. The threat or lack of these roles may substantially effect her individual role homeostasis and lead to mental illness, impair a large range of roles and relationships, and re-threaten her role relationship to her husband, and therefore her role as wife. Stress is likely to result. Should she face hospitalisation her role of wife, as will be her other roles, will be threatened, adding further stress, or increasing the stress potential. In the

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1 See "Areas for Further Study", Chapter IV, Page 106, Point 5.

2 See "The Concept of Interrelatedness of Roles", Chapter I Page 11.

cases studied this situation was felt to be especially applicable in Case 4, and variations of it were felt to be apparent in Cases 1, 2, and 5.

The writer was inclined to feel, however, that the cyclic process of threat, stress, adaptation, stress, threat etc. was apparent in respect to at least one role in the majority of cases. The process was also felt to be applicable to both patient and reciprocal irrespective of who was ill or originally the primary pathological agent.

The degree to which a reciprocal is able to adapt as a consequence of a patient's illness and the degree to which he can contain his resistances to stress, will depend on the biological, psychological, and social constitution of the reciprocal, especially the range of social roles which function as a support, or outlet. Other influences that will determine adaptation and adjustment, and set up resistances to seeking help, will include such things as the availability of social resources such as money, hospitals, food, etc., the patterns of socio-economic class structure, the ideas and values of the reciprocals reference group, ignorance and current ideologies prevailing in society.

In all cases at least one of the above factors mentioned were felt by the writer to explain the reasons why a fairly lengthy period of time (from four months to seven years) elapsed between the onset of symptoms and a patient's admission to hospital. However, it is clear that despite the influence of these factors, there came a stage when the stresses felt by either reciprocal or patient

could no longer be contained and the family or the patient was required to think in terms of hospitalisation in the belief that help would likely make a change, thereby sustaining any stress resistances they have.

This was confirmed by the responses made by patients and reciprocals in all cases. In Case 9 for instance, the perceived attitude and values of the reference group, the lack of social resources - money, combined with the threat of weakening his role position in the family network by submitting to treatment in a psychiatric clinic, the patient set up natural resistances to the stress he felt about his own problem (homosexuality). When he could no longer sustain these resistances, because the adjustments he made were pathological (heavy drinking) and a further source of stress, he felt obliged to act in spite of the continued existence of value threats, which had initially helped erect resistances, in the belief that help would alleviate the stress he was experiencing. His marriage was threatened. In other words, he felt threatened because of the fear of losing his roles, and the reciprocals on whom his roles were dependant. However, the fact that the influence of the social environment continued to have an effect on the patient's attitudes is readily apparent by the particular arrangements he made while in hospital. The writer assumes that this role situation may have a relationship to the client's psychiatric problem.

The responses obtained from family reciprocals, both in the area of role performance, role relationship and feeling indicate that the period before hospitalisation, when the family member is

mentally ill and not functioning adequately in the role network, is most stressful and problematical for all concerned. Therefore any stress likely to occur when the patient is hospitalised is moderated by the sense of relief it immediately brings to those family members, who can appreciate the situation, and constitute the reciprocal units in the family role network. However, the feeling of relief does not mean that the reciprocal experiences no stress as a result of the patient's displacement from the family role network. That stress is apparent may be realized, when consideration is given to the meaning of such responses, elicited in interviews, as to the length of period the patient is likely to be in hospital, whether he can be helped and whether he is likely to recover. Such responses appear to illustrate that the stresses generated in the period before the patient was hospitalised have not been completely resolved. In a sense the reciprocal seems to be asking for the assurance that the family member will return to the family network on discharge and be able to resume his role situation and function in the manner he functioned before the onset of mental illness.

Accepting the principle that the patient's maladaptive role patterns and relationships were threatening to the family reciprocals, it is not unnatural to expect them to be experiencing stress, in case the patient should return to the family network unchanged.

The facts collaborated by the writer show that stress experienced by family reciprocals is inclined to relate more to mental illness than to displacement. In only one instance, Case 9,

where the patient was functioning relatively well in the family, and whose internal problems had not yet reached the stage where they seriously impaired his role performance and role relationships, was the stress of displacement intense. In general, most reciprocals adjusted relatively quickly and in a short period of time, indicating that they were able to sublimate what stress hospitalisation brought, in the interest of a far more desireable goal, namely, the hope that treatment would cure or change the patient so that he could return home and resume his significant role situation in the family structure.

The arrangements made to cope with the absence of a wife of husband, mother or father, homemaker or breadwinner, were generally satisfactory and working reasonably well according to responses made. In three cases where the person chosen to perform some of the roles previously performed by the displaced family member, did not have a good relationship with the patient there was a degree of stress. Five out of six reciprocals reported inconvenience at having to assume extra roles, and reported feeling uncomfortable, nevertheless maintaining that they had adjusted to the situation. The absence then of a reciprocal who performed certain roles expected of them in the network, eg. homemaker, mother, constitutes a threat, to which the reciprocal reacted by adjusting and adapting, by assuming at least some of the components of displaced family members' roles. In the case of a female patient, her husband would give up functioning in certain roles temporarily, and take on certain new roles, as in Case 3 for example, where the patient's husband gave up temporarily, his role of builder of a new home in order to per-

form domestic roles. In the case of a male patient as in Case 6, the oldest son gave up his role of school boy, in order to perform the role of breadwinner. This adjustment in role was necessary to alleviate stress caused by the threat of poverty. There will therefore, likely be some modification of role performance in other areas of functioning as well.

The assumption of new roles temporarily may increase the number of roles performed and overburden the individual's network of interrelated roles, thereby creating stress for him. Affectively he may respond to such a situation by feeling inconvenienced. Such inconvenience may strongly cause him to wish for the displaced family member's return to the family role network. Such a desire on the part of a reciprocal may set up an ambivalent conflict, because the degree of inconvenience will make him wish for the return of the patient as soon as possible, but at the same time he desires that the patient remain displaced, until well enough to resume customary family roles. This was found to be the case situation in respect to Cases 1, 3, 6, 7, and 9. In Case 1, for instance, the situation athome was expressed in letters to the patient, from the reciprocal husband, who also related that if she didn't come home, she should consider not coming home at all. He further posted money for the necessary transportation arrangements. The patient felt threatened at the possibility of losing her role as wife, mother and homemaker and attempted to leave the hospital before the psychiatrist felt she was ready to do so. In Case 7, it was the child who expressed his desire that father return home quickly. The patient felt his father role threatened as a result

of his displacement and handed in his notice at the hospital which he later retracted.

When there is modification of role performance and reciprocals verbalize their feelings in relation to the new roles they are performing, or advertantly express the functions performed by the patient in the family network, that they are missing or having difficulty with, or had difficulty with, the writer considers that the reciprocal is possibly relating that he or she is experiencing stress in the performance of the new roles, because he or she is using as a frame of reference for performance, their perceptions of what the displaced family member used to do. The new roles are foreign to the reciprocals, and they may eventually experience stress as a result of role confusion or role ignorance. Such confusion and ignorance in the case of all reciprocals whether wife, husband and children are likely to result in stress.

Cases 2, 3, 6, 8, and 9 confirm this interpretation. In Case 6, when the eldest son started assuming more of the roles typically performed by displaced father, other reciprocals, including father, set up resistances, and were unable to interact successfully with the new roles assumed by the son. The two roles, father and son, to his reciprocals, comprising mother and siblings, were incompatible and led to confusion and subsequently stress for the son and the rest of the family. In Cases 2 and 3, for example, it was difficult for father (reciprocal) to move from his set roles as father and breadwinner to the set of roles performed by the patient before hospitalisation. This created confusion. Apart from the

confusion he was, as he pointed out, ignorant about cooking, and generally did what was immediately necessary. The children complained about the cooking. He felt

> "the inconvenience of extra domestic chores and general feelings of inefficiency." [1]

The reciprocal in Case 2 expressed himself as a frustrated housewife, and generally felt that the displacement of his wife from the family network, threatening to the marriage, and continued existence of the home.

In a psychiatric hospital attempts by patients to leave without permission, or through the submission of five days notice of intent to discharge themselves against medical advice, constitutes a major problem for the clinical staff. It is frequently thought to be due to one or more than one of the following reasons:

1. Resistence to treatment.
2. Dissatisfaction with the hospital generally.
3. Pressures exerted by the social environment.
4. Refusal to accept mental illness.
5. Fear of stigma.

It is therefore extremely difficult to identify the actual reasons for self-discharge. However, in the light of family problems related to role functioning difficulties and family problems of interaction with the social environment due to the displacement of a significant or key family member from the family network, the resultant stress experienced by the family is frequently communicated to the patient, who then feels threatened that his continual

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1 Case 3. Interview with reciprocal, response to question 9. Appendix B.

absence from the family will lead to it's disintegration. His reaction to threat will be to arrange discharge or weekend leave, and if either one or the other is refused, seek self-discharge.

In Cases 4 and 7, this problem was felt to be the primary reason why the patients gave notice. For example, in Case 4, the patient feared that her alcoholic husband was neglecting (1) the home which she tried so hard to maintain, and (2) the children she had to wait a long time for. She was also aware of some difficulties in arranging for a housekeeper.

Despite the evidence suggesting that the major areas of stress are related to mental illness, there is also evidence to suggest that displacement is threatening and leads to stress in eight of the nine cases studied.

It is also clear that there is evidence to support the assumption that displacement bringing absent new roles and inter-relationships in relation to the new roles assumed, are stressful for both patient and his family reciprocals.

Measurement of Stress

One of the important issues raised in this thesis revolves around the question of measurement of stress. That this is an extremely difficult task is well recognized when the researcher approaches the difficulty of analyzing highly subjective responses. Normally it is a relatively simple matter to identify stress in terms of 1. factor causing stress

2. the value threatened

3. the reaction to stress

and since it can be determined by differences in role definition and expectation, and by the character of adaptation in role performance, and adjustments to role perception in response to role conflict. It can also be identified in the type of affective response an individual makes in the process of communication between himself and others. Therefore if one is to retain some degree of objectivity the researcher will tend to select as a framework for identification and analyzation data pertaining to role performance - role expectation, role perception, and may where possible correlate the results with the subject responses.

In this particular study such a method is likely to produce unscientific results if one takes careful note of the components of the sample. Firstly, six of the nine patients (Cases 1, 3, 4, 5, 6, 7) had all undergone electro-convulsive therapy and therefore likely to be suffering some degree of memory impairment. One of the following three patients (Case 8) has such severe memory impairment due to chronic brain syndrome associated with brain trauma sustained as a result of an accident. Inevitably one is led therefore to question the validity of many responses obtained in the interview situation. Secondly, in view of a test question to study in very limited content the reliability and correlation of familiar terms and concepts, the writer obtained such a variation of responses indicating and confirming the findings of many well known researchers that the same words have different meanings to different individuals. There is little value to be obtained in analyzing affective responses singularly in an attempt to develope a schema for measurement. Thirdly, the general poorness in description and vagueness of

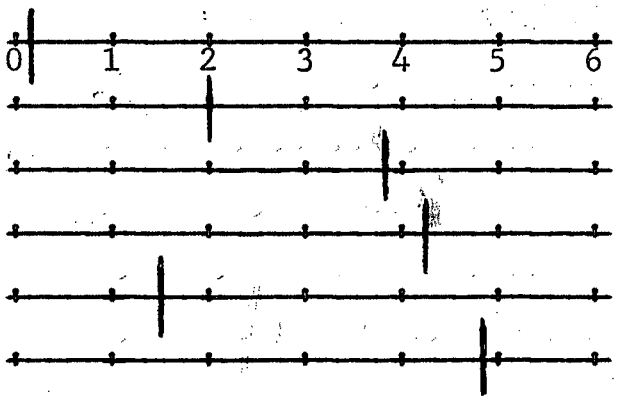
responses did not provide sufficient information to make it possible to organize the data in such a manner to make it of use in developing a satisfactory scale of measurement.

Nevertheless, the writer considered that some experimentation in the area of stress measurement would be of value if only to indicate that stress was a measureable entity. In order to measure stress the writer used a rating continuum with six assigned values (0 - 6). In each instance only those cases where both patient and reciprocal were interviewed, each threat to role functioning and the network were listed and assigned a value position on the continuum. The numerical values for each threat were averaged and divided by the total number of threats, the average then was viewed in terms of the overall reaction to stress and rerated on the stress continuum to give a final measurement rating. In spite of the subjective judgemental factors, the writer when comparing the numerical position designated stress on the continuum with the subjective value responses in terms of affective response, they correlated highly. The writer is of the opinion that an approach to the measurement of stress using a rating continuum may be found to be of practical value and make a worthwhile contribution to the problem of stress measurement. The system of continuum rating as used in this study is extremely primitive and therefore the final evaluation of stress should be weighed in terms of the primitiveness of the measurement used.

STRESS CONTINUUM

PATIENTS

Case 2
Case 3
Case 6
Case 7
Case 8
Case 9



RECIPROCALS

Case 2
Case 3
Case 6
Case 7
Case 8
Case 9

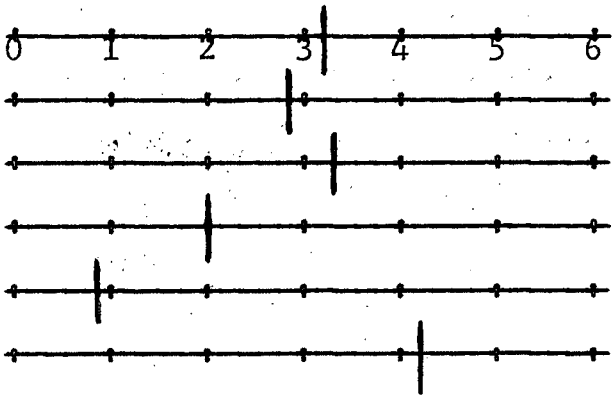


CHART II

RECONSIDERATION OF THE HYPOTHESES IN RELATION TO THE RESEARCH DATA

Assumption 1

When a member of a family unit is displaced from his networks of roles and relationships with reciprocals which make up his social network, a threat is produced, and results in stress. Displacement in this context will be identified as a stress factor.

In that section of this chapter dealing with role as a determinant of stress, we discussed the position of this hypothesis in relation to the data acquired in interviews with the patient and reciprocal. It was confirmed that the assumption made in the first chapter of this thesis has value, however, it became clear that the stress produced by the stress factor - displacement of an individual from his social network, is minimized by the over-riding stress related to mental illness and the effects that it has on the social network before hospitalisation. It would appear relevant to think of stress due to displacement as secondary, and the stress related to mental illness as primary in the immediate period of hospitalisation, but that the longer the patient remains in hospital, the more likely that the secondary stress will in point of fact become primary. Furthermore, it is important to understand the relationship hospitalisation has to mental illness. In the cultural setting in which we live, mental illness is becoming less of a stigma, and the community attitudes to the illness are slowly changing, however, it would appear that changes in attitude towards the mental hospital are taking place at a slower rate. This may explain in some degree why families wait so long before seeking psychiatric help. Despite

these problems, it is clear that hospitalisation, though stressful, is also a relief to the family burdened with the maladaptive role functioning of a family member for a long period of time. Relief is bound to lessen the stress of displacement, and perhaps one of the reasons why so few of the cases sampled seemed to show any high or intense degree of stress.

Assumption 2

That the individual patient and his family reciprocals reacts to this stress or threat brought about through displacement, by changing, adjusting and withdrawing from roles and role relationships. The reaction to stress may be positive or negative.

There is no conclusive evidence to suggest as postulated by this suggestion that the individual patient or his family reciprocals react to the stress of displacement by withdrawing from roles and role relationships. The evidence strongly supports the assumption that there is change and adjustment. In the hospital, the patient appears to adjust fairly soon, and would be required as part of the treatment to engage in role activities and relationships. The patient is in point of fact not permitted to withdraw. As far as the reciprocals are concerned the adjustments made to the family network of roles, as a result of displacement stress, often include the taking on of new roles and experiencing new relationships in relation to the roles they perform. In terms of these facts it is necessary to reformulate this hypothesis.

That the individual patient and his family reciprocals reacts to the stress or threat brought about through displacement by changing, and adjusting roles and relationships to meet the demands of the social environment.

Assumption 3

That displacement bringing about new roles and relationships for the hospitalised family member produces stress for the family reciprocals, as well as for the patient.

The research undertaken by the writer did not, however, substantiate the value of this assumption in terms of hospitalised patients. There was evidence that some patients had difficulty functioning for a brief period shortly after admission to Crease Clinic. Three patients and one reciprocal interviewed actually experienced mild stress, and severe stress respectively as a result of the new roles a hospitalised family member assumes.

The assumption as far as the writer is concerned has value, but it's value as a general hypothesis is questionable.

Assumption 4

That displacement to a social environment of a particular kind - the hospital community, is both stressful to the patient and his family reciprocals.

The evidence strongly refuted this assumption. Without exception, displacement to the hospital community brought relief, and a general lessening of the stress accumulated over the months the patient spent at home mentally ill, and in most cases unemployed. Similarly, patients were also relieved. Assumption 4, may therefore be reformulated thus -

That the displacement to a social environment of a particular kind - the hospital community, is both stress relieving and stress reducing for the patient and his family reciprocals, particularly when patients were mentally disturbed and remained at home for a long period of time.

Areas of Further Study

1. The writer has only touched on the problems of measuring stress, however, it would appear to be of professional interest in the field of social work. As to what would actually be accomplished in such a study remains to be discovered, and to what extent a measurement scale would be of value to the practising caseworker remains to be explored.

2. Following from the remarks made by three individuals interviewed for the purposes of this study, an area that would conceivably be of inestimable value to social workers in the field of mental health is a study of community attitudes to mental illness, and psychiatric hospitalisation. Such a study might analyse present methods of educating the public, and the usefulness of them. It was interesting to note the references made by informants to mental hospital. Two informants called it the "nut house" and three informants were generally surprised that Crease Clinic was not what they thought it would be like, inferring perhaps that they expected it to be something like the mental hospitals of past years.

In a society such as ours, where the stresses of mid-century living are increasing the admission rates of persons to mental hospital, it would seem highly desireable to cultivate a healthier community attitude and understanding of one of the major health problems of an era. Such an understanding could well pave the way to early arrestation of the symptoms of mental illness, which if left untreated are known to cause chronic deterioration to the extent that the individual may suffer impairment of his social roles for the remainder of his life.

In the first sections of Chapter III, it seemed apparent that the majority of cases were aware of conflict, clinically stress, before the onset of mental illness. (Cases 1, 2, 4, 5, 6, 7). For example in cases 2, 4, and 5, there had been stress over marital role functioning for a long period. In case 6, eventual stress was caused by a stress factor over which the individual who became mentally ill had no control- economic depression. Further study and research is needed to confirm the significance role pathology has in symptom formation. If it has significance, then observations such as the ones mentioned suggest a vast field awaits the professional attention, a field if exploited to the fullest may prevent to a large degree, the problem of mental illness.

3. An area that seems to require considerable attention in relation to social role theory is that area of semantics. How does one communicate role and role concepts in a manner that will be understood by clients. How does the client express his roles and role relationships. When we ask questions about role functioning - role perception, role performance, what meaning is placed on the social workers translation of these professional terms. Such a study might also clarify some of the ambiguities inherent in the definition and description of role and stress concepts.

4. In Chapter III, reference has been made to the idea of the invisible father [1] (Case 9), where Mr. E. arranged a situation where he carried on his roles and relationships in the home in such a manner, as if he was there, in spite of the fact that he was at Crease Clinic. It would appear that in certain types of disorder,

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1 See Chapter III, Page 68.

such a possibility is more than just an idea. It may also be due to the particular set of characteristics peculiar to Crease Clinic with it's open atmosphere, and privileges for mentally ill patients. It may have both positive and negative aspects. The writer feels that it warrants further study, because the behaviour may suggest the possibility of structuring a new type of treatment clinic, which may still necessitate displacement, but minimise the effects that such displacement has on family members. The suggestion being that there could well be a treatment setting that is a compromise between the day clinic and Crease Clinic.

5. The writer has observed in the analysis of data a chain reaction of threat, stress, adaptation (reaction), threat stress, adaptation repeated in respect to one role. [1] Other roles may be similarly affected. The evidence seems to suggest that a key role in the individual and social role network is severely threatened, and that the role adaptations and adjustments made in order to establish homeostasis, or meet the pressures of the social environment, which may include reciprocal's roles, are self-defeating, and only serve to rethreaten the key role, with repercussions for other roles in an interdependent relationship to the key role. The writer is not necessarily claiming that such a situation is new, however, it would appear to have significance in the fields of treatment prevention and analysis. It would appear to the writer to justify some further study.

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1 See Chapter IV, Page 91.

APPENDIX A

Appendix A is divided into sections A_1 and A_2.

A_1 shows the Interview Format in it's original form, phrased in professional language, and setting out the kinds of questions that would need to be asked of interviewees, to provide a background of information that could be subjected to analysis in terms of the focus of the thesis.

A_2 constitutes of the Interview Format for Patients and Reciprocals as used in interviews. The introduction remained the same for both patient and family reciprocal.

APPENDIX A_1 - INITIAL INTERVIEW FORMAT MODEL

Role

What is your understanding of the term 'role'?

What were your roles prior to your wife's/husband's hospitalisation?

What do you feel your wife's/husband's roles were prior to hospitalisation?

What were your family's roles prior to your wife's/husband's hospitalisation?

How well do you feel you were performing your roles?

How well do you feel your wife/husband was performing their role?

How well do you feel your children were performing their role?

When your wife/husband was hospitalised what happened to your roles? to your children's roles?

What sort of compensations or adjustments did you make in order to contend with roles previously performed by your wife/husband?

Were these compensations or adjustments successful, unsuccessful, adequate, inadequate?

How long did it take to effect the adjustments that were necessary?

What would you say is the role of the hospital in your situation?

Does it meet with your expectations of it?

What is the role of the patient?

Do you feel that your wife knows what her role is in hospital?

Stress

How do you understand the term stress?

In terms of your understanding what would no stress, average, severe stress signify?

Would you consider that your wife's/husband's hospitalisation was stressful to her/him, to you, to your family?

What made it stressful?

In what way did the stress show itself in your situation, in your family's situation?

Do you feel the question of roles caused stress to you, to your family?

If not, what do you feel did?

How long did you experience stress? your family experience stress?

Why was the hospitalisation factor stressful to you, if it was not, what do you think was?

What situations related to your wife's/husband's hospitalisation were most stressful to you, your family?

What situations after your wife's/husband's hospitalisation were most stressful to you, your family?

Why do you feel this way?

Do you think your wife/husband is aware of any of the stresses in the home, connected with her/his hospitalisation? If so, what particular stresses?

What do you think is most stressful to your wife/husband?

How does this make you feel, your family feel?

As a result of stress what changes have taken place in the home, in your life, in your family's life?

How do you feel about these changes, your family feel, your wife/husband feel, anyone else?

APPENDIX A_2

INTERVIEW FORMAT FOR INTERVIEWS WITH PATIENT

INTERVIEW FORMAT FOR INTERVIEWS WITH RECIPROCALS

Introduction

In these interviews we are asking your help and advice in order to understand a little more of what actually happens to a family when a member is admitted to a hospital. This information we feel will help us to appreciate some of the important problems caused by a situation of this kind.

We are presently making a study of the effects that hospitalisation has on a patient, and a patient's family. This study is important to us because it can increase our awareness and understanding of the important problems created by a situation of this kind.

The areas that we think you can advise us about, are the ones that deal with the sorts of things you and other members of your family do in the home, in the community and socially, and what the things that you do, mean to you and to others. How hospitalisation of a member of your family may have affected the things you and others do, and what sort of problems have arisen as a result.

INTERVIEW FORMAT FOR INTERVIEWS WITH PATIENTS

1. Could you describe what sort of things you do in your home.

2. Could you describe what sort of things you do socially - things you do for entertainment.

3. Could you describe what your husband does, in the home; socially.

4. Could you also give me a picture of what your children do in the home; socially. (Give a few leads)

5. What do they not do either in the home or socially that you would like them to do.

6. In your opinion, what are your feelings about the things you do at home; socially.

7. When you came to Crease Clinic what arrangements were made to manage at home. (Explanation. What did your family do in your absence.)

8. What would you say are your feelings about the things they are doing, (that you did before your hospitalisation).

9. What did you feel about leaving your family.

10. How did your family feel about you leaving them.

11. Could you tell me about any relatives that you have who are important to you.

12. What things that you did, do you miss now that you are in hospital. (Things that you did before your hospitalisation that you now miss.)

13. Can you describe your relationship with your wife/husband, and others in your family.

14. Could you tell me how your wife/husband felt about you leaving home.

15. Could you tell me how other members of your family felt when you left home.

16. Can you tell me what you felt about visiting arrangements at the hospital.

17. Can you tell me how your relatives felt about your admission to hospital.

18. Can you describe what a patient like yourself does at Crease Clinic.

19. How long do you think it took you to fit into the clinic program.

20. Can you describe the sort of difficulties you experienced adjusting to the clinic program.

21. What feelings do you have about the clinic.

22. What would you say are your feelings about home now that you are away from it.

23. Have you any thoughts as to what your wife/husband feels about the hospital.

24. Could you describe what in your opinion caused your illness.

25. When you were admitted to Crease Clinic what word do you consider would describe best the way you felt; your family felt.

26. Before your admission and after your admission to Crease Clinic what in your opinion worried you.

27. Can you tell me about your friends and how they felt about your hospitalisation.

28. Can you tell me about your feelings about life's situations now that you are in hospital.

INTERVIEW FORMAT FOR INTERVIEWS WITH RECIPROCALS

So that we may understand the meanings of words that are sometimes used when we talk about family life.

1. How do you understand the following words: Duty, Job, Responsibility, Way of Life.

3. Before your wife/husband entered Crease Clinic, can you describe the things (a) you did, (b) your family , each member of your family did at home; in the community; socially.

4. What is your view about the things (a) you did (b) they did (this includes hospitalised patient) at home; in the community; socially.

5. What is your view about what happened to the things (a)you did (b) each member of the family did when your wife/husband was admitted to Crease Clinic.

6. Can you explain the sort of changes that were necessary in your way of life, the things you did as a result of your wife/husband's admission to Crease Clinic.

7. Can you also explain the sort of changes that were necessary in your family's (specify each member) way of life, the things they did as a result of your wife's/husband's admission to Crease Clinic.

8. Can you rate these changes, using the following words.

successful	unsuccessful
adequate	inadequate
easy	difficult
they took a short time	long time (specify how long)

9. If you do not feel there were changes, can you explain in what way you and your family (specify members) were affected as a result of your wife's/husband's admission to Crease Clinic.

10. What do you expect of the hospital.

11. Can you explain whether the hospital met with your expectations.

12. Could you explain what your wife/husband feels about the hospital. Can you relate any examples that would indicate how she/he feels about the clinic.

13. What do you think your circle of friends feel about your wife's/husband's admission to hospital.

14. Can you describe things they have done to help, or things they might have done to help.

Stress

15. When your wife/husband was admitted to hospital can you describe what worries you had
    (a) about your wife/husband
    (b) about the hospital
    (c) about your home
    (d) about your social life
    (e) about your family
    (f) about your friends
    Are there other things that were worrying you.

16. If there were changes can you describe (a) your family's (b) your feelings about them.

17. If your wife's/husband's admission affected you what were your feelings.

18. What in your opinion caused the problem that made it necessary for your wife/husband to be admitted to Crease Clinic.

19. Can you explain whether the problems, changes worries started with your wife's/husband's illness or hospitalisation.

20. Could you describe what your wife/husband means to
    (a) you
    (b) your family (specify members)
    (c) others in the family
    (d) friends, neighbours.

21. Could you describe what situations caused by your wife's/husband's hospitalisation were the most upsetting to
    (a) you
    (b) your family
    (c) her/him
    (d) others that are important.

22. What is (was) your opinion about visiting hours, weekend leaves, day privileges.

23. What are your feelings about your contacts with the hospital staff.

24. What are (a) your family (specify members) (b) your feelings about your wife's/husband's absence from the home.

25. What do you think the hospital could have done (a) to relieve your mind (b) to relieve your wife's/husband's mind about hospitalisation.

26. In your wife's/husband's absence what did you miss about them.

27. What were your feelings about your wife's/husband's admission to Crease Clinic.

APPENDIX B

The following Appendix comprises of Verbatim Responses obtained in Interviews with Patients and Reciprocals. Paitents are listed first, and Reciprocals last.

Appendix "B"

(1) INTERVIEWS WITH PATIENTS

Case #1, Mrs. F.

1. I make the beds; I see that the children get ready for school; on Thursdays and Fridays I do the floors. I live in a four bedroom house that is being rented.

2. I do not have the time and we haven't got the money. Sometimes we go to dances and mess dinners. My husband is a Sgt. in the Medical Corps. He works regular hours from 8:00 a.m. to 4:00 p.m. I have trouble keeping friends. I visit many of my friends but no one comes to see us. The reason for this, I think, is that I keep things to clean. I have two or three friends and with a few of them I play cards. In the evening I play Monopoly with my son. I go to town on Fridays twice a month for groceries. I would like more friends and when I started work I became religious. No one minded.

3. My husband cleans the garage; he washes the walls and he has a house inspection in May. It is conducted by the Medical Corps. Sometimes he helps with supper; waxes the floors. I have been working as a Nurse Aide for one month from six a.m. to three p.m. The woman up the way looks after the youngest child. Father takes care of the nine year old. He is also good around the house. My husband is opposed to me working for fear of mental illness. I have had two other breakdowns after the birth of my children. Most of my husband's social life is with me. Occasionally we watch T.V. I do some sewing and I had been coping well until I left Manitoba.

4. Danny and David make their own beds. They keep an eye on Dennis, the youngest. They go to swimming classes. They attend cubs and they play with their friends. We bought them some trains but they have lost interest in their trains. They play ping-pong. Sometimes they help dry dishes and they get paid a quarter a week. They sometimes go to the store.

5. I would like to spend more time with housework. My husband is more educated than I am and I feel that he should help the children with their homework. He also stops me from working at night because he doesn't like me cleaning. I feel that I am too strict with the children and there needs to be more relaxation in the home.

6. I am too hard on the kids and my husband. For instance, when the boys went to a night show recently, I would not have approved of this if I had been at home. But now I feel that the children don't have enough freedom. I wish that I had more time for cooking and spending less time cleaning.

7. My husband had to take time off from work and my mother-in-law from Vancouver is looking after the children. It is working quite well.

8. Everything seems to be alright. My mother-in-law told me that she didn't love the child and I have a bad relationship with her. I am still grateful that she is there but I also have some feelings about her. I was a well fed child.

9. I cried half the way. I felt lonely. I didn't want to leave my family but my mother sent me a ticket. My mother and I are not too close. She drinks and has her own troubles. I went against my will.

10. My husband was quite hurt. The children keep asking,"Where's Mommy?" The children know I am in hospital. I get letters once a week from my husband. He has also mailed the train fare but the problem is that the doctor will not let me go home on my own. This has caused a lot of inconvenience. My husband wants me to come home but said in a letter that if I didn't feel wanted and needed, I needn't come back. I think actually that he takes a lot of things for granted.

11. I hardly ever see them. I have relatives in Ottawa that I would like to see as I haven't seen them for twelve years.

12. I miss the children and my husband but I am glad to get away from cleaning. It also bothers me about the condition at home.

13. He's quiet, sits down a lot. He lets me visit neighbours a lot. We are very close and get on well together. I need my husband. I have a good relationship with the children and I also need them.

14. My husband felt very hurt because two days before I left I spent in a hotel. I feel upset that my mother-in-law has not written and I feel that she could at least have sent a card.

15. It was alright with my mother, but I shouldn't have come out here. You wonder why you do certain things. Because of my husband's inspection job, I tried to keep up appearances.

16. Generally, I have no visitors except my mother on the week-end. I cry when the kids visit the hospital and it makes me sad.

19. I think it took me a week and a half. I wanted to come to the Clinic. I wasn't happy and I knew I needed help and I wasn't afraid.

20. Coming out in the morning made me feel better. I can get on easy with the staff and I don't mind the Clinic at all.

21. Treatment is good. I have lots of freedom and ground priviledges but I don't use them.

22. I'll have to mend my ways on cooking, keeping myself smart and make things easier at home. I did try to help out with the bills but when things get hard I disappear. My husband feels it was mean.

23. My husband calls it the mental home and he is annoyed that they wouldn't let me go home without him. The car is not in good shape so it is difficult for him to come down and fetch me.

24. It could have been the strain of working and I was also worried about leaving home.

25. I felt easier - at peace, but I was still crying and upset.

26. After admission, I was worried about the kids and getting home. Before admission I worried about my mother and step-father.

28. It's awful hard. It's what you make of it. If you can't help yourself no one else will. You've got to motivate yourself to help. I'm happy at home - I keep busy. Sometimes I'm awfully grouchy and cranky and always harping on something.

Case #2, Mrs. D.

1. I have a baby seven months, a child five and a child age 8. I do housework every day.

2. I used to belong to the Women's Institute, a sewing circle, the P.T.A., a horticultural and alpine Club. I used to attend meetings once a month. We live in a rural area. I visit neighbours occasionally - once a week. I watch T.V. but not often. I visit with my husband and sometimes I see neighbours in the evening, once or twice a week. When I became pregnant last year it stopped me from doing all these things. Only in the last month have I started going out to Chilliwack.

3. He helps with the dishes. He baby sits. He built us a new house. He makes cement blocks. He reads. He is a teacher and works from 8:00 a.m. to 5:00 p.m.

4. One is at school and the other is at home. They do not have many friends because of the location in which we live but my son has two friends and my daughter has one. Usually the children play with each other and I take my son to the Library and he gets sports at school.

5. While sick I was dissatisfied with everything. It was all a very tremendous effort. I went to bed and cried. No one knew that I was sick and I still went visiting. I tired of the baby. Friends came to visit more frequently but it didn't mean anything.

7. My husband's mother took the baby. My husband looked after the other two children and during the day the five year old stayed with a neighbour. My husband does all the domestic work in the home.

8. I'm happy about the baby but not too happy about my husband looking after the children. He has a whole day of work and comes home feeling tired.

9. I had to leave. I was doing a terrible lot of damage to my husband. I was really too sick to worry.

11. All my relatives are in Switzerland. They do not know that I am in hospital.

12. Sunbathing. I enjoyed more freedom. Physically I am very comfortable. I miss the housework, the children, and I miss my gardening.

13. I have a superb relationship with my husband. We communicate. We are very good mates and friends. We love each other and I am fascinated by my husband. I have a good relationship with the children and they are very good.

14. I was all broken up. I was close to suicide. I felt disturbed. I wanted to cry. He didn't know what to do with me. He tried to spend more time. He did more things for me. He took me out much more. He bought me a second car but I couldn't accept the car or the house that he built. I now accept them.

15. My son was terrified because his friend's mother is at Centre Lawn and the friend had been talking to him. They mind being without a mother and it is inconvenient for them. It has more to do with household chores. They like comforts. They wanted to be with father rather than grandmother, who has the baby.

16. My mother-in-law visits; so does my brother-in-law and his wife.

17. It was a terrible shock to my husband's mother. At first she thought that it was a terrible thing and she talked about me as being the poor so-and-so at Crease. I don't know what other relatives think but I know that my mother suffered in the way that I'm suffering all her life.

19. I fitted in and had no trouble adapting to the new situation.

21. I have the finest regard for the clinic. I have a good relationship with the staff and I do not have any contact with the social workers.

22. I look forward to going back. Time is very precious to me.

23. I think he thinks it is a wonderful place and he comes to visit and takes me home on week-ends.

24. It had something to do with bodily changes during pregnancy. My behavior changed during this time and I have been depressed ever since. I judge myself so harshly.

25. I do not remember very much about my admission but I was unhappy and I was relieved to be back at Crease Clinic. It's a shelter.

26. Before my admission I couldn't enjoy anything. I had no joy - as if being dead. Even the smallest task seemed like a gigantic effort. My husband and the family made me tense and I had no interest in cultural goings-on or friends. At the back of my mind there was a dread of disaster. After admission I didn't worry about anything. But the first time I came to the Clinic I worried about treatment.

27. All my friends were surprised but everyone has been very nice to me.

28. I am eager to go home and start in again with the family. I feel I can give more to the children now that I am cheerful.

Case #3, Mrs. M.

1. Housework - cleaning - washing - cooking food. I care for my son. I went shopping every Friday. I do no knitting or sewing. I read murder books. I have no part in my husband's activities. I do no gardening.

2. I spend a lot of time with Mrs. M(S). I stayed there on week-ends. In the mornings I had coffee with the neighbours. I watched T.V. in the evenings, it stopped me from thinking. I used to sit in the corner reading. My husband was involved with son and other things. He worked in the basement. I played cards on the week-end with Mrs. M(S) and went for drives with her.

3. He eats supper, washes up, makes his own sandwiches, waxes the floors. When I am away, makes his own food, washes the kitchen floor, cares for my son and plays in the garden with him. He messes around in the basement. We are never together. Occasionally he would go for a walk together with the son, visit a friend, got to a union meeting once a month. He also went to a fish and game club once a month. Occasionally he would watch T.V. There was little communication between us and when we talked it ended in a quarrel. The atmosphere was tense.

4. He plays with toys. He goes to the neighbours. After Christmas he went to Mrs. M(S)s.

5. I would like my husband to sit and talk to me, give understanding and comfort. He remains in the kitchen, reading sexy books. He works for the Burnaby Municipality as a labourer. I am ashamed of him. He is a ditch digger. As for my son, I would like my husband to discipline him more.

6. I got very bored and bitter. I wanted to go out but couldn't. I went out with Mrs. M(S) but her way of life is very different to mine. I refused to go to my husband's club. I didn't like the people. Sometimes I liked the people but couldn't bring myself to go. I do not like housework but still I had to be tidy and this got on my husband's nerves. I didn't want to go out with my husband because he makes me feel embarrassed.

7. We contacted the Welfare in order to find out whether they could provide a housekeeper but we couldn't pay for the service because of debt so I arranged for neighbours to look after him during the day and my husband picked him up at night time. When I came into the hospital Mrs. M(S) took the child back against my wishes. My husband takes care of the house. He is good at mending and in a manner he gets a kick out of it.

8. I don't mind domestic work. He objected to the care of the child by the neighbours. He refused to cope with the child but he takes care of the child on the week-ends.

9. I was glad to get away from my husband, glad to leave him. I have no feeling about my son - he gets on my nerves.

10. They haven't said anything and my sister is not interested.

11. My sons in the Navy are important to me and I write to them.

12. I don't miss anything.

13. I do not love my husband and I don't talk to him because it ends in a quarrel. He threatens me and thinks that I am crazy. We are distant sexually. We have no sex and before I thought of it as a duty I had to perform. It seems to be an answer to all my husband's problems. We don't do things together. As for my son, I have no patience with him. I didn't want the child.

14. Don't know. He didn't seem to care. Two days before I left he told me to take all the sleeping pills.

15. I do not know.

16. I think they are adequate. I look forward to seeing my husband but it ends up in a quarrel.

17. I don't know.

18. I have done more things here than I have ever done - dancing, Recreational Therapy, Occupational Therapy, enjoyed being with girls. I am on insulin and a member of a group. I watch T.V.

19. A week.

20. At first I didn't want to mix or go out.

21. It is very nice. I like it and I am happier here.

22. I don't want to go back.

23. He told me in no uncertain terms. He sees it as an escape for me. He thinks that the doctor is all wrong and that I am not sick. He refuses to bring dresses in for me when I asked him to.

24. Relationship with my husband. Relationship with Mrs. M(S). I was unhappy. Poor social life. Nothing in common with my husband, except sex.

25. Escape from my husband. Get away from my family and Mrs. M(S). Felt awful first off. Mrs. M(S) wanted me to go to a Naturopath. She said I was weak and intervened in the relationship that I have with the doctor. I was happy.

26. (a) My husband. My son. Mrs. M(S). Poor appetite. Loss of interest. (b) Had no worries about admission. I am not ashamed of being here.

27. The neighbours thought it was a good thing and they even told Mrs. M(S) to quit bugging me and she thought that I was running away and even wrote to the doctor to say she could help me.

28. I am happy here. I don't want week-ends. I want to leave my husband and obtain a legal separation. My husband wants our relationship with Mrs. M(S) to continue. He won't understand. I don't know what the future holds.

Case #4, Mrs. S.

1. I left my husband for awhile because he has been a alcoholic since marriage. I went through the Family Court and lost my children. At home I do housework. I kept house in a poor part of town and with little money. I do the shopping and cooking and look after the children - clean. I never cared for social life. Kept contact with the family in Vancouver. I enjoyed dancing. I took physical education for six months which I enjoyed. I took the boys to the park on week-ends. I am not interested in T.V. and sometimes I see the neighbours.

3. My husband is very handy. He is a Polish man. He thinks that wives are servants. He is a great cook and the odd time has made something to eat. He was a violinist but played only four or five times after marriage. The whole block is full of alcoholics but he has stopped drinking since he has had a job as a delivery man for a newspaper. He sleeps a lot. He is not strong and has had T.B. When he communicates he is cranky. When I open my mouth I get scared.

4. My sons dry dishes - tidy up their clothes. My husband teaches them carpentry in the basement. They play with their friends and one boy is a Cub.

5. I would like my husband not to drink and to give up his crazy friends in the block.

6. I am not contented. I hate the way he talks and I am treated as a servant.

7. I am still worried. My mother and sister got a lady to do the work in the house but something happened and she left. I am worried about the children and the fact that the work won't get done. My husband can look after the children if he doesn't drink. He's very cranky when he's sober.

8. I am very happy they are getting on alright. I worried and I tried to go home sooner. That day my husband was very mean. I had the horrible feeling I was going to do something insane. I can't remember very much more.

10. The boys were sorry. I don't know what my husband feels about me.

11. My mother and sister live in Point Grey. I have a married brother with six children. They are awfully nice.

12. I miss home. I am homesick. I miss the children. I love my children. It was a long time before I had them.

13. He treats me as a servant. He's cranky. I look after a sick and drunk husband. He shows no kindness, love, affection. He doesn't know how to treat me. He's not unfaithful but he feels he buys the groceries and therefore can do anything he wants to. There is a good relationship with the sons. They know that I am in hospital because I get headaches.

14. I don't know.

15. I don't know how they felt.

16. I don't like visiting in a room full of people. I see my sons and I want to go home today.

17. They were worried and they tried to help with the boys.

18. I rise and dress 7:00 a.m. Breakfast, go to Occupation Therapy then lunch. I may sleep and I do knitting and sewing. I have tea at 2:00 pm. Supper at 4:20. The meals are very nice. I watch T.V. and listen to music and have become intimate with another patient on the ward.

19. I was here three years ago and I just fitted in but I wanted to go home and gave my notice, but they refrained me and now I am glad.

20. Because I was homesick. I have not adjusted very well. I want to be home with my children.

21. It was quite wonderful I was grateful when I came. I needed help. I was not made to feel insane. This worried me. I was worried for the children. Today people don't think much of people being in Crease Clinic.

22. I want home more. When I think of my husband I just couldn't have any normal feelings about living with men like him. I think of the sun shining through the kitchen window and myself sitting there.

23. He has proved a point - that there is something wrong with me and not him. He is pleased I came here. He has visited with the boys but I cannot expect too much. Sometimes he can be nice and when he is I like him. He is very sensitive about money.

24. Abnormal marriage and the relationships at home.

25. Confused.

26. I felt confused. Before coming into the clinic I had the feeling that I might be doing something insane. After I came to the Clinic I was glad to have help.

27. The wives in the block stick together. They blamed my husband for my hospitalization. I made some friends at ballet class

but my husband stopped me attending. They don't know that I am in hospital.

28. I feel much better now. I manage to keep going and this is not bad. My husband getting a job is the best thing that ever happened and I find it difficult to believe it. It is possible that things may be very different in the future.

Case #5, Mr. B.

1. I help my mother once in awhile. I wash dishes.

2. Some bowling. Occasionally I go drinking with my friends. I go to parties quite often.

3. I am separated - I don't know what she does.

4. No response.

5. When I was living with my wife she wouldn't cook but she took good care of the children. All in all she didn't do very much. She has not been a good wife to me. I am not in love with her and I would rather not be with her.

6. I feel that I did not do the things that I should have done. I treated her roughly and I refused to sleep with her.

7. I have not had a job for a long time and my wife receives social assistance.

8. I don't care what she does, but its funny when she does something that I don't like, I get mad.

9. I didn't feel anything.

10. My family have no idea but I guess they feel sympathetic. I have no visitors and I don't want my wife to visit.

12. I miss driving and I miss going out for a beer. I have been in jail before and this place is somewhat like the jail, and I am used to it. I get a little bored. I adjust within a week. At firstthe clinic program annoyed me but I fell in with the program.

17. They know that I am at a mental hospital and that it is doing some good. The doctor says that I am a hypochondriac.

18. I do recreational therapy in the morning. Sit out in the sun. I play pool. I sit in,in the evening and I have been to a dance. I enjoyed it but I am a little shy. It is hard for me to dance with a girl unless I know her.

19. A week.

20. Not any.

21. It is run like a jail. There is a restriction of freedom. At first I thought it was a crazy house but I didn't know and I am surprised to see that everyone is sane.

22. It is a relief to leavehome and a relief to be in hospital but I wish I could get out.

24. The relationship with my wife,whenever I went near her I got a stomach ache.

25. Relief.

26. Before admission I was worried about getting better.

27. Nothing.

28. There is no real change. I feel a little more energetic.

Case #6, Mr. C.

1. The home served as his business office. Many evenings were taken up with bookwork. Wife often helped in this. Children watch T.V. a great deal of the time. No hobbies - not fond of gardening, etc.

2. Socially - rarely went out, but often had friends in for conversation, a glass of beer, coffee. (Again, much time taken up with business transactions). Plays golf in summer.

3. Wife sold real estate the last few years; previous to that looked after the home and some of the bookkeeping connected with the business. Was fond of baking - plays golf in summer, belongs to a curling team in winter.

4. Children look after their own rooms; watch T.V. a great deal of the time. Entire family belonged to a winter club and children went there often for skating and swimming lessons. Girls took dancing, piano, singing lessons. Older boy had a large circle of friends and was out a lot. Second boy described as "nervous and shy" - spends much time with his dog. Children often went to shows on week-ends.

5. He wishes children were neater - other than that, no complaints. Though the older son led a very active social life, he said they had had no worries about him but did wish he would "settle down" in school. Feels wife was entitled to whatever recreation she wanted as she was often tied down with business. Is worried about how both his sons are going to "get along in the world" as neither are good students.

6. He evidently found this life quite satisfactory, though he said his wife often got "fed up" with him working so much.

   (All this material refers to the time previous to Mr. C's business failure. Since moving out to Vancouver those activities costing money have been eliminated, and they have few friends out here. The family is very distressed by this and want to move back to Calgary. Mr. C. would have a hard time facing "the embarrassment").

7. Mrs. C. was working. Gary (oldest son) was looking for a job. They were receiving a compensation cheque.

8. "Not a pleasing thing to think about." Feels it is very hard on his wife. Doesn't like to think of his son "selling shoes". Feels there is nothing he can do. Is distressed that compensation has stopped because"as long as that was coming through I felt they were benefitting in some way from my work."

9. He cannot remember much of what went on at the time of admission. He had, "nothing to do with it." Misses them badly now - worries about them.

10. "They don't seem to say much". Feels Gary is more concerned than the other children because he knows more about his father's condition.

11. None particularly. A little closer to a sister in Calgary than some of the others. She is dying of cancer. Did not elaborate more here, and I did not feel it was too good an idea to pursue subject as Mr. C. is inclined to be a bit depressed today.

12. Misses not being able to do anything about looking after his affairs.

13. "Very good", relationship with wife. "Common knowledge" among their friends that they got along exceptionally well. No serious problems in any area. Got along well with children, but less patient, more stern than their mother.

14. "It is very hard on her". She doesn't say much, but I read between the lines. (Actually, wife told me she was "relieved" to have him admitted he was so depressed).

15. "They didn't think too much about it." Elaboration on this indicated that he meant they didn't attach much stigma to it. He had had a very reassuring letter from another sister to this effect.

16. Feels afternoon hours are adequate, but that the evening ones are too short and too early. His wife cannot get here by 7:00 and nothing goes on on the ward from 8:00 to 9:00 anyway.

17. Emphasis always on the "stigma" aspect of being in a mental hospital - emphasizes that his relatives do no look at it in this way.

18. Goes to physiotherapy (injured knee) every morning. Attends Mr. W's group (reality testing - group of men in their late twenties and on - discussion on problems they may face returning to community). Belongs to relaxation group. Goes to Occupational Therapy. Goes swimming every time its offered and enjoys it very much. Eats his meals with a certain group all the time. Has ground priviledges.

19. He thinks it took him a couple of weeks to get used to the program.

20. Being without his family. The thought that he was in this kind of institution (mental hospital) bothered him. Lack of privacy very much of a sore point. He likes to get away from everything if he has a migraine. Was in the Airforce and found lack of privacy there almost unbearable. Dislikes having to ask the nurse to get into his personal belongings, etc. Is very fastidious and likes to look after his own things.

21. He said he thinks we try very hard but can only do so much.

22. Misses home very much - looks forward to returning and to his week-end visits, though he found himself irritable on last visit. Puts this down to a skin rash he is suffering from.

23. He thinks his wife feels the same way about the hospital as he does, i.e. that they do their best to get a person back on his feet. Again mentioned that carrying the whole load is pretty hard for her.

24. Worrying about his unfinished business in Calgary.

25. Doesn't remember being admitted at all. After his first shock treatment he woke up and realized where he was. In one word he felt "bewildered". Could not say how family felt - thought the younger children weren't hardly aware of what happened. Felt oldest son would be worried. Again mentioned stigma aspect; emphasized his family did not feel this.

26. Financial difficulties - what would happen to family.

27. Only two friends in Vancouver and they encouraged admission.

28. Sometimes extremely confident that things can be worked out. At others, old fears return, ie. fear of not getting a job, of losing everything that's left. Tends to refight the old battles, "only this time I win". In general not overly optomistic, but feels some of it can be worked out. Trying to decided whether he really will be able to face things "head on".

(Worker's note - Older (19 yrs) son quit school to get a job to "help out" - was unemployed two months previous to his father's admission and looked after him, ie. cooked lunch for him, etc. Was instrumental in persuading his father to come here. I talked to the son and he said his father continually worried about being a "failure as a father". Said he tried to give his father advice, but this only upset him because as son sees it "I'm his son after all, and it doesn't work for me to talk to him like that".

Mr. C., even now, doesn't like to have his son contribute his whole salary).

Case #7, Mr. R. - Social Service not active at this point.

1. Presently unemployed - quit job following troubles - arguments at home - was a barker operator (taking bark off logs) - kept a big garden at home - kept 3 milking goats - family fishing for a past time.

2. Keep within own little set of friends - visit with them - social conversation - family-like feeling.

3. Housework, milking - socially: doesn't belong to any clubs or anything, visits with neighbours - helped equally with husband in building the barn - "doesn't shirk from work at all."

4. Girl - helps with dishes and the housework & helps feed the rabbits - plays with friends, school friends - visits with them and they with her. "I'm afraid I made it pretty rough on her when I quit my job". Union. (Wife crossed a department store picket line with woman friend across the street, despite patient's feelings about it.) Boy 8, tries to be helpful - pretty good with kid - same as older sister - has friends. Youngest - pre school - "exceptionally sociable, I think he takes after his mother". Always playing around the barn, looks after his rabbits - asks Dad if he can help and usually with his Dad.

5. They do everything that they're supposed to - when they're reminded. The latter not too often - they're responsible.

6. I don't like to be forced into sociable activities, e.g. a visit, I like to do it as I am ready but I don't mind the wife doing it, (e.g. union friend). I don't like to get tangled up with neighbours; prefer to have a certain amount of freedom.

7. "Wife always at home - neighbour across the road (the man) has offered to do the ploughing and take care of the garden and another neighbour with the goats (kids expected and will be sold at auction)". Apart from these developments, no other arrangements. "She was damn glad I was coming."

8. "Carrying on as if I was there" - very pleased with their attitude and they seem to want me to stay till I really get better - because its for their own sakes. I'm sorry for the arguments I start.

9. "Felt lonesome and sorry not to be there to help them."

10. "They were shoving me off - wanted to see me get better."

11. "My mother is in Montreal and most of the family are there. Letters from them are very important to me as far as my outlook on life is concerned 'cause I know they're really sincere and my wife is really sincere too." I guess we argue because we have two different points of view.

12. Miss all the work around the house. Miss the fishing - quiet and peaceful.

13. Pretty close together (with wife). She's very considerate towards me - puts me more important than the kids: very close to the two boys but kinda hard to get close to the girl - she keeps her distance - because I'm a little too strict with her I think - and maybe also because we're both nervous.

14. Didn't like me leaving home but wanted me to come to get better. She tells me that she misses me at home.

15. "I wouldn't know about that". Commented that the youngest when he came to visit "cried and didn't want me to stay - wanted me to come with him."

16. Pretty good - excellent in fact.

17. My mother phoned from Montreal but I don't know what she said.

18. We look forward to R.T. a lot, O.T. Enjoy the work - the social activities on the ward - would do more reading if lights were better, e.g. side lights on wall.

19. Two or three days before I realized what was going on - i.e. the routines - didn't know the purpose until then.

20. I don't think I had any difficulties.

21. Staff is pretty reasonable, very considerate, I noticed that right away - awful lot better than St. Mary's in Montreal - keep us more occupied and don't give us time to fret. If it wasn't for the activities I think I'd be just as bad as when I first came in - nurses occupy you.

22. Appreciate it a lot more. Better understanding about my wife - even more sincere than I thought she was.

23. She thinks its a real good thing - she was instructing me to do everything I was told - to obey the rules - e.g. I was a little peeved at not getting week-end leave but she snapped me out of it.

24. Fear of the future - always afraid of being laid off and losing the job until I got so bad I just quit it - out of the frying pan into the fire - used the picket line incident as an excuse to quit.

25. (a) Confident. (b) Relieved.

26. About getting along well with my family, with my wife and kids.

27. They were concerned - neighbours trying to be helpful.

28. Don't take them as seriously - don't have enough time to sit and think about them.

Case #8, Mr. C.

1. I was a machine operator. I did some gardening. Gave some help with domestic chores and I worked in the basement.

2. I have no social life - I watch T.V.

3. My wife does most of the disciplining in the house. The children are spoilt. My wife shares the domestic duties with my mother who has been a patient at Essondale. My wife has lots of friends in Richmond. She is very active. She is really a farm girl.

4. All my children are at school. They do help with domestic chores and they are always out of the house.

5. Nil. Not thought about it. As long as I don't get into trouble.

6. I am never satisfied. I would like to spend more time with the children and have more social life. I had a lot of friends in Richmond once.

7. I used to be in Shaughnessy Hospital.

8. Yes, satisfied.

9. I mind being away from the family. I miss the whole family.

11. I don't know.

12. I miss working with my tools.

13. I have a very good relationship with my wife - it is good too with the children.

14. I wouldn't say she was much upset. She kept her feelings to herself.

15. They were upset for awhile - no Daddy around.

16. My wife cannot visit. I don't really want to see the family as the kids would only worry.

18. I sit around - relax - walk around and receive pills.

19. I fitted into the Clinic.

21. I never thought about it. I don't know why I am here.

24. I had an accident I can't remember about.

25. No memory.

26. I have no expectations. The hospital is too close to the road.

27. No friends visit but they know I am in hospital.

28. I want to go back to work. I miss work. I am restless to be doing nothing. I have my tools at home.

Case #9, Mr. E.

1. Upkeep of the home, gardening, I wash dishes once a month. I don't do anything towards the functioning of the house. I am generally the disciplinarian in the family. I spend a lot of time with the children in the evening. My wife works in the evening. I talk to the children, play with them and I will clean the chesterfield and rugs.

2. I generally listen to records. I do a lot of reading and a lot of gardening. My wife works six nights a week. She has little social life. She may visit friends on Sundays. In November, December and January we took dancing lessons twice a week. She is Secretary-Treasurer of the Diabetic Association. She attends two meetings a month in the evening. We plan our social activities separately. She does everything - dishes, washing, ironing, cooking. She is an excellent housewife. She makes the clothes, does the shopping, works at a drive in two nights in the week now that I am in hospital. Socially, she visits a lot on the telephone. She goes to a coffee club in the afternoon.

4. Nothing. They don't help mother. They have a greatmany friends and go to dance parties except the child of 8. The other daughter goes to girlfriends' parties. My son is a Scout and my older daughter a Pioneer. The youngest spends the night with her Dad.

5. Nothing. I would like to visit perhaps a little more with my relatives and have more time together with my wife.

6. Bored being alone with the kids. Kids are not suitable for adults. I would like to do more dancing, social visiting, playing bridge, swimming and I need other adult company. I feel my role at home is adequate. At home I am the Court of Last Resort and I feel that I am the father in the house.

7. I phone my wife every day and they put off any decisions about money until they have discussed it with me. I sign the cheques and if the children want to do something they 'phone me at the hospital. My wife is working two nights a week now. I insisted on this before leaving for hospital. My eldest son looks after the house and family while mother is working. My son does a lot of the gardening for me on my orders. For example, when my wife refused permission for my son to take records to school, they had to phone me to gain my consent.

8. Nothing I object to except no social life. Now is the first time in twenty years I have been away from home. I didn't discuss my illness with my wife because it went against all general principles to do so. I wished to discuss it but it

would be to emotional for my wife so I made all the arrangements before I told her. I felt I had to go if I didn't want my family to break up. I was unhappy about leaving my family because you can't feel anything when you leave them. I had to yield to the inevitable. I felt that the family would manage.

10. Very badly. My son was glad in a way. He didn't want to see me go. The youngest was heart broken, the middle daughter was not too anxious. All the children cried. Before I came to hospital it was a hard ten days. My wife got used to the idea and I felt that I couldn't go in unless my family were adequately provided for. We have no savings and no medical plan. I went to Social Service in Vancouver and they agreed to help with $140. per month. My wife was allowed to work up to an amount of $170. per month. My boss does not know that I am in hospital but the job is still waiting. It mattered little one way or another. My family supported me over my decision. I left my wife feeling that I cared for her and this was a comfort to her. I have a brother and he was told that I was going to hospital and that was all. We wanted it kept quiet.

12. I miss a goodnight kiss, records, social life and I would just as soon that people don't see me here because of the attitudes of others. There are a fine bunch of fellows on the ward. I do not miss work. It is the first holiday in 28 years. I find things to do. Lack of freedom doesn't bother me. When I first came I was worried whether all information would be kept confidential. It bothered me that things might not be confidential. I was upset that they took away my very personal things.

13. Ideal relationship. Close. We are no longer two people, but an extension of each other. This has been a great help to me while in hospital because I feel half out there anyway. We discuss things together - except hospitalization. When my wife comes home at midnight we get together - its a ritual. I am an avid reader - interested in science and history. I have a good relationship with the children and I have no discipline problems with them because they know that I mean what I say.

14. I hoped to be out of hospital today but it is clear that I am not ready to go. I am not emotionally fit.

15. My parents are in Alberta and they don't know.

16. Fine. The younger two children don't know that I am in hospital. I go home on the week-ends and they are fine. I have my ground privileges.

17. They do not know that I am in hospital.

18. I am an early riser - I get up at 5:00; I wash; make the bed; polish the halls and have breakfast. I play cards; I go to R.T.; I swim and go bowling in the afternoon. In the evenings I play pool, bridge and attend dances on Saturday evenings. Personally, I wouldn't invite my wife and I prefer to keep my wife away from the hospital so that I will not depress her.

19. Two days. The environment is simple, undemanding, and I fit in easily. I had no problems adjusting.

20. It is the most marvelous place in the world. The longer I am here the better. The people are wonderful. It gives you a sense of well being. I expected a great deal more restriction. I was ill informed and it is clear that the hospital needs more publicity. I realize that my attitudes were not healthy and that stress made me seek help and that this ruled out everything else. I didn't care what people thought. In any case, people's thinking is out of line and, as I did, thought of the hospital as a nut house, but the majority of people here are capable.

22. Home is the place I would like to be but I am not fit to be there yet and I am not anxious to go.

23. The same as mine. This is the place where help is.

24. Isolation - the problem I have has been mine for twenty-five years. It is directly an individual problem due to the manner in which I was brought up and the social environment.

25. A sense of relief and a foreboding of what was to come in the way of treatment.

26. Before admission my personal problem worried me and the affects that it would have on my life. You keep suppressing the problem, and I either had to leave the family or destroy myself. I was worried about the affects that my personal problem would have on the family because the family mean a lot to me.

27. Some of our friends know that I am in hospital but not specifically Crease Clinic.

28. I have had my own way in everything. Life never denied me anything. I have done pretty well. We have our own home and we started with nothing. We dress and eat well. We go out very little and we have an emotional sense of fulfillment. I would like to mention that the first time I applied for admission I was refused and this made me very anxious but later they accepted me.

Case #2, Mr.F.

1. Duty means to your wife when you are married. When you were married you swore to love her, take care of her, support her, make sure that she's happy. It has to come from the other side too. To provide a home. Got to be employed - to have steady work and look after finances. Job - this means employment. Responsibility - this means face up to things whatever they are and take care of things. Way of life - what you make of life.

3. Tell Edna the right way of going about life as I understood it. If she had listened to me there would have been no need for her to come to the hospital. I do my own sandwiches, make my own breakfast, take my wife a cup of tea at night. When my wife was at Mrs. M(S)s I made my own supper. Mrs. M(S) was against it. I washed up the dishes, waxed the floors, washed the kitchen floor. When I came home from work I spent most of my time with my son. On week-ends I was with him most of the time. She (wife) couldn't stand him (son) around. In the last four months I couldn't go out. I couldn't go to union meetings and you have to attend one in three. Some nights I read, watched T.V. I didn't get a chance to sit down until 8:00 p.m. when my son went to sleep. I had to keep Edna's pills locked up. My mind is upset. I would rather stay at home and help her. In any case she did not want me to go out. I have got my own friends and they are constantly giving invitations for me to bring Edna along but she doesn't feel like it - she's got nothing else to do and she makes excuses then I have to make excuses to them. It really annoys me. In the community I work for the Burnaby municipality. As far as my wife is concerned, she sat down most of the time. She did some washing, house cleaning, watched T.V., went to Mrs. M(S); she couldn't be bothered with anything. I have been her errand boy. I do it but I also mind. She won't even walk to the store to get cigarettes. She doesn't say a kind word in this house and is always ready to jump down my throat. My son wakes up in the morning; he plays with some toys or some children next door. In the week-ends when he's at home he is me all the time.

4. I am definitely not satisfied. I have tried to talk to her but it is no use. We cannot afford to go out - we cannot even cover expenses now. She doesn't do very much at all in the home and I am not satisfied.

5. When my wife came to the hospital I carried on doing the things I had been doing before and a little extra.

6. I look after the house because I have too.

8. The changes were not difficult. You manage somehow. It takes up more time thinking about the next day's meals. I felt like a frustrated housewife, thinking about it all day long and what the future holds. Generally I felt uncomfortable.

9. I do not feel that there were too many changes.

10. I am at wit's end. In a way I hope it will make a change but the hospital will not be able to change her bitterness.

11. No, the hospital doesn't seem to have made any difference.

12. She likes it. She's happy there and would sooner be there than at home. I do not feel so good about this and I feel hostile towards the hospital and I don't think she should be there and what she says to people at the hospital makes me feel very bad. Why should I visit? It is not pleasant to visit her because she is so unpleasant towards me. She is certainly not eager to get home as any normal person would be. A normal person going into hospital would want to get out, but not Edna. It is just an escape for her.

13. Not very much. They cannot understand it when she's got the security of her home. Mrs. M(S) pleaded with Dr. T. to let her fight it out at home.

14. Without Mrs. M(S), I wouldn't know what to do with my son. Initially she offered to take him but Edna arranged for him to go to some neighbours but this proved to be inconvenient. My friends have offered to help in the way of food and I have been out to dinner once or twice. It is nice to know that they are there.

15. (a) Worrying where it was actually going to end also what actual good they could do out there. It is a problem a person can fight themselves. For instance, Edna wouldn't eat and is was largely because she didn't want to. (b) The hospital should administer the reverse treatment - a hard one instead of a soft one - for it only encourages her to stay there. She's not facing up to the responsibilities and she cannot be bothered making friends. I am scared to bring my friends into the house. I could have lots more friends and it is natural for anyone to want more friends but it is impossible with my wife. (d) My wife talks about me leaving but this is not likely because then she would have no support and my son would have no father. It would be inconvenient without a wife.
(d) I do not have any worries about my social life.
(e) The family do not know that she is in hospital.
(f) Her friends accepted the situation. They were surprised that she went back because eight weeks before she had been doing so well.

18. My wife says that it was because Mrs. M(S) was running her life, but in effect Mrs. M(S) was only trying to put her on the right path. My wife never keeps her promises and seems to like trouble. Mrs. M(S) helped her to go to a Naturopath and was even paying for it. Now the doctor wants us to move away from the friends that we have. This makes it extremely difficult because Mrs. M(S) has been very good for all of us. Sometimes she has taken my wife away on holiday and I have stayed at home. She has looked after my son numerous times. She encouraged my wife to go to Church and we liked Church. My wife developed the idea we were imposing a religious complex on her. Mrs. M(S) helped my wife join the Ladies Church circle and she used to attend meetings once per month. There they made bandages and scarves for India but she moaned about that. She just couldn't be bothered. She starts something and she never finishes it.

20. (a) I believe my wife can make good and be normal. Somebody has to make her and will not be able to do it by gentle ways. I am not one to use force but I do think she needs some discipline. Some nights I was scared to come home because I thought she had done something to harm my son. (d) She puts on a good impression and before Mrs. M(S) met me, I was considered the worst bum in Vancouver. It is the same with her other friends and I fear that the same thing is true with the new neighbours. I know that she tells them that I am terrible and frequently runs me down but I have accepted this because what can I do about it anyway.

22. In some cases, good, because this is the way people will learn to settle into the community. But for others it is not right. Visiting hours are really very adequate and it depends on the type of treatment that the patient receives.

23. The only contact that I have had with the hospital has been with the doctor. I have no bugs myself. The doctor has me as a patient as well and has been acting as go-between every month. He has done something to help but there appears to be no helping my wife. I had no contact with nursing.

25. This is my wife's third admission and it was very much the same old routine.

26. I did not miss very much. Perhaps companionship up to a point. I was glad to be relieved of the stress.

27. I think that my wife has the wrong outlook on life. There is a goal if she knows what it is but she doesn't want it. In fact I wonder if she has any goals at all. She does not have any conception of family roles. She takes no interest. She makes no attempt to do anything at all.

Case #3, Mr. D.

1. Duty - obligations by law; morals; love; a sense of righteousness; family in society; work. Responsibility - duty. Way of life - I feel alien to this term because I have never felt I have a pattern of life. It sounds like a prechosen path of life.

2. I helped with the dishes. Most of the time I spent working on another house. I put my daughter to bed. I discipline the children when I see the situation and I do anything that has to be done that I am asked to do. In fact, I do a bit too much to the frustration of my wife. I do a lot of reading. Socially, not nearly enough. I do not have much social life owing to the location in which we live. I have been working hard on building a house. I visit three or four friends. I do not play any family games and I do not attend Church. As far as the children are concerned, my son goes to school and his activities are confined to week-ends. He reads and makes model airoplanes. My five year old daughter plays with cats and the children play together.

4. I have quite enough social life. It is in fact a little hard for us to go out. We are self-sufficient and happy to be doing things together. I am satisfied with the things I do at home and I am also satisfied with the things that the children do.

5. Nothing altered. Things were not so efficient in cooking and I had to take on extra roles. I did the minimum of everything. I loved the kids more than usual. I did everything that had to be done and reserved my strength. Not as much working on the house but I continued socially. One child is staying with my mother and the younger son with a neighbour.

6. When my wife went to hospital I had to do some of the things at home. I cooked but my cooking was poor and the children remarked about it. We enjoyed the meals I cooked by myself. I spent more time with the children talking to them. Consciously it was an enjoyable effort.

8. Adequate.

9. The children missed their mother but they are generally content and solid. As for myself, I suffered from boredom and I was making time. It was lonelier; there was extra inconvenience as far as domestic chores. There was a feeling of inefficiency and I made no attempt to remedy it.

10. I do not expect anything from the hospital but I hope for my wife's recovery.

11. They have surpassed themselves. She went into the hospital sick and scared. The fear died out quickly. The first time fear didn't mean too much to her. She liked the hospital and thinks it is terrific. "Well I wouldn't be afraid if you and the kids became insane."

13. Sympathy, understanding and they are very supportive.

14. They phoned up and they took the kids out. They sent out invitations to meals and they promised to visit when my wife returns from the hospital.

15. (a) I was worried that she couldn't be cured and it was based on my personal ignorance. I worried about our marriage and I had a fear of the unknown. (b) I did not have any worries about the hospital - I had complete confidence. (c) If my wife's hospitalization was to be long-term, I worried as to how we would get on. (d) I had no worries about my social life. (e) Yes, I worried about the effects my wife's illness would have on the child and the fact that they would be without a mother. (f) I had no worries about friends.

16. The children joked about the food but they took it in their stride. They didn't ask too many questions except, "Where is Mommy?" As far as my feelings are concerned, I felt ambivalent. I was sorry, worried and scared, yet at the same time I felt pleased that I was able to do something to help and that she was actually doing something herself in order to get better.

17. Nothing beyond what I have already said. The news of her hospitalization was broken to me smoothly. I asked the doctor in town and he recommended that she return to Crease Clinic. In a sense I see Crease Clinic as a poor man's Florida and when my wife was admitted I felt a great wave of relief. I said to myself, "Thank God she's in capable hands". Before she was admitted I felt completely helpless. It seems to be something chemical and may have something to do with the wind shaking the house.

19. The problems and worries started with my wife's illness 13 months ago.

20. (a) My wife means everything to me and we are very close. (b) She is very close to the children and a good mother to them and she gets on very well with the children. (c) We have good relationships with the relatives and similarly we have good relationships with friends.

21. (a) I was not so upset with my wife's admission but I was really upset to see her so terrifically upset at home.
(b) It was not really a shock to the family. I was honest with the children and they didn't seem to mind too much but I worried about them being without a mother.
(c) Fear that she was insane and would remain so. She suggested at one stage that I should leave her and marry somebody else. At the time I agreed with her and went along with the idea to set her at ease.
(d) My mother was upset a good deal and this is because she does not have an understanding of the modern view of mental illness.

22. I think they were excellent and they were much wider than I expected and I didn't feel foreign from my wife.

23. Excellent. I found Dr. C. very pleasant and the nursing staff very kind and understanding.

24. (a) I miss her very much.
(b) I felt less tense and worried when she was admitted to hospital but there is a little tension and I shall be worried when she is out of the hospital. The children miss her too and things are less tense at home. We are thinking very much about her now that she is in the hospital and in any case the situation is really out of our hands.

25. (a) Nothing.
(b) An unreasonable fear - afraid to go or not to go.

26. Her interest and company. I miss her domestic functions. There is some slight discomfort and inconvenience.

27. Relief that she was in the Crease Clinic. I had a fear when my wife was at home. I was nervous and I could do nothing and I felt at ease when she was in the hands of professional people. As far as anything else, I feel that we have to take what comes and, if cured, well forget it. On my wife's first admission to hospital we were afraid to let people know because we felt that they might not understand but now, on her second admission, the situation is much better and we do not have the same fears.

Mrs. C.H., Case #6.

1. Duty - obligation - to work and cooperate if you expect results. Job - employment. Responsibilities for family taken care of well. I feel that if a patient is here it is up to the family member to do their part. Way of life - way of living, every day living.

3. At home I do the baking, cleaning, preparation of meals and I play golf in the summer and I curl. My husband doesn't care to curl. In Calgary my husband operated a business and I did books. We did not have many friends. Now that we are in Vancouver we only know two couples. Since Sept. I have had no interests - I have curled twice in Vancouver. My sister visits once a month from Seattle. The family are a terrific help. They haven't made friends in Vancouver either, and want to return to Calgary. The children used to take dancing, go swimming, but now we cannot afford it. The girl, age 12, makes breakfast. Together we watch T.V. more here than at any other time. The children have no other interests. The girl has recently joined the Explorers Club. All the children are having difficulty at school. My son is now working and he took a job because of the trouble he had at school. Their school reports have been pretty bad and this is evidence that they are having a lot of difficulty. We don't go out and since my husband's business fell apart in Calgary he has had financial worries. This has affected the children. We have all had to give up a lot and my husband has had to give up. I am dissatisfied.

4. I am not happy where we are and we have had to give all sorts of things up because of lack of money and my husband's illness has made things worse. Generally, I feel that I am dissatisfied.

5. No particular changes.

6. Hospitalization meant that my husband was not there to help with the discipline and care of the family. I had to assume added responsibility. My son started working and has been working ever since my husband came into the hospital. Presently we are receiving no compensation and we are going to have trouble with the rent and food.

7. On my day off I come to the clinic.

8. Changes up to a point have been successful and adequate but also difficult.

9. The children took my husband's illness and hospitalization very well. They told their friends and they never kept it a secret. Because my husband's compensation has been cut off, it certainly creates a problem for the future.

10. The hospital has been very good. They have done a lot for him and he is in a different frame of mind. He came to the hospital for treatment and so far there have been good results.

11. So far we have not had much help. We have had two supportive calls and a social worker has looked into different things. We didn't expect very much so we are pleased. We talked to other people and they told us how much good is done at the Clinic. My brother-in-law from Seattle, who is a doctor, helped make my husband's mind up about hospitalization and also suggested that he see a psychiatrist. He went after this advice from my brother-in-law and my friends talked to him as well.

12. So far my husband seems pleased with the results. He tells me that the hospital is comfortable but I think that visiting hours are inadequate and badly planned. They interfere with family arrangements.

13. The few friends we have thought that it was the right thing to do. They have visited us frequently and they have also visited my husband and have noticed improvement.

14. The friends that we have offered to help financially although we have not accepted. However, they have helped with transportation and they invited us out. They have been very good to the family and they have also provided us with food.

15. (a) Before my husband came into the hospital I knew that he was terribly depressed. He got very thin. I figgered he would get help at the hospital and encouraged him to go, but he would not go until he was assured that we would manage.
(b) No worries.
(c) I had no worries about the home but did have some worries about finances.
(e) The children are not worrying too much and we really cannot complain. I think that they are a bit young to understand.
(f) Genuine friends don't look at mental illness the wrong way. They have been very understanding and I have had no worries about them.

17. I felt kind of lost but then I decided to do things and I became so busy I didn't worry anymore. I missed his presence in the home but in any case one has to make the most of it.

18. My husband's illness started with financial worries, his coming to Vancouver and finally unemployment.

19. The problems we have in the home are connected much more with illness. If he could work;my husband felt that he was no good.

20. (a) My husband means a great deal to me. He is a companion, a good provider, a hard worker. He is kind and understanding.
(b) The children are very fond of him.
(c) He gets along with most people. He has a younger sister dying of cancer.
(d) Most friends seem to like my husband. He doesn't mix too well and he is quite hard to get acquainted with.

21. (a) His illness was very upsetting. He was so depressed that I could do nothing for him. He was not interested in anything. He was beginning to be a strain. I tried to draw him out but this did not seem to help. I thought that if he was away from home he might feel a bit better.
(b) Illness - they missed him a great deal.
(c) He realized that he was too ill to work but he also worried that if he came here he would not come out. He felt that he was a failure as a husband and a father but I do not think he was a failure and that this was due to his mental state.

22. Satisfied. I have already mentioned what I feel about visiting hours.

23. The social worker has been quite good to us. We have not had too much to do with the staff.

24. I miss him and so do the children. We visit. On the weekends he sometimes comes home and if he doesn't then we visit him at the hospital. I think the family have accepted his absence. Since my husband has been away, my son has assumed a lot of extra responsibility. He checks on the girls to see that their bedroom is tidy. He tries to be bossy and this sometimes leads to conflict.

25. When my husband was admitted to hospital my son came with him and I think the hospital should have explained the situation to him. My son didn't want to say good-bye to my husband.

26. Companionship.

27. I felt it was a necessity. I had the backing from the whole family. I felt that he needed help a long time ago. In Calgary he was worrying about the business. It is nice out here for patients but it might be better if the hospital were nearer the community and there would be not quite so much

rushing. When my husband came into the clinic I felt relief at first; then I didn't want to talk to anyone and my husband felt the same way and each time I have visited I notice a great deal of improvement.

Case #7, Mrs. R.

1. Duty - doing things for one's husband and children - what is best for the family. Responsibility - duty too. Job - support for the family. Way of life - how you live and think about things.

3. Regular routine - house and family, children. There has been no change except that I have to visit him. I have also had to get better at driving. I have had most of the responsibility before my husband actually left for the hospital. He has been sick a long time. I go shopping once a week and sometimes we go shopping together as a family. Two of the children go to school. My daughter takes piano lessons. The children help clear the table and make the bed. The seven year old burns newspapers, feeds the rabbits and picks dirt off the floor. My husband worked at the mill and he worked as a barker. He quit in September, 1962, he hasn't worked since. He used to build a barn and he cleared the brush;for most of the time since September he has sat around doing nothing and walked the floor. Socially my husband does nothing. He has nothing to do with any kind of organization. I was interested in Brownies until my husband became ill and insisted that mydaughter quit. When she quit, I stopped going. I took music lessons. I visited the neighbours but this all stopped last September. All winter long I saw nobody. Now that my husband is in hospital things are back to normal. He has no friends. Socially, the boys have a few friends but the problem is that my husband would not let certain people here. I had more friends before Sept. My daughter was not allowed to have any friends. On the other hand the boys were much freer before my husband's illness and enjoyed a certain amount of freedom when he became ill.

4. I was pretty satisfied with things I did when myhusband didn't object. When my husband became ill things were pretty awful because he could be dangerous. He argued all the time and no matter what subject one took up with him he seemed to want to have a radical view. He would go into a depression, have drinks, become violent and destroy the house. I have been unhappy for seven years, since the second child was born. At that time my husband became ill. He was referred to the doctor but he refused treatment and accused me of wanting to have him committed. I wouldn't know how he did at his job but he worked there for six years. My daughter is mentally retarded due to my husband's problem. His illness does not seem to have effected the boys. When my husband is ill he turns on the daughter.

5. Nothing is really changed.

6. Not so far. I have started going out more. At first I was afraid to because I thought my husband would object. Since his hospitalization I have resumed my social relationships with people I know in the community. I get along well with them and sometimes I do some baby sitting.

7. There have been no changes really in the children, except they felt freer and have been able to contact their old friends again.

8. Things have been fairly easy because we have had this problem for a long time.

9. At first I felt relieved until a neighbour walked in drunk and asked me why I had put my husband away.

10. I don't know. The doctor has told me that he can never be cured but he can be kept under control. It is hard to talk to the doctor and I would like to have much more contact with him. I would like my husband to show the daughter more love. I am not asking for miracles. He can have his ideas if he wants to, but I do not like him to pass them on to the children because they don't see things through his eyes.

11. On the Easter week-end the hospital allowed my husband to come back, but there was an awful lot of trouble and he wrote all over the walls. As a matter of fact, I haven't really seen any change in him. I am not expecting too much, but I think that he should stay in hospital as long as possible. The shock treatment that he is having bothers me a little bit. I have often suggested that he go to his family as he does not seem to respect me. It would seem that he respects no one.

12. He doesn't feel any resentment, but he does dislike being forced to go to dances. On the week-end he was saying he was going to sign himself out.

13. Most of the friends know and they thought that it was the best thing. Many of them had a lot of trouble with him. Friends here are pretty tolerant and inclined to regard it as just another sickness.

14. The friends I know have been a great help to me. They have helped me with the animals and the repairing of an electric switch and a water pump. Some of them babysit when I visit my husband.

15. (a) I don't know. Not many.
(b) He might take a notion I had put him in and come back and hurt me. He has threatened my life when I asked him to go and see a doctor.
(c) I have no worries. Financially, we do not have money worries because I do receive unemployment cheques quite regularly, and the money is sufficient. We have our own milk and our own fresh vegetables and we do not have any bills.
(d) No.
(e) He hasn't been very much of a father to the children and I don't think they miss him but the little one does.

I was worried about not being able to talk to people. For the first few weeks I felt very lonely and would have liked to have talked to someone. I don't think that it is good to talk to neighbours. I was lucky because I had my sister come up from Seattle on the day my husband was admitted and spend a couple of hours. It was good to be able to talk to her. In the future I may have to go out to work. The only trouble is I am afraid of leaving my husband alone in the home. He is not able to look after himself and he would be very much alone all day long. In fact, he might go backwards. He cannot cook and he cannot care for himself.

16. Because of the fact that my husband has been ill for a long time there were no real changes.

17. I was happy. It is the first time that he has actually admitted that he has a problem. Before he said it was all my imagination. I didn't worry too much about being lonely but I was worried because the goats were due to kid and I wasn't sure how to help them. When he came into hospital I felt relieved and the tense atmosphere at home dissolved. I had no difficulty accepting my husband's admission and accepted it without question. Just before my husband came into the hospital, things got so bad that I decided to take the children and leave. At this time he was kicking me around. We left and I came back to the house and he was there and he begged me not to leave. I said that I would return to the home if he would go and see a doctor. He then said that he would try and seek admission to Crease Clinic.

18. I am not too sure but I do know that my husband had this illness in the Army before we were married.

19. It started with husband's illness.

20. (a) Hard to say - I am very mixed up and I don't know.
(b) He means something to the boys but as far as my daughter is concerned she would be better off with another family. He is awful to her.
(c) The in-laws are not happy. His relatives in Montreal

have only met me once and when he was admitted they called me up on the telephone. They supported my actions and they seem to know that he is sick.
(d) All friends realize that he is mentally ill. He has caused considerable trouble in the neighbourhood and people all know each other's business and I think that they recognized that he is not responsible for his actions. My husband doesn't like people. I had to learn to drive and my husband's hospitalization forced me to do things that I had put off for years. It upset me to see him in the hospital but I felt that it was the best thing for him. When I visit he concentrates all the attention on me and tends to ignore the boys and this makes the children very jealous. My husband cannot do anything alone. He cannot function without me. I feel that it is unnatural but I have had to get used to it. He picks on the daughter so much that I have to stop him. I think it is only the responsibility of the children that had made me stay so long. Maybe I love him but I don't know. I feel very badly about putting the children through this. No one can get close to my daughter now and this is partly due to my husband's lack of concern and lack of interest in his daughter. She likes music and she is progressing very well.

22. I do not think there is anything wrong with visiting hours but I think that the hospital should not let him come home too soon. On the long holiday when they let him come home he was very disturbed and buried money in the house. It took a great deal of time and effort to get the money back again.

23. I would like to talk to the doctor more. I seem somehow to get more over the telephone. I have small problems and they mean a lot to me. I have no contact with the social worker but I think that would be a great help. In the first week I was in a bit of a daze and would have liked to talk to someone at the hospital.

24. I do not think they feel very much. In any case I have been both a mother and a father to the children. I keep the children; my husband is unable to do this. With all the responsibilities that I have in the home and to the children, it is sometimes difficult for me to give them my time and I would like my husband to do this. When my husband was at home I didn't burden him with any problems. He didn't seem to be able to be responsible enough to cope with them. There was very little communication between us. He would watch T.V. occasionally and spent most of his time walking up and down the floor.

25. I don't expect miracles and I found the booklet that is given to families when the patient is admitted to the hospital very useful. It has lots of answers, sometimes the answers are not applicable when the breadwinner goes and for this reason it would be nice to talk to somebody at the hospital.

26. One thing I do miss about my husband and that is in relation to the water pump. He seems to be the only one who knows how to work it. It revolves around the pump and if it doesn't work then everything goes wrong.

27. I felt happy.

Case #8, Mrs. C.

1. Duty - duty towards the family. Look after them as well as possible. Job - your being a housewife and looking after the children. Responsibility - looking after the family. Way of life - take it as it comes. Social life - way I live.

3. At home I look after my husband. Seeing that he changes his clothing, washes, rises, see that he goes to bed at the right time. I take him out to visit his friends but he does not remember them. I do housework, cooking, cleaning, washing, shopping once a week and I go to the centre across the street. I have four children to look after and I supply them with lunches and help them generally. I have a mother-in-law who has returned recently from Crease and try to give her some help. Socially, I go bowling in the evenings once a week. I visit friends. Not many friends visit the home because it is rather inconvenient for me to have visitors. However, they understand. I sew, I watch T.V. but not very often. The children have hobbies. They go fishing and hunting. The second eldest boy plays golf. All the others go to school and the two other boys take turns washing dishes and tidying their rooms. We have made it a necessity and in any case I figure that they should have done it before, but my mother-in-law interfered and they seem to resent what I was asking them to do, but when I was alone I had no trouble. Generally we have not had to give up anything. We live in the same house as my mother-in-law but she has her own work to do. I help her. When it comes to cooking, we do our own cooking in the same kitchen.

4. A few problems. I would like to go out to work but I can't. My mother-in-law cannot take the responsibility of looking after the home and the children. I cannot bring in a stranger because it would upset my mother-in-law as she would think that I did not think she was capable. I am as satisfied as can be expected. I do not have very much choice. The children object to the lack of money and they had a good deal of money before my husband was in an accident. They moan a lot about inconveniences. My mother-in-law favours one of the daughters and this leads to a lot of jealousy among the children.

5. I had just as much responsibility, in fact, more, when he was actually home before admission to hospital. When he came into hospital I felt relieved. It was getting hard on my nerves and with my mother-in-law at home I had tocare for two of them.

6. I had a year before my husband came to Crease Clinic and things didn't change very much except that I went out more often as an escape to get somebody to talk to and I feel that this was the only thing that kept me going. My

mother-in-law is not a person you can talk to.

7. Most of the changes in the family have been brought on through lack of money. We have had to learn to adapt ourselves to the small income received from social assistance. This means that we have to be more frugal.

8. I would say things have been inadequate but this does not apply to my husband's admission to Crease Clinic but rather to his admission to the Vancouver General after his accident. We used to go out together to banquets and visiting a lot.

9. I don't think anybody was really affected by my husband's admission to the hospital. We have had the same thing for ten months. The children are not fully aware of how ill father really is. They don't understand. He used to get mad at the childrent and say they broke his tools. This made the children very fed up so that they were not too unhappy when he came to the clinic and generally felt relieved.

10. I want to see what they can do. I don't hope for very much and I wonder whether they can change him at all.

11. He seems to be much quieter. He is walking without the cane now and this is a tremendous improvement. Before he seemed to want to use the cane for tripping other patients.

12. I think my husband feels satisfied. He's not worried about coming home and we have put no pressure on the hospital to let him come home.

13. Any friends of value approved of what I had done and the majority identified with me. My mother-in-law objects and tried to prevent my husband from coming to hospital. My father-in-law does not object and thought that it was a good idea.

14. After my husband's admission to Crease friends have not had very much occasion to be of help. Certainly before when he was at Vancouver General they helped with transportation. As a result of my husband's illness I have forced myself to learn to drive a car sometime ago - last December, and this makes things easier on everybody at home.

15. (a) I had worries about the cane that my husband used to walk with. I was worried in case he would hurt someone.

15. (c) I could not leave him alone - there was a flight of stairs to the bedroom and I worried in case he fell down the stairs. I worried about money but I was able to get money from Social Welfare shortly after his hospitalization at Vancouver General. The money is not really sufficient but it is something to live on. I cannot say that I am exactly happy and I feel that there would be no need to depend on social assistance if I was able to work. The only trouble is that I have no special trade.
(d) There were many places we went together and now we cannot go out to visit the people we used to visit before together.

16. I don't think he understood why he was going.

17. It didn't affect my feelings because I felt that he got the proper care and attention at the hospital. In any case, I had become accustomed to the time when he spent a year in hospital after the accident. In a sense he has not been a husband or a father or a breadwinner to the family. I have been much more of a nurse to him and I have had to watch him constantly.

19. Before Christmas.

20. (a) He means the same to me as he did at the time we got married.
(b) I am sure he means the same to them.
(c) He gets fed up that he cannot do things for himself. He is not fully accepting of his limitations and his inability to perform in the way that he did prior to his accident. When he gets upset he blames me sometimes. He tells me to get a divorce and tells me he is no more good to me.
(d) My husband's mother means everything to him in fact it has been one of the causes of family problems. She has never let him live a life - interfered constantly with the children and the majority of the times when we wanted to go out she would sulk. My husband gave in to his mother and I had no choice. I thought of leaving him but the responsibility of the children stopped me. Now I wish I had taken the children and I might have been farther ahead. The presence of my mother-in-law made me feel as if I was a poor and inadequate wife. She denied my position as her son's wife.

21. My mother-in-law caused a rumpus. So that there would be a minimum of trouble I arranged everything before I informed my mother-in-law one half hour before my husband came to the Clinic and during that half hour she spoke to him and caused me very much trouble. She did not seem to accept the fact that we could not do anything for him at home.

22. Week-ends are alright providing they are not too long. Last week-end my husband came out. It was a long week-end and he wanted to get back to the hospital. There was a lot of activity in the home and he couldn't take it.

23. Very good. Satisfied and they have helped with anything that I wanted to know.

24. This relates much more to the way the family felt when my husband first went into hospital over a year ago. At that time the family were quite shocked because they were used to him being around and they missed him very much. I guess they probably still miss him.

25. I would like to know if they can do something for him or if he is going to be like this all his life because if I know this I can learn to accept it. You have to face facts and this helps with the future and will enable me to plan and do something about the insurance claim.

26. Marital relationships, but I have had to get used to this and it is a long time since we have had any social contacts so that most of the time now I go out by myself. He has been an influence in spite of the fact that he has not been able to function in the home. When I started working at Crown Zellerbach at a part time job I felt much better.

27. I felt it was the only thing and I have a great deal of respect for Crease Clinic. My mother-in-law is no help and when both she and my husband are at home, it is a question of taking care of two mental patients. I feel the lack of sufficient education so that I can know what to do with him when he is going through bad times. I am in good health. Generally I think the family were quite relieved when father went into the hospital. In fact, I am quite sure that he was relieved himself.

Case #9, Mrs. E.

1. Duty - something that must be done. Job - necessity - domestic. Responsibility - something you have to understand and do - responsibility of children and marriage.

3. The same things I've always done - but crankier than usual - working, looking after the kids - everyday living.

4. Fine - just what I wanted to be doing - I wish we had more money.

5. The children don't know that my husband is at Crease Clinic. They know that he is in hospital and we all took it as a matter of course. It had to be. We are doing quite well during his absence, except that I had to do all the worrying myself and controlling the kids. I think we are managing very well. The kids are not so bad, but one thing I had to do was to get my driver's license - this was a necessity.

6. Just being alone - living alone and adjusting to my husband's absence.

7. Very few things were changed. We all had to take on extra responsibility and we all had to watch the money closer.

8. I think we adjusted adequately - everything fell into place. It took some getting used to going to bed alone, - a long time - about five weeks.

9. We all learned to get along together - the family has always been close. I am not socially inclined but what social life I have carried on as usual.

10. I didn't expect anything but I hoped that he would be helped to quit his drinking - this is something we were all interested in.

11. I had little to do with the hospital and only went inside once. All that I've heard has been good. I used to meet my husband outside.

12. He has nothing but good to say about the hospital. He has told me that it is a good place.

13. Very few of our social friends know that my husband has been to Crease Clinic. Some of them know that he is in hospital but that is all. We decided to keep it a secret.

14. No response.

15. (a) I worried about money, being alone and to a certain amount, I worried about the children.

15. (b) I had no worries.
(c) Yes, I suppose so - a home needs a man to keep it going - to fix windows and water pipes - I had some trouble but I called a plumber.
(d) I carried on as usual.
(e) I knew they would miss him, especially the youngest - they adjusted fairly well.
(f) No one knew where my husband was - some of them knew that he was in hospital - I hated being caught up with lies, but we both agreed to keep it a secret.

16. The oldest child took on the responsibility of looking after the other children. He did this quite well - he started slapping his sisters around and I had to put a stop to it. The family missed him. They were anxious and every other day we telephoned the hospital. I used to visit three or four times a week.

17. It didn't effect me all that much.

18. Drinking.

19. We knew about my husband's intention of going to the hospital a week before hand so what changes we made we did in that week. It was much better this way, because my husband planned everything before he went to the hospital. Instead of working six nights, I worked only two.

20. (a) Everything.
(b) Everything.
(c) Relatives don't mean that much - its nice to have them around - sometimes not.
(d) Most people like my husband.

21. (a) Loneliness - he wasn't at home in the evenings and when something went wrong it was upsetting but calm thinking fixed that.
(b) The fact that he wasn't here.
(d) Nothing.
(c) He was lonely too, and missed all of us.

22. They are a great advantage. My husband had a lot of freedom which made it easier.

23. The doctor was very nice and the person at the Information Desk was very helpful.

24. He decided that he had to go to the hospital - we supported him and did not have too many feelings about it, but we knew we would miss him.

25. Not much - I knew nothing at all and it wouldn't have made it any easier.

26. We just missed him. It was lonely and I had nobody to go to bed with.

27. He was anxious to go and I knew it had to be. Most people are very narrow-minded and I was reluctant to tell people because they always talk about it. If we had told them I think it would make a difference because it gives people something extra to talk about. I gave my husband all the support and was relieved that he felt it the best thing to go to Crease Clinic. We made arrangements for money from the City Social Service and this has been a great help. The one thing that has been difficult was the first week-end. Everything was tense and we were all glad to see him go back to the hospital. He was also glad to return. Perhaps the hospital should make some effort to prepare people for the first week-end so that they know what to expect.

APPENDIX C

The following appendix, comprises of three samples of Ward Notes, selected mainly because reference has been made to them elsewhere in this thesis. They are typical examples of the clinical notes used and prepared by the psychiatric staff at Crease Clinic. Where necessary identities have been deleted.

The ward notes were consulted as an aid to the analysis of the data obtained in interviews with patients and their reciprocals. This was done partly to prevent the possibility of viewing the cases and material, in isolation of other significant biological and psychological factors.

WARD NOTES - MRS. S.

Previous Admissions to Crease Clinic

Date of Admission - March 1, 1959.

Date of Discharge - April 24, 1959.

Diagnosis: Schisophrenic Reaction - Acute Undifferentiated

Result: Improved

Date of Admission - November 30, 1958.

Date of Discharge - January 20, 1959.

Diagnosis: Schisophrenic Reaction - Schizo-affective

Result: Slightly Improved.

This patient was admitted to the Crease Clinic of Psychological Medicine, Essondale, B.C. on March 28, 1963 from Vancouver, B.C. as a certified patient.

History of Present Illness: Mrs. S. seperated from her husband six months ago. She says that he is an alcoholic and that he isn't but that she drives him to drink. They re-united three months ago because she had no other place to go, not because she wanted to. She came back on his condition, that is to say that she must obey orders, etc. Since the re-union she has been upset and hearing voices. These voices are her mother's, her husband's, and also unknown ones, generally speaking they re-hash old events and give her many orders. She recognises the voices as being hallucinatory phenomena, most of the time. In addition she says that she feels dreadful and would like to be dead except for the children. Prior to her admission she claimed that she got some notion that she was hypnotising the children.

Personal History: This is adequately documented on the patient's previous file to which the interested reader is referred. In summary, the patient was born in Edmonton and moved to Vancouver with her family when she was 8 years of age. She was a very timid apprehensive child and recalls being enuretic when away from home visiting and said that she wouldn't dare to be at home. She left school in Grade 12 because no one seemed to care if she attended or not. She was a very clever student but always very poor socially. After leaving school she worked in a department store as a clerk and elevator operator and also forced herself to undertake office work for awhile.

Mrs. S. experienced the monarche at 12 years of age and was ignorant and alarmed thereby. Her periods are regular and untroublesome. She married at 29 years of age after knowing her husband a short time. Her family objected to it but she was mad at them because she said "all I wanted was my own home." The marriage was never satisfactory, she says that the husband drank all the time and that she is terrified of him. Her husband is 45, and is a driver for ..... but has only been with them for six months. He has never kept a steady job. To spite this they own their home but their finances are shaky. There are two children, 8 and 6, both are doing reasonably well but one is emotionally upset.

The patient smokes a package of cigarettes a day but doesn't drink at all. She is a participating member of the Catholic Church and gets a good deal from her faith. As to her social and recreational life, she says that she could be happy but that her husband won't let her, that anything she undertakes he makes

sneering remarks about and is very critical. She has been trying to make friends with a neighbour and does some reading, watches television, and also does sewing and homemaking.

As to her personality when I inquired about this Mrs. S. said "I love my children I know that" and was not able to elaborate further. Her personality makeup is pretty obviously schisoid.

The patient's father died at 51 after being paralysed for four years by a stroke. The mother lives in Vancouver. The patient is the middle of five children, two boys and three girls. The father was a Spanish Consul in Vancouver but didn't have a penny. Apparently the parents were very society, money and status conscious. They got on okay together. The children fought a great deal. The father was a very strict, crude, primitive man. The patient sees her homelife as unhappy and insecure. The younger brother has had a nervous breakdown but was not hospitalised. The siblings are all on the West Coast and relationships between them are reasonably good.

Mental Status Examination: Mrs. S. is a slim, sharp featured woman. She shows some ability to relate but is rather vague in her manner. Her conversation is coherent and relevant and there is some schisophrenic blunting of thought. Her reality testing is impaired at times. Her affect is flat and a bit inappropriate and she indulges in tearless crying. She is hallucinated as already described. Her sensorium is clear and I would estimate her to be of average intelligence. She has some insight into the fact that she suffers from a severe illness, motivation is difficult to assess.

Diagnosis: Chronic Undifferentiated Schisophrenic Reaction. This would appear to have flared up in recent months under the stress of the discordant marital relationship.

Management: Mrs. S. will be exposed to the therapeutic milieu of the hospital and incorporated into it's activities program. She will receive ataractic and anti-depressant medications in conjunction with E.C.T. which has already been started. Nursing attitudes of active friendliness and reassurance have been prescribed. We will ask Social Service to have a look at the family situation, but they have done so in the past and apparently it is pretty hopeless.

WARD NOTES - MR. CH.

This patient was admitted to the Crease Clinic of Psychological Medicine, Essondale, B.C. on February 19, 1963 from New Westminster, B.C. as a voluntary patient.

West 3: The patient started out by stating that he was just a "hopeless case" that he had wound up here, his wife and family were destitute, had no clothing, "only what I've got with me which won't last more than a few days." At this time it was noted that the patient was very smartly dressed.

The patient had a plumbing business in Calgary, lost it, and came to New Westminster in September of 1962. Things have not been going well since then, "only worked a few days". According to the patient's wife the "few days" was actually two to three months. Plans had been worked out for him to work for wages but his health broke down due to his worrying and this could not be carried out. The patient has never been so low before and does not know why he should be now. His wife is working. They have four children which were at home yesterday, but the patient cannot vouch for their existence today because he left them destitute. The patient is now 52, his wife is 45. They have four children, aged 18, 15, 12, and 9. They have been married for 25 years.

The patient stated his eldest boy couldn't get started at school again so he had to quit and look for work.

For the past 12 years business has been good and kept functioning steadily. The patient kept good records but when the economy went downhill and business started going sour, with poor collections etc. the patient became depressed and stopped keeping such good books. The patient feels he is "not as young as I used

to be" and had a nervous stomach for years. This "invalided" him out of the R.C.A.F. He has also had migraine for years for which he obtains relief with medication. He lost a lot of work through the migraine and it usually occurred at the end of the week.

The patient has always been consciencious and set store by respectability. He likes his family and himself well dressed and neatly turned out. He keeps his hair cut short and has it cut frequently.

When business started to go down hill the patient borrowed against the children's education policies and lost them for which he now has regrets. He says his children are his life, he had set great store by their future and he has now ruined it for them.

Past History: The patient has one brother and six sisters. They had been brought up in a small prairie town. The patient is third youngest. Father was a farmer, and ended up as the secretary-treasurer of the municipality. He died in 1948 at the age of 77. When the patient's family moved into town he was expected to work quite hard and felt he was being driven and he resented it, but he did the work anyway.

He appears to have been brought up to be conscientious and worrying.

It is not easy to say which came first; financial set-backs or his depression, but probably the former which then gained pace as he would not and couldn't cope with it.

The present situation seems to be that he left Calgary hoping to leave his troubles behind. He owes most of the money to wholesale houses. He has never consulted a lawyer and has rather an ostrich's attitude to the problem with subsequent guilt and

depression. He lives in fear of the mail each day (from his creditors) and his wife says he doesn't even open it.

Bringing his family to B.C. has also gained them nothing, and removed from the family, their home-roots, Mrs. Ch. has turned to the church for help and support.

Mental Status: The patient is a scrupulously neat and cleanly dressed individual. Mood is one of severe depression and his psychomotor activity is moderately retarded. His speech is a slow, monotonous repition of hopelessness, and obsessive concern for his wardrobe. He asked to be moved to a ward where he could be provided with clothes. His thought content is restricted to the above. He denies suicidal attempts or ruminations. He is correctly orientated. He has no insight and judgement has been quite defective, recently and in the past.

Diagnosis: Psychotic Depressive Reaction. He is considered incapable.

Treatment: The patient will be started on a course of E.C.T.

DISCHARGE SYNOPSIS - MR. E.

Mr. E. is a 37 year old married man who was admitted under voluntary application because of depression, alcoholism, both secondary to a conflict over homosexual impulses.

This patient has apparently always had confusion in sexual identification from earliest childhood although the first overt homosexual experience occurred at the age of 15. Although married at the age of 21 he continued periodically having homosexual experiences usually released through excessive consumption of alcohol. The patient, however, only became concerned over these activities around five years prior to admission when he began to feel that the whole thing would "blow up" and ruin his marriage. He states he and his wife have always been very close, she is totally unaware of her husband's homosexual inclinations. For these reasons the patient began feeling more depressed and finally sought treatment by his voluntary admission to this clinic.

Examination on admission revealed a slightly undernourished, effiminate appearing man of small stature and asthenic build. On the ward he was very pleasant and cooperative, socialised well with the other patients, slept satisfactorily, and was exceedingly active in all our ward activities. In the interview he spoke in a soft voice, enunciated his words clearly and gave his history in a spontaneous, well integrated fashion. Although usually superficially cheerful, he had, at the time of admission and following an unsatisfactory weekend at home, appeared quite depressed and showing some suicidal ideas. He has, himself, frequently remarked on his lack of self-respect and feelings of guilt and remorse over his homosexual activities. No evidence,

over the period of hospitalisation, of thought disorder was elicited, and sensorium and memory were clear.

For statistical purposes this patient will be diagnosed as Sociopathic Personality Disorder - Sexual Deviation - Homosexuality with Depressive Features. On Kinsey's scale he would probably be classified as a Grade 3 homosexual. The psychodynamics in this case are quite clear, there being evidences of some degree of emotional deprivation from infancy and certainly practically no male figures with whom he could identify. He can remember one probably significant incident, shortly after his admission to the convent, when he was feeling very depressed and rejected and was comforted by an older boy who took him to bed with him. This was obviously concurrence of gratification of sexual as well as security needs.

In treatment the patient was encouraged to participate actively in the usualy ward, occupational and recreational therapies. We tried briefly to treat him with a mild tranquilizer which was very soon withdrawn. He was seen in a number of psychotherapeutic interviews, largely on a fairly directive basis.

At the time of discharge he is classified as Slightly Improved in as much as the subjective reactions to this conflict have improved although the basic conflict is, of course, still there. He realizes, at this point, that rather than total elimination of his homosexual tendencies he can perhaps achieve greater control. He would like to obtain a more satisfying and more financially rewarding employment so that his wife could quit work and therefore the lonely evenings at home would be avoided which have contributed to the release of this mechanism. In addition to this,

the patient will attempt to get into a number of group activities, to satisfy this need. He will be continued in therapy at our After Care Department with a male therapist.

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