THE CONCEPT OF STRESS IN THE EXPERIENCE OF RELATIVES OF CREASE CLINIC PATIENTS

A Study of the Subjective Responses of Relatives to the Hospitalization and the Post Hospital Period of Psychiatric Patients

by

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ABSTRACT

Psychiatrists and social workers are aware of the existence of relatives when a patient is hospitalized in a psychiatric treatment centre. Current research points to the importance, in the patient's environment, of many variables, and among these, the presence of relatives who inter-act with the patient is one which may have a significant bearing upon the outcome of treatment. This thesis examines the stress factors which influence the relatives behavior toward the patient, as they arise from the fact of hospitalization at the Crease Clinic of Psychological Medicine, and from the subsequent period of post hospital adjustment.

Literature on the subject of environment in relation to personality has been consulted, and nine families were studied. The main technique employed was the structured research interview with the relatives. Supplementary information was obtained from a review of the Crease Clinic files on the patients, and from discussion with the case-workers and the casework supervisor. The information obtained from the interviews concerned the relatives' responses to the fact of hospitalization, to their understanding of mental illness, and to the practical problems and emotional stresses of the rehabilitation period.

The sample group was divided into two groups, wives and mothers, to examine the effect of family structure in the patient's post hospital experience. The sample also contained a number of cases receiving social casework services, but no conclusions could be reached in regard to this variable owing to the difficulty in placing specific research focus on this factor while examining the stress areas.

The study reveals that the relatives of mentally ill patients experience stress in two phases, that of hospitalization and that of the post hospitalization period. In the first, stresses centre around fear of mental illness, the kind of hospital required, and the relative's isolation from the treatment program. In the latter phase, stresses originate in two sources, practical problems such as employment or housing, and the role relationships with the patient. The most forceful stresses are connected with interrelationships, and there are differences between the group of wives and the group of mothers in this regard.

The results indicate a need for more family oriented casework both in hospital and community. Present trends to treat the patient in the community find support in the study.

A C K N O W L E D G E M E N T S

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CHAPTER I - THE MATTER OF MILIEU

The patient leaving a psychiatric hospital often re-enters the same community[1] from which his illness made withdrawal necessary. Relatives[2] may be an important part of the patient's immediate environment in that community, especially if they share a home with the patient, or live close to his home. Psychiatrists and social workers[3] frequently recognize the presence of relatives, but do they weigh the importance of that presence in the patient's return to community? Often the attention paid the relative seems to be of superficial nature, as when the psychiatrist sees the relatives once or twice to tell them about the patient's illness, and perhaps to suggest what they "ought" to do to be helpful to the patient, or when the social worker sees the relatives only to discover their material resources for helping the patient. In social work practice, relatives are often

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1 The term "community" is used throughout this paper to signify the environment in the geographic community to which the patient returns and which is different from the environment of the "hospital community" in that it is not protective, but instead, requires individuals within it to function responsibly.

2 The term "relative" in this paper applies only to those persons in the family whose day to day living is closely connected with that of the patient.

3 The terms "social worker", "worker", and "caseworker" are interchanged throughout this paper and there is little difference in meaning except that where "caseworker" is used there is the implication that the technique of casework is being specifically employed at the time, whereas "social worker" or "worker" implies that the writer is speaking of the field generally and of a person potentially capable of using any of those techniques - casework, group work, community organization, administration and research - which have been developed in the profession.

categorized as "collateral" or "resource person", and it is the opinion of the writer that labels such as these tend to lead social workers away from a consideration of the dynamic role it may be possible for the relatives to play in the patient's milieu.

Especially during the post hospital period, the configuration of his environment[1] may have a bearing on the patient's adjustment to the community, and if relatives are a significant feature in this configuration it seems relevant to accord them closer attention. It is the purpose of this study to review the thinking found in current literature in regard to the significance of parts of the environment and especially of relatives in the rehabilitation process; to describe, using the case study method, the meaning of the patient's hospitalization and post hospital period to the relatives; and to examine the stresses which affect the relatives during the rehabilitative phase of treatment.[2]

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1 The term "environment" is used in this study in the sociological rather than the biological sense, and has a comprehensive intent, to include all the physical and emotional elements in the milieu of the patient. It is exclusive of any meaning pertaining to the internal functions of personality except as external and internal influences are related, and as this relationship is discussed in this paper.

2 In this study the assumption is made throughout that "treatment" forms a continuum from the initial recognition of illness by a medical person through post hospital adjustment in community. It does not begin and end behind hospital doors.

It is an attempt to bring into focus the problems and conflicts experienced by the relatives at the time of hospitalization and when the patient comes home from hospital, and to perceive the relationship between these and the behavior the relative displays toward the patient.

Assumptions and Hypotheses of the Study

In this study it is assumed that there is a correlation between relative's behavior or attitudes and the patient's post hospital adjustment. This assumption is based on and substantiated by studies conducted by Howard E. Freeman and Ozzie G. Simmons. In their paper entitled "The Social Integration of Former Mental Patients"[1] they emphasize the special significance played by the relatives in the patient's rehabilitation, stating

> "..... that the tolerance of deviant behavior on the part of family members is a key factor affecting the course of post hospital experience."[2]

They found that

> "... the perception of a person as 'normal' by his family, peers, and occupational associates is essential to his integration into kin, friendship and work groups."[3]

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1 Freeman, H.E., and Simmons, O.S., "The Social Integration of Former Mental Patients", in The International Journal of Social Psychiatry, Spring, 1959, vol iv, number 4, The Avenue Publishing Company, 9 Fellows Road, London WW3, England.
These authors have published several studies from their research conducted under the aegis of Harvard University, for the Community Health Project, sponsored by the Social Service program at the Harvard School of Public Health. Another article on their studies appears in Social Forces, Dec., 1958, and presents corollary material.

2 Ibid, page 264

3 Ibid, page 266

And they suggest that

> "... patients who express alienating characteristics on either the level of abnormal or of work and social performance remain in the community only when there is a high tolerance of deviance on the part of their significant others."[1]

The "significant others" studied by Freeman and Simmons were relatives of the patients[2], and they discovered that characteristics of the relatives, such as "authoritarianism", "rigidity", and "frustration" bear a relationship to the social performance of the patient.[3] Freeman and Simmons did not examine relatives' reactions and the bases for them, and this is a logical next step. An understanding of the reasons for the individual relative's response to crucial events such as hospitalization and post hospital problems of housing, employment, recreation, etc., should contribute to our knowledge of family life and facilitate professional practice in developing a salubrious atmosphere for the psychiatric patient on his return to community.

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1 Ibid

2 This study was conducted amongst wives and mothers of male patients of a psychiatric hospital after the patients had been in the community for one year following discharge from hospital.

3 It was found that patients who ranked low on the authors' social integration scale were likely to have relatives who were "anomic, frustrated, withdrawn, authoritarian, and rigid", and a table is provided on page 269 giving numerical weights to these relationships. These are rather vaguely explained figures, "anomia" being assigned .30, and "rigidity", .15, with no indication of the extent of the range, but it is assumed that the figures indicate a positive significance for the effect on performance for all the characteristics listed.

In regard to crucial events, it is an hypothesis of this study that the period of hospitalization and the post hospital period represent critical experiences for the relative. Causative relationships between the personalities of the patient and the relative are not studied here, but rather the meaning to the relatives of the crisis experience of hospitalization and post hospitalization. (The assumption is stated above that the relative's personality at this time has an impact upon the patient's personality as manifested in his social performance.) Rennie and Woodward state the assumption that

> "All behavior has real and adequate causes. Each person is what he was born with plus all that has happened to him in his total experience."[1]

Hospitalization is part of "all that has happened to" the patient and also the relative, thus affecting not only the patient's personality but also the relative's. Kluckhohn and Murray elaborate this thinking:

> "Personality is not always 'a whole'; that is, it is seldom perfectly integrated (completely unified). Since the course of life is punctuated by countless occasions when some choice must be made (between alternative, if not opposing, needs, goals, goal-objects, concepts, tactics, or modes of expression), indecisions and conflicts are common and final resolutions of conflicts are rare. Consequently, the psychologist is well advised to include some

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1 Rennie, Thomas (M.D.), and Woodward, Luther E. (Phd.), Mental Health In Modern Society, The Commonwealth Fund, 1948. 41 East 57th Ave., New York 22, N.Y., page 197

> account of his subject's major dilemmas and conflicts during critical periods of his life."[1]

The hypothesis in this study, then, is that hospitalization and post hospitalization are critical periods not only for the patient, but also for the relative. The "dilemmas and problems" which are stressful to the relative during these critical periods are to be examined to ascertain how they affect the personality of the relative, since it is assumed that it in turn affects the performance of the patient.

Relation of Study to the "Total Situation"

To fully understand one part of a situation, it is helpful to examine its interrelations with other parts in the "total situation", and to comprehend the situation itself as a whole. When the patient leaves hospital, he enters a "total situation" which is complex. He must re-orient himself not only to the physical factors of the community, such as where street cars or buses are boarded, and how to locate housing, but also to the human factors. There are various groups of people with whom to greater or lesser degree he must interact if he is to be a functioning member of society. Neighbours, employers, friends, relatives, club members, etc., are some of the groupings which may combine to make up the patient's environment. The "total situation"

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1 Kluckhohn, Clyde, and Murray, Henry A., Personality In Nature, Society, and Culture, Alfred A. Knopf, 1956, New York, page 31

of the patient is a synthesis of two components, his own subjective reactions, and the objective elements over which he may have little or no control. Lewin's concept of "fields", cited by Kluckhohn and Murray, expresses this idea:

> "According to Lewin's definition the field at an instant includes both the external situation (say, the smile of a certain acquaintance who wants to borrow money) and the internal situation (say, fatigue and a feeling of depression) and both are within the head of the subject, because for him external reality is what he perceives and apperceives out there, no more, no less. Since this formulation abolishes the important difference between normal verifiable perceptions and apperceptions, on the one hand, and illusions and delusions, on the other - not to speak of the many extravagant projections of normal people - it has seemed advisable to call the external situation as it actually exists (insofar as this can be determined by careful inquiry) the alpha situation, and to call the external situation as the subject apperceives it the beta situation. Although the subject's response to a given situation provides a fairly reliable clue to the nature of the beta situation, the latter should be ascertained, whenever possible, by direct inquiry."[1]

The "beta" situation in the present study is narrowed to only the activity, within the entire "field", of one segment, that occupied by the relatives.

Marie Jahoda[2] has shown how perception of environment influences personality and behavior, in her studies in Austria and in Great Britain. Austrian children adapted themselves to an environment of poverty by limiting their powers of

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1 Kluckhohn and Murray, ibid, pages 9-10

2 Jahoda, Marie, "Toward a Social Psychology of Mental Health", in Rose, A.M. (ed.) Mental Health and Mental Disorder, W.W. Norton and Co., Inc., New York, 1955, pages 561, 562

imagination and restricting ambition in themselves. British school girls traded values of intelligence and industriousness for their opposites when they moved to work in a factory where these values did not represent the accepted norm. Jahoda also points out that the inner parts of personality may be functioning as a well integrated unit, but that conflict between this unit and the outside environment (or the"beta" situation, the environment as it is apperceived by the individual) may occur. Jahoda concurs with Kurt Lewin who believes

> ".....behavior is always a function both of personality and environment, a formulation which encompasses the facts regarding changes in later life and is complementary to, rather than inconsistent with, psychoanalytic theory. It would seem, then, that the answer depends on whether or not the behavioral change persists when the original environmental conditions are restored. All through life environment acts as an agency mobilizing selectively different facets of the personality ..... It is the pressure of the external world that can alternatively favor or reject some personality traits, for shorter or longer periods."[1]

In the complex environment, many causes of pressure are to be found. Only one aspect of the complex network of potential pressures is to be studied here, and while this may be a limitation to the ultimate value of a study of environment, it is a necessary one for conducting the study since total knowledge may be attained only slowly, and by the piece meal

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1 Jahoda, Marie, ibid, page 568

process. There are times, of course, when work must be done within one segment, and knowledge of that part alone is useful then.

Relevance to Social Work and Society

Society benefits from the satisfactory functioning of its members, and social workers on the psychiatric team are concerned with facilitating better functioning of persons who have been in hospital for treatment of mental illness. As a "secondary gain", the better functioning of relatives may also result, thus increasing the numbers of individuals who are better able to contribute to community life. Increased knowledge of the various aspects of life is becoming more important in social work practice. Gordon Hamilton predicts:

> "The social worker of tomorrow can no longer restrict himself to consideration of how the client feels about his situation - he must be equally attuned to the effects on the client of ethnic, class, and other significant group determinants of behavior."[1]

Setting of the Study

Because the hospital period is considered to be a significant aspect of the treatment experience for both patient

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1 Hamilton, Gordon, in Preface to Stein and Cloward (eds) Social Perspectives on Behavior, Free Press, Glencoe, Illinois, 1958 page xi

and relatives, it is necessary to have an understanding of the hospital setting familiar to the patients and relatives among whom this study was conducted. The hospital[1] from which the subjects were selected for the study was Crease Clinic, at Essondale, B. C. It is a hospital where prevention of more serious illness through early treatment, is the aim, and therefore patients in early stages of illness often experience their first hospitalization for a psychiatric illness at Crease Clinic.

Crease Clinic is housed in a single building which shares the well kept grounds of the Provincial Mental Hospital, and the clinic is, in fact, a part of the administrative organization of the larger hospital although it functions separately as a treatment unit. The buildings of the Provincial Mental Hospital and Crease Clinic together comprise the village of Essondale, which has its own post office. The village is located in a rural area on the Lougheed Highway, about twenty miles from the centre of Vancouver City.

The original building was opened in 1934 as a Veteran's Block, and in 1946 work was begun on the additional wings. In 1948, the "Clinics of Psychological Medicine Act" was enacted in British Columbia, and in November, 1949 the building was opened, with the west wing housing wards for

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1 Throughout this study the term "hospital" will refer to Crease Clinic, and is used to differentiate the institution's actual function from confusion with the day centre type of clinic.

men, the east wing, wards for women, and the centre section

> "incorporating the administrative headquarters of the mental Health Services, and the specialized medical departments for investigation, diagnosis, and teaching."[1]

On April 3rd, 1950, the first patients were received into the building, and from that date to December, 1950, the building was used as an admitting unit for the Provincial Mental Hospital. On January 1st, 1951 the "Clinics of Psychological Medicine Act" was proclaimed effective, and on that date, the first patients came to the clinic for whom were intended its specific treatment services.

Purpose of Crease Clinic

There are two essential differences between Crease Clinic and the Provincial Mental Hospital and these represent a departure from the older procedures for hospitalization of the mentally ill. The first is that admission may be on a voluntary basis, and the second is that patients may not be held for longer than four months. Voluntary admission can only be made by those

> "whose mental condition is such as to render him competent to make application"[2]

and thus the illness cannot have progressed as far as the illnesses which necessitate legal committal to the Provincial

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1 Annual Report of the Mental Health Services Department, 1953, page 18

2 "Clinics of Psychological Medicine Act", section 8, subsection 1

Mental Hospital.

The admissions procedure of Crease Clinic has one outstanding feature. Patients are admitted in one of two ways, by voluntary admission, or by certification by two physicians upon the application of a relative or interested person that the patient requires care in a hospital for psychiatric illness. Neither of these methods requires a legal committal, with consequent loss of civil rights. The patient thus remains a member of the community at large while temporarily removed from it. His retention of community identity is a valuable asset to the patient for whom the treatment goal is reintegration into the community.

Treatment at Crease Clinic is designed to be preventive, and the question might be asked "what conditions are treated in prevention?" The Policy Manual of the Provincial Mental Health Services for Provincial Mental Hospital and Crease Clinic states

> "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 community."[1]

It further states that

> "..the function of Crease Clinic is to treat acute cases of mental and emotional disorders. Although the maximum period of time is four months, it is to be noted that the average period of treatment is about two months."[2]

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

2 Ibid

The manual lists the following as types of patients considered 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."[1]

Those cases considered unsuitable for treatment are:

> "... the long term psychoses and neuroses, and persistent behavior disorders, cases of mental deficiency, chronic neurological disorders, senile brain diseases, alcoholism and drug addiction."[2]

From the statistical tables of the 1958 Annual Report, it can be seen that the early states of illness treated at Crease Clinic cover the entire range of diagnostic categories in the field of psychiatry. In the group of patients with psychosis, all the schizophrenic disorders are represented, such as hebephrenic, paranoid, latent, etc., etc.; the manic-depressive reactions are present in varying types; there are instances of senile psychosis, cerebral psychosis, alcoholic psychosis, anxiety reactions, hysterical reactions, obsessive compulsives, etc. In the group without psychosis, all the categories are present, such as disorders of character, behavior and intelligence under headings of pathological personality (schizoid, paranoid, inadequate, antisocial, etc.), immature personality (emotional instability, passive dependency),

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1 Ibid, page 33

2 Ibid

alcoholism, drug addiction, primary childhood behavior disorders, and acute situational maladjustment. To list the entire catalogue would be needlessly space consuming. The examples above suffice to show that in a clinic of psychological medicine which has as its purpose the prevention of the more serious forms of the illness, all types of mental ill health in its early stages may be found.

Facilities of Crease Clinic

Crease Clinic is equipped with facilities to meet most standards for psychological hospitals. Dr. Davidson in the 1951 Annual Report reviewed them:

> "The Clinic is furnished attractively, providing a comfortable environment for the relaxation and treatment facilities that the patient receives. Adequate facilities are provided to enable a thorough diagnosis of all medical and psychiatric conditions; these include clinical laboratory, X-ray facilities, neurological consultation services, and complete facilities for psychological testing. Every medical aid also is provided to enable the best in psychiatric therapy, including physiotherapy, hydrotherapy, occupational and recreational therapy facilities, etc. These facilities are auxiliary aids and assist in the other more specific forms of psychiatric therapy. All necessary facilities, including electroshock, electronarcosis, coma insulin, etc., are available in the new Clinic."[1]

In addition, there is a library, amusic therapy department, and a social service department.

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1 Annual Report of Mental Health Services Department, 1951

Crease Clinic can accomodate 312 patients, and locked doors are kept to a minimum. There is only one "closed" ward in each wing, for the segregation of patients who are so seriously disturbed upon first arriving in hospital that they require special precautions for their own safety, and for the safety and peace of mind of the patients who are somewhat recovered.

Social Service Department

One of the facilities of Crease Clinic is its provision for social services. The Crease Clinic Social Service Department has operated as a separate unit since 1952, although in 1951 the Social Service Department of Provincial Mental Hospital, originally established in 1930, gave service to Crease Clinic patients. There is a provision for nine social workers on the Crease Clinic staff, and at the time of the study there were five workers giving service to about fifty percent of the patient population. Of the referrals made to the department, adolescent patients, pregnant patients, and patients with young children in the home are considered to be the most urgent cases. However, marital problems, rehabilitation problems and relationship therapy for schizophrenic patients seem to occupy most time as the numbers of patients in the first group are not so large.

Function of the Social Worker

The social worker's task is directly influenced by

the unique nature of the institution, which represents the first focus upon the psychiatric illness of the patient outside of his own home and for twenty-four hours a day. Earlier attention to the illness may have been received in the form of interview therapy on a private basis or in a general hospital, but admission to Crease Clinic signifies that the psychiatric illness as such has assumed dominance to the point where the patient needs to be segregated for its special treatment.[1] This segregation has an impact upon the patient and upon his family, and thus has implications for the activities of the social service department personnel. The worker in this situation functions as a member of the treatment team and is both a therapeutic instrument in direct work with patient and relatives, and an enabler in work with others in the patient's environment both in the hospital and in the community. Generally there are three aspects of the hospital experience with which the social worker deals: admission, treatment, and discharge planning. Ernest Schlesinger in his thesis on the services given by this department, states that the social worker potentially is involved in every stage of the patient's and family's needs, and divides the needs into six phases;

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1 In the Mental Health Services Annual Report of 1953, Dr. Davidson commented "It is pleasing also to note the large number of patients who come to the Crease Clinic as their first psychiatric referral without previous treatment." (page 33)

1. Admission services
2. Diagnostic services
3. Treatment services
4. Pre-convalescent services
5. Convalescent services
6. Family services.

It should be made clear that "discharge planning" and "convalescent services" include rehabilitation planning and activities. Schlesinger says

> "Treatment, in this survey, defines the process whereby the patient is helped to overcome or live with his illness. Rehabilitation, on the other hand, represents all the other processes whereby the patient and his family are restored to a more satisfactory adjustment internally and to the community."[1]

The goals of the social service department include not only treatment of the patient and rehabilitation of patient and family, but also prevention of further mental breakdown.

That hospitalization for mental illness is an event which jolts relatives was recognized by Schlesinger at the time of his survey in 1953. He said:

> "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 may feel responsible for the patient's breakdown, and may be affected

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1 Schlesinger, Ernest, Social Casework in The Mental Hospital, Master of Social Work thesis, University of British Columbia, 1953, page 2. These definitions were utilized by the present writer in conducting this inquiry.

> 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, and may decide to break all ties with him because they find his bizarre behavior too painful to face again. All these feelings and attitudes have a disrupting influence on the patient and the effective functioning of the family. The social worker can give realistic assurance and support to the family, and encourage it to participate actively in the treatment and rehabilitation of the patient. He is also in the position to help the family with the material and emotional issues which it may encounter."[1]

Schlesinger found that there has been a move away from the social work done in the beginning of the department's history when services were mostly related to changes in the external environment. More work is now done to help the patient in his relationships with other people, and the less tangible aspects of the worker - client relationship require more time than formerly. He stated that

> "..... personal difficulties (of relatives) usually cause difficulties for the patient upon his discharge from the clinic to his family.."[2]

and he listed the kinds of help a worker might give families as:

1. Support around anxieties related to patient's hospitalization.
2. Help around the inability to accept the patient's illness
3. Support around social problems in the home
4. Casework services based on emotional needs of the patient's relatives.

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1 Ibid, page 9

2 Ibid, page 32

The conclusion which Schlesinger reached in regard to the importance of work with relatives was at that time unsubstantiated by research, but has since found support in the studies like the one referred to earlier, by Freeman and Simmons, and is subscribed to by this writer as the premise from which research starts into the problem of how to create an accepting and helpful environment for the discharged patient. Schlesinger commented:

> "Understanding and accepting the patient on the part of the relatives improves the social relationships between the patient and his family. It helps the family overcome their reluctance to visit the patient and helps them be a constructive force in the patient's rehabilitation."[1]

The concern of the present writer is how understanding and accepting of the patient by the relatives may be promoted through understanding of the relatives responses to the experiences of hospitalization and rehabilitation.

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1 Schlesinger, Ernest, ibid page 32

CHAPTER II - CASE STUDY METHOD

The case study method was employed as the vehicle for conducting this investigation. For the examination of interrelationships and subjective material, it is the most usable instrument available, especially for the researcher working alone. Though some writers argue about its limitations and consider that it should be combined with other methods (such as the survey) when a large study is being undertaken, most research workers today find it has peculiar advantages for the limited study in its ability to highlight detail and nuances of experience. Pauline V. Young opens her chapter on the case study method with a quotation from Charles H. Cooley, who felt that:

> "Case study deepens our perception and gives us a clearer insight into life."[1]

In the opinion of Young, the case study of an individual:

> "Is capable of revealing his inner strivings, his way of life, the motives that drive him."[2]

and she cites the evaluation by Thomas Znaniecki of case study material as "the perfect type of sociological material" because it gives:

> "...(a) more enlightening and fundamentally more real record of personal rexperiences, with a wealth of concrete detail, vivid memories, tension situations, and multifarious reactions to social situations which escape the attention of most skilled investigators using other techniques."[3]

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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 231

3 Ibid, page 235

The present writer is of the opinion that the forming and gathering of detailed impressions in this manner leads to the deeper understanding of the individual. The impressions gained through intensive study of a small number of cases are the moulds of future knowledge. Myers and Roberts, considering the limited numbers of cases examined in the case study, sum up the advantages:

> "The case study method.....provides a vertical view of a small number of cases with a few restrictions on the number of traits studied in any one case. It is a 'microscopic' approach, permitting a detailed and dynamic study of any part of an individual's life cycle. Since materials are usually collected by free association or clinical interviews, they are not limited by pre-arranged plans. The researcher can collect a vast amount of unique data on his subjects which he could not obtain by the survey method. Clinical experience and judgment are used in analyzing materials, often providing greater insight than is possible in more standardized analytical procedures."[1]

The method is, of course, limited in that replication of the study or adding to a certain study, is difficult, and prediction may not be possible. Rubinstein and Parloff have also observed that the variables of the patient's personality and the interviewer's personality may combine to direct attention away from the research focus.[2]

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1 Myers, Jerome K. & Roberts, Bertram H. Family & Class Dynamics in Mental Illness, New York - John Wiley & Sons Ltd., London - Chapman & Hall Ltd., 1959, page 23.

2 Rubinstein, E.A. & Parloff, M.B. (eds) Research in Psychotherapy, Proceedings of a Conference, Washington, D.C., April 9-12, 1958, National Publishing Co., Washington, D.C., 1959.

The writer of the current study, however, is of the opinion that this very inter-action may be controlled so as to bring forth more findings for research into the nature of being. Young quotes Professor Read Bain who comments that techniques in case study have improved in recent years so that the method now is

> "indispensable for therapeutic and administrative purposes".[1]

The controlled or structured interview and the analysis and classification of responses into significant categories, has given the case study technique new value.[2]

In the present study, the case method consisted mainly of interviews with relatives. The data was supplemented, however, by information from the files about the patient's illness, and where the social worker had been active in the situation, discussion with the worker was held about the patient's progress. Discussion with the supervisor of the social service department was held about the choice of all the cases in order to minimize possible danger to the success of the patient's rehabilitation period due to the research interview.

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1 Young Op. Cit. page 238

2 The present writer's interest in the interview as a technique in case study was a determinant in the choice of the case method.

The Sample

To obtain a group of patients' relatives to interview, the patient population was screened according to a set of criteria drawn up to limit the group chosen. Included in the criteria were the variables which had been deliberately singled out for attention. They were the type of family (procreation or orientation) to which the patient returned, and the presence or absence of hospital casework services. A cross section of patients and relatives in the hospital and post hospital periods is not contained so that representativeness cannot be claimed and is one of the limitations to the selection finally made.

The Criteria

The following criteria were used in selection for the reasons given:

1. The patient should have experienced his first admission to Crease Clinic.

This test was chosen for the obvious reason that first admissions would be expected to have an impact upon family different from that of readmissions, which might have less or greater impact, depending on the circumstances. Also, in keeping with the preventive aspects of treatment, it was felt that it would be useful to learn more about the time following first admissions in hopes of adding to general knowledge information which might help develop measures preventative of readmission.

2. The patient should have remained in hospital for at least six weeks.

It was felt that the time in hospital should be sufficient to make the separation from community significant both for patient and relatives.

3. The patient should have been in the community since discharge no longer than six weeks.

It was the purpose of the study to examine relatives' feelings while the rehabilitation experience was current, and questions and discussions would have meaning for the relative closely related to post hospital problems.

4. The relative should be a wife or mother of the patient. The patient whose mothers were to be interviewed could be either male or female.

Female relatives are usually in the home a larger proportion of the time and thus might be sensitive barometers of the impact on the home of problems at the rehabilitative period. It was also felt that it would be interesting to observe whether type of family (procreation or orientation) might make a difference to the relatives' experience.

5. The age range of the patients should be between twenty and forty-five. It could be assumed that general problems of social adjustment would be similar from a physical standpoint.

6. Casework services should have been provided in half of the cases.

It was hoped to assess the significance of this variable in the post hospital situation by noting differences in the group receiving services from those not receiving them.

7. The families should live in the lower mainland area, to be accessible for interviews.

The Variables

Rubinstein and Parloff comment:

> "Ideally the investigator might wish to comprehend the complex interaction among all variables. However, for the practical purposes of research, each of the variables is arbitrarily separated and studied. The particular element that one chooses to work with reflects one's own taste and clinical judgment."[1]

In the community situation comprising the total "beta" perception incorporated by the patient into his personality adjustment, there are many factors, and in working with an individual it would be necessary to review all of them to discover which were of significance to that individual. For study purposes, however, certain of the sections are set apart for separate examination. The presence of relatives is not a constant factor in the environment of patients returned to the community but it is, rather, a variable one, and it is this variable primarily with which this study is concerned. Two additional variables have been added purposely, and other variables difficult to eliminate are present. The two added are the structure of the family, and casework service. Different kinds of relatives are a variable, and two of these, wives (family of procreation) and mothers (family of

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1 Rubinstein & Parloff - op cit page 288

orientation) were chosen for study. Not all patients receive casework services, and thus social work also constitutes a variable. The group was therefore structured to contain a number of cases presenting this variable. Other factors which vary from patient to patient are age, and location of home. The latter may be a significant variable because in the metropolitan lower mainland area, many more resources are available than in the outlying places. It is the opinion of the writer that such a variable does not deter from the value of the study since comparative groups in rural areas might be studied in further research.

Representativeness

Since this was not a random sampling but instead a selected one, no effort was made to assure representativeness. The selection was made in accordance with specific criteria which had been deliberately limited so that not a cross section, but one segment of experience would be examined, and so that the impact of certain variables might be assessed.[1] It is not a typical group because no patients from outlying areas could be included, but the group does indicate the trend toward admission in the early stage of illness insofar as the patients were all quite young. The sample breaks down roughly

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1 Attention was also given in selecting cases to the possibility of endangering the patients' progress through research intervention and some cases were discarded on this count, so that the sample is truly a selected one.

into social classes of two groups, the working class and the "professional" or middle to upper middle class and may be said to be typical of the large majority of patients in this respect. From the point of view of illnesses faced by the patients or relatives, the sample is also fairly typical.[1]

The nine cases in the sample were characterized as follows: (the lists do not follow the same order, so that the 32 year old patient is not the patient with a diagnosis of obsessive compulsive neurosis).

Age of Patient	Diagnosis of Patient
1. 32	1. Obsessive compulsive neurosis
2. 30	2. Schizophrenic Reaction
3. 27	3. Neurotic Depressive Reaction
4. 23	4. Psychoneurotic Depressive Reaction
5. 20	5. Anxiety Reaction
6. 26	6. Psychoneurotic Conversion Reaction
7. 31	7. Schizophrenic Reaction - Chronic Undifferentiated Type
8. 16	8. Chronic anxieties in Schizoid type of individual
9. 34	9. Chronic Schizophrenic, simple type.

Social level, According to Occupation and Home Setting

1. Working Class, neat suburban home.

2. Professional class, select residential area, beautiful home.

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1 At the beginning of the study period the writer considered examining only relatives of schizophrenic patients, but decided to broaden the focus to include all types of mental illness because social workers in a psychiatric setting are usually engaged in helping patients in all diagnostic groups and the post hospital problem of rehabilitation applies to all patients.

3. Working class family, rented home, run down city neighbourhood.
4. Working class, own home in residential area.
5. Professional Class, small apartment in good residential area.
6. Professional Class, attractive suburban home.
7. Working class, own home near industrial section of suburb.
8. Working class, small home in an almost rural part of suburb.
9. Working class, older home in older part of town near commercial section.

Limitations of the Sample

The sample is small in numbers,[1] and it is not representative of all groups of relatives (e.g. fathers, brothers, husbands, etc. are not included). There was no way of knowing, at the time of selection, whether or not psychiatric help had been received in the community prior to or following hospitalization for those patients not receiving social service from the hospital, and therefore this is a variable which is not uniform in the study. It proved to be impossible to find enough cases receiving social casework services from the hospital of a similar nature to make examination of this variable a useful one in this study. The study does not speculate on the nature of the families who

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1 Of about 70 cases in hospital during a period which provided the necessary post hospital experience, only ten could be found to meet the criteria. Of these only 5 agreed to participate, the others either declining or being considered unsuitable for interviewing. The remaining four were selected from ten suggested by Social Service Department as the only ones of the ten meeting this criteria.

declined to participate, and it might be of interest to conjecture on the significance of the fact that some relatives agreed to the interview while others did not.[1]

In order to select a group it proved necessary to modify some of the criteria. For example, length of stay in hospital was a difficult criterion to meet, especially as there seems to be a trend toward earlier noting of illness and therefore shorter periods in hospital. (Shorter hospitalization makes it difficult for social service to be provided all referrals and added to the difficulty in sampling the social service variable.) It became necessary to use some cases where the patients stay in hospital was less than six weeks and also where the post hospital period had extended past six weeks. These periods then are not strictly uniform, and some variation may exist among relatives responses due to the differences in experience in terms of time. Such variation is not accounted for in the study. It might be of interest to measure the intensity of response in relation to length of time the rehabilitation period had extended. The writers impression in the present study was that while the relatives feelings were of a piquant quality at the time of discharge, they became even less endurable as time went on. There was no separation into groups on this score, however.

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1 It might be said that those who agreed to the interview had some awareness of a need for help, but it might also be said that these were more altruistic or curious, etc. and study into this particular aspect would be necessary to determine its significance. The number of relatives refusing to participate in the project was smaller than those agreeing. Fourteen were approached and nine responded positively.

The Method of the Study

To select the cases for study, a memorandum listing the criteria was circulated amongst members of Crease Clinic Social Service Department and the writer also spoke to the social workers at staff meeting and privately. The cases to be used in the group receiving social casework services were chosen from the names the workers submitted. The group of cases in which no social service was given was selected by proceeding from the file number of each social service case to the next file numbers following it and applying the criteria until one was found which could be used.

In the group receiving social service, the relatives were prepared by a discussion with their own caseworker for the writer's telephone call to arrange an appointment. Letters were sent to the groups of relatives where the social service department had not been active, advising them of the research project and preparing them for a telephone call.

The main method of obtaining data was the interview, and in research the technique differs slightly from that in the casework service interview. Edna Wasser advises:

> "It is always the research setting and the research design that determine what the basic role of the caseworker is to be. This role needs to be clearly defined if his practice is to be consciously and purposefully adapted to the needs of research.[1]

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1 Wasser, Edna, "The Caseworker as Research Interviewer in Follow-Up Studies" in Social Casework, October 1957, vol. xxxviii, number 8, page 423

To help preserve this focus, the interview was prepared beforehand by constructing a guide with general areas of discussion marked out and types of questions outlined. (See Appendix "A"). This guide could be used only to focus the interview and not in the manner of a survey.[1] The areas around which the interview was constructed were chosen from the problems with which social work finds most concern in rehabilitation, plus the topic of reaction to hospitalization and mental illness.

The topics of the interview were:

1. Education or retraining plans of the patient
2. Employment plans or problems of the patient
3. Housing arrangements of the patient
4. Recreational activities of the patient
5. Financial problems of patient and relatives due to illness
6. The impact of hospitalization on the relatives
7. The understanding of mental illness gained by the relatives

The interview was designed around the first five topics as they seemed to be concerns that might be shared by patient and relative, or which might have a meaning to the relative which could result in her manifesting attitudes toward the patient which might affect his performance in these areas.

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1 It was found that the word "survey" seemed reassuring to the relatives upon opening the interview, whereas the word "research" seemed to put them a little on guard before further explanation could ease their fears.

The latter two topics were intended for examination of the relatives' personal reactions to crisis.

Recording during the interview was done by means of a code card, three by five inches in size, on which the areas of discussion and responses were indicated by abbreviations and symbols, to be marked by the interviewer when the subject was touched upon by the relative.

The introductory phase of the interview proved to demand special attention. It was necessary to overcome the relatives' initial reserve, and this was accomplished by explaining the purpose of the visit in simple terms and making sure the relative understood. A sense of harmony and trust had to be created in order to free the relatives to display her feelings about her experiences, and the interviewer had to sense the relatives' mood and adapt the style of discussion to it. With some relatives, the discussion had to start where the relative felt most comfortable, preliminary conversation leading into such an area. Strict adherence to one topic at a time was often impossible, as the relatives, in open discussion, often jumped to other subjects, and the worker followed their lead as long as focus was maintained. It proved simple enough to bring the informants back to an area, once they had been allowed to discover that they were not being "forced" and that what they contributed seemed to be helpful. Use of the structured outline, of course, was

helpful with informants who found open discussion somewhat threatening, or needed help to participate.

The end of the interview required special care, because of the tendency for the relatives to discover the possible comforts in relationship with a person in whom the "giving" element has not been eliminated in the interests of research. Edna Wasser comments:

> "Inevitably there is a quality of giving to the client, not in a service or treatment sense but in terms of the interviewer's expressed interest and what he reveals of his appreciation and comprehension. The interviewer tries to make the experience a constructive one for the client, and to repair any distress it may cause. Any such 'service-like' aspects, however, are subsidiary to the primary research focus."[1]

It will be recalled that Rubinstein and Parloff noted the influence of the interaction between interviewer and interviewee, and with the basic "giving" attitude of the caseworker, plus the deliberate efforts mentioned by Wasser, it is not possible to prevent the relatives from sensing a new quality in this experience. (See Appendix "B"). For that reason, the writer found it necessary to weave into the structure of the interview certain features to minimize any pain which might occur as a result of withdrawing the comfort of relationship after displaying it. Especially in cases where there was an obvious problem, the following measures were observed:

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1 Wasser, Edna, Ibid

1. Recognition of the problem.
2. Stating that the research worker cannot help with the problem.
3. Giving factual information about where to obtain help.
4. Conveying warmth.
5. Controlling the kind of information the relative might reveal.
6. Giving the relative a sense of value because of his contribution.
7. Careful closing.[1]

In closing the interview, the research focus was stressed, the relatives were thanked for their help in terms of future help to others, and were reminded that no further visit would be made. The worker at that point tried to convey, through general attitude, warmth and appreciation of not only the relatives' contribution to research, but also of the relatives' qualities as a person.

The structured type of interview, used in an "open" manner was useful in several ways. General feelings and attitudes could be noted, specific feelings towards problems could be ascertained, and some of the specific questions brought out material which required interpretation but which was valuable in that way. For example, the question:

> "Had you any special hopes for the patient when he came out of hospital and how is this turning out?"

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1 This method was composed by Edna Wasser and the seven steps given here were compiled from a review of her method.

revealed attitudes of frustration, hostility, disappointment or withdrawal from the situation.

There were some questions which might bring forth more response in a group setting. Few relatives, for instance, could think of what specific questions they had had about mental illness in general. The quality of the one to one relationship, and the fact that in only one interview only a certain amount of time could be given to developing a relationship or to allowing reflective periods, may have affected the response to this question. (It is of interest to note that several relatives had read popular articles on the subject, but did not raise questions about them, whereas perhaps in the anonymity and acceptance of a group situation they might have done so). Most comments about mental illness were centered around the particular illness of the patient and whether or not questions had been satisfactorily answered by the hospital psychiatrist.

The request for "your suggestions" gave opportunity for free expression of attitudes. The ideas ranged from practical ones such as, "there should be more buses" (there are only two a day at inconvenient hours for visiting) to "sick patients should be segregated from ones like my son". The latter indicated persevering protective tendencies in the mother. There is segregation to a point in that one ward is "closed", and patients with severe disturbances remain there until their health improves. The several relatives who wanted

"desegregation" were speaking of this ward, feeling their patients to be less ill than the others in it. Denial of the illness, and, possibly, lack of adjustment to the hospital setting were thus indicated.

The interview in the case study method is time-consuming and often tiring if the interviewer is to be alert to all the nuances of meaning and feeling in the interchange of conversation, but it seems to be a device capable of bringing data to research from the sensitive areas of human experience.

CHAPTER III - STRESSES OF HOSPITAL AND POST HOSPITAL PERIODS

The aim of this study is to describe the impact of hospitalization and the post hospital period upon the relatives of mentally ill patients and to consider the stress experienced by the relatives in the rehabilitative phase of treatment. For these purposes, the case study method, utilizing mainly the interview technique, has been employed, and Appendix B gives some examples of this process. For this chapter, the relatives interviewed have been divided into two groups, the group of wives and the group of mothers. The cases in the group of wives have been designated by the letters A,B,C, and D, and the mothers, by the numbers 1,2, 3,4, and 5.

In all of the following presentations, the statements are given as they were revealed in the interview situation, and thus represent objective and subjective fact as experienced by the relative. Where the impressions of the interviewer are included, drawing inferences from the material, these are noted in the record as the opinion of the worker. The case records are presented in two groups, first the group of wives, then the group of mothers, with some general observations drawn at the end of each group. The total group is then discussed. In each case record, the headings of the interview outline are employed to divide the case material. The headings "Education or Training", "Employment", "Housing", "Recreation", and "Finances", are used not to indicate that descriptive information about the actual situation follows,

but information regarding how the relative feels about this aspect of the patient's experience. The heading "Pressures" is used in the case studies of the first group because the wives were able to state where they felt strain, whereas the mothers were not so articulate. The section under the heading "Assessment" is the workers interpretation of the material preceding it.

WIVES

Case A. "Mrs. W"

Mr. W is a university trained professional person aged 26 who experienced difficulty in his first year after graduation when he was not comfortable with his employer. His brief illness consisted of an "Anxiety Reaction" and he was sent by his psychiatrist in the community to Crease Clinic, where he remained only two weeks. He then went into a business on his own and at the time of the interview was just getting it underway. He continues to see a psychiatrist in the community and still has periods of tension. He and his young wife of less than two years have a baby, and live in a small apartment in a pleasant district.

Mrs. W at first denied any problems but soon began examining some of her feelings about her experiences.

Employment

In regard to her husband's employment,[1] Mrs. W displayed some anxiety, which the worker considered justifiable under the circumstances, since his new venture was in its beginning stages. She balanced her anxiety with her pleasure in her husband's improved outlook, however, and she felt convinced that this was the right course for her husband to take. She had noticed that he experienced occasional periods of tension in relation to his work, and this caused her concern, which she did not wish her husband to perceive. She felt that he needed her positive support and encouragement in this venture. Mrs. W spoke knowledgably of her husband's

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1 Since the patient had completed his professional training, education was not a topic for discussion in this interview.

future prospects in his job.

Housing

The small apartment occupied by the family was an attractive one, and Mrs. W enjoyed maintaining a happy atmosphere in it. She expressed concern, however, for her husband's response to its limitations, feeling that he needed more scope for such activities as gardening, carpentering, and general homey "puttering" as outlet for his pent up energies, and for feelings of accomplishment. Mrs. W hoped they would be able to move to a home of their own in the near future. In the meantime, the worker had the impression that she was making the most of the possibilities in their apartment.

Recreation

This wife participated fully with her husband in his social life. They enjoy visiting and having friends in. Mrs. W., however, was concerned about whether or not her husband should be encouraged to maintain friendships with one or two patients he had liked in the hospital, and who had since visited. The patient tended to take on a good deal of responsibility in a club he belongs to, and Mrs. W was concerned about this, too.

Finances

This couple had not experienced severe financial set back because the patient's period in hospital had been brief and his previous earnings had been good. Their families had also been able to help. Mrs. W, however, expressed fears in thinking of the possibility of future unemployment due to illness. She said "I wouldn't know what to do -- I panic when I think of it."

Hospitalization

The act of hospitalization was a shock to Mrs. W. Her husband had been seeing a psychiatrist in the community for a year, and she had considered that sufficient treatment to insure no further development in the illness. She added that she had thought if he did need more intensive treatment, it would take place at the General Hospital. "It was a blow when Crease Clinic was prescribed." When she visited the patient, she suffered further shock on discovering locked doors, and the severity of illness some of the patients around her husband displayed. She spoke to the hospital psychiatrist once, but otherwise developed no feeling of

communication with hospital personnel. She had no preparation for the patient's homecoming, and she felt he might have benefited from a slightly longer stay, "but nobody asked:" She said she did not like to pick faults, because she felt her husband had actually benefited from his experience in Crease Clinic, but she was not well impressed with the physical setting.

Understanding of Illness

Mrs. W. had never before known anyone with a mental illness. She felt her questions about it had not been satisfactorily answered, and she would not turn to magazine articles feeling that they would not be authoritative, nor help her understand her husband's specific illness. She had wondered about her own involvement in the illness and had therefore visited her husband's psychiatrist in the community. She had been reassured, but occassionaly wonders about it now.

Pressures

Toward the end of the interview Mrs. W. talked about her own feelings of tension and strain. She said she "could not take" another period of hospitalization right now. She reviewed the situation, and felt that having had to adjust to marriage, then to motherhood, then to mental illness, hospitalization, and rehabilitation, all in less than two years, had reduced her stamina.

Assessment

The worker's impression was that hospitalization was a rude awakening to Mrs. W. regarding mental illness. She was unable to utilize the resources of the hospital and possibly failed to understand the continuum of treatment, expecting her husband to be "cured" when the hospital door closed behind him. She seemed to suffer feelings of isolation, of being left out of the situation, in her comment, "nobody asked me" in respect to the hospital experience.

It seemed to worker as though this relative may have avoided asking probing questions about mental illness in an effort to deny its existence, or not to face all the implications. In her emphasis that mental illness carries no stigma, it seemed that she might be denying her real feelings.

The post hospital period for Mrs. W. means watchfulness on her part not to upset the patient, plus strain for her arising from anxiety over the new employment, the housing limitations, fear of the financial implications of future illness, and from her lack of emotional support.

The dependency needs of this wife did not seem to be receiving gratification, and it was the worker's impression

that her emotional resources were being drained, so that it was questionable how long she could maintain positive attitudes if she did not receive specific support for her emotional needs.

Case B. "Mrs. X."

Mr. X. is a 34 year old semi-skilled person who was transferred from a local gaol to Crease Clinic owing to the condition of poor mental health he seemed to be in at the time of his offence. He was in Crease Clinic six weeks, diagnosed as "Chronic Anxiety State in a Schizoid Individual," and upon return to the community has been unable to obtain employment. The family is composed of the patient, his wife, their pre-school son and their infant son.

Mrs. X saw the research interview as an avenue to obtaining help, and she presented the situation clearly.

Employment

Mrs. X. seemed to worker to be realistically anxious about her husband's unemployment. She felt her husband was growing increasingly depressed by his belief that prospective employers look unfavorably on men with gaol and mental health experiences. She said that at first she had been inclined to dismiss this possibility, but now was beginning to share her husband's opinion, although she would not let him know it. She had taken into consideration the minor economic recession of the country and had tried to help her husband recognize it as a feature in his unemployment, but she could not feel reassured herself.

Education or Training

Mrs. X. expressed confidence in her husband's intelligence and specific abilities, and felt he lacked education up to his capacity. She felt he would benefit from further training in his trade, not only because of increased skills, but also in increased confidence in himself and regard for his own worth. She wished that a course of training could be arranged for him.

Housing

The two roomed apartment was felt by Mrs. X. to be too small for two adults and two children, and said it presented problems of heating, cleaning and storage, but worker

observed that she kept it in clean and comfortable order. She said she had suspended any thoughts of moving, knowing they were not financially in a position to do. She was grateful to "new Canadian" neighbours in the upstairs apartment who "baby sat" cheerfully and refused payment.

Recreation

Mrs. X had proved to be resourceful in finding recreational activities she and her husband could share at little cost. A community group provided a young adult's program and she and her husband had joined it. They also spent some evenings visiting friends. This wife also expressed concern about her husband's continuing friendships made in hospital. In one particular friendship she did not know if it would be wise to encourage her husband, since the friend might be helpful to him in terms of education and employment, or to discourage him, since the two might emphasize each other's illnesses.

Finances

Although realistically concerned about the limitations of unemployment insurance, Mrs. X stated that she felt capable of managing on whatever income was available. She herself would like to work, and had done so for a time but gave it up because of her husband's illness. An evening job which she enjoyed had to be relinquished because her husband became upset caring for the children at night.

Hospitalization

The events surrounding the patient's hospitalization all came as a shock to Mrs. X, although hospitalization itself was seen as a "rescue" from the more damaging incarceration in gaol. Mr. X had seen a psychiatrist in the community for a time, but had then become unable financially to continue this treatment. When his health seemed to deteriorate, neither he nor his wife could think of any way to obtain the cost of treatment, and they did not know whom to consult about the matter. Mr. X therefore received no treatment, and Mrs. X felt that his tension built up until it exploded in the minor offence which caused his apprehension. Fortunately, Mr. X's former psychiatrist was consulted, and he advised Crease Clinic care. Mrs. X visited the patient in hospital, but felt at a loss in the setting. She did not know how to communicate with staff, although she very much wished to consult with someone. She had many questions, and all were left unsatisfied. She felt that she was not taken into participation in treatment at all, and was left with a helpless feeling.

Understanding of Illness

Mrs. X visited the psychiatrist in the community whom her husband had seen, and learned that she encourages her husband to "lean" on her "stronger nature". This came as a completely new concept to her, but she said that she could understand it and note how it operated in her relationship with her husband. However, she said she now felt very confused and very much wished for help in modifying her attitudes for her husband's sake.

Pressures

The strains felt by Mrs. X seemed to be caused by:

1. her inability to sort out the material and emotional problems of herself and her husband, and take steps to solve them. (Her employment could perhaps have been facilitated had there been someone to help her and her husband to look at the matter.)
2. her confusion about the illness and how she should modify her behavior to help her husband.
3. her lack of knowledge of "where to turn". Although Mr. X was on good terms with his probation officer, Mrs. X commented "his (probation officer's) job is not a psychiatric one." She said she felt definite need for psychiatric consultation.
4. her feelings about family relationships. She remarked that she did not know how long she could go on creating a positive atmosphere for her husband, because she found herself having little to give the children, and actually sometimes bursting out in her frustration at them, and she was becoming increasingly alarmed at her own reactions.

Assessment

This relative seemed to have a good potential for helping her husband but lacked guidance and support. It appeared that Mrs. X would be capable of providing an income but subordinated her desire to do so to the needs of her husband's condition. She was confused and hurt by the hospital's lack of attention to her, and was at a loss as to how she might proceed to find psychiatric help which she felt was desperately needed.

In this case, the worker felt that the relative showed need for emotional support as well as help regarding practical matters and help in obtaining information about the illness.

Case C "Mrs. Y."

Mr. Y is a 32 year old clerical worker who developed excessive fears about germs and about the danger of his bringing disease to his family. He was in hospital six weeks. The family consists of the patient, his wife, their school age son and their pre school age son.

Mrs. Y's attitude was casual and calm throughout the interview although toward the end of it she began to express her feelings about the illness with more spontaneity.

Education or Training

Mrs. Y did not respond to discussion in this area, feeling her husband was not in need of any form of training.

Employment

Mr. Y had returned to his former job which had been held for him. Mrs. Y commented that while her husband's employer had acted kindly in this regard, there was little reason why he should not, since her husband had been a steady worker for over ten years, never being absent a day. She thought her husband liked his job, and had established a place for himself with the other employees, with whom he engages in recreational sports. She appreciated the security the job offered, but did not think what it really meant to her husband in terms of satisfactions derived from it or advancement possible in it.

Housing

There was no question in this area, since the patient returned to his own home, a modern suburban bungalow.

Recreation

In this area, Mrs. Y stressed that they "just took up where they left off". She noted some improvement, however, in that her husband resumed an interest in sports which had lagged just prior to hospitalization. She noted, too, that friends remained loyal, some of them disclosing that they had also had experience with mental illness.

Hospitalization

The patient was referred by the family doctor to a psychiatrist in the community just before hospitalization. Although Mrs. Y at first seemed to cover her feeling of shock regarding hospitalization, she returned to the topic

toward the end of the interview, saying "it really was a blow, actually." At the time of hospitalization, Mrs. Y knew nothing about Crease Clinic, not even where it was. She felt her husband suffered shock at first, but later enjoyed the experience. Despite the inconvenience of buses[1], Mrs. Y visited her husband almost every day. She spoke to his psychiatrist in hospital several times, and was very pleased that her husband liked him a great deal whereas he had not been so comfortable with the community psychiatrist who recommended hospitalization. Mrs. Y felt that her opinion was not considered regarding discharge plans. She telephoned the psychiatrist to discuss whether the patient was quite ready for discharge, did not receive a satisfying reply, and then suddenly found the patient at home. Mrs. Y remarked that she had talked with the social worker two or three times, but had not been engaged in intensive casework.

Understanding of Illness

In this area of discussion Mrs. Y showed deeper interest. She showed a fairly good grasp of the general origins of mental illness, and in the worker's opinion, an intellectual capacity to come to grips with the specific terms of her husband's illness, if she could obtain more information. She said she desired information about the "rarity of the illness" and its implications. She read magazine articles eagerly in attempts to learn more about mental illness. She wondered why referral to Mental Health Centre had not been made rather than to Crease Clinic, feeling her husband was not ill enough to cease functioning in the community.

Pressures

Mrs. Y revealed that she is sometimes concerned over what might be the effect on her husband if he or the children developed physical illness, and she feels a little tense about things the children do, such as playing in the dirt, for fear they might upset her husband, whom, she suspects, still harbours some anxieties. She copes with these little things on her own, rather than tell her husband about them. When he talks over any of his feelings she has learned to respond without haste, but she finds it a strain trying to think what she should say.

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1 There are only two buses a day, at inconvenient times for visiting.

Assessment

This wife appeared to be a capable person who was consciously trying to help her husband. She tended to minimize the impact of illness, in her emphasis on "picking up where we left off", and there may be some tendency to withdraw from facing the implications of illness. Her real concern about the illness seems to underly this attitude, however, and given support, she appeared to have good potential for participating actively in treatment. She gave the impression of having been denied a full opportunity to participate. Her willingness to do so would seem apparent from her frequent visits to hospital and her several talks with the doctor. Despite her comment that they "just picked up where they left off", it seemed that she needed preparation for his homecoming, and more information and guidance about how to conduct herself and family matters for the sake of the patient. Hospitalization, itself, she admitted, had been a "shock" to her.

Case D. "Mrs. Z"

Mr. Z is a thirty year old labourer whose illness became apparent after family relationships became entangled. He was in hospital for a month, with a diagnosis of "Psychoneurotic Depressive Reaction." The family consists of the patient, his wife, and three children, one school age, two, pre school.

Mrs. Z spoke of her experiences and feelings openly.

Employment

The patient had returned to a former job, but wanted to leave it and start a business which he could operate from his own home. Mrs. Z concurred with him in this because he does not like living too far away from work to come home at noon for a hot meal. Mrs. Z could also help in the business, and as she appeared to the worker to be an extremely capable person it seems quite possible that her share of the work would be large. Mrs. Z spoke of herself as though she were a real part of a team concerning her husband's work and his future prospects in it.

Education or Training

Neither Mrs. nor Mr. Z had given any thought to this matter.

Housing

Mrs. Z's awareness of her part in her husband's illness was brought out in discussion of this section. The home is an old one, in need of repairs, and Mrs. Z ordinarily does all the carpentry tasks, but now understands her husband should be allowed to do some of these things, and so she refrains from doing them, although they are easy for her to do. She said she felt some tension living near the city and would like to return to their property in the interior of the province, where the countryside is more to her liking.

Recreation

Mrs. Z was concerned about her husband's lack of interest in specific forms of recreation. She has no form of entertainment by herself, and her husband will not go out anywhere. She had enjoyed sports before marriage, and missed these activities. She was concerned by his unwillingness to go out to make friends although he is disappointed that few friends visit, which he enjoys. This wife also wonders whether her husband should continue a friendship made in hospital.

Finances

Despite financial shortages during the hospital period, Mrs. Z expressed no concern in this regard. She was aware that social assistance would be available should illness recur.

Hospitalization

Mrs. Z felt hospitalization as a shock. Her husband had been seeing a psychiatrist in the community for a year, but she did not consider him to be ill. She visited regularly while patient was in hospital, and spoke once with the hospital psychiatrist, who prepared her for the patient's discharge. She felt the hospital period was not long enough and that it therefore did not have much effect on the patient's condition. She felt the doctors did not know enough about the "whole situation", by which she meant the social entanglements which seemed to have precipitated the illness[1].

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1 These "entanglements" were fully recorded on file, so that it seems the doctors were well aware of their significance. Little interpretation of a helpful nature seems to have been given - or perhaps to have reached - Mrs. Z. in this regard, however.

Understanding of Illness

Mrs. Z had found partial answers to her questions from magazines, friends, social workers and doctors. She felt she had a good understanding of the effect on the patient of her "mothering" him, but she felt sceptical about general information she had received pertaining to the origins of mental illness. Both she and Mr. Z had had a few interviews with social workers following hospitalization, but felt disinclined to continue them.

Pressures

Mrs. Z spoke about her attempts not to "mother" her husband, saying that she was beginning to feel a strain in "always watching myself". Apart from this, she felt able to take financial, employment, recreational and other problems "in her stride" despite their inescapable presence.

Assessment

Mrs. Z is one of the most unusually capable women to be met with in the writer's experience. Her refusal to consider her husband ill prior to hospitalization, and her scepticism regarding roots of illness may be a denial of the illness, or perhaps indicative of a failure to fully understand her own "mothering" role, because she appeared to be so self sufficient and genuinely capable that she would not need to be aware of her husband's inadequacies. Having to stop and look for them, and then adjust her behavior accordingly, seems to be some disturbance to her ordinary routine of life. She undertakes to modify her behavior, however, with good will, and with her usual capability. She was not unresponsive to interest taken in her, and encouragement given her, and the interviewer felt, from Mrs. Z's excursion into the personal matters of the "social intanglement", that there were matters she would like to discuss which she had perhaps been coping with herself in her own self sufficient way. This woman would require much deeper diagnostic evaluation to assess her basic needs, yet it was felt that her potential for taking a meaningful part in her husband's treatment would be enhanced by an agent providing support and interest in her.

Summary of General Observations Made by Worker In Interviewing Wives

This summary draws together the main impressions

gained from the interviews with wives, which are to be analyzed after all the cases are presented. Since the impressions gained from the two groups of interviews are somewhat different, it seems helpful to summarize them for each group before examining the factors operative in the families' experience.

It is interesting to note that the wives in personality were not unlike the mothers. They seemed to be capable and confident women, although unmet dependency needs, such as in case A., where the young wife had had too rapid adjustments to make and had apparently lacked the emotional support usually received from husbands during these times, could be detected, especially when the interview became a little deeper than the research focus of this paper strictly permitted. While the wives did not express any wish to dominate, it seemed that their natural capacities might make them seem the dominant figures in their families. Since similar impressions were gained from the mothers, it seems possible that the wives had been placed by their husbands in the dual role of wife and mother, with resulting confusion for both patient and wife. The stress occassioned by this role confusion will be discussed later, in the analysis of all the interviews. In the interviews, the wives indicated that they had gained some understanding of the matter, but wished to receive more help and guidance in handling it.

It seemed that to the wives, the illness and the post hospital experience created a group of completely new

feelings which had been foreign to them earlier. These arose from their realization of their husbands' illnesses and the sense they had that they could contribute to the recuperation process. They became aware of themselves in the situation and developed feelings of anxiety and tension around their handling of themselves. They kept these feelings hidden from their husbands, however, fearful of disturbing him, and perhaps causing recurrence of the illness. These wives seemed to appreciate, and, indeed, almost to ask for support, encouragement, and guidance in involving themselves in a struggle to help the patient win his battle against mental illness.

The fact of hospitalization was of great significance to the wives, who had not realized the full extent of the illnesses previously. The greatest difficulty for them in the post hospital period seemed to be not so much in the variety of material problems facing them as in the need to evaluate the implications of the illness and to modify their own conduct for the welfare of the patient. Feelings of tension and strain were general in this regard.

This group of wives all made conscious efforts to be helpful to their husbands, and it is to be noted that only one of the husbands was unemployed.

Mothers

Case 1. "Mrs. P"

The patient in this family was a twenty-three year old girl who was hospitalized for two and a half months for treatment of simple type chronic schizophrenia. The family is composed of the mother, the patient, her sister and her two brothers.

Mrs. P was a little resistant when the writer telephoned to make an appointment, and seemed to indicate her mixed feelings toward the patient when she burst out rather truculently "well she hasn't got any work yet" but then added, as if feeling guilty for complaining, "but she's trying." In the interview Mrs. P was not at all resistant, and gave information freely. Her basic frustration and her attitudes of over-protectiveness and hostility toward the patient could be detected by the worker in her pattern of comments which resembled the one outlined in the telephone conversation.

Education or Training

Mrs. P said she would like her daughter to have a hairdressing course, and the patient herself would like to have a practical nursing course, but Mrs. P disparaged the patient's ability to complete any course, saying she was not strong enough, or clever enough, and never finished anything she started.

Employment

Mrs. P thought that the patient would feel better if she could contribute to household expenses. As Mrs. P had earlier complained about not being able to paint the kitchen because of the patient's medical expenses, it is worker's opinion that Mrs. P also would have felt better if the patient were contributing. Mrs. P was pessimistic about the patient's chances of getting work.

Finances

The family depended on a DVA pension and the children's earnings, and they had always had difficulty in making ends meet. The patient contributed nothing, and despite Mrs. P's affirmation that it wasn't necessary, that the others could take care of the patient, it seemed to worker that the subject was heavily laden with emotional overtones for all members of the family.

Housing

The family had adjusted well to the absence of the patient from home during hospitalization. The older son had made his own breakfast and had done the shopping. He and the daughter had helped with the housework. Upon the patient's return "both are gradually slipping into their old ways" while the patient resumes these tasks.

Recreation

Mrs. P expressed no interest in her daughter's recreation outside the home and did not encourage the patient to bring friends home. She did show interest in the patient's hobbies which could be persued within the home, such as embroidery.

Hospitalization

It was a shock to Mrs. P when the patient telephoned home one day to announce that she was in Crease Clinic. The family adjusted well, however, to her absence. Mrs. P enjoyed visiting the hospital because she likes sick people. She spoke with the doctor and the social worker, but did not receive specific preparation for the patient's homecoming. On the patient's return home, Mrs. P noticed the change her presence made in their budget.

Understanding of Illness

Mrs. P denied that her daughter suffered mental illness, and insisted that it was "only an emotional disturbance". She felt the patient had learned to talk more freely through her hospital experience, and now spoke to the family, surprising them by revelations about how she feels about things. Mrs. P felt the other children did not accept this very well, and said she herself did not know how to respond to her daughter, and wondered if her former handling had been remiss, although she could not believe that it had been so.

Assessment

The impact of the hospital period was to let the family discover that they could manage nicely without patient. They did not face up to the fact of illness, and their participation in treatment seemed mininial, as they could not meet the patient's new efforts at changing

relationships. The financial situation was perhaps a factor increasing the family's negative attitudes since they seemed to be covering up impatience at her inability to contribute. The patient was being sustained by the social worker, but the family had not yet been reached.

This relative seemed to experience frustration due to the patient's finances, and showed some hostility in resisting the idea that changes were necessary in family attitudes toward the patient. Overprotectiveness in the areas of employment and training seemed to spring from basic feelings of hostility.

Case 2. "Mrs. T"

The patient, a 27 year old university student suffering a schizophrenic reaction, was hospitalized for four months. The family consisted of the patient, his widowed mother, and a married sister (not at home).

Mrs. T was reluctant to participate in research because she wanted to "forget all about" her experiences, but decided in favor of the interview for the sake of helping future patients, and gave material quite frankly.

Education or Training

Mrs. T expressed lack of confidence in her son's ability to continue his studies, feeling he had not progressed far enough in his treatment.

Employment

Mrs. T seemed to withdraw from this subject, having doubts as to the patient's readiness, and the general availability of summer work.

Housing

There was an air of distress about Mrs. T as she discussed patient's presence in her home, because she said his evidences of remaining illness made her uneasy. It was felt by worker that she projected her own real wishes in saying "He would probably prefer to live elsewhere", if his finances permitted.

Recreation

Mrs. T was grateful to the patient's friends for

their continuing kindly attitudes, but apart from acquiesing when he invited someone in to dinner, she did not participate with him in any form of recreation.

Finances

There was no financial strain in this family due to lack of funds, but Mrs. T suffered acutely when creditors telephoned regarding debts the patient had accrued during the onset of illness. This was felt as a blow to family standing in the community.

Hospitalization

This mother was in favor of hospitalization and urged it on the patient, feeling it was the only solution to his long standing problems. She visited seldom. She took the part of the hospital on an occasion when the patient went "AWOL" one day, and she discussed with him his need to accept hospital rules. She was disappointed when he was discharged, feeling he needed a longer period of hospitalization for complete treatment. She told very few people about his illness, and was surprised to learn that the one neighbour in whom she confided had had experience with mentally ill relatives.

Understanding of Illness

Comprehension of the nature of the illness was limited. She sought answers to her questions from doctor and social worker, but rejected some of their interpretations. She continued to believe that the patient should be able to use his superior intelligence to "think his way" out of the illness.

Assessment

Hospitalization was viewed as the final possibility of "cure" for the patient, and was welcomed probably because it removed the "cause" of strain from the home. It also represented a blow to family prestige, and not many acquaintances were told of it. The post hospital period, despite some preparation from the social worker, seemed to mean only a renewal of tension for Mrs. T., who seemed to withdraw from involvement in continuing treatment. Family status seemed to be a significant factor here, forming a component of the relative's feeling of comfort, which suffered from the patient's illness and his presence in the home.

Case 3. "Mrs. E"

The patient in this family is a 31 year old man who suffers from a "habit spasm of the choreoathetoid type", and who entered Crease Clinic for help with emotional problems, staying for nine weeks. Diagnosis was "Psychoneurotic Conversion Reaction". The family consists of the patient, his widowed mother, married brothers and sisters away from home, and the daughter of one of these, being cared for by the patient's mother.

Mrs. E readily assented to an interview from which it was impossible to exclude the patient. It was of interest to observe the interaction between the mother and son.

Education or Training

Mrs. E blamed the hospital for not providing a program of training for the patient.

Employment

Mrs. E disparaged the patient's chances of getting a job but wished he could find work "with his hands" feeling that it would "cure" him. She would not have him help her in her small business in which there was such work, however.

Housing

There were no plans for the patient other than to live at home, but Mrs. E confided (during an absence of the patient from the interview) that she had problems when her daughter, currently receiving treatment in a mental hospital, was home, because the two (son and daughter) "get on each other's nerves". The house was very small and it could be observed in the interview that tension rose whenever the patient came in, partly because there was little space for him to move about in or find privacy in.

Finances

This relative had struggled with financial problems since the husband's death many years earlier and because of advancing age, found more difficult to carry her responsibilities without feeling "edgy".

Recreation

Concern was expressed by Mrs. E in discussing the recreational pursuits of the patient, which consisted of

quite daring sports. It was observed by the worker in this "joint interview" that the patient resented his mother's attitude.

Hospitalization

Hospitalization did not distress Mrs. E and she was happy in the hospital setting, where she was able to get along well with the other patients. She discussed the patient's illness with one of his doctors and felt her ideas were given a fair hearing, but were not implemented (eg - training program for the patient)

Understanding of Illness

Mrs. E was unable to communicate any understanding of her son's condition. She confided that the patient "gets on my nerves sometimes", but she apparently made no effort to understand the relationship between herself and the patient.

Assessment

Hospitalization seemed a pleasant interlude for this overworked mother, and the post hospital period a wearisome picking up again of her whole burden.

Mrs. E showed little understanding of the emotional complications of her son's physical condition and apparently continued in her life-long relationship with him, of providing for his needs. There seemed to be a new element following hospitalization in that the "holiday" for her had been pleasant and returning to the old problems and tensions seemed harder because of her age and increasing family and business probelms.

Case 4. "Mrs. G"

The patient is a sixteen year old girl who experienced a schizophrenic reaction ("Chronic Undifferentiated Type") and was hospitalized for almost four months. The family was composed of patient, mother, and father.

Mrs. G displayed a great deal of hostility in this interview, but it was felt, after the hostility had been handled by the worker to some degree, that there was, beneath

it, a long standing wish for help and a fear of rejection if it were revealed (see appendix B). Otherwise it would be difficult to understand why Mrs. G had eventually agreed to the interview, because she had angrily attacked the method of research. Information was not given directly, and there were many areas this mother refused to discuss, but from her comments on other subjects, her general attitudes could be discerned, although her specific problems could not.

Education or Training

Mrs. G also blamed the hospital for providing no plan of training for the patient.

Employment

Mrs. G was angry with the hospital for not following her daughter's problems into the community and thus helping her find work.

Recreation

The worker felt that Mrs. G tended to keep the patient away from groups, in that she said she arranged outings and "projects" for the two of them.

Hospitalization

This mother visited regularly but found no satisfaction in talking with treatment personnel. She criticized the "isolation" of the hospital, feeling that it could not expect to be effective if it did not keep in touch with the community aspects of mental illness.

Understanding of Illness

It could not be observed that this mother had any understanding of the nature of the patient's illness and she would say no more than that the hospital staff had not given her any helpful information.

Assessment

This mother was described in the file as having paranoic tendencies, and it is difficult to assess the validity of some of her statements, such as that the psychiatrist would not listen to her. Nevertheless, it was felt that she needed and wanted help. She burst out at the end of the interview - "This may have helped some people -- but where does it leave me? I've still got all my problems". It seemed to the interviewer that there were obvious social problems in this situation for which referral to social service was indicated, and that some of her anger was justified. The period of hospitalization was perhaps a period

in which this mother tried, in her warped way, to call for help, and being unheard, she was left embittered in the post hospital period, feeling it to be a continuation of the hospital's "neglect". Her participation in this period was more participation in illness than in treatment. Her own deprived life, plus the practical problems she encountered and her failure to evoke a response in anyone to herself as a worthwhile person, seemed to have combined to make her involvement after the hospital period perhaps even more of a negative one than before.

Case 5. "Mrs. J."

The patient was a twenty year old university student who suffered a "Psychonuerotic Depressive Reaction" and was hospitalized for three weeks. The family consisted of the patient and his mother and father.

Mrs. J proved to be an exceptional mother, with responses more like those of the wives than those of the mothers in this study. She had entered fully into treatment, and she found the research interview an opportunity to test her thinking.

Education or Training

Mrs. J wished to maintain a helpful and positive attitude to her son's return to University. She cared not so much that he pass his year, as that he find satisfaction in his studies and activities.

Employment

Despite the parents' tendency (which they now understood) to protect and indulge the patient, the mother had come to realize that the patient needed to develop his independence, and therefore she hoped he would find work for the summer.

Housing

The parents had discussed with the hospital psychiatrist the advisability of the patient's returning to their home. Although the psychiatrist was of the opinion that the patient needed to establish an independent life, it was decided to let him move at his own pace. The patient therefore returned home, but after a short time decided on his own to move closer to his studies. The parents curbed their impulses to encourage him to stay home, and, instead, bent their energies to making the experience a happy one. The resulting relationship has been pleasant as the patient feels free to come home when he wishes but is learning to live independently.

Finances

Again, the patient's need to grow toward independence was recognized, and the parents thus restrained their protective attitudes in the area of finances, letting the patient experiment for himself in the use of limited funds.

Recreation

This mother, like the wives, was concerned about the poor influence of certain friends, and wondered what to do about it. Mrs. J participated with her son in fairly frequent outings.

Hospitalization and Understanding of Illness

Both parents saw the hospital period, although it was a difficult event for them to accept at first, as an opportunity for them to engage themselves in treatment. They visited the psychiatrist regularly but not the patient, who did not wish visits. They thought through all the psychiatrist's interpretations, and Mrs. J did not become too threatened by them, but saw her husband's discomfort, and found it difficult to help him and the son at the same time.

At the hospital, Mrs. J. was dismayed by the grouping of apparently severely ill patients with less ill ones, and she found disagreement in the opinions of the hospital psychiatrist and their community psychiatrist confusing. She felt that the patient should have been better prepared to meet negative community attitudes to mental illness upon his discharge.

Assessment

Hospitalization represented an extension of the community psychiatrist's services, and a resource for their deeper involvement in treatment for these parents. The mother proved most able to adapt her thinking to the treatment orientation, while the father found some ideas a little disturbing. The post hospital period was seen as a continuation of treatment, and Mrs. J felt her responsibility to continue testing her own attitudes against the psychiatrist's thinking and to change them accordingly. She and Mr. J, who was interviewed on request following Mrs. J's interview, both expressed a need for support and reassurance as they engaged in the new experience of helping their son through a difficult period.

Because of Mrs. J's different involvement from that of the other mothers, it is interesting to speculate on the reasons for her more positive attitudes. Several

factors seem note-worthy. First, the mother had reached an unusually high level of education and was more than usually intelligent. Second, she was attractive and fairly young, keeping her age well. Third, her age was considerably less than her husband's (Mr. J. was also a highly educated person). It seemed possible that the relationship between mother and son reflected unresolved oedipal wishes which the mother unconsciously encouraged since she had formerly found some satisfaction in social activities with her son. (She now felt he might find it embarrassing to be seen with his mother, and was thinking through this aspect of the relationship).

Also of importance is the fact that in the family there were no problems of housing, employment, finances, etc., to distract their energies from concentration upon the treatment of the patient.

Summary of General Observations Made by Worker in Interviewing Mothers

As in the case of the group of wives, the main impressions from interviews with the group of mothers are drawn together before viewing them analytically. With the exception of case number 5, the mothers seemed to differ greatly from the wives in that they did not seem to have developed awareness of the part they played in the illness or could play in the rehabilitation period. They lacked enthusiasm for entering into the treatment of the patient, and their attitudes towards the patients were mainly of hostility, overprotection (stemming from guilt), and withdrawal. Pessimism imbued most of their responses with negative tone. The mothers seemed to be more concerned with practical problems, and with their own feelings of frustration and deprivation than were the wives, whose concern in relation to their own feelings was focussed around adjusting their attitudes for the patient's welfare.

The mothers, with the exception of case number 5, referred in the interviews to areas of deprivation[1], such as loss of parents, or husbands, or financial difficulties, they had suffered in their earlier lives, and found continuing episodes of deprivation, however small, painful. For example, in case number 1, the mother was frustrated in being unable to paint the kitchen and seemed to feel this a painful deprivation. In case number 2, the blow to status was painful when creditors telephoned for the patient. These kinds of problems seem to further deplete the mothers' low reserves of strength and warmth and leave them less able to create a positive atmosphere for the patient.

Discussion

In these case illustrations, the objective reality of the "beta situation" for the patients, as it involves certain relatives, is observable. The wives were consciously (and conscientiously) presenting to the patients an appearance of faith and encouragement. Most of the mothers, on the other hand, could not conceal hostility, frustration, overprotectiveness, or withdrawal in their feelings toward the patient. To such realities in the objective environment must be added the patient's subjective perceptions of them to complete the beta situation, but from the performance of

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1 This was not included in the interview presentation, since it was not a standard area for discussion, but came up spontaneously in some interviews. This may be another area for research to which the interview method might be adapted. It would be of interest to know, for example, if and how the mothers of schizophrenic patients had experienced deprivation.

the patients in the community, as reported by the relatives interviewed, it would seem that the objective factors are not too disparate from the patient's subjective perception of them.

To briefly illustrate some of the "objective realities" viewed in the relatives, the matter of employment, since it offers the most obvious area in which to see performance, is reviewed for each case:

Case A: - encouraging attitudes in the wife, together with anxiety which was being concealed from the patient.

Case B: - anxiety present, but the wife made an effort to quell her feelings and be encouraging to the patient in his attempts to find work.

Case C: - neutrality of affect seemed the keynote in relation to the patient's employment, although the wife's appreciation of the security it offered perhaps was felt positively by the patient.

Case D: - encouragement and actual help came from this capable wife in connection with the patient's employment plans.

Case 1: - frustration because the patient could not contribute to household expenses was noted, together with pessimistic attitudes towards the chances of the patient's obtaining work or keeping it.

Case 2: - pessimism again noted, in the mother's doubt that the patient could perform in work, or get a job.

Case 3: - discouragement, rejection, and frustration were discerned in that the mother did not think the patient could find a job, would not let him work with her, and yet wished he had work to "cure" him and to provide income.

Case 4: - hostility projected onto the hospital by the mother may have been felt by the patient as inhibiting

Case 5: - the attitude discovered in this mother was positive, being hopeful of the patient's chances of getting work, and supportive of his efforts.

The case illustrations also bring into focus the fact that the objective situation is influenced by elements inherent in the total situation which may be viewed as "stressful". The purpose of this study is to develop better understanding of the stresses which cause relatives to behave in certain ways toward the patient, and as all of the relatives interviewed gave evidence of experiencing "stress", it is this element which is indicated for examination.

"Stress" is a concept recently adapted to the biological and social sciences. Dr. Hans Selye's theories of stress as it applies to the human body have led to similar developments in the thinking about human behavior. Jessie Bernard[1] has studied the phenomenon of stress in our present day society as it is manifested in the performance of human beings and her formulation is useful for the present study. She defines a stress situation as one involving threat, and divides it into three parts:

> "(1) the stress factor, which threatens,
> (2) the value which is being threatened
> (3) the reactions ... to the threat." [2]

Although stress may arise within one's own body, or from nature, or from the social system, it is the latter only with which this study is concerned. Bernard states that

> "a certain amount of threat is implicit in the very process of socialization, 'by which the individual as a biological creature with limited endowments is forced into roles assigned to him by society and pressed into the mold of

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1 Bernard, Jessie, Social Problems at Midcentury, The Dryden Press, New York, 1957

2 Ibid, page 70

STRESSES IN HOSPITAL PERIOD

Threat Value:	Facing Mental Illness Homeostosis of Family	Kind of Hospital Prestige	Physical Factors Freedom, Dignity	Isolation from treatment group participation, confidence in role performance.
Case A	X	X	X	X
Case B	X			X
Case C	X	X		X
Case D	X			
Case 1	X			
Case 2	X			
Case 3				
Case 4				X
Case 5	X		X	

CHART 1

> its culture.' As a result of the 'inevitable press of standardized socialization techniques' there is always a certain amount of so-called 'free floating' anxiety in most populations."[1]

This study, then, disregards all threat factors except those operating in the context of society.

Bernard notes that "change" is a threat to stability and security, and is felt in role relationships and in status. The case illustrations corroborate this idea. Bernard also postulates a difference between "objective probability" and "subjective probability" in stress, and this can also be demonstrated in the cases studied. Stress reactions of anxiety, hostility, apathy, etc., are also observable.

To view the experiences of the relatives studied in this context, the following analysis is divided into examinations of the threat factors, the value threatened, the influence of the subjective probability of threat, Role Relationships, and Stress Reactions. It should be noted, however, that, as Bernard states;

> "This break down is purely for analytical purposes; in real life, stress situations occur as unitary wholes, not as separate elements."[2]

Threat Factors and Values

It is felt by this writer that threat factors and values are so closely intertwined that a distinct separation of them interferes with the meaningful comprehension of the

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1 Bernard, ibid, pages 71-72

2 Ibid, page 70

stress situation, and so they are here examined together, rather than in separate sections.

In examination of the case illustrations, the stress situation for the relative is divided for study purposes into the hospital period and the post hospital period.

In the hospital period, a number of threat factors are observable, with accompanying values being threatened. As an overall threat, there exists the fear of change, which endangers the security - or the "homeostasis" - of the family group. The fear of mental illness, and facing up to the fact that it can affect one's own family, are components of this threat. Once the relative has adjusted to this threat, there are threats within the changed situation: the threat of the kind of hospital to which the patient is sent - a threat to the value of prestige, or status; the threat of physical factors in the hospital which affect values of freedom and dignity;[1] the threat of being isolated from the treatment process, endangering the values associated with participation and belonging to a group, and also the value of confidence in one's role performance.

From chart 1, it can be seen that seven of the relatives were threatened by the necessity of facing mental illness as it was represented by hospitalization at Crease Clinic. Only cases 3 and 4 seemed immune to this threat,

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1 Values may relate "to one's self, to one's loved ones, or to one's group, or to all three" according to Bernard, ibid, page 75.

possibly because of the long standing nature of the illness. Two relatives, in cases A and C, suffered threats to prestige or status in the kind of hospital necessary for the patient. The relatives in cases A and 5 were "distressed" by the locked doors and non-segreation diagnostically of the patients, which threatened values of dignity and freedom. Four relatives, in cases A,B,C, and 4 were threatened by being left out of the treatment program, a danger to their values of belonging to the group and of role confidence.

The threats or stress factors noted in the chart may be illustrated by reference to some case examples.

Case A

Facing up to the illness was a stress factor, or threat, for Mrs. W because she had considered her husband's visits to the community psychiatrist sufficient treatment for a condition she did not regard as serious mental illness. Facing the reality of illness signified for her a severe set back to the security or "homeostasis" of the family, because this was in the process of developing, and she had had to adjust to several new forms of family in a short period and had not established a feeling of a secure establishment which could withstand shocks. Despite Mrs. W's protestation, it was felt that she had a "hidden" value of prestige and status, which was threatened by hospitalization at Crease Clinic because she had previously thought only in terms of hospitalization at the General Hospital. Her values of freedom and dignity were threatened by the locked doors of the hospital

PRACTICAL PROBLEMS - POST HOSPITAL PERIOD STRESSES

	Education or Training		Employment		Housing		Finances		Recreation	
	Threat to Opportunity	Threat to self image as worthwhile individual	Threat to security	Threat to health	Threat to privacy	Threat to peace	Threat to independence	Threat to Status	Threat to pleasure	Threat to health
Case A			X	X	X					X
Case B	X	X		X	X		X			X
Case C										
Case D				X			X		X	X
Case 1			X			X		X		
Case 2						X		X		
Case 3	X			X		X		X		
Case 4	X									
Case 5		X		X			X			X

CHART 2

and the association of severely ill patients with less ill ones, the latter group, she felt, including her husband. A feeling of isolation was stressful to Mrs. W regarding her lack of communication with treatment staff as indicated in her comment "nobody asked me", a fairly obvious blow, not only to one's sense of belonging to a group, but also to one's confidence in the significance of one's role.

Case B

In this situation the threat factor of being left out of treatment predominates, complicated by the general feeling of isolation suffered by Mrs. X in "not knowing where to turn" for help with psychiatric, and also with social problems.

Case C

Facing the illness was a threat which Mrs. Y attempted to avoid. Prestige may have been threatened as she wondered why Mental Health Centre had not been recommended in preference to Crease Clinic. This also may have been part of her avoidance of facing the stress factor of mental illness.

Case 1

Facing up to mental illness threatened the personal security of Mrs. P, who did not wish to admit that her earlier handling of the patient had been remiss.

Case 4

Mrs. G's references to the "isolation" of the hospital led the worker to think she was objecting to her

experience with treatment staff, which she perceived as neglect or perhaps rejection. She seemed to be extremely threatened by lack of inclusion in treatment and by lack of attention to her role.

From the foregoing case illustrations it appears that the group of wives was more susceptible to the threats inherent in hospitalization than were the mothers, on the whole.

In the post hospital period, the threats or stress factors are of a different nature, and the values threatened seem more complex. They exist in two areas, that of practical problems, and that of role relationship. Chart 2 divides the practical areas discussed in the interview into the two values which seemed most threatened. Thus, the problems brought by the relatives under the topic "Education or Training" relate to values of opportunity, which often hampered by lack of education or training, and of the self image as having worth because feelings of inadequacy often arise from lack of education. Threats in employment endanger family security, and the patient's health due to lack of achievement or satisfaction in work. Housing entails threats to privacy for the patient, or threats to peace and comfort felt by the relative. In finances, threat to independence indicates that the family would have to become dependent upon a public agency if funds were depleted, and threat to status indicates that money is regarded as one of the marks of standing in community, and of maintaining or advancing to social levels. In the

area of recreation, the threat was to the pleasure of the relative, or to the health of the patient. In these dichotomies, it may be noted that the threats are of two kinds, one, threats to one's self, and the other, threats to the patient as felt by the relative. The reason for the dichotomy is that wives tended to experience stress in terms of values centered on the patient, while mothers were primarily concerned with personal values.

Stresses Felt in Relation to Practical Problems

In the area of education or training, only four relatives felt stress. In case B, the wife felt her husband's opportunities were hindered by his lack of training, and she felt this barrier as a threat which she would like removed. She also suffered stress because his lack of training made him feel inadequate. The mother in case 3 blamed the hospital for not permitting the patient to increase his opportunities through training, but this threat was probably a side effect of the general stress in regard to all practical matters with him because they combined to threaten her security and comfort. The same applies in case 4. The mother in case 5 reacted only to the possible threat to her son's health if education failed to increase his sense of adequacy, thus improving his self image.

Employment implies values for six of the relatives. In case A the threat to security is less than the threat to health, because the family has resources, and the patient

would have little difficulty in finding work in his profession, but if he failed to make a success of his private business venture, his wife feared his health would suffer. In case B, the patient was unemployed, and despite the actual danger to their security, the wife did not feel it as such owing to the fact that she felt herself capable of finding work and providing an income if the worst happened.[1] She feared that without work, however, her husband would suffer acute loss of self esteem, adversely affecting his mental health. In case D, the wife was concerned for her husband's health if he did not establish a business he could conduct at home. She disguised her concern in a physical garb, saying he liked to be at home to have a hot lunch, but it seems likely that she was actually concerned for her husband's sense of adequacy on his present job and feared for his emotional well being if it declined. The mother in case 1 disguised her concern with family security under the pretext that the patient would feel better if she were working and could contribute to family expenses, but it was not felt that this was a true concern with health, but a stress arising from income problems, especially as a change for the worse in the family budget had been noticed since the patient's return home. In case 3, the mother saw employment as a path to health. Lack

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1 See section on "subjective probabilities",

of employment thus threatened the possibility of the patient's being "cured". The exceptional mother in case 5 feared for her son's developing independence if he failed in summer employment, and thus experienced the problem as a threat to his health.

Five relatives experienced stress in regard to housing. In case A, family privacy was highly valued in order to allow the patient to "putter", which he could not do in a building owned by someone else. In case B each member of the family lacked privacy in the tiny apartment. In cases 1, 2, and 3, the mothers revealed that the presence of the patient was a threat to their personal comfort, as tension arose when the patient was at home.

Financial problems had stressful meaning for five families. In cases B and D the wives recognized that cessation of income meant dependence on social assistance, robbing them of independence. The mothers in cases 1, 2, and 3 were sensitive regarding threats to status. In case 1, status consisted of the family's attempts to improve the status of the home by improving its physical appearance; in case 2, status meant standing in the community which the mother felt was lowered when tradespeople made efforts to collect payments on the patient's debts; in case 3 status combined the meanings of case 1 and 2, since lack of income from the patient reduced possibilities of improving the home, and the mother would not let the patient earn money in her own business because her standing, she felt, would suffer from his presence.

ROLE RELATIONSHIPS - STRESS IN POST HOSPITAL PERIOD

Factor Threat	Lack of Knowledge About Illness Threat to role performance	Maintaining Self Awareness and Adapting Threat to Self Image and comfort	Interaction with Patient Threat to comfort
Case A		X	
Case B	X	X	
Case C	X		
Case D		X	
Case 1			X
Case 2			X
Case 3			X
Case 4			X
Case 5		X	

CHART 3

In only one family did recreation offer a serious threat. In case D, the wife was unable to pursue recreations by herself, such as sports, which she had previously liked. This did not concern her as much as the threat to her husband's health of his inability to gather friends. In cases A, B, and 5, there was some threat felt in regard to the patient's health. In all of these three cases, the relative feared that certain friendships threatened the patient's health.

Role Relationships

> ".... Any of the countless social relationships that ebb and flow around the individual can at times upset his personal equilibrium and intensify stress."[1]

In this study, it appears that social relationships form the most serious varieties of stress. The "individual ... is forced into roles assigned to him by society ..." and threats to the performance of the roles may create great anxiety. In all of the interviews, the impression was gained that practical problems were stressful, but less so than the problems of relationship.

A difference in relationship structures was noticeable between the two groups, wives and mothers, and it was noted that there seemed to be a liklihood that the husbands had placed the wives in dual roles of wife and mother, and confusion, which arises under such circumstances, is a stress

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1 Bernard, ibid, page 73

causing anxiety for human beings. It is akin to fear of the unknown, and is complicated by the variety of possibilities for choice, so that the individual is immobilized and cannot select one course of action because of being confronted with so many avenues at once. There is stress then, inherent in some role relationships where confusion reigns. In this study other threat factors were discerned within the role relationships. Chart 3 divides the role relationship first into "Lack of knowledge about illness", which is a threat in that it endangers the adequate performance of a role. It may also add to confusion, in itself a stress factor[1] since the lack of knowledge about the illness hinders the relative from knowing what kind of a role is expected of her. The next division in Chart 3 is "Maintaining self awareness and adapting". Change of any sort is a threat, and changing one's self is perhaps the most anxiety provoking. It is also a threat to comfort, since alertness is always required. The relatives who exercised positive attitudes all had a need for a stress reducing relationship, in which they need not fear that their unguarded reactions might threaten the health of the patient. The final division in Chart 3 is entitled "Interaction with patient" and refers to the situations in which knowledge was not felt as a need, and self awareness was not present, but the quality of the relationship with the patient produced tension which threatened the personal

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1 Bernard, ibid, page 73

comfort of the relative.

In case A, the young wife found the necessity for continual self awareness more than usually threatening not only to her comfort but also to her self image and her role concept, because she had had to adjust rapidly to a series of new roles: wife, mother, "psychiatric nurse". In case B the wife was threatened by lack of knowledge about mental illness and desired psychiatric consultation to help her learn how to perform for her husband's sake. She also found the necessity to watch her responses to the patient threatening because it drained her energy for fulfilling her role as mother. In case C the wife's insufficient knowledge about mental illness seemed especially threatening. She displayed an eagerness for information which belied her casual approach to the interview. She turned to every source available for answers to her questions about "the rarity of the disease" but found inadequate answers. In case D the necessity to maintain self awareness and adapt her actions to the needs of the patient was stressful because it was alien to her nature, although she was unusually capable of doing it.

In cases 1, 2, 3, and 4, the mothers experienced the patient's return home as repeating the situations which created interpersonal tension. The "exceptional" mother in case 5 needed support for her comfort diminishing efforts to consciously avoid enhancing the patient's propensity for illness.

Subjective and Objective Probabilities for Stress

Bernard points out that there is a difference between actuarial, or objective, probabilities of threat, and subjective probabilities for threat.

> "Some people, for example, have much higher subjective probabilities for threat than do others. If the actuarial probability of contracting some germ disease is, let us say, one in five, their subjective probability is one in three, or one in two, or even, in extreme cases, one in one. If they hear of a single case of the disease in the community they behave and make decisions as though they were going to contract it..... These people are under much greater stress than others living under actuarially identical probabilities of threat."[1]

In the case illustrations, some of the relatives had higher or lower subjective probabilities for threat than others in certain areas. For instance, in case B the subjective probability for threat to security arising from her husband's inemployment was lower for the wife than it might have been for the wife in case A, owing to the fact that she felt capable of earning an income on her own if necessary. The same applies to case D. In case A the higher subjective probability of threat was indicated in the wife's remark that she would "panic" if another bout of illness disrupted their life.

It seems probable that the subjective probability for threat to status was higher in the mother in case 2, for whom telephone calls from creditors were stressful, than in all the other cases, which would probably have varying degrees

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1 Bernard, ibid, page 75

of subjective probability on this score. The indication here is that a device for measuring these subjective probabilities for threat is needed and further research may prove enlightening in this area. The subjective probabilities in the area of role relationships requires research in its own right, as this would seem to be an element in the objective component of the "beta situation" with which social workers might deal, and prediction of the differential amounts of stress relatives might expect to feel would be helpful.

Stress Reactions

From this study it may be observed that the stress reactions of wives and mothers differ. The wives become anxious in relation to the threats they felt to their ability to continue showing positive, encouraging attitudes to their husbands. The mothers reacted by feeling frustrated or hostile, or by withdrawing from the situation. These reactions to stress form an objective reality in the components of the patient's "beta situation.", and the reactions themselves perhaps increase anxiety for the relative who may feel somehow at odds with society generally for being unable to cope with the situation. This anxiety produced by stress in the relative calls for attention from those whose calling it is to treat mental illness in patients, because of its effect upon those patients.

CHAPTER IV TOWARD TREATMENT IN THE COMMUNITY

In this study, the operation of stress factors upon relatives is indicated despite the limitations of the small sample. Differences in stress for the two groups, wives and mothers, are observable, but the effect of the social work variable could not be measured.

The size of the study does not allow conclusive generalizations from it, such as might be used to make recommendations regarding legislation, but it does permit speculation on areas where further study seems indicated. The small sample is a microcosm of the broader group, and is representative of the larger whole as is a sample of cloth taken from a large bolt of stuff. From this study the implications must be viewed in relation to the limited sample, but as they form a fairly distinct pattern, they may be applied to testing in larger areas.

In summary, the stress factors examined seem to arise in two areas. The first cluster of stress factors for the relative occurs with the event of hospitalization of the patient, and the second, with the discharge of the patient into the community. Stresses occuring in the hospital period are concerned with facing the fact of mental illness, which may threaten family solidarity, security, or prestige; with features of the hospital itself which threaten the relative's concepts of freedom and dignity for the patient; and with lack of involvement in the treatment program which "isolates"

the relative, again threatening the solidarity of the family. Stresses in the post hospital period concern practical problems and role relationships, the latter being found to be the most forceful stresses upon the relatives interviewed for this study.

Differences in the group of relatives appears immediately in the way they are affected by the stress of hospitalization. To the wives, hospitalization seemed a sudden and serious proclamation of mental illness in her own family. To the mothers, the absence of the patient in hospital seems to allow a respite from the strain imposed by the illness of the patient when in the home. There is a third division in which the relatives see the hospital, after recovering from the initial shock of facing the fact of illness, as a logical step in treatment, and use it as such. In this study, the mother in case number 5 occupied this division, and it was felt that the wife in case B would also have done so, had she received guidance and help. Facing illness appears to be a major stress in hospitalization and wives seem to need support in accepting it, while mothers need help to take stock of the situation and their long standing avoidance of the subject. The third group also need help of a sustaining and encouraging nature while they work through the treatment implications.

Some of the stresses of the hospital period seem

influential in creating the atmosphere in the home when the patient is discharged. For instance, the relative may feel inadequate to cope with the patient because no one discussed the nature of the illness with her. It would seem that several measures might reduce the major stress of "isolation" during the hospital period and thus create a more positive threshold for the rehabilitative phase of treatment:

1. Drawing the relative into participation with the treatment team in helping the patient.

2. Giving information about mental illness in general and the patient's illness in specific, with help around the relative's involvement in it.

3. Preparing the relative for the patient's discharge and the problems likely to occur in the post hospital period.

In the post hospital period stresses arose for these relatives in the practical problems of employment, housing, etc., but were outweighed by the impact of the strain in relationship with the patient. The wives experienced confusion and anxiety in becoming aware of their own role in the relationship, and of the patient's needs. The mothers became more uncomfortable in the interaction with the patient from which they had had a respite during hospitalization. It appears that these relatives require assistance in the area of relationship of the kind which may be provided by social workers.

The Social Work Variable

From this study it was not possible to observe effectively the operation of the social work variable upon the situation. In four of the cases, two wives, (in cases C, and D) and two mothers, (in cases 1 and 2) social workers had been involved to some extent, but the work had been of varying kinds and intensity. The two wives had seen the social worker on two or three occassions, but no intensive relationship had been established. In cases 1 and 2, the social worker was concerned mostly with the patient, although plans for future work included the mothers. With one of these patients, it was doubtful if a meaningful relationship could be established.

To conduct a study of the social work variable it would be necessary to standardize the factors to be considered such as the kind of work done, and the intensity and length of the relationship. If the interview method were used, it would be necessary to build into its structure some specific focus on the area of social work, and a number of influences, such as the relative's feelings in talking about a third person, would have to be taken into account.

In this study, all nine cases indicated problems of social or relationship nature which seemed to require attention, but the group in which the social work variable was present did not display any significant improvement over

the other group, no doubt because of the factors listed above. One exception did exist in that in the family where the worker had a sustaining relationship with the patient, (case 1) the patient seemed better able to withstand the resistance of the family toward her developing ability to talk about her feelings. The worker attempted to help the family with the latter problem as time went on. However, this case points up the further need in examination of the effect of the social work variable for a measuring device to determine the amount of influence social work had in the patient's progress. From this experience, it sees that examination of the various sections of the patient's environment should proceed one at a time in the small study.

Areas for Further Study

The study of the many variables in the "beta situation" and the weighing of the significant factors in the total, generally requires more study. One of the first social workers in B.C. to attempt a case study of some of the objective elements of the "beta situation" was Miss A.K. Carroll, who referred to her research program in the 1958 Annual Report of the Mental Health Services. She studied eight patients who had received long term care and were discharged to the community from the Provincial Mental Hospital. The patients in this group who later returned to the hospital had experienced difficulty in the community in one or more

of the following areas: accomodation, employment, loneliness, recreation, residual illness making the patient inaccessible to casework help. From Miss Carroll's report it is apparent that there are gaps in community services for these needs. It seems to the present writer that services present in a community form variables which may influence the total "beta situation" of the patient and thus the operation and influence of each service requires study, and the interraction of the services should also be examined. However, it also seems that the attitudes of the people involved require study, and, too, the way in which "significant others" may affect the patient's reception of these other parts of the environment such as the services. It would appear that close family members are significantly influential and that their needs affect the performance of the patient in regard to community services, so that further study of the needs of relatives is indicated.

Freeman and Simmons remind us that not only one significant "other" may affect the patient, but that the group close to the patient may be significant in its interraction:

> "There is obviously, a strong probability that prediction could be improved if the personalities of all individuals in the family were assessed, rather than that of a single member."[1]

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1 Freeman, H.E. and Simmons, O.S. "Wives, Mothers, and Former Mental Patients" in Social Forces, Dec. 1958, vol 37, no. 2. Published for the University of North Carolina Press by the Williams & Wilkins Co. page 158

This study is limited in that it does not extend beyond one member in each family, although in case 5, there was indication of the problems of interaction when the father was also interviewed, and had somewhat different perceptions of the patient's illness than had the wife. In case 3, there was reference to a sister with whom interaction in the family was a problem. Nevertheless, as stated earlier, it seems a workable approach to begin with one factor at a time. Further research into the significance of family interaction, however, seems necessary for full comprehension of the "beta situation".

From the present study it appears that relatives often need help to withstand the stresses they experience when a patient is hospitalized, and, later, discharged. Further study seems necessary into the kinds of help they need, for some seem to require intensively supportive help, while others might be able to maintain their roles adequately with only "information giving" kinds of help. Their relationship needs, then, as well as their observable needs, may require further study.

There seems to be evidence that some relatives have experienced deprivation of material goods or emotional supplies during their earlier experiences, and studies into the effect of earlier deprivation upon the "subjective probability of stress" for these people would perhaps be helpful in better

understanding the rehabilitation experience of the patient and family.

In view of the negative attitudes displayed by four of the five mothers toward the patients, it would be of interest to study the effect (in the family of orientation) upon family interrelationships of discharging the patient to a foster home rather than to the relative's home. Especially where parents remain in touch with the patient although he is out of the home, the resulting interrelationship pattern might offer suggestions for working with relatives toward more successful rehabilitation of patients.

Suggestions

The need for more family oriented casework seems to be indicated from this study. It is very easy to focus only on the patient in hospital and forget that his problems have an impact upon his relatives. It is, of course, more difficult to work with relatives because their needs are hidden and it takes time and effort to discover the stresses affecting them, and their attitudes toward the patient. It would appear that efforts should begin in the hospital itself to "reach" the relatives, and let them feel a part of the process of treatment.

Although the treatment team may devise ways of drawing the relative into participation and of helping them to adjust to the hospital and to the fact of mental illness,

a consistent pattern does not seem to have developed in the hospital studied, and perhaps there would be merit in considering group methods similar to the one described by Jacob Brower and Richard R. Brown in their article "The Relatives' Conference in an 'Isolated' Neuropsychiatric Hospital."[1] At the Veterans Administration Hospital, Sheridan, Wyoming, the authors noted:

> "The tragic fact was that family and patient drifted inevitably apart. Bonds with the community were cut..."

They therefore instigated a two day "conference" of some of the patients' relatives, inviting a group of relatives to come to the hospital on a given week end for visits with patients and staff, and for group meetings in which questions could be asked and discussed. After general group discussions they were given the opportunity for individual consultations. In evaluating the conferences, 97% of the relatives said they would like to have the conferences continued.

Such a project is a huge undertaking, but perhaps smaller group plans might be arranged as beginning steps in helping the relatives become a more positive part of the objective component of the patient's "beta situation" upon

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1 Brower, J. & Brown, R.R., "The Relatives' Conference in an 'Isolated' Neuropsychiatric Hospital" in Journal of Psychiatric Casework, Sept. 1955, reprinted by AAPSW, Columbia University Press, New York.

discharge. One of the aspects of the Wyoming program which seemed to give it a broad philosophical base, and which perhaps gave the relatives a feeling of contributing such as was noted in the research interviews for the present study, was the talk by a staff psychologist to the relatives

> "emphasizing that a relative's role could be that of ambassador for better understanding in his community".[1]

Although every effort should be made in the hospital to help the relative in making adjustment to his stressful situation, perhaps even earlier attention to the entire matter is indicated. Where possible, it seems that while the patient is still in the community, attention should be given to the total situation in which he finds himself. In this study, several of the patients had been attending psychiatrists in the community before hospitalization, and three of the wives, and at least one of the mothers, had visited the psychiatrist once or twice to express their concern about the illness. It seems that it would be helpful to the patient and his family if referral to a social worker could be made at that point. In this way, the relative could be helped to help the patient, and perhaps hospitalization might be avoided. If hospitalization became necessary, the relatives could be helped to understand the "continuum" of

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1 Brower, & Brown, ibid, page 216

treatment, and the hospital's place in it.

The need for reaching out to the relatives while the patient is still in the community is perhaps the most urgent one in present day treatment of the mentally ill. Current psychiatric thinking tends towards the belief that greater numbers, although not all, psychiatric patients, may be cared for in the community. Dr. Gee, in his introduction to the 1958 Annual Report of the Mental Health Services, had this to say:

> "Certainly there is no indication that mental hospitals will be entirely unnecessary, but there is every indication that mental hospitals can be greatly reduced, and further, that the majority of future patients need not go to hospital if given early diagnosis and help in the community."[1]

Understanding of the stresses contributing to attitudes of the community members toward the patient may make such "help in the community" possible.

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1 Mental Health Services Annual Report, 1958, page VI

APPENDIX A - INTERVIEW GUIDE

In preparation for the interview the following subjects were prepared, with the type of information required formed into questions which might or might not be asked, depending upon the individual situation. A rigid structure was avoided, and this guide was intended more as a frame of reference than as a questionnaire.

Education or Training

1. Has patient resumed school or begun any training?
2. Do you think he/she is enjoying it?
3. Do you think it will be useful to him?
4. Do there seem to be any problems - difficulties for you or him?
5. Do you feel very concerned about this?

Employment

A.

1. Has patient resumed former job?
2. How do you think he is getting along?
3. Do you think it is a suitable job for him?
4. Would you prefer another job for him?
5. What kind?
6. Why?
7. Do you know any of the people he works with?
8. Do you think they are helpful to him or otherwise?
9. Do you have any hopes for his future in this job?

or B.

1. Is patient looking for a job?
2. What job would you like him to have?
3. What do you think his chances are?
4. Why?
5. Do you foresee any difficulties?
6. How do you think employers will react to him?
7. Do you have any talks with patient about employment and how does he seem to react to this conversation?

Housing

1. Did patient live here prior to hospitalization?
2. Were any changes necessary such as room?
3. If patient did not live here previously was there any difficulty in arranging this?
4. Was there a decision to be made about patient coming here?
5. Was the decision difficult to make?
6. Was it discussed with the patient?
7. How long did it take to arrive at the decision?
8. Were there any disagreements, and to what do you attribute these (patient's illness, lack of co-operation, realistic problems)
9. Can you remember how you felt on the day the patient came home?
10. Are there any difficulties because of his being here?
11. Is there any plan which you think would have been better?
12. Because of his being here do you ever have upset feelings?

Recreation

1. Does patient have any form of recreation - hobby, club, sport?

2. Do you think it helps him feel better? (think he should)

3. Since coming out of hospital has he made any new friends or renewed any old friends?

4. What is your opinion of these friends?

5. Do you think they are helpful or otherwise to him?

6. Do you think patient is ready to enjoy friends?

7. Do you go out with patient much or have people in to visit?

Illness

1. Have you ever known anyone else who experienced illness of this kind?

2. Have you any lasting impression of your feeling about that person?

3. Most people have one or two special things they would like to know about mental illness, such as heredity, danger, etc.,. Did you have any such questions before hospitalization?

4. Have you received satisfactory answers during patient's treatment?

5. Can you tell me the source of the answers -- Doctor, Magazines, friends?

6. There are usually a number of people involved in helping the patient get better. In your personal opinion, were there any of these people who had special significance in the patient's recovery eg Doctor, others in hospital, family, friends?

7. Have you ever sought, or would like to, professional help?

8. In helping patient get better is there anything you think might have been done or anyone who might have added anything?

9. Had you any special hopes for patient when he came out of hospital? How is this turning out?

10. Quite often various family members react rather strongly to the patient just home from hospital. Have you noticed how other family members feel?

11. What is your opinion about the way the world at large responds to persons who have had mental illness?

12. What have your experiences been, for instance with neighbours -- how do they seem to feel about patient's illness?

13. How do you handle this problem with neighbours -- tell them about hospital, keep patient away from them, etc?

Financial Aspects

1. Has the patients illness created any financial difficulty for you?

2. Have you wondered if there was any way you could get help with this matter?

3. Would you like to talk it over with someone, or did you find it helpful to do so?

4. Should financial problems crop up in future, can you predict what you might do -- request help from relatives, suggest social agency, or hospital worker?

Hospital

1. Did you understand hospital's purpose and regulations?

2. What did you think of patient's experience there?

3. Did you visit often?

4. How many times did you talk to Patient's Doctor?

5. Did you feel hospital considered your thoughts and feelings?

6. Were you consulted about plans?

7. Were you included in preparation for patient's coming home?

8. How soon did you know of discharge date?

9. What was your impression of the hospital?

Relative's Suggestions

The relatives should be asked if they wish to make any comments on their experience or suggest any changes they might have wished.

APPENDIX B THE INTERVIEW -- "The Cry For Help."

In all the interviews an impression gained was that the relatives needed and wanted help. As each interview drew to an end, the relatives, realizing the comfort of dropping protective defences, allowed their real feelings to peep through, and thereby revealed a person, basically frightened, tired, or at a loss, trying bravely to keep up appearances.

This tendency of relatives to suddenly discover the comfort of relationship made it necessary to conduct the research interviews carefully, because, as no further work was to be done with the families, it would be cruel to hold out a suggestion of promise and then remove it entirely. By stressing the research focus and explaining how useful the interview would be in terms of future help to others, the matter was handled sympathetically.

Four of the relatives interviewed showed a need for help that was almost irresistable. In case B, the wife was able to articulate her need openly. She said she had agreed to the interview because of her desperation to find some avenue leading to assistance, even though she realized the interview was intended for research. Her obvious need constantly enticed the worker to abandon the research slant and enter into a helpful relationship. Her need to talk made her reveal a great deal of material, much of it valuable research information, but surrounded by material highly

charged with diagnostic and treatment significance.

The interviewer was tempted to encourage her outpouring for the sake of research, but the matter of professional ethics is to be considered in such interviews, and the individual's welfare cannot be subordinated to scientific interest. The interviewer is responsible in the situation for deciding what material is to be brought forth.

To bring out the necessary research information, while at the same time discouraging some discussion, yet communicating sympathy, warmth and endeavouring to minimize frustration, requires professional skill. It was found that the interviewees gained a feeling of worth by knowing of their contributions to the future good of society.

The end of the interview must be made warm and final, giving the "client" a clear understanding of the nature of the visit. Recaptulation of the research purpose and of the fact that no further visits would be made, were combined briefly with gratitude for the individual's help in research.

The steps in the research interview where real need is detected are given in chapter two. Application of these in Case B resulted in what appeared to be a successful research interview in that information was obtained, and the "client" did not appear to have suffered any loss of dignity but instead seemed to have gained some value from the experience.

The interview in case 4, while not so successful from either the point of view of obtaining research information or of leaving the interviewee with positive feelings, made even greater demands on the interviewer, and was stimulating because of the dynamics involved. It concerned the mother who was thought to have paranoic tendencies.

When the research worker, after sending the letter signed by the Medical Director of Crease Clinic explaining the research project, telephoned "Mrs. G" to ask if she would participate in the project, and if so, to arrange an appointment, Mrs. G spoke with an air of suspicious ambivalence. At first it seemed that she would not agree to an interview, and the worker, respecting her right of self determination, did not press the matter, but suggested that it was to be expected that there might be some questions since the letter did not explain the project fully. Mrs. G grasped this opportunity, and rigourously cross examined the worker about the intent of the research, and about the method. Her remarks were quite threatening, and it was difficult to remain calm and deal with her points in an accepting and logical manner. Finally, Mrs. G agreed to an interview, but when the worker attempted to make an appointment, Mrs. G refused all suggestions until the worker remembered her need to control and allowed her to set the date, even though she set it (probably to express hostility and to prove her control) more than two weeks hence.

The worker arrived at Mrs. G's home almost precisely at the time arranged. The moment the door opened, however, the worker was thrown into confusion and nervousness, for Mrs. G opened the door only partially at first and showed no change of facial expression when the worker introduced herself. She said nothing, and the worker wondered if she had arrived at the wrong house, and nervously asked if Mrs. G recalled the appointment, and if so had the worker noted the time correctly. Mrs. G with no change of expression, said "Of course: I'm ready", and, opening the door a little wider, moved slightly to allow the worker in. Wordless hostility filled the room and the worker for quite a few minutes considered giving up this interview. Even after the first attempts to draw Mrs. G into participation, there was a strong temptation to discontinue the effort and withdraw, because Mrs. G followed up her suspicious and hostile greeting with a barrage of openly hostile answers to the worker's comments. The worker began to feel extremely insecure, since in all of these interviews the right of the researcher to visit these homes and "pry" into personal matters could be questioned, and could be justified only by professional concern for improving human welfare generally, a rather flimsy sounding debate when used against such a forceful opponent.

With the uncanny sensitivity of the emotionally disturbed child, or the patient in hospital for mental

illness, Mrs. G sensed this weak point in the interviewer immediately and her angry questioning of this right of research threw the worker into a near panic. It was a dramatic experience for the worker to battle with her own conflicting feelings for few moments. There were two distinct currents of thought and feeling within her. One was of outright fear in the situation; the other, a strange sense that beneath her anger, the woman was hurt, and had a need for help which she dared not admit. Had it not been for the latter impression, the worker would have left. Because of it, however, she resolved her inward conflict with the decision to communicate to Mrs. G the feeling that she was liked and respected as a person. With the worker's returning calm and determination not to be upset by hostility, the tide turned, and although Mrs. G never entirely relinquished her air of defiance, and of reluctance to help anyone, she did begin to talk about the "research project" and how she felt about the hospital. Throughout, she tested the interviewer, who had to be careful to respond without any hint of condescension, ruffled feelings, or returning fear, and with constant warmth for Mrs. G as a person. Mrs. G proved to have intelligence, although with a bias, and the interviewer eventually found that she could respond with genuine appreciation of some of the things Mrs. G said, and felt very gratified when Mrs. G slightly smiled once or twice. In this interview the client's right of self determination had to dominate, and for this

reason, many questions could not be discussed because Mrs. G flared up suspiciously when they were approached and refused to consider them a valid part of research. Her attitudes to the topics could be observed easily, however.

Throughout this interview the worker felt keenly that Mrs. G. was desirous of attention and help, and this seemed to be borne out when, at the end of the interview, she burst forth angrily: "Well, it may help some other people, but where does it leave me? I'm still left with all my problems!" The vehemence with which she pronounced that she was "still left" with problems, suggested that she was angry with the worker for showing her some attention, then "rejecting" her by leaving, with no indication of return. The closing was not as successfully carried out in this case as in others. Nevertheless, the interviewer was delighted when Mrs. G suddenly asked if she would like a cup of tea before she left, and felt a sense of regret that in all the months of the patient's hospitalization, no one had made any attempt to become acquainted with Mrs. G and to try to "reach" her.

The implication for research in this interview is that a rather different kind of research may be possible in discerning whether or not certain interviewing techniques can be effective in bringing service to persons who otherwise tend to be neglected. A uniform diagnostic group would be necessary, however, for such a study.

In two other cases, the need for help was noted especially. In case number 5, an intangible kind of help was needed. The parents were participating fully in the patient's rehabilitation. The mother, after a long interview, requested that the worker also speak to the father. Both mother and father were giving their best thought as to how best to help their son, and they had arrived at sound conclusions. The worker did no more than agree that the effort of thinking these matters through and changing one's attitudes accordingly is a heavy strain on one, and support them in their way of approaching the problem, at the same time as obtaining research material, but they reacted by saying warmly at the end of the interview, "Thank you so much - you've been such a help to us." They had also been able to verbalize their need for a sustaining kind of help in the interview.

In case number 3 there were obvious kinds of need. Care of grandchild and the necessity to operate a business requiring much hard work in order to support her family presented problems for the mother. The presence of the patient during most of the interview made it impossible to conduct the interview in the manner in which it had been designed, but it was possible to depart from the standard method and combine observational data with verbal. Attitudes could be observed in action, and here again, if the situation could be reproduced in a number of cases, this might prove to be a valuable method of research.

In the interview, both mother and son seemed to desire attention, and besides the help apparently needed with obvious social problems, there was felt to be need for help through individual relationship therapy. The situation in this home was a heart-rending one, but the "giving" attitude had to be tempered with respect for the independence of the family group. Their need to be accorded a sense of dignity rose above their need for help, and the research focus of the interview had to be used in such a way as to promote it, because it would have been possible for the family to feel "Oh - you want to find out what it's like on the other side of the tracks!" Both the mother and the patient seemed to feel that they had made a contribution to society, through the research interview and the mother was able to show her need for attention and support after she had been made to feel helpful.

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