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SELF PERCEPTION OF IMMEDIATE FAMILY SUPPORT BY MANIC DEPRESSIVE EX-PATIENTS

by

Robert Ostrow

A Thesis
submitted to the
Faculty of Graduate Studies and Research
through the Department of
Sociology and Anthropology in Partial Fulfillment
of the requirements for the Degree
of Master of Arts at
the University of Windsor

Windsor, Ontario, Canada

1986

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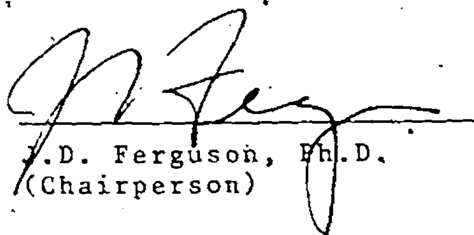

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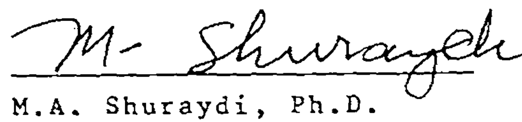

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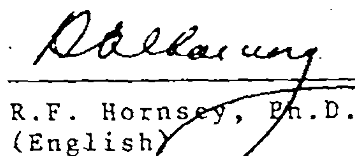

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ABSTRACT

The purpose of this research was to understand the self perception of immediate family support by manic depressive ex-patients. Utilizing a qualitative method with the concepts of: Physical Security, Expression of Love, Hostility, Spontaneity and Membership in a Human Group with respect to Family Social Integration, Social Interaction and Instrumental Performance(the ability to function). These processes were also evaluated by the strategic behaviours of: Normalization, Passing and Dissociation.

Data was collected by using a focused interview given to sixteen females and six males who were manic depressive ex-patients. Included within the sample of 22 respondents were two family members. Respondents volunteered from manic depressive support groups in York Region as well as the Windsor, Ontario area.

The present research determined that the majority of respondents indicated moderate to high levels of social integration and interaction with respect to their immediate family social environments and instrumental performance was considered to be moderate to high also.

Dual support from both the family and manic depressive support group were very important in improving the overall

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environment of the ex-patient and outside associations were also beneficial to the ex-patient's reintegration.

Finally, most respondents said that they used the strategies of Normalization and Passing as a way to improve their situations; those respondents who indicated that they used Normalization demonstrated higher levels of social integration and social interaction with their immediate families. In this study, only a few respondents said that Dissociation was important for their social readjustment and this strategy was associated with lower levels of social integration, social interaction and instrumental performance. With respect to these three strategic behaviours, all of the respondents including family members said that they used the strategies in different combinations depending on the severity of the disorder while in the social readjustment stage.

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This Thesis is dedicated to all those in Windsor and York Region who were instrumental in the creation of this research, as well as to all people who suffer from manic depression. I would also like to extend my deepest gratitude and appreciation to my wife Margot, whose love and encouragement helped me achieve the completion of this important research. Without her it would not have been possible.

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Chapter I

INTRODUCTION

The purpose of this research is to understand the social dynamics of interaction between the immediate family and the ex-mental patient. The development of this project, is based on the premise that social interaction and successful social readjustment patterns are dependent on the types of support given by the Bi-Polar ex-patient's immediate family. The present research may accomplish this by concentrating on ex-patient perceptions and specific strategies that are directed at immediate family members in order to gain much needed reinforcement during those stages of treatment where the medical community does not have direct control over the ex-patient. Respondents chosen for this study will have been diagnosed as having a Bi-Polar Affective (Manic Depressive) disorder. Organically derived, this unique pathology presents sociological consequences for those individuals trying to adjust to everyday life.

The importance of this study is that it identifies the need for immediate family members to become part of the treatment process during the social readjustment phase. The psychiatric community does not pay enough attention to the social readjustment stage of treatment, and usually confines

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itself to giving medical attention during the hospitalized stage. For the ex-patient, the social readjustment level is very important. Recently, communities have begun to address this topic by developing outpatient programs that try to assist the ex-patient reintegrating into the community. In this study, the Bi-Polar advocacy support group plays an important role in helping the ex-patient through this long period of transition, by concentrating on issues that are socially and medically important. For the ex-patient suffering from Bi-Polar disorders, there are advantages for both the ex-patient and the immediate family who use these advocacy groups for information and support. Shared membership in these social groups allows both the immediate family and the ex-patient to be in an open forum with other ex-patients who suffer from the same problem.

1.1 STATEMENT OF THE PROBLEM.

The problem of this research is to determine the perceptions and feelings about immediate family support by Bi-Polar ex-patients.

If immediate family support is given by significant others in the social environment of the family, then the social readjustment process for the Bi-Polar ex-patient will be easier and less complicated. The categories of analysis are: social integration, social interaction and social behavioural strategies utilized during the posthospital and

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non-hospitalized phases. In accomplishing this, a theoretical approach using symbolic interactionism to evaluate Bi-Polar ex-patient perceptions will be used and a middle range theory will be devised in carrying out this research.

Traditionally, when mental illness was encountered, the primary care giver was a physician who specialized in psychiatry. The patient was treated as a solitary entity without the inclusion of the immediate family. Afterwards, the patient returned to the immediate family in a state of confusion because the treatment process had not necessarily addressed the whole social surrounding of the patient. Therefore the scope of mental health problems could be reduced to three main phases:

1. Pre-patient phase.
2. Hospitalization phase.
3. Posthospital and non-hospital social readjustment phase.

The progression of these three separate stages is what determines the quality of the relationship between the ex-patient and the immediate family. In Bi-Polar Affective complications the perceptions of the ex-patient may be distorted by the illness. In Bi-Polar Affective disorders, lithium carbonate, other medications and psychotherapy are the usual choice to deal with the disturbing problems associated with mood swing fluctuations. A further problem

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is how the ex-patient feels about the reaction of his immediate family and others in his social network. The immediate family may resort to tactics that insulate the ex-patient and immediate family from harmful stigmatizing affects, because mental illness is considered as undesirable for the community and society at large. Freeman and Simmons(1963) find that some of these behavioural support systems are based on tolerance, high expectations for social readjustment and a need for the Bi-Polar patient to develop outside social networks in order for the person to function as a capable member of the community. Freeman and Simmons(1963) further state that readjustment expectations are directly dependent on how society perceives behavioural changes that are associated with mental illness and that it can, in fact, react to it as some sort of "deviant" act that is not to be tolerated. As Freeman and Simmons(1963) elaborate:

> Familial expectations affect the patient's participation in other interpersonal networks, acceptance of the patient as a deviant restricts his exposure to others usually less tolerant of non-instrumental performance.

Finally, the development of patient perceptions and immediate family support may be grounded in the notion that important generalized others have some effect on the ex-patient's willingness to participate in society. As Cockerham (1981) suggests, community response can be the single most driving force in this endeavor. This explains

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the importance of the support group as a vehicle for ex-patient social readjustment. Cockerham(1981: 291) notes:

> Knowledge of how a particular community feels about mental illness is an important indicator of what kinds of situations expectations and those associated with them will be required to contend with as the former patients attempt to return to their lives there.

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Chapter II

THEORETICAL FRAMEWORK

Symbolic Interaction, as a central theme for this research, theoretically defines the perceptions of Bi-polar respondents in respect to three central ideas that are incorporated into this type of theoretical application. The first level of interaction relies on actions taken by human beings on the basis of meanings these actions have for them. Secondly, these meanings are derived from social interaction in human society or social groups. A third emphasis is that these meanings can be modified, revised or re-evaluated through an interpretive process that is used by each individual in dealing with signs, symbols or objects that are encountered during day-to-day interactions(Blumer 1969).

Symbolic Interactionism, as it is applied in this theoretical conception, interprets and transposes these three levels into specific phases that the Bi-Polar respondent finds important in the social readjustment process. The first includes social interactive processes between the ex-patient and immediate family: specific strategies that the ex-patient uses in the self perception of immediate family support. Secondly, the introduction of

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interactionist theory allows for the development of self through perception as a primary source of understanding social interaction, and thirdly social behavioural strategies developed as a means to evoke social interaction.

In discussing the social readjustment of ex-patients during the posthospital and non-hospital stage of their illness, several topics appear in prior research. Most research deals with mental illness, in general, and does not focus on Bi-Polar illness. But several of these studies do deal with family structure and reactions to particular problems associated with mental illness.

2.1 Family Interaction and the Re-Integration of the Patient

Au-Deane S. Cowley(1978) describes the environment of families who have members who are mentally ill. Even though these are not Bi-Polar patients, her study identifies the importance of social interaction and integration in regards to the immediate family.

For instance, interaction and integration are closely related to expectations(pressures) and reinforcement patterns that a family utilizes in order to cope with this problem. These determinants may be closely associated with the social interactions that Bi-Polar ex-patients face with their own families. A composite picture of a family with a mental health problem is described by Eisenstein(1953): "In

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many respects the family relationship resembles what physicists call a closed energy system, by law and tradition it is one of the most protected relationships existing in civilized society. Indeed, the family is a law unto itself, a microscopic state within a state." Baldwin(1968) says that the posthospital period of patient readjustment produces controls that are directed by the immediate family, to augment the therapeutic process. This is often seen as the difference between a well balanced family organization and one that is not. In Bi-Polar illness, this balance takes many forms because confusion and rapid behavioural changes are part of this situation. In fact this drive for equilibrium is promoted in the literature as a need to view the immediate family and the ex-patient as a system moving together to accomplish some important readjustment processes. As Baldwin(1968) contends: "In a naturalistic situation like the home, each person in a situation stimulates the others around him who, in turn, stimulate him. In such an interacting system, there gradually emerges a stable pattern of behaviour on the part of all members of the system." In Bi-Polar illness, this behaviour may take the form of immediate family members assuming specific roles that may be required for the ex-patient's survival in that family. Cowley suggests(1978) that this balance between immediate family members is accomplished within this closed system and may be defined as a specific support system. In

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fact, this equilibrium is crucial to the posthospital and non-hospital social readjustment of the ex-patient. She continues (1978: 5): "The family equilibrium can either be positive, or negative and dysfunctional, for the individual member's development." Cowley may be commenting for mental illness as a whole, but this statement is relevant for the immediate family that has a Bi-Polar patient as part of it. In other research, coping is dealt with as a strategy. The research reviewed was selected for its explanation of social readjustment factors for both the immediate family and the ex-patient.

In developing an account of coping procedures, a study by Sampson, Messinger, and Towne (1961) traces the beginnings of the relationship between the ex-patient and the immediate family that occurs when the person first demonstrates symptoms, enters the hospital, and finally is released back to family and community. Even though this research is generalized to mental illness as a whole, many of its findings may be relevant to the Bi-Polar ex-patient.

The authors divide into three parts the process of a patient becoming mentally ill.

In the first stage the patient exhibits symptoms that cause the immediate family to wonder what is going on. At this time the family may seek out professional help in order to restore balance to the family itself. In the second stage, a shift may be seen between the person about to

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become a patient and the immediate family who enter the mental health system for the very first time. According to the authors, these symptoms which produce the illness may cause the immediate family to make specific accommodations to the newly transformed patient, who is undergoing treatment for the first time. Finally in the third stage attitudes by the ex-patient towards the immediate family begin to take shape and cause problems for immediate family members who are considered significant others. In Bi-Polar Affective illness, this appears to be seen as aggressive if not violent reaction by the patient due to extreme mood fluctuations, which cause this person to become suspicious of the immediate family and its overall intentions. The ex-patient may be uncooperative in seeking out treatment when it is indicated. In this sense, the ex-patient develops hostile attitudes towards the immediate family.

2.2 Social Support Systems

In the hospitalized phase, the immediate family turns to community institutions in order to seek out treatment for the sick family member. In this case, according to Sampson, Messinger and Towne (1961), the patient becomes isolated from the immediate family and comes under the control of the psychiatric community. At this stage, a complete disruption and alteration is seen in the family's life style and working habits. In Bi-Polar Affective illness these changes

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initiate coping mechanisms that cause extreme hardship and withdrawal for both the immediate family and the hospitalized person. In this sense then, accommodations and shifts in immediate family life styles directly lead to coping mechanisms that are defined by attitudes and strategies by both parties. These attitudes and coping strategies are seen quite frequently in the literature as an equal problem for both the immediate family and the community--the latter also comes into contact with this problem to some degree. This interpersonal relationship between the community and the immediate family structure, creates what the researchers call "inner" and "outer" isolation. Accordingly, this process becomes complicated and causes great confusion for all concerned. Subsequently, if tolerance and coping strategies are perceived as important for both the immediate family and the ex-patient, at this time, social complications will be avoided. On the other hand, if they are absent, then the ex-patient will perceive support from the immediate family as being detrimental to socially readjusting to society. Gallagher(1980) comments that the answer may lie in the posthospital phase of social readjustment where the attitudes for coping with mental illness have already been established in prior stages of adjustment and interaction between the immediate family and the ex-patient. Gallagher(1980: 303) states: "Perhaps no other aspect of

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mental illness is as clearly determined by sociological factors as is the success or failure of the patient's attempt to rejoin society. To be sure, psychiatric hospitalization alone does not insure positive posthospital community adjustment to the extent that factors in the ex-patients social world do."

To elaborate this position established in the literature, several arguments based on relevant support mechanisms by outside familial groups may be portrayed by looking at two different positions presented by Thomas Szasz(1960) and David Mechanic(1968) who study the overall implications of the mental health system for society and communities who are trying to take responsibility for the care and implementation of mental health care. From the standpoint of the patient these services can appear to be one sided because the ex-patient's care is taken out of that individuals hands.

Szasz(1960) has stated, that there is a polarization between what mental illness is and what it is not. He further comments: "Since mental illness was considered to be basically like bodily illness, it was logical that no attention was paid to the social conditions in which the alleged disease occurred(1960: 308)."

As extreme as this statement might be, it is true in many cases that Bi-Polar Affective illness produces a type of care that is biologically controlled by the psychiatrist who

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stops short of dealing with the social consequences of the illness itself. In furthering this argument, Szasz(1960) suggests that people who are involved in mental health programs are restricted to systems that do not include outside forces that should be helpful to the ex-patient as social readjustment continues. Consequently, a difference of opinion develops among professionals between the physical needs of the patient, such as lithium therapy, and the social needs such as immediate family support.

From a more socially oriented perspective, Mechanic(1968), suggests that mental illness causes patients to readjust by seeking outside help only if these support systems are willing to accept and provide vital reinforcement that is necessary for an ex-patient to return to the community. The pressure of support systems will cause the ex-patient to succeed or to fail during the posthospital social readjustment process. This could indicate why support groups such as the immediate family and outside social networks have become part of the social psychiatric organizational services.

In developing these services, recent research has indicated a need for the family to become involved in the process of posthospital and non-hospital social readjustment. For example, Hatfield(1984: 306) has suggested that mental illness has caused the immediate family to "sustain a large portion of the burden", in

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response to helping an ex-patient readjust to the surroundings that the ex-patient comes from. For the Bi-Polar patient these burdens become very intense due to the severity of the illness. Therefore, the advent of the outside support group can be very important to the immediate family and the ex-patient as well. There is also the fact that the patient develops a perception of this support that interferes with the social readjustment process. As Goldman(1982) suggests, sixty-five per cent of all ex-patients return to their immediate family. Caplan(1976), stresses the need for support groups to be established, similar to the family, to produce information and guidance to the ex-patient in order to develop "concrete action, practical service, and a haven for rest and recuperation"(1976: 21).

In support of Caplan's(1976) contention, Uzoka(1979) has noted that persons who are deemed to be mentally ill, usually turn to their families before using all relevant services that are available to them for the purpose of obtaining mental health care. Uzoka(1979) claims that mental health professionals have been too quick to label families as dysfunctional if they do not fit the clinician's stereotype of an adequate family.

A report by the President's Commission on Mental Health in the United States(1978) stresses the need for family support groups, and other care-giving systems and networks after the patient has been stablized on medication. The

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report also states that ex-patients are better off in settings that include the immediate family and other support groups. In developing a study of ex-patient attitudes on immediate family support, researchers have traditionally taken a negative position towards psychiatrists who do not include the immediate family in the treatment process. In a study by Falloon et. al. (1981), there is a criticism of mental health services creating an image that the immediate family is overprotective as well as being too restrictive.

In further developing this notion of ex-mental patient perception and burden in the literature, Kriesman and Joy (1974), discover that since 1974 the assessment of family burden has been poorly analyzed and they suggest not much is known about this social process. According to Kriesman and Joy (1974), when an illness occurs, the caring system that the immediate family supported is considered ambiguous, and an episodic eruption places the immediate family in a highly stressful situation. This is probably especially true for ex-patients with Bi-Polar Affective illness, because their problems are chaotic and ever changing. Gallagher (1980) suggests that communities are dealing with the problems of the mentally ill in a more humane fashion, because psychiatric and medical knowledge is becoming more available to the public as well as the immediate family. He notes, that the public has obtained a greater understanding as to what mental illness is.

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To support this point, Harbin(1982) states that mental health facilities are working hard to include the immediate family as part of the therapeutic process and families are becoming more vocal about their own responsibilities. Hatfield(1984) conducted a study of eighty-nine members of a self help group where fifty-seven per cent of the family members had a "mentally disabled" person in their family unit. Many of the patients in the study, displayed a number of psychiatric disturbances of considerable severity and a third of these individuals had tried or threatened suicide(with four succeeding). Hatfield(1984: 309) found that many families suffered from "periods of extreme tension, always being on the defensive, and wondering what would happen next". Other family members suffered because attention was being focused on the sick family member. Also, Hatfield(1984: 309) found that neglect led to exhaustion of immediate family members, and that non affected family members "could not understand" the patient's so called "bizarre" behaviour. In Bi-Polar Affective disorders the onset of exhaustion of immediate family members was a common occurrence during a manic phase. There was also a tendency for family members to blame the patient for causing them great pain and problems.

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2.3 Developing a Model for Analysis

In developing a theoretical system of analysis, several factors must be taken into account in order to build upon present knowledge in this area. These are:

1. Theoretical definitions of family integration and family interaction.
2. The classification of ex-patient strategies that are important in understanding the relationship between immediate family support and ex-patient viewpoints during the posthospital and non-hospital stage of Bi-Polar illness.
3. Description of stages of recovery in terms of middle range theory.

When one discusses the idea of immediate family support and ex-patient viewpoints about posthospital and non-hospital social readjustment and Bi-Polar Affective illness one must realize the complexity of the relationship itself. The ex-patient has extreme mood swings. These range from psychotic reactions during the manic phase, to deep depressions that often are accompanied by attempted suicidal episodes. It is not uncommon to see a patient in the hospitalized phase exhibit many different versions of this illness. This is also true for the ex-patient. In fact, there may be mood fluctuations which are mild, those that are diagnosed as serious in nature, and some that fall in between.

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The development of the theory must also consider the parameters surrounding the different types of treatment available to the patient who becomes an ex-patient. In Bi-Polar Affective illness, the major form of treatment falls into three catagories;

1. Lithium Carbonate as the major control factor in this illness.
2. Lithium Carbonate combined with other medications.
3. Psychotherapy as a means of dealing with emotional problems in the posthospital and non-hospital social readjustment phase.

From a sociological position, all three forms of treatment have been successful in returning the patient to the family and community. However, the important intervening variable here is that compliance to treatment must be maintained for the ex-patient to resume a normal living pattern.

In this project, a theoretical framework is devised in order to analyze the self perceptions of immediate family support by significant and generalized others(defined later in this research) in the immediate familial environment of the Bi-Polar ex-patient. The choice of this theoretical method allows for a specific comprehensive approach in structuring this research.

In describing middle range theory, Merton(1967: 39) says there is a marked difference between larger general theoretical frameworks and theories that are more

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intermediate and focused in content and application of important sociological phenomena. Using middle range theory in this researh is a way of introducing a theoretical construct that can be built upon and expanded in the future.

> Middle Range theory is principally used in sociology to guide empirical inquiry. It is intermediate to general theories of social systems which are too remote from particular classes of social behaviour, organization and change to account for what is observed and to those detailed orderly descriptions of particulars that are not generalized at all.

In this context, middle range theory contributes a new intermediate theoretical perspective about how one understands the relationship between immediate family support and relevant ex-patient perceptions and strategies.

As a further explanation, Merton (1967: 39) defines the mechanism by which this theoretical system works:

> Middle Range theories lie between the minor but necessary working hypotheses that evolve in abundance during day to day research and the all inclusive systematic efforts to develop a unified theory that will explain all the observed uniformities of social behaviour, social organization and social change.

It is this process that allows the researcher to focus on the major components of the research itself. From a theoretical position these descriptions provide the researcher the ability to focus on the social dynamics between the ex-patient and immediate family: how immediate family reactions towards mental illness are affected by the mood structure of the ex-patient. These might be characterized by the following.

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1. The manic phase of the ex-patient in relation to the reaction of the immediate family itself.
2. The depressive phase of the ex-patient in relation to the reaction of the immediate family itself.
3. Ex-patient strategies and perception in relation to significant others during the posthospital and non-hospital stage of readjustment.
4. The reaction to medication as it affects the overall relationship between the ex-patient and the immediate family.

With these concepts in mind, a focused middle range theory allows for a better understanding of the relationship between the immediate family and the ex-patient. Specifically, middle range theories start small but become wider in focus as they are consolidated. As Merton(1967: 68) contends:

> These theories do not remain separate but are consolidated into wider networks of theory, as illustrated by theories of level of aspiration, reference-group and opportunity structure...and transcend sheer description, or empirical generalization. The theory of social conflict, for example, has been applied to ethnic and racial conflict, class conflict, and international conflict.

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2.4 Definition of Family Interaction for the Ex-Patient

Family interaction may be described as that point when the immediate family and the ex-patient enter a relationship after the patient has left the hospital, or has entered an outpatient treatment program. Included within these interactions, are the support mechanisms that the family provides for the ex-patient. These include many types of reinforcement that establish and define this system of interaction.

2.5 Definition of Family Integration for the Ex-Patient

Family integration relates to economic stability and the home environment of the immediate family as the ex-patient enters the social readjustment stage of mental illness. It is unlike family interaction which describes on-going relationships and determines the perceptions and reactions of the ex-patient.

The middle range theory developed here specifies the family's immediate situation and the Bi-Polar ex-patient's reintegration into that family during adjustment to Bi-Polar disorder. Social readjustment problems involving the ex-patient and his family may be related to levels of self perception within the family itself.

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2.6 Indicators of Family Interaction and Integration

As a rationale for understanding self perceptions of the Bi-Polar ex-patient through definitions of social interaction as a separate social component, Cowley (1978: 9) provides a definition of social interaction that helps to explain more fully this process:

> Interaction is a term used prolifically in the newer descriptions of family dynamics. It is a diffuse concept that refers to a variety of phenomena, physical contacts, cognitive interchanges in which roles are created and validated with affective behaviour. Interaction gives rise to interpersonal meanings which the members have for one another.

As a means of theoretical clarity then, this formulation will combine the attributes of family support, and ex-patient perceptions, in determining what family support is. The first part of this theoretical framework focuses on various attributes of the immediate family. This may be characterized as types of support given to the ex-patient in order to assist in the overall care (Cowley 1978: 9):

1. Physical Security.
2. Expression of Love.
3. Securing Love.
4. Expression of Hostility.
5. Expressing Spontaneity.
6. Membership in a Human Group.

Each one of these characteristics has an effect on the quality of interaction in the first tier of this middle range theory. For example, one might provide a small operational definition for each one of these catagories.

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1. Physical Security:This term relates to the immediate family providing economic support and the security of a home for the ex-patient while social readjustment is taking place.
2. Expression of love:This is where the immediate family shows love to the ex-patient through feelings that are generated during the posthospital and non-hospital experience of social readjustment and assimilation into the community.
3. Securing Love:This variable may be applied for both the immediate family and the ex-patient. In this context, it will be used for the immediate family, in order for them to gain insight and develop ways of providing love for their ex-patient.
4. Expression of Hostility:This concept will measure the overall negative feelings that the immediate family has for its ill family member and what impact this may have.
5. Expressing Spontaneity:This variable describes spontaneous behavioural changes of the immediate family and the ex-patient that are seen with an illness that has many mood changes and is part of the immediate family's interpersonal relationship with the ex-patient. During the posthospital and non-hospitalized periods of social readjustment, many fluctuations in behaviour can occur while the ex-patient is trying to readjust.

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6. Membership in a Human Group: In defining this variable, one must remember that mental illneses of all types carry a specific type of social stigma that is assigned to both the immediate family and the ex-patient. For the Bi-Polar ex-patient this label may carry heavy connotations of destructiveness in the manic phase. Consequently, the immediate family may try various methods of reinforcement that do not exclude this person from feeling part of the family unit.

In explaining these specific interactive processes defined by Cowley (1978), the development of self perception through Charles Horton Cooley's "looking glass self" (1902: 150-151) can give us a better sociological understanding of this social interactive process.

> How ones's self--that is any idea he aappropiates--appears in a particular mind, and the kind of self-feeling one has is determined by the attitude toward this attributed to that other mind. A social self of this sort might be called the reflected or looking-glass self.

There are three components or stages that are part of Cooley's looking glass self:

1. Our imagining of how we appear to others.
2. Our imagining of that other person's judgement of our appearance.
3. Some feeling of pride or mortification as a result.

Following Cooley, these symbolic processes can cause an imbalance in the interacting function of those primary

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support mechanisms that provide substance to the immediate family during a critical time in the individual's social readjustment experience.

2.7 Definition of the Situation

Following the tradition of Thomas and Mettugh's, Robert Stebbins(1969) presents a social psychological discussion on the importance of the definition of the situation in trying to explain the process of self perception by actors in specific situations.

Stebbins believes that most of our definitions of the countless situations one encounters, may be classified as belonging to one of the following modes:

1. cultural definitions
2. habitual personal definitions
3. unique personal definitions

Stebbins defines "cultural definitions" as collective representations or standard meanings of events consensually shared by the community culture as a whole, or a subculture. Habitual definitions are the meanings or definitions shared by a particular class of actors. Unique personal definitions refer to the person's interpretations of events rarely or never encountered in the community.

Two questions, formulated by Stebbins, could guide the present research. These are:

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1. What cultural or habitual definitions are available to those in a given social identity for use in one or more specified kinds of recurring situations?
2. For classes of actors within an identity, what common pre-dispositions are activated by elements in the ongoing setting that influence the selection of one of these definitions instead of another?

2.8 Significant Others vs Generalized Others

In this research, there are several categories of actors important to the Bi-Polar ex-patient's social readjustment and level of social support.

Significant others, means the important immediate family members who are willing to give support and promote positive action during the course of the ex-patient's reintegration into the immediate family collective. Mead (1934), implies that conduct from these individuals arouses responses that can be taken by the ex-patient and used as a positive action in that individual's social situation. In his interpretation, significant others, in the course of providing reinforcement and support, implement significant symbols that are included in the Bi-Polar ex-patient's perceptions, modes of conduct and important self perceptions. Following Mead (1934), immediate family support and its reflection in ex-patient attitudes, can be defined as taking specific significant symbols of positive support

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from the significant other as an important way to adjust to difficult social readjustment problems.

In this particular study, if significant members of the immediate family are to have a positive influence on the ex-patient, then immediate family support depends on shared symbols and meanings that promote action by the ex-patient. As Mead(1934: 70) says:

> How difficult it is to show someone else how to do something which you know how to do yourself! The slowness of the response makes it hard to restrain ourself from doing what you are teaching you have aroused the same response in yourself as you arouse in that other individual.

In this case, the Bi-Polar ex-patient tries to incorporate important vocal gestures and symbolic meanings from significant others into personal modes of conduct while interacting in the social environment of the immediate family.

The next stage of this explanation involves the identification of the generalized others, who comprise the outer edges of the Bi-Polar ex-patient's level of interaction during the social readjustment process. Mead(1934: 154), defines this concept as being: "The organized community or social group which gives to the individual his unity of self may be called the generalized other." In analyzing this concept with respect to support given to Bi-Polar ex-patients, generalized others may be defined as outside associations, extended family, the community in which the individual lives and support groups

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which can frequently or under certain conditions operate both as significant and generalized individuals. As Mead (1934: 155) states:

> It is in the form of the generalized other that the social process influences the behaviour of the individuals involved in it carrying it on, i.e., that the community exercises control over the conduct of its individual members: For it is in this form that the social process or community enters as a determining factor into the individuals thinking.

In support of this assumption, both the significant and generalized others in the Bi-Polar ex-patient's surroundings can be important in respect to conduct and personal reflection. Both categories of individuals have influence on the social readjustment process and relevant actions taken by the ex-patient. In this study, these theoretical definitions assume that certain ex-patients develop actions and self perceptions enhanced by a self conscious actor who tries to develop support systems that include influences from generalized others who are positive in the social readjustment process, or take the role of a negative force in the Bi-Polar ex-patient's life.

Finally the process of identifying significant versus generalized others is theoretically not an easy task. Bi-Polar Affective Disorders, produce systems of reinforcement where both categories are essential, and the Bi-Polar ex-patient can choose from the groups that give the most positive support and are perceived as being important during the social readjustment process.

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2.9 Strategies for the Ex-Patient

The second part of the theoretical framework is devoted to the idea that ex-patients develop strategies in order to receive and cope with immediate family support during the posthospital and non-hospital social readjustment stage. Referred to as "coping modalities", the ex-patient maneuvers particular behavioural patterns in order to gain access to the immediate family itself. These concepts may be placed on a continuum that ranges from positive to negative, with the negative exhibiting the most extreme position. In affective illnesses, such as manic depression, the destructive forces can cause these inputs to be confusing to the immediate family and the ex-patient. In order to clarify this point, Cumming and Cumming(1968: 106) state; "Some ex-patients decide to explain the nature of their problems and how they overcame them; others to demonstrate that they are changed."

In evaluating these strategies as important social behavioural components, Cumming and Cumming(1968) suggest that acceptance of a particular mental illness, allows one to be open about experiences that are unacceptable to society at large. In this context, the burden of being mentally ill is reduced for both the immediate family and the ex-patient. The advent of lithium therapy allows the ex-patient the luxury of recovering at a faster rate. In effect, positive strategies are produced and carried out

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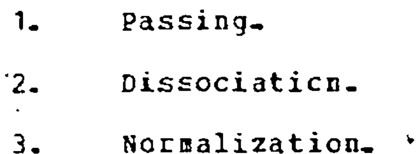
between the immediate family and the ex-patient. On the other hand, when medical compliance is not carried through by the ex-patient, negative perceptions are seen as destructive to the individual and rehospitalization may occur as an aftermath. Consequently, the second tier of this theory is important because patient perceptions are fundamental to this study. In defining the main strategies used by the ex-patient for this research, Miles(1981: 131) has determined that there are three main types:



1. Passing.
2. Dissociation.
3. Normalization.

These three strategies, according to Miles(1981), can be used or seen as being separate. For example, a Bi-Polar ex-patient may oscillate between one or the other. As one might expect, these rapid changes can confuse immediate family members so that they become hostile and withdraw from the ex-patient. As Hatfield(1984), Harbin(1982), and Arey and Warheight(1980) have pointed out, these are the main problems associated with relationships involving immediate families and their mentally ill members.

When operationally describing these strategies, there are clear cut separations between them, making it easy to integrate them into this middle range theory. Subsequently, the definitions provided here are typical and straightforward in terms of what is seen as interaction

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between the immediate family and the ex-patient who suffers from Bi-Polar illness.

1. Passing: The concealment of particular aspects of a mental illness that could damage the overall relationship between the family and the ex-patient. This strategy could be viewed as a manipulation by the individual in order to gain specific protection from being rejected by family members. This strategy may also be used to gain sympathy from the family in order to profit in some way.

2. Dissociation: The most extreme type of strategy refers to the complete withdrawal and breakdown of the relationship between the immediate family and the ex-patient. This may be more characteristic of the Schizophrenic patient than the Bi-Polar one. In essence, this withdrawal is complete with the ex-patient entering into alternative treatment programs such as half-way houses, community dwellings that are operated by social service agencies, and of course, rehospitalization. In this research, because of the support group, not many ex-patients using these strategies were encountered.

3. Normalization: Probably the most positive of all three strategies, this one relates to an ex-patient developing an open and honest relationship with the immediate family. In this context, the ex-patient

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will talk about the illness openly, without the fear of stigma and retribution from other family members and social networks.

Theoretically, these three strategies operate at many levels when considering the structure of the support group itself. Social networks, developed by group members, allow for the ex-patient who is entering the posthospital and non-hospital stage of social readjustment, to talk freely about problems associated with Bi-Polar Affective illness and with other members who have common experiences. Subsequently, Miles (1981: 133) suggests that these strategies should be considered as an interactive process of building a new relationship with the immediate family. "The choice of interaction strategies is not always clear cut; people may oscillate between one and another or try to combine them." The main point is that choices made by the ex-patient are made because social circumstances dictate them. In Bi-Polar Affective disorders, these selections are not totally controlled by the individual, but also by the illness.

In developing a more comprehensive understanding of strategic behaviour in reference to immediate family support, one can refer to social psychological discussions of role positions and power that are important in social readjustment.

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The establishment of roles may be explained by traditional values created by society with regard to mental illness. Specifically Thomas, Franks, and Calanico(1972) dichotomize these particular positions as subordinate and superordinate in reference to specific interactionist perspectives(Thomas, Franks and Calanico, 1972). Theoretically, the Bi-Polar ex-patient can use these three strategies in order to obtain control over immediate family members in order to affect an orderly social readjustment phase. In particular, the Bi-Polar ex-patient may feel that power directed at the immediate family will reduce his subordinate status. This symbolic power, however, can only be achieved through others, such as family members. Family integration is an important concept. This variable may have a direct affect on the choice of strategy that an ex-patient chooses in reacting to immediate family support. One could speculate that the greater the disorientation that appears in any one immediate family the more confusion that will be felt by the ex-patient. As a specific focus therefore, this middle range theory will consider family integration as antecedent to family interaction, that in turn is the main determinant in evaluating an ex-patient's strategies for receiving immediate family support.

Finally the creation of this middle range theory is limited to the perceptions of the ex-patient with respect

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to immediate family support. Its range is an empirical explanation that is devoted to the specific strategies that the ex-patient uses in relating to the family during the posthospital and non-hospital social readjustment stage. Hypotheses are developed from the theory and tentatively tested against the findings.

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Chapter III

METHODOLOGY

The methodology creates a middle range theory which emphasizes the relationship between immediate family support and the perceptions of the Bi-Polar ex-patient who is trying to readjust to the social environment and the problems associated with the illness. In doing this, it is necessary to use descriptive statistics, such as percentages derived from the demographic information supplied by the focused interview schedule in order to gain an understanding of the different social environments of the respondents themselves. This is needed because Bi-Polar Affective illness causes drastic mood changes that reduce the social integration of the immediate family and the type of social interaction that is seen. Since the middle range theoretical assumptions and hypotheses are dependent upon the overall relationship between the Bi-Polar ex-patient and the immediate family, it is necessary to create a typology of the process of social support.

In constructing a typology, Lazarsfeld (1973: 21) suggests that in specific social systems, there are particular variates that need to be taken into account. It is these social sub-types that give certain social organizations

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unique status and separate them from other social systems. In this research, the immediate family can be seen as a social organization that has unique differences from one family to the next. Subsequently, one might assume that a particular respondent may view immediate family support from different perceptual positions based on the social integration of the immediate family itself. As Lazarsfeld(1973: 21) states:

> Much writing of sociologists includes the use of typologies. Personalities, social systems, organizations occur in so many variations that some way of ordering them is an indispensable preliminary for further analysis.

The use of a typology is required because the ordering of perceptions by the respondent is necessary in order to obtain a sociological understanding of immediate family support when comparisons are made between one respondent's viewpoints and another's. With the use of this theoretical typology, the researcher can compare the various components of immediate family support and how the respondent reacts to each of these. As an example of this ordering process, Lazarsfeld(1973: 21), suggests that:

> Erich Fromm has proposed that the relation of young people to their parents can be classified into four types: complete authority, simple authority, lack of authority and rebellion. The authority relationship in a family is classified by the way in which the parents exercise their authority and the way in which children accept it. Through questionnaires, the parental exercise of authority was rated as either strong, moderate or weak; likewise, the children's acceptance of authority was rated as high, weak or low. Logically, this makes nine combinations possible.

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From this example it can be seen that a typology can be ordered and measured through the use of a generalized diagram that places individual children and their authority processes into a concise scheme.

A data gathering procedure was developed by using Bi-Polar advocacy groups. Since the researcher was unable to obtain volunteers from in-patient units, it was felt that the advocacy group would be the best possible place to gather respondents. In doing this, negotiations were carried out with two specific groups in the Toronto and Windsor, Ontario areas. It took about one year to obtain approval from the executive boards of these two groups and to recruit volunteers who would consent to a one-on-one interview with the researcher, or his wife who holds a Masters degree in Sociology and is trained in interviewing.

During these negotiating sessions, the researcher agreed to prepare a consent form which covered all of the rights and responsibilities of the researcher and the respondent(see Appendix E). After a period of one year, a total of 22 respondents--six males and sixteen females--had volunteered to be part of the interviewing process. Since this was a pilot project, it was felt that the number of respondents would be enough to satisfy the requirements of the methodology.

In using the mental health advocacy group for this study, the researcher felt that a wide range of respondents would

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be obtained because of the goals and specific orientations of these groups. These groups, run by patients and ex-patients themselves, have become an important part of the mental health system. In part, groups have provided the patient an important base for social support and information that may not otherwise be obtained through the medical system which is overloaded with patients. Meetings for each of the two groups were held on a monthly, or bi-monthly basis. They were held in a hospital or rotated from one location to another.

The interview schedule used for this research is based on a model created by Robert K. Merton et. al. (1956) using a focused interview with the respondents. In doing this, the researcher can focus on specific sociological information that is important to the theoretical framework of the study. For this research, a three part format was created so that the researcher could obtain specific data from the respondent. Since each interview required elaboration on the part of the respondent, it was necessary to order it into three sections. (Appendix A)

1. Demographics.
2. Immediate Family Viewpoints.
3. Strategies.

Since the focused interview required a certain amount of control, organization and precise question format was utilized so that each interview could be carried out with as

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little confusion as possible. In building the questions themselves, the researcher devised a three part format so that each respondent had the ability to give a short non-descriptive answer to the inquiry, or the respondent could elaborate on each topic as much as was required. This was necessary because the respondent could have found a particular section to be too painful and therefore the particular question would be eliminated if the respondent so wished. It was also important to note that the respondent had the ability to skip entire sections of the interview if particular areas did not pertain to the individual social readjustment situation of the respondent. Subsequently, the respondent could answer most of the interview schedule, but could eliminate those individual parts that were not relevant. For example, if a given respondent did not perceive that dissociation was part of a primary stragegy in receiving immediate family support, then that section would be eliminated and the next section would be implemented by the interviewers. This was done because the researcher was interested in the perceptual viewpoints of the respondent and it was not necessary to pursue certain sections if the respondent felt that they were not important to him.

The basis of this methodology and theoretical framework is based on the development of a conceptual typology in order to analyze whether there are substantial comparisons or cases that stand out with reference to immediate family

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support viewed by the respondent. This typology is constructed from three separate dimensions:

1. Social interaction between the Bi-Polar ex-patient and his immediate family.
2. The social dynamics of immediate family integration.
3. Perceptions of strategies employed by the Bi-Polar ex-patient in relation to immediate family.

This methodology incorporates the development of a middle range theory which focuses on Bi-Polar ex-patient self perception of immediate family support. It also can analyze those respondents who were never hospitalized as well as those family members who live with a Bi-Polar ex-patient.

The first set of general hypotheses, which are tentative, deal with the Bi-Polar ex-patient's perception of social interaction as it relates to family support. These are:

A:If immediate family interaction is very positive then the Bi-Polar ex-patient's perceptions of immediate family support will be good during the social readjustment stage.

B:If immediate family interaction is very negative and the ex-patient is socially distant from his immediate family, then the respondents perceptions of immediate family support will be problematic as well as troublesome during the course of the illness and the social readjustment process.

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When one considers social readjustment as a primary problem in mental illness, the situation of the immediate family relationship is most important. Social integration refers to the amount of environmental stability in the immediate family. Consequently the following hypotheses are introduced in conjunction with the middle range theory and the conceptual typology:

A:If immediate family integration is poor, then the Bi-Polar ex-patient may respond poorly and exhibit negative feelings towards the immediate family and the perception of the quality of immediate family support.

B:If immediate family integration is good, then the Bi-Polar ex-patient will respond favourably towards the immediate family, and the quality of immediate family support will be perceived as being very good.

Specific strategies may be adopted by the ex-patient in dealing with the problem of the stigma of mental illness. The following hypotheses are proposed:

A:NORMALIZATION-If an ex-patient is open and honest about all aspects of the illness, then the respondent will perceive immediate family support to be beneficial and social readjustment factors will be easier during the course of the respondents illness and social readjustment.

B:PASSING-If an ex-patient is not entirely open and honest about all aspects of the illness, then social

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readjustment factors will become more complicated and relevant perceptions of immediate family support by the respondent will be negative.

C:DISSOCIATION-If an ex-patient hides certain aspects of the illness from both the immediate family or from others, then social readjustment factors will cloud perceptions of immediate family support and complicate the respondents social readjustment.

All hypotheses will be evaluated by examining the middle range theory evolved for this study and the conceptual typology as an analysis of the respondents own self perceptions. Consequently this analysis will be formulated in three stages. The first is to establish the background of the respondents through demographic and simple descriptive indicators. The second is to discuss the respondents perceptions of immediate family support with an emphasis on the family's individual social environment. And finally the third stage is to establish a conceptual typology that explains the theory and what the various strategic combinations are.

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Chapter IV

THE ANALYSIS

Respondents belong to one of two advocacy groups. The first organization, is located in a small community just north of Toronto. This association is well organized and provides assistance to many Bi-Polar patients and ex-patients who desire assistance. During the year, the York group can expect to get sixty to seventy respondents attending their functions in any given month. This figure changes, however, because meetings are not compulsory for any of the members, and their attendance fluctuates. Some of the respondents join after referral, or other communication such as advertising in newspapers or in other publications. The base of membership covers a large geographic area so that potential membership levels are high.

The second advocacy group, the Windsor Group, is an organization that was formed two years ago, and serves both the city of Windsor and Essex County. Membership is much smaller and this particular group is still building a base of operations that centers around social support for its members. Roughly half of the respondents used for this study came from each group. Meetings of the Windsor group

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are held twice a month and its purpose is the same as the York group, although the style and approach of each is somewhat different. While the York group tries to reach a wider spectrum of the Bi-Polar population, the Windsor group has a smaller geographic base to draw membership. To further elaborate, psychiatric facilities available to people living in and around Toronto are more numerous and serve a larger population then does the community of Windsor and its surrounding areas. Although this does not affect the end result of this study, the difference in facilities available to the Bi-Polar patient and the different social environments of these two communities may have some bearing on the two organizational climates.

4.1 Demographic Characteristics

Since this is a pilot study and exploratory in nature, the number of respondents for this study is small (N=22). Bi-Polar illness appears to affect more women then it does men, the number of women interviewed outnumbers the men:

Females-72.7% (16)

Males-27.3% (6)

These percentages also reflect the fact that more women attend and belong to these groups then do men. It is not clear if this is due to the conjunction of gender and Bi-Polar illness, or that more women attend and seek support from these groups. From a sociological position, the

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determination that more women attend these manic depressive support groups can possibly be attributed to the fact that women may be more open about their problems then men. Another interesting demographic point to consider in respect to the background of the respondents is the general age distribution of the volunteers themselves. Age category is an important theoretical indicator, because the older a person is in respect to manic depression, then the problems associated with social readjustment experienced by Bi-Polar ex-patients and significant others in the immediate family can become more complicated. The range of age for repondents was from twenty years old to sixty. The mean age of the entire respondent population was calculated to be 43.9 years of age. This is significant because most of the subjects either had long standing careers with Bi-Polar illness, or showed the disease later in life.

It was indicated earlier in the methodology, that there would be two primary sub-groups established for this research, and that the researcher would also incorporate this classification into the selection process. During the data gathering procedure, the researcher also included family members who wished to be interviewed. The resulting classification shows that:

Respondents who are currently married-63.6%

Respondents who are single, divorced, widowed, separated-27.3%

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Respondents who are family members(without the illness)-9.1%

These percentage trends reflect the general feeling of the researcher that, most of the repondents would be married, whether they had children or not, and that the core of their support system would be maintained in a family of marriage. Theoretically, this type of social situation should not be construed as changing a particular response towards family support as being positive, or negative, because mood structures may be the overriding factor that contributes to a given perception of family support. There are also children found in each of the types of respondent families. Children can be an important vehicle for support, because they may be looked at as buffers between the main role players in the social readjustment process of the respondent. An example of this can be seen in the number of respondents who were married:

Total number of respondents who were married who had children-16.

Number of children in this category-47.

Number of male children-27

Number of female children-20

The significance of these statistics, in developing a demographic picture for these respondents who are married, seems to indicate that there are many support factors within the married sub-group. The age of these children is not

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calculated here, because the respondents perceptions of immediate family support was the main focus of this research. In the single, separated and widowed categories, there were 14 children.

The primary focus of this study was on the Bi-Polar ex-patient who entered a psychiatric facility and then experienced a posthospital and non-hospital readjustment phase with his immediate family. It was discovered, during the interviewing process, that a small number never entered the hospital at all, and that a number of them were treated in different treatment settings that did not require hospitalization. These respondents may, in fact, be classified as exhibiting mild symptoms of the disorder, for most of the respondents did enter a psychiatric hospital and underwent a posthospital phase of social readjustment. In keeping with the original theoretical and methodological requirements set forth in the study, these individuals were not rejected, because valuable sociological insights could be gained by comparing their perceptions along with those of the hospitalized respondents:

Number of respondents hospitalized-15

Number of respondents not-hospitalized-7

Percentage of respondents hospitalized-68.2%

Percentage of respondents not-hospitalized-31.8%

From these percentages it can be assumed that support from the advocacy groups themselves is both important for those

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who were hospitalized and for those who never entered a psychiatric facility at all, because of the same adjustment difficulties that could arise for both groups of respondents.

The use of medication in treating Bi-Polar illness is an important issue in the social readjustment of the respondent and the relationship with family can affect medication compliance. In contrast to this, there can certainly be a number of individuals who become allergic to these medications at the onset of their treatment, or their bodies may significantly reject all chemotherapy after a given period of time. It is important to realize that lithium carbonate has become very effective in the treatment of Bi-Polar disease for those individuals who can adjust to it. It is also important to note that lithium can be administered to people in combination with other medications.

In the demographic section of the interview, the respondent was asked if medication was used as part of the interviewee's treatment process:

Total number of respondents who took medication-81.8% (18)

Total number of respondents who did not take medication-18.2% (4)

Even though the number of respondents interviewed is small, there is support for the notion that the number of

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respondents who needed lithium and other types of medications in order to function was quite high.

The introduction of religion into this analysis is important because a number of respondents perceived religion as a corner stone in their social readjustment process:

Protestant-40.9%

Roman Catholic-22.7%

Other-36.4%

The significance of religious orientation, may well have a bearing on the perceptions of the social integration of the immediate family because the respondent may use this as a further support mechanism if the immediate family is not well integrated and united throughout the social readjustment stage.

The need to belong to immediate family social structures, seems to be a very important issue for the respondents in this study. Out of 22 respondents only one respondent indicated that living alone and maintaining a distant relationship was most important. Even though these individuals could be considered immediate family for this respondent, a relationship was achieved and accepted by the respondent as being important to the overall social readjustment. In examining the patterns of living with immediate family during the entire course of social readjustment, the following results were indicated.

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For all of the respondents in this particular research, the period of any one respondent living with another person, lasted from three weeks to thirty years. This is significant, because the immediate families of each of these respondents appeared to be totally involved in the social readjustment phase of the illness no matter what the social conditions were. Essentially, the following contrasts were found in reference to the following sub-groups for this study. For the entire sample, the mean duration of the illness was 13.9 years:

Total span of years for married sub group-3 weeks to 30 years.

Mean years for married sub group-13.9 years.

Total span of years for single, widowed and separated respondents-5 years to 19 years.

Mean years with illness for those who are single, widowed and separated-11.4 years

One respondent lived alone but had contact with immediate family.

Since economic stability is a primary feature of the social readjustment patterns of individuals who suffer from such disorders the work histories of each of these individuals is quite varied, dependent upon the length of the illness and the changes seen in the immediate families themselves. For some people their jobs never changed and they maintained the same occupational positions in life.

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For others the onset of Bi-Polar illness meant a change in career because of job loss during the course of the illness. The following delineations represent the most recent occupations held. It is important to note that many of the respondent's occupational positions and shifts are too numerous to mention here, so the most recent information is given. For the married group the following occupations are:

Professional and semi-professional-5

Sales and Clerical-2

Housewife-7

Unemployed-1

For the single, separated and widowed catagories the following occupational statuses are:

Professional-2

Semi-professional-2

Sales-1

The following occupational percentages are for family members not afflicted with the disorder itself:

Professional-1

Semi-professional-1

4.2 Analysis of Interaction and Integration

The primary focus of this analysis is to analyze, through the respondents own perceptions, the quality of the relationship between the Bi-Polar ex-patient and the immediate family. The following hypotheses are presented in this section.

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A:If immediate family interaction is very positive then the Bi-Polar ex-patient's perceptions of immediate family support will be good during the social readjustment stage.

B:If immediate family interaction is very negative and the ex-patient is socially distant from his immediate family, then the respondents perceptions of immediate family support will be problematical as well as troublesome during the course of the illness and the social readjustment process.

A:If immediate family integration is poor, then the Bi-Polar ex-patient may respond poorly and exhibit negative feelings towards the immediate family and the perception of the quality of immediate family support.

B:If immediate family integration is good, then the Bi-Polar ex-patient will respond favourably towards the immediate family, and the quality of immediate family support will be perceived as good:

The following indicators, which have been reviewed earlier are used to categorize responses in terms of interaction and integration.

1. Physical Security.
2. Expression of Love.
3. Securing love.
4. Expression of hostility.
5. Expression of spontaneity.
6. Membership in a human group.

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4.2.1 Physical Security

The term physical security, as defined in this study, refers to economic support and the maintenance of a home for respondents who are married or are non-married. This concept is important because the social readjustment of Bi-Polar ex-patients who retain contact with significant family members can affect how well they reintegrate into the immediate family and adjust to their individual living environments.

The explanation of this variable through self perception of the respondents while coping with Bi-Polar Affective Disorder, also suggests that there are significant differences between ex-patient's family environments based on levels of social interaction determined through contacts with members of the immediate family.

For married respondents who are Bi-Polar, a complete family social structure provides support that can be positive or negative depending on the severity of the illness and the length of time it takes to reintegrate and socially readjust to the family. Living in a complete family setting can be advantageous because the married ex-patient feels more secure in this type of situation although the complete family environment does not decrease the problems linked with the illness. The threat of separation, high expectations and non-caring family members produce marked effects on the married respondents living

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with the immediate family. "I am dissatisfied with my home life, there are drinking problems that cause extreme difficulties for me."

In particular, physical security was threatened by those family members who wish to withdraw from the ex-patient because of a lack of awareness of the illness itself. Most married respondents, who had children, felt that they had played an important role in keeping the family together; higher levels of physical security were perceived by the respondents as protecting these children from a possible separation or divorce. In some cases where divorce and temporary separation may have come about, the family was able to be reunited with a greater understanding of the illness.

> During rough periods of my illness my husband and I decided to separate. I had to leave home because I could not handle other problems with members of the family.

In the non-married classification, security is achieved by the respondents own choice which in this study meant that the non-married ex-patient were living alone and essential family contacts was maintained at a distance. All respondents who were not married, provided homes for themselves and in most cases they were self sufficient. In other instances, economic security was sometimes given by socially distant significant family members.

> My children provided a lot of support while I was separated during difficult periods with the illness...Because my family put pressure on me, I had to live on my own...My mother was most supportive and gave me partial economic support.

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For the non-married respondent, social isolation and immediate family separation seemed to be mildly troublesome to them, whether social support was given or not. It is this type of family social setting that at times produced anger and frustration with those family members who did not wish to become involved with the non-married Bi-Polar ex-patient. "My parents did not want to bother with me and my husband withdrew from me. I felt at this time that no one cared for me."

In this case, physical security is not all that clear because separation from a complete family social environment could have occourred before the trauma of the illness and being married was not all that important to them. For other non-married respondents social distancing and the need for independence is quite important in order to control the amount of contact with important family members who are perceived to cause problems for the respondent.

Although differences in physical security are quite clear for both classifications of ex-patients, the need to reintegrate and establish levels of social interaction is primarily important to all respondents whether married or non-married. With regard to the hypotheses, those who are married ex-patients, demonstrate higher levels of reintegration while those ex-patients who are non-married experience moderate levels of social interaction and reintegration because they live alone and do not have the closeness of a complete immediate family social structure.

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4.2.2 Expression of love and Securing love

The expression of love and securing love, can be linked together because similarities exist between both concepts and the respondents self perceptions are comparable.

The primary interconnection of this system of sharing love is based on symbolic interactionist references that relate to the subordinate who is the Bi-Polar ex-patient and family members who represent superordinate, or power positions. In theory, the expression of love and securing it are directed at family members who struggle with the ex-patient's problems with the disorder and many methods are used by the ex-patient in order to bring the immediate family closer together.

In discussing these feelings, the ex-patient tries to reduce the subordinate status that is characteristic of mental illness in general. The ex-patient may also show love to important family members in order to reduce this negative social position that results from the illness. In theoretical terms, ex-patients will try to secure love from family members so that they can reduce anger and frustration by expressing feelings of love that are defined as showing important inner feelings to receptive family members. In conjunction with this, these two variables are intertwined and reflect the ex-patient's defined level of social interaction whether the individual respondent is married or not. In this sense, expressions of love and

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relevant actions taken in securing it are described as being more related to social support with respect to relationships developed with family members during the social readjustment stage of recovery.

For most of the married respondents who live in a closed family system, all feelings of love are perceived to be directed at those family members who are willing to help the ex-patient readjust to a new living situation. It is this changed way of life attributed to the illness that presents many complications in expressing inner feelings. In particular, the married respondent displays affection and states in most cases, that love is expressed and secured with members of the family who are willing to be genuine and try to understand the ex-patient's problems.

> I feel that my entire immediate family showed love and support. The most love came from my husband...In the beginning there was no love for me. As time went on my family life stabilized. Medication seemed to improve my situation, and my husband became more supportive.

All married respondents who were interviewed felt that they could express their feelings and secure love from important significant family members. They also indicated that there were three reasons for this important process to occur. The first requirement suggests that family members who cared for the married respondent were approached by the ex-patient in order to express feelings and secure needed support and affection while adjusting to medication and mood changes with the illness. In these instances, married

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respondents said that levels of social interaction were moderate to high as knowledge of the problem became less confusing to significant family members. The second factor indicates that positive interaction from caring individuals in the family, was determined by empathy that these individuals had for their sick family members. Finally, when positive support was established, all of the respondents said that knowledge of manic depression was necessary for them to secure and express feelings to important relatives who understand. For married respondents, the self perception of expressing affection and securing reinforcement from positive family members was defined by them as possibly keeping the immediate family together. "At this time I feel that my immediate family provide love, caring and support. My husband was most supportive after medication was stabilized."

In the non-married classification, the same perceptions exist, although for the non-married the fact that they lived alone reduced their ability to interact with positive significant others in the family. With respondents who were not married, contact with empathetic family members allowed them to express feelings and also to secure valuable social support.

> My mother was very empathetic, but my sister did not care...I really felt they did not care for me at times...My mother tried very hard to understand...I feel that I am self supporting I develop my own support. If I need support it comes from my sister and adopted son...My family always showed me love and caring, they never withdrawed

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> from me. I feel love and caring is vital to myself and family. My brother's and sister's gave me a lot of love and support.

For all respondents in this category, non-married ex-patients indicate that they liked the way their defined immediate family cared for them. For these respondents selecting those family members who were caring and tried to understand their problems was an important factor in developing levels of support and social interaction. They also said that this process of selection made them feel that they could reduce the amount of anger and frustration associated with individuals in the family who chose to withdraw and did not care at all.

Finally, for both classifications of ex-patients, expressing love and interacting with positive family members is similar in perception, even though their immediate family social settings are quite different. For married respondents expressing vital inner feelings can be perceived as being more direct while levels of social interaction can be reduced because those family members who wish to withdraw from the respondent live with the ex-patient in a complete family social environment. In this case, expressing feelings of affection and securing support, from positive significant family members can be problematic. "During difficult periods with my illness, my husband put up a wall and withdrew. I felt that I could not give love back to him."

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With respect to non-married respondents, expressions of love through the transference of inner feelings and attempts to secure affection are selective because of being separated from important family members. Here social interaction can be perceived as being lower because the respondent lives alone. In conjunction with this, the non-married respondents say that maintaining this separation allows them to control the amount of contact that they had with family members who would not tolerate their problems and choose to withdraw from them. In both categories of respondents, patience, knowledge of the illness and encouragement, are closely interrelated with expressions of love and the ability to obtain it.

4.2.3 Expression of hostility

The expression of hostility as a social component for married and non-married ex-patients, examines the social interaction that is expressed through overt behaviour that is extremely negative and affects the overall social condition of immediate family support. The expression of hostility refers to withdrawal of the respondent from the immediate family. Although this type of social behaviour can be displayed in other chronic types of mental illness, this behaviour is frequent in Bi-Polar illness. In this respect some specific contrasts are developed.

For all married respondents, the self perception of overall social conditions with the entire immediate family

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was considered to be moderate to good, even though for some individuals, there were problems that were always apparent. In understanding how expression of hostility conceptually fits with such an unpredictable illness such as Bi-Polar illness, many of the Bi-Polar married ex-patients stated that during periods of mood fluctuations and emotional disorientation there was frustration, anger, and discontent. In a number of married cases there were no real problems with expressions of hostility, but most of the respondents who experienced this reaction thought that it occcurred during the depressive phase of the illness.

> I felt pressure due to anger from my illness. Because people would not respond the way I wanted them to...Just before I was given lithium, I was catatonic, I became angry and withdrawn. I felt frustrated during periods of depression. I felt that maybe my mood swings were responsible for this.

For respondents who were not married, they indicated that they had a fairly stable relationship and contact with their immediate family. With these respondents, most suggested that they experienced the same reactions as married respondents when they entered the depressive cycle of the illness. In some cases, the non-married respondents suggested that their immediate families became angry because of a lack of understanding of the illness. In all cases, expressions of hostility did not cause any of the respondents to completely cut off their relationship with their immediate families.

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> During mood changes I became ambivalant and isolated....Because I was alone I became frustrated and angry during periods of depression. I also had many family problems. I felt all of my relatives were frustrated by my illness.

Married respondents also said that problems that frustrated them during periods of social readjustment, were related to extended family and other outside individuals. For all respondents the feeling of aggression towards immediate family members did not negatively affect the overall condition of the immediate family even though the scope and severity of the illness changed specific levels of social interaction,and possibly caused marked charges in social behaviour for all. Only one respondent stated that complete withdrawal from the immediate family was necessary in order to socially readjust.

> I felt very withdrawn from my immediate family....At times during depression I became very angry. I am not open about my problems and this gets everyone angry.

Finally, expressions of hostility can reduce the amount of social interaction that is experienced between a person who suffers from Bi-Polar illness and the immediate family. Withdrawal in some of these examples, seems to alter the need to obtain important caring systems which are related to moderate levels of anger and frustration. For all married and non-married respondents interaction levels charge from positive to negative depending on the respondent's phase of the disorder.

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4.2.4 Expression of spontaneity

The expression of spontaneity, is a concept that is directly related to the biochemical changes in mood cycles that Bi-Polar respondents experience. In respect to these changes, immediate family relationships are affected by sudden changes in the ex-patient's mood patterns and attitude. Consequently, social interaction between the ex-patient and family, can shift from positive to negative levels, depending on the Bi-Polar ex-patient's emotional condition.

For some of the married ex-patients, they said that problems related to mood cycles could be handled by patience and acceptance of these sudden changes. In these cases, the married respondents felt that higher levels of social interaction were dependent on how close their families were during periods of biochemical fluctuation. In other instances, the mood cycle relating to depression caused family members to withdraw from the ex-patient because of confusion and a lack of understanding.

> My family did not react differently because of my illness. Belonging to the manic depressive advocacy group helped me a great deal...I try to stay in control of my general situation...My family is always quick to point out my mood swings especially when I am depressed.

Social interaction was lower and the immediate family relationship becomes more complicated. In most of the married examples, both the manic and depressive phases caused some embarrassment and immediate family members were very concerned about their ex-patients.

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In the non-married classification, the same concerns are perceived for biochemical changes in mood state. For these respondents, living alone means that they must cope with mood cycles by themselves. In this regard, the non-married respondent feels all support systems are important to the social readjustment process. In particular, these respondents try to interact with all available individuals who are positive, empathetic and who try to understand their emotional difficulties. Because all of the non-married respondents are alone, these important social support systems are: family, outside relationships and support given to them by the manic depressive advocacy group. Consequently, if mood cycles are perceived to be a problem for these ex-patients then social interaction is reduced because of withdrawal and possible problems with these sudden changes in mood structure.

> Even though my immediate family relationship is not that good, my mother was always there and concerned...I felt that I was an embarrassment because of my mood changes. I withdrew and tried to escape from reality...I withdrew from my sisters before my understanding of the illness, but we became closer as I became better.

Finally, manic depression and its biochemical process of cyclic behaviour from mania to depression can decrease the amount of social interaction between the ex-patient and his family. In all cases, both the married and non-married respondents say that they feel that experience with the illness is an important factor in dealing with these

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problems. Included within the self perceptions of the respondents, is the need for important biochemical information about medication and mood cycles to be given to significant family members as well as the respondent.

4.2.5 Membership in a human group

The social process of remaining within the immediate family for those Bi-Polar ex-patients, is perceived by all respondents who are married as being very important in readjusting to Bi-Polar Affective Disorder. All of the respondents stipulate that acceptance of the illness by themselves and their immediate family is a key to their remaining with their families.

> I feel that acceptance of my illness made me feel part of the family. It helped me adjust better and faster...I am still trying to improve my relationship with my immediate family by trying to accept my illness. I find it to be a difficult task.

The notion of belonging to family and outside associations is important, if not critical, to those who suffer from mental illness. For non-married respondents initial contacts with significant others while still independent, is for them a way of reducing frustration, social isolation and anger. What was perceived to be important for these respondents in this study, is the feeling that they could maintain contact with these significant others who accepted their illness and this is important in reducing social distance. In comparison with

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married ex-patients, belonging to immediate family social structures allows them to develop a stronger relationship with important distant family members.

> My mother was extremely important in giving me support. I feel it is important to belong to social groups as well as making friends...During my separation from my husband, my children were extremely supportive and made me feel part of the family. I also felt it was necessary to develop outside relationships, such as friends and people at work.

In some non-married cases where immediate families did not accept the illness, there were problems to deal with such as withdrawal and expectations to function and develop outside relationships. "I did not feel that acceptance of my illness made a difference for my sisters and did not improve my relationship with them."

In developing an explanation as to why belonging to an immediate family support system is so important, three reasons are presented for married respondents who stay with their immediate families while they are in their social readjustment phase.

The first explanation, suggests that a sense of belonging is a vital part of the ex-patiemts recovery process that is reinforced through membership in the immediate family. The second point relies on outside relationships, such as extended family and friends giving additional support and understanding to the ex-patient. Finally, the role of the Bi-Polar advocacy group can fill needed gaps with information and social support that is not apparent during

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the course of treatment. For married respondents who have positive social readjustment experiences, all three social determinants are perceived to be present to some degree. In respect to negative social situations, some of the respondents who have difficult periods of social readjustment with their immediate families feel that a lack of acceptance and information made adjustment problems for them more severe.

Generally, the self perception of support through acceptance and understanding of Bi-Polar Affective Disorder increases the level of social interaction for those ex-patients who are married and have a positive outlook towards social readjustment. In this category, for most of the Bi-Polar respondents, the level of interaction is supported through immediate family members who are willing to take part in the social readjustment process, whether hospitalization is required or not. For those married respondents where social readjustment is not positive, social interaction is lower and the prospects for recovery are perceived to be troublesome, with many ongoing difficulties. In all cases, important social support from one of the advocacy groups seems to be a positive step in this type of reinforcement system for married respondents.

The self perception of membership in a human group for non-married respondents is quite similar in comparison to married. All of the respondents in this category said that

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strong levels of immediate family support and social interaction could be achieved through acceptance of the illness by immediate family members. They also indicated that social interaction should be established with outside individuals who are considerate and can empathize with a respondents problems during the social readjustment period.

4.2.6 Self Perception and the Non-Bi-Polar Family Member.

During the interviewing stage, two family members wished to volunteer and become part of the research because they felt that it was important to become involved. Their self perceptions included in this analysis provide a sociological contrast that is valuable in understanding the attitudes and feelings in conjunction with their Bi-Polar family members.

The two family members who participated in this research are not representative of the entire family population who live with the disease, but their contribution is important because of that what they perceive to be important with respect to social readjustment parameters.

With respect to self perception and social readjustment, the family members' feelings are guided by extreme difficulties with Bi-Polar ex-patients who manifest the illness in a severe form. When asked to respond to the various topics important in adjusting to Bi-Polar social problems that affects them, they say that social isolation, withdrawal, and violent anger, at times produced many complicated situations for them and that separation from the

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patient was necessary in the beginning. "I contemplated leaving home because problems with the illness were too much for me. I had to have time for myself. Too many family problems."

In many instances physical security was threatened by divorce and separation while specific manipulations were perceived to be used in gaining medical compliance in the early stages of the illness. Levels of social interaction were seen to be quite low in the beginning. Irritating aggression attributed to the manic-phase was viewed as blocking needed affection, and expression of love for family members was difficult to achieve. As a source of reinforcement and support for these immediate family members, other significant members of the family were approached in order to keep the family together. In these two cases, social interaction levels changed according to drastic mood patterns.

> My sisters were very helpful to me in trying to understand these problems... I felt that because there was illness in the family, my parents were overprotective and put a lot of pressure on me.

Specifically, the acquisition of love for both immediate family members was maintained through all phases of the illness and because children were involved, breaking up the immediate family was in these two cases never really contemplated. Consequently these family members said that they never at any time rejected giving or receiving love. "I had problems in receiving love during the illness of my

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family member, but I never stopped giving love although it was very difficult for me."

For both of these individuals, hostility and anger was produced by frustration towards an illness that they do not understand. Their self perception of anger was mostly confined to the manic phase where agitation by the ex-patient produced the most problems for them. They also stated that when mood transitions became very bad for them they felt that retaliation was needed in order to protect themselves and other family members. In these two examples, the respondents took responsibiltiy for, and said that they had the most problems in adjusting to, the difficulties associated with Bi-Polar Affective Disorder.

> I got very angry and upset. Mood changes caused me to get angry and I found myself withdrawing when things got very bad for me. I tried to get along with everyone and got support from a friend who had a brother with the same illness.

The need to cope and maintain immediate family stability for these two family members, was comparable in self perception to Bi-Polar ex-patients. For the two respondents interviewed the fear of violence related to the manic phase and the need to understand these problems was quite apparent in their perceptual reactions.

Social interaction, for the family members interviewed in this study, fluctuated from negative to positive and in these two cases never fully stabilized even though the immediate family remained.

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Figure 1: Total Property Space For Primary Conceptual Variates.

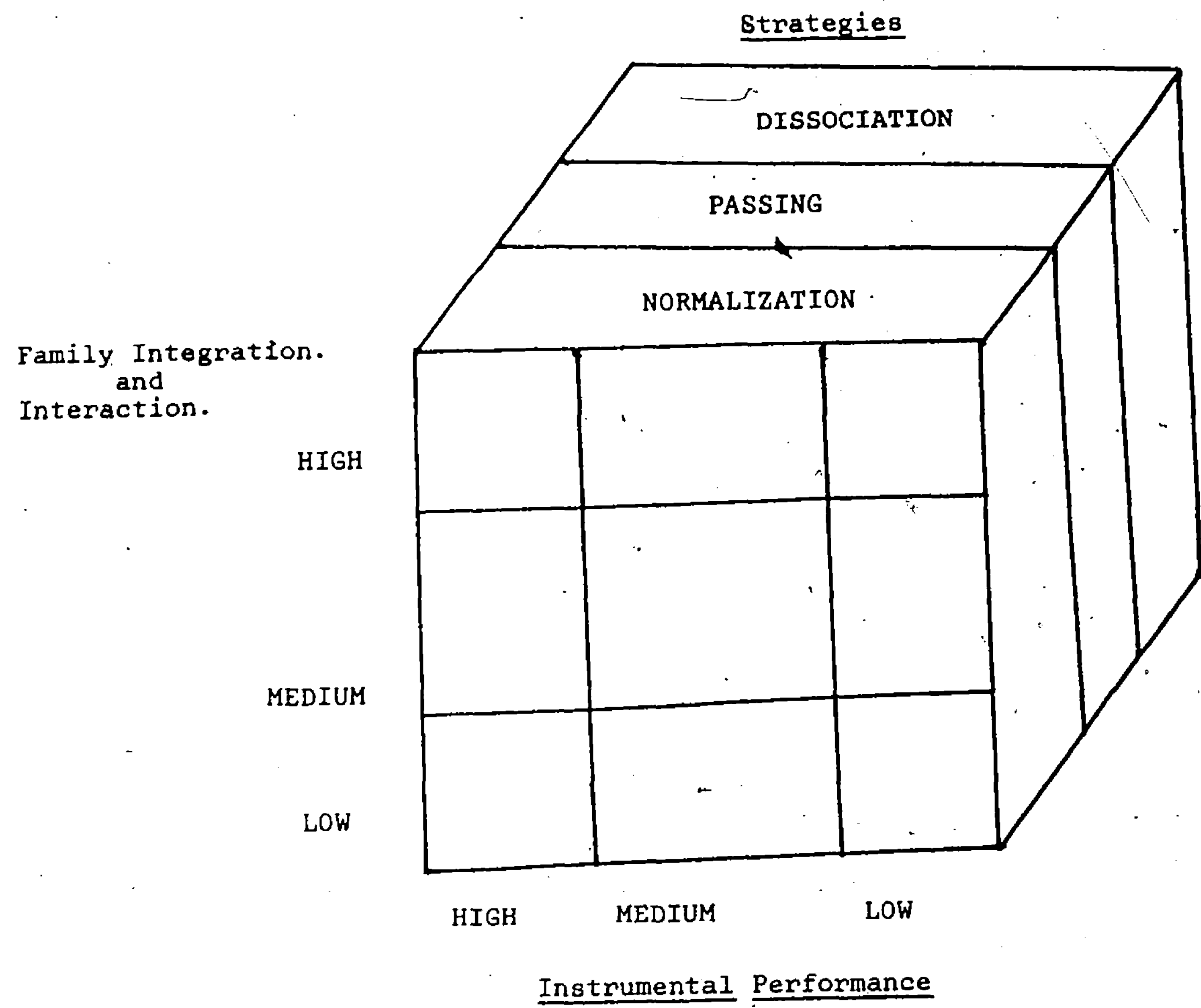

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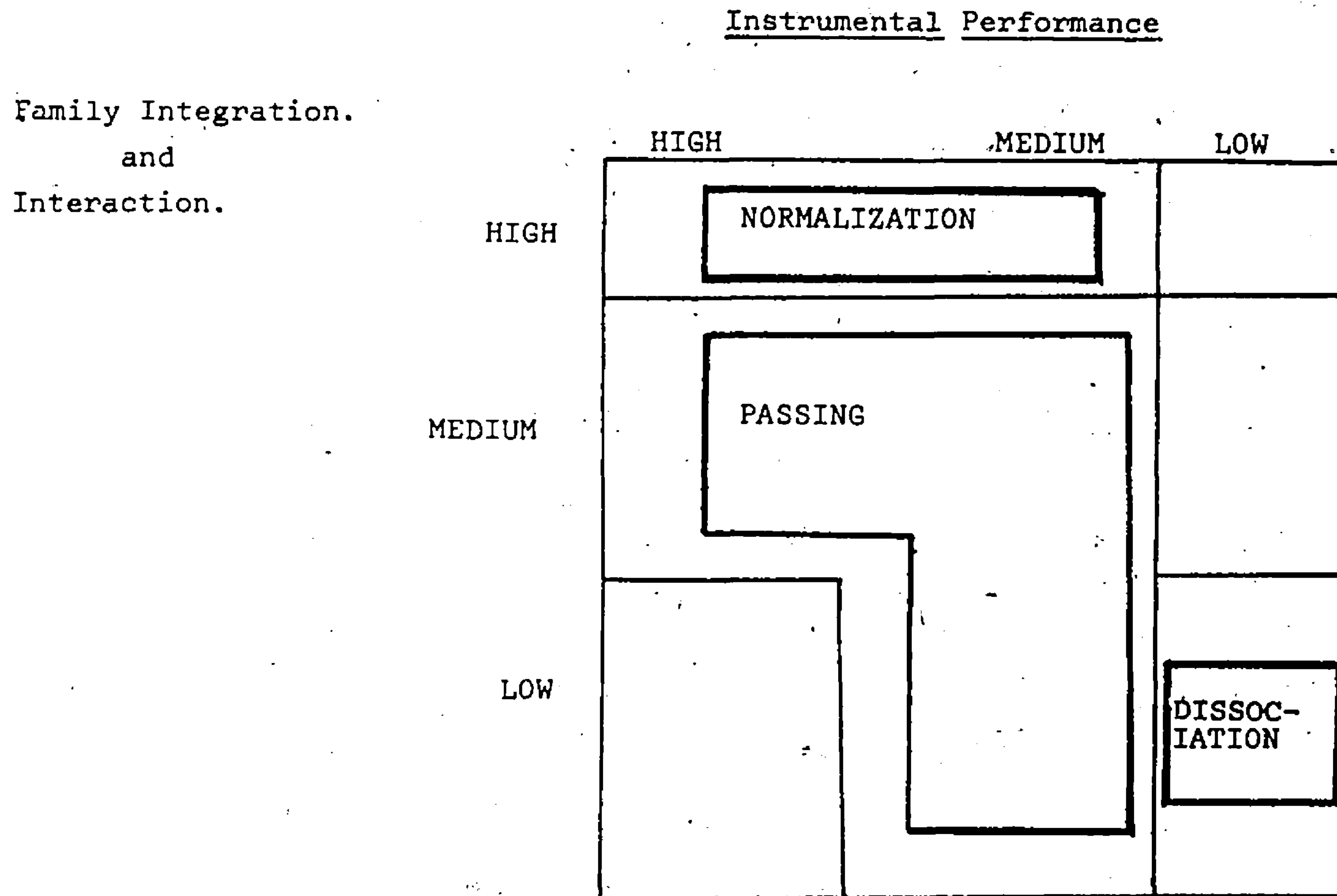
Figure 2: Substructed Property Space for Primary Conceptual Variates.



Chapter V

THEORETICAL ANALYSIS OF THE TYPOLOGY

The following chapter will examine how important reactions and perceptions of the Bi-Polar respondents can be theoretically represented. In accomplishing this, the primary relationship between the responses of the ex-patient and the immediate family will be discussed through the use of the theoretical framework for this research and the typology of a substructed property space for primary conceptual variates. However, the central analysis will revolve around the general figure that shows the different levels of strategic behaviour that occurs in the social readjustment of the Bi-Polar ex-patients interviewed in this research.

In constructing the typology, placement of strategies in the various cells demonstrates the combinations of strategies that are used by the respondents. This format allows for an assesment to be made as to where the three primary strategies are used in this study.

Figure 1 demonstrates the total property space that includes the major conceptual variates. The vertical axis illustrates social integration and social interaction as being High, Medium and Low. The horizontal axis represents

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the levels of instrumental performance of High, Medium and Low.

The third dimension represents the strategies of Normalization, Passing, and Dissociation. These three perceived strategies are used by ex-patients in social readjustment to their immediate families and other outside relationships. These three specific social behaviours are implemented in order to deal with the pressure and expectations that are associated with mental illness. In most cases that are referred to in this research these strategic behaviours are used as a way to reduce the impact of stigma associated with Bi-Polar Affective Disorders.

Figure 2 is two dimensional and is the reduced property space of Figure 1. The left axis illustrates social integration and social interaction as theoretical indicators. It is categorized as being High, Medium and Low. The axis at the top of Figure 2, indicates instrumental performance as a theoretical designation of levels of functioning during the social readjustment stage and is categorized in terms of being High, Medium and Low. The interior of the figure contains the strategies placed in cellular form with black cells indicating improbable choices of social behaviour. It is this conceptual scheme, that will be used in theroretically explaining the respondents self perception in reference to the strategies.

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The hypotheses that are evolved will rely on these three essential modalities to focus on the perceived reactions of the ex-patients in their social readjustment periods. Other strategies could be used by the ex-patient in order to deal with problems with mental illness, but these three primary strategies best explain what is taking place.

5.1 Normalization

Normalization, which is the most positive social behavior, may be explained and defined as an ex-patient being totally open and honest about the illness with respect to social stigma attatched to mental illness. Specifically, a person who suffers from Bi-Polar Affective Disorder does not feel that information relating to the mental pathology should be hidden from members of the immediate family, or society. In this instance, the ex-patient does not use social isolation, withdrawal, or other types of social behavior of this type in order to interact with significant people. Two hypotheses are presented in order to analyze the nature of this strategy.

A:If an ex-patient is open and honest about all aspects of the illness, then the respondent will perceive immediate family support to be beneficial, and social readjustment will be easier during the course of the respondents illness.

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E:If an ex-patient is not entirely open and honest about all aspects of the illness, then social readjustment problems will become more complicated and relevant perceptions of immediate family support by the respondent will be negative.

5.2 Passing

The term Passing is a strategy that is defined as an ex-patient hiding information from immediate family members and others who are important to him during the social readjustment process. In using this behaviour, the Bi-Polar ex-patient tries to protect certain individuals in the immediate family who have been negatively affected by his disorder. Another reason for the ex-patient to engage in this type of behaviour, is to neutralize anyone in the social environment who may be in conflict with him, and this may not represent a positive influence for social readjustment. In this case, the ex-patient may try to manipulate these individuals in order to gain needed support from them. Finally an ex-patient may choose passing behaviour because he feels that revealing all aspects of the illness would not make a difference at all and might complicate the social readjustment phase even further. In Passing, the process of social isolation and withdrawal is exhibited in mild forms and in most instances is used where immediate family members do not understand the scope of the

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problem or do not wish to tolerate the apparent difficulties of the disorder. Two hypotheses are presented:

A:If an ex-patient hides certain aspects of the illness from the immediate family, then social readjustment factors will result in him partially withdrawing from the family environment.

B:If an ex-patient hides certain aspects of the illness from both the immediate family and from other people, then his perception will be clouded and this will complicate his social readjustment.

5.3 Dissociation

The social behaviour of Dissociation, as defined in this study, is when the ex-patient uses total social isolation and withdrawal as a primary modality in readjusting to the illness. Two hypotheses are used for this theoretical evaluation.

A:If an ex-patient completely suppresses information about the illness from the immediate family, then all perceptions of support will be negative and cause the ex-patient to become socially isolated from the family.

B:If an ex-patient completely suppresses information about the illness from the immediate family, and others in society, then all perceptions of family support will be very negative and cause the respondent to become socially withdrawn and isolated.

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In reality, all three strategies are used by ex-patients in trying to cope with immediate family members.

For these respondents who feel that normalization is an important part of the strategic process, most of these individuals are considered to exhibit high to medium instrumental performance, where levels of social interaction and integration are considered to be high also. Most of the respondents indicated that passing behaviour was a primary choice in interacting with immediate family members. In Figure 2, passing is associated with medium levels of social integration and interaction while a small group of respondents exhibited lower levels of social interaction and integration. Only a few respondents engaged in dissociation as a strategic mechanism and there levels of social integration and interaction were low, and instrumental performance was also considered to be low. Normalization and passing were used most frequently by a majority of respondents, and dissociation was not used often as a primary mode of strategic behaviour during the social readjustment process. All of the respondents use all of these strategies at some time in their social readjustment period, but there was typically a moderate level of social interaction and integration.

When one examined hypotheses relating to normalization the fact that some respondents were open and honest about their illness seemed to be consistent with higher levels of

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social interaction and social integration. However, passing behaviour could also have been connected with normalization and the numbers of individuals using those combinations indicated that hiding certain aspects of the illness in order to protect ones own social position in the immediate family, could have been a more acceptable explanation. More people mildly withdrew rather than totally became open and honest about their problems with immediate family members.

Dissociation behaviour was an infrequent strategy. This cell, located at the bottom of figure 2 indicated extreme withdrawal and social isolation, with lower levels of instrumental performance, and social integration and interaction. Both hypotheses, related to this strategic mechanism, suggest extreme detachment from both the immediate family and outside associations. These hypotheses could be accepted for a small group of respondents.

Upon further examination of the substructed property space conceptualization in Figure 2, a number of blank cells appear in reference to social integration, interaction and instrumental performance. These empty cells represent social behaviours that are very unlikely to occur. For example, a respondent would be unlikely to exhibit high levels of social integration and social interaction with accompanying very low levels of instrumental functioning. This is considered a theoretical impossibility with regard to strategic social behaviours during the social readjustment process.

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5.4 Theoretical Discussion of Strategic Behaviour

The qualitative findings through the perceived responses of the twenty Bi-Polar ex-patients reflects the social distancing levels that are subsequently related to social integration and interaction and can be inferred from the middle range theory. The hypotheses that are incorporated in this study, do not clearly reflect respondents' perceptions. The explanation for this is that many of the respondents interviewed for this research did not understand the biochemical basis of their disorders, and this could have had a great deal to do with their selection of strategies. Another important sociological fact that should be commented upon is that traditional philosophies of mental illness held by society seemed to guide their reactions to the interview. They tended to adopt standardized and stereotyped definitions of mental illness. In fact, a number of respondents felt comfortable with simple biochemical explanations of the illness which seemed to reduce the social distancing between themselves and the immediate family. With respect to associations on the outside, the traditional influence of norms related to mental illness seemed to lower the interactive expectations of some of the respondents and reduced their levels of instrumental performance particularly in terms of employment and outside relationships. A number of factors may affect this explanation. The first one suggests that

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many of the respondents and their primary support members did not understand the illness or how to respond to it. There are marked differences in social distancing that are related to social integration and interaction.

The twenty respondents used each of the specific strategies in a combination of different ways depending on the severity of the illness and the length of time that the respondents were in the social readjustment phase. The justification of these perceived selections was contingent on a dual support system that was established by both the immediate family and the chosen advocacy group. Having that added support seems to have increased the level of instrumental performance, and reduced the need for the respondent to withdraw entirely from the immediate family and other support. In fact, the typology as an explanation seems to demand a higher level of social integration and interaction within the context of the immediate family social environment although this could result from some of the respondents overestimating their social readjustment experiences. With respect to the hypotheses that are developed from the middle range theoretical framework, a precise evaluation of the sociological parameters is not clear because many of the twenty respondents had manifestations of the illness that produced mood cycles that were changing from the manic phase into the depressive phase at different intensities. As a consequence of this, the

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respondents perceived evaluation of events during the time that the interview took place could possibly have influenced the general perception of the respondent's relationship with the immediate family and social readjustment stage.

Finally, the concept of normalization and its higher levels of social integration and social interaction along with instrumental performance may be an extension of passing and dissociation behaviours. This can be supported by the notion that dual support systems--belonging to advocacy groups--increases the overall understanding of biochemical mood alterations associated with the disorder. The sociological explanation is that these groups provide all of the necessary information and education that members require in order to improve their understanding of a complex illness.

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Chapter VI

CONCLUSIONS

The following sociological findings can be developed from this analysis. It is quite clear from the personal descriptions and the theoretical discussion, that instrumental performance must appear if social integration and interaction between the ex-patient and family is to be maintained. If instrumental performance (the ability to function) is quite low or non-existent, then the ex-patient will not be able to reintegrate and social interaction is not maintained. It would appear that instrumental performance must come before social integration and social interaction for immediate family support to develop. In this research, instrumental performance is moderate to high in most cases, and very poor in a few instances.

In developing this important point, the following determinations are made with reference to the two central questions that are included in research conduted by Robert Stebbins.

Self perception of immediate family support by manic depressive ex-patients is deeply rooted in cultural definitions that refer to shared attitudes about mental illness incorporated within society. Therefore, in this

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research habitual definitions are those that link manic depressives together with the various attributes of their disorders, such as medication to treat mood swings, and different types of treatment that are available to them by the medical community at large. In association with this process, negative cultural attitudes affect ex-patient levels of social interaction and instrumental performance. Consequently, the manic depressive ex-patient confronts cultural definitions that are negative and destructive, by joining support groups where habitual definitions are guided by the common goals of the groups. This may be defined as re-socializing the ex-patient along with important members of the immediate family.

If the patient at first perceives the cultural values of society to be negatively directed at his illness, then the support group can develop a new set of shared meanings with him that protect all of them from the generalized negative attitudes in society. The banding together also allows advocacy groups to direct their energies outward against these cultural attitudes. A sense of purpose and a goal to change those negative values of society also gradually emerges.

Specifically, the manic depressive support group tries to help those ex-patients with problems associated with behavioural manifestations of the illness that come into direct conflict with destructive cultural definitions held

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by negative actors who can influence the ex-patient's level of instrumental performance.

In reaction to this common problem associated with this type of disorder, the shared goals of the support group concentrate on first re-socializing the ex-patient through unique personal definitions of manic depression and then proceed to help the ex-patient confront and change negative cultural definitions that reduce the ex-patient's level of functioning with repect to family integration and interaction.

In this research, the typology illustrates that the combinations of strategies that an ex-patient uses and his interpretations of these important social behaviours, are interelated with all of the three types of definitions defined in Stebbin's work on the definition of the situation. The support group and its series of educational programs allow the ex-patient and immediate family to confront all of these important issues, even though the cultural definitions in society that refer to mental illness are still most important in developing the social readjustment of the ex-patient.

Another important conclusion that is supported in the research of other sociologists, is that people who suffer from mental illness do return to their immediate families in order to receive needed love and support. This is quite apparent from the interviews and is supported in the

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development of the typology. The fact that Bi-Polar illness can be controlled and that people who have these problems can overcome the obstacles that stand in the way of their overall recovery is evident, even though traditional social problems still remain. In this context, only one respondent indicated that levels of social distancing and interaction prevented the respondent from adjusting quickly to the illness.

While Bi-Polar affective disorder is considered to be an illness that can be controlled through medical technology, the traditional social problems associated with mental illness are still there and do affect the perceived levels of instrumental performance and social integration within the immediate family. For all of the respondents, including the two family members, the prospect of having a family member who is mentally ill is quite troublesome. Many of the responses make reference to uncertainties about how they will function with a disorder that society sees negatively. Most of these reactions and feelings expressed by the respondents seem to be confined to the manic phase which for some is very explosive. As a primary sociological conclusion here, the moderate levels of instrumental performance are suggestive of individuals picking up the pieces of their lives after a destructive encounter with the illness. During depressive cycles the emphasis is on strategic choices that respondents make in

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order to socially integrate and interact with their immediate families. For some of the respondents, the need to become socially distant and isolated is dictated by changes in mood structures. This can be seen in their own reactions and what is portrayed in the combinations of their strategic behaviour.

Another essential conclusion was the need to understand more about mental illness and the medications to treat Bi-Polar illness. Most of the respondents who indicated that they took medication to control their moods did not understand many important ramifications. In fact, all they knew was that the chemical substance worked in the majority of instances and that there would be side effects associated with their implementation. In this respect, the need to seek out vital medical information from the advocacy group was presumed to help them a great deal in understanding their illness, because it could be concluded that compliance with this type of treatment was a necessary component of their social readjustment. For those who were not taking lithium or other drugs, the same conclusions could be made, because they faced the same types of social readjustment problems. In the context of this research, those respondents were thought to have milder cases that could be controlled and handled through other treatment modalities. The importance of these conclusions is that some of the respondents felt that their membership in the advocacy group

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was a way to obtain needed medical information that was not given by the medical establishment.

Specific conclusions and findings from this study indicate that the division of respondents according to whether they are hospitalized or not, does not make a large difference. Upon entering the psychiatric system of medical care, the respondent still is considered to be a mental patient and for these respondents interviewed here, the same social problems occur, even though the level of care is not as drastic and medication can control various forms of social behaviour. In this study, several respondent's social readjustment stages are greatly attenuated by multiple illness and allergies to medication.

A further conclusion relates to the fact that the length of time that it took to readjust to their problems was decreased by the dual support system. In some cases the advocacy group helped to increase their own understanding of the problem, while for others, it did not greatly change the attitudes and perceptions of their support mechanisms, even though it eased the burden for them and their immediate families.

The levels of social integration and interaction when compared with the instrumental performance of the combined sample, suggests that when these respondents were interviewed, they may have been in different stages of their mood cycles. It is not clear how this affected their

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responses, but in some respects there may have been some overestimations in regards to conditions within their immediate families.

Finally, what really determines the true nature of what occurs with such an illness? One can conclude that initial traumas in the beginning of symptom formation with the disorder greatly affect the social dynamics of family support systems. Many of the respondents indicate that social and medical problems not associated with the disorder also complicate the perceptions of the respondent. These include multiple illness, mental illnesses of other immediate family members, and problems in finding medical personnel who are best able to treat the respondent. In this case, the bases of social integration and interaction, and instrumental performance, can be perceived as being affected. It is clear however, that the incidence of non-related trauma and Bi-Polar affective disorder is psychologically as well as sociologically intertwined.

6.1 Future Research

The results of this pilot study justify the need for more sociological studies to be carried out. Understanding the social dynamics of Bi-Polar illness and immediate family relations, is not simple because of the complexity of medical and psychiatric problems associated with them. In order to understand the social mechanisms of this illness

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better, this research could be replicated with an equal number of ex-patients and family members being interviewed so that a more global explanation could be made.

Another project could be developed examining the implementation of newer methods of treatment and how they correspond to the social readjustment process. In this context, the immediate family relationship could be analyzed by ascertaining how the respondent views medical treatment and lithium carbonate in particular. This is justified because many of the respondents interviewed in this study talked a great deal about their medication and what it meant to them. A wider study might possibly deal with the relationship between the immediate family and advocacy social support systems. This is important because many immediate family members come to meetings looking for answers to problems with their kin. This proposed study could also lead to other studies focusing on children and their problems with afflicted parents.

Finally, it is hoped that this research has revealed sociological information that will lead to a better understanding of biochemical mental illnesses. A good deal of research has been done on immediate families with complex psychiatric problems, but a greater understanding of how the mentally ill patient feels is very important. It is apparent from these exploratory findings, that the ex-patient's viewpoint and adjustment to one particular type

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of mental illness is useful and that future studies of this type are essential. The consequence of these efforts will lead to a greater understanding of how mental patients feel about themselves and their immediate families during a time of crisis and social readjustment.

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Appendix A

INTERVIEW SCHEDULE

A.1 DEMOGRAPHICS-

1. Age-What is your age?
2. Gender-Male Female
3. OCCUPATION-What is your occupation? (if none) Previous occupation.
4. MOTHER'S OCCUPATION-What is your mother's occupation? (if none) Previous occupation.
5. FATHER'S OCCUPATION-What is your father's occupation? (if none) Previous occupation.
6. MOTHER'S EDUCATION-What is your mother's education?
7. FATHER'S EDUCATION-What is your father's education?
8. RELIGION(OPTIONAL)-What is your religion?
9. ETHNICITY(OPTIONAL)-What is your ethnic origin?

1. (TYPE OF FAMILY)-Do you live with a family at this time? yes no.
2. IF YES-Are you a wife a husband or a single person(child).
3. IF SINGLE OR CHILD IN FAMILY-Are you a sister brother only child divorced parent single parent widow/er other.

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4. IF NO-Do you live by yourself? yes no.

5. IF NO-Whom do you live with?

1. MARITAL STATUS(IF NOT SINGLE)-Are you presently married? yes no.

2. IF NO-What is your marital status? Have you ever been married? yes no.

3. PARENT MARITAL STATUS-Are your parents married presently? yes no.

4. IF NO-What is your mother's marital status? What is your father's marital status?

1. MARRIAGE QUESTIONS(NOT TO BE ASKED OF NEVER MARRIEDS).

2. Were you married before you became ill? yes no.

3. Were you married before you went into the hospital? yes no.

4. OR Did you get married after you came out of the hospital? yes no.

5. Do you have any children? yes no.

6. IF YES-How many do you have? How many males? Females?

7. How long have you been in your present marital situation?

1. HOSPITAL QUESTIONS-Have you ever been hospitalized? yes no.

2. How many times?

3. How long was each time?

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4. What was the longest time that you were out of hospital before returning?

5. How long has it been since you were in hospital last?

1. MEDICATION(OPTICNAL)-Do you take medication? yes no.

1. FAMILY QUESTICNS-Did you live with your family while you were ill? yes no.

2. IF YES-For how long? Did you live with your family after you left the hospital? yes no.

3. IF YES-For how long?

4. IF PARENTS DIVORCED-Were your parents divorced before you became ill? yes no.

5. OR-Did they get a divorce after you became ill? yes no.

6. Were your parents divorced after you left the hospital? yes no.

7. Were there any deaths in the family after you left the hospital? yes no.

8. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

1. RESIDENCE-Where do you live?

2. City.

A.2 VIEWPOINTS RELATING TO IMMEDIATE FAMILY SUPPORT.

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A.2.1 PHYSICAL SECURITY-

1. Does your immediate family provide a home for you at this time? yes no.

2. How do you feel about your home life at this time?

3. Do you feel that during your illness you had to leave home for any reason? yes no. IF NO? SKIP TO QUESTION #8.

4. IF YES-Was there anyone who forced you to leave home because of their lack of understanding and support? yes no.

5. Did your illness occur after you left your family and were living alone? yes no.

6. While you were getting your life back together, did one of the following cause you to go out on your own? A divorce, A death of one of your relatives, Pressure from your immediate family, Other.

7. Do you feel that any one of these factors caused you to change certain attitudes about your immediate family during this period in your life? yes no. PLEASE ELABORATE HERE.

8. Which immediate family member showed the most patience while you were getting your life back together? (READ LIST #1).

9. Which immediate family member did not care for you at all? (READ LIST #1).

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10. Which immediate family member did care for you and provide support? (READ LIST #1).

11. Which member(s) of your immediate family showed you the most understanding while you were:? (READ LIST #2).

12. Does your immediate family provide the following? Money to buy things with Clothing Food.

13. Does your immediate family place pressure on you to do the following? Get a Job. (If in a family) Move out of the house. Develop normal relationships with your relatives. Develop normal relationships with your family. Act in the way your immediate family wants you to. Develop relationships with the opposite sex. Other. PLEASE ELABORATE HERE. IF NO PRESSURES, SKIP TO NEXT SECTION.

14. How do you feel about these pressures placed upon you by your immediate family? I live with them. I try to live up to what they want of me. I reject their help. I do nothing at all. Other.

15. IS THERE ANYTHING YOU WOULD LIKE TO ADD HERE?

A.2.2 EXPRESSION OF LOVE-

1. Do you feel that your immediate family showed you love and caring in doing one of the following? (READ LIST #2).

2. Do you feel that your immediate family did not care about you doing any one of these things? yes no. PLEASE ELABORATE HERE.

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3. Do you feel that your immediate family gave you support and encouragement in doing any one of these things? yes no. PLEASE ELABORATE HERE.
4. Which immediate family member cared for you the most? (READ LIST #1)
5. Did you like the way your immediate family cared for you during this period in your life? yes no.
6. IF YES-Did you feel good about it? I liked the way they cared for me. I disliked the way they cared for me. I did not care at all. IF NO PLEASE ELABORATE.
7. Do you feel that love and support from your immediate family helped you get your life back together? yes no. PLEASE ELABORATE.
8. Do you feel that embarrasement from your illness caused your immediate family to withdraw love and support from you? yes no. PLEASE ELABORATE.
9. IF YES-Which immediate family member felt this way? (READ LIST #1) PLEASE ELABORATE.
10. Can you tell me what love, caring and support means to you at this period when you are trying to get your life back together?
11. Do you feel that your immediate family provided enough encouragement for you during this period in your life? yes no.
12. Did they provide encouragement for: (READ LIST #2). PLEASE ELABORATE.

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13. Which immediate family member was willing to give you the most love and support? (READ LIST #1).

14. Which immediate family member did you feel was less willing to give you the most love and support while you were getting your life back together? (READ LIST #1).

15. Did you like the way your immediate family cared for you during this time? yes no.

16. Do you feel that love, caring and support from your immediate family was important in getting your life back to normal? yes no. PLEASE ELABORATE.

17. Can you tell me what love and support mean to you at this time?

18. Do you feel that your immediate family provided enough encouragement for you during this period in your life? yes no. PLEASE ELABORATE.

19. Which immediate family member was willing to give you the most love and support? (READ LIST #1).

20. Can you tell me which immediate family member gave you less encouragement during this period in your life? (READ LIST #1).

21. Which immediate family member helped in getting your life back together? (READ LIST #1).

22. Do you feel that love, caring and understanding from your immediate family helped you to do one of the following? (READ LIST #2).

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23. Do you feel that love and caring were tied to pressures placed on you while you were getting your life back together to do one of the following? (READ LIST #2).

24. Would you say that caring and support that you got from your immediate family was because they just put up with your illness? yes no. OR-

25. Would you say that caring and support that your immediate family gave you is based on love and understanding? yes no. PLEASE ELABORATE.

26. Would you say that pressures to live normally according to society, created problems for you during this time in your life? yes no. PLEASE ELABORATE.

27. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

A.2.3 SECURING LOVE-

1. What do you feel love is?

2. How would you define the type of love you received from your immediate family?

3. Were you satisfied with the love you received from your immediate family? I was very happy to have this love. I was not very happy to have this love. I did not care if they loved me. Other.

4. Which member of your immediate family did not want to give you this love? (READ LIST #1).

5. Which member of your immediate family did want to give you this love? (READ LIST #1).

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6. What did you do to get this love during this period in your life?

7. How did you go about responding to this love? It was very hard to get along with them. It was very easy to get along with them. I was afraid to try. I did not try at all.

8. Do you feel that your immediate family's attitudes stopped you from getting proper love and caring? yes no. PLEASE ELABORATE.

9. OR-Would you say that your immediate family did not consider your illness to be a problem at all? yes no. PLEASE ELABORATE.

10. Could you tell me which immediate family member you felt was most willing to give you love and understanding? (READ LIST #1).

A.2.9 EXPRESSION OF HOSTILITY-

1. Can you please explain the overall relationship between yourself and your immediate family since you came out of the hospital? Good, despite my overall situation. Fair but could be better. Not good, there are always problems to deal with. I do not bother with them at all. PLEASE ELABORATE.

2. Can you tell me how pressure from your illness caused problems for you during this period in your life? Did you get angry. Did you feel frustrated. Did you completely withdraw. PLEASE ELABORATE.

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3. Do you feel that negative behaviour from your immediate family caused you problems in trying to do one of the following? (READ LIST #2). PLEASE ELABORATE

4. IF THERE WERE NO NEGATIVE REACTIONS; SKIP TO QU. 6

5. Do you feel that your immediate family's negative reaction toward you were understandable? yes no. PLEASE ELABORATE.

6. Do you feel that your immediate family was frustrated because they were trying to come to grips with your illness? yes no. PLEASE ELABORATE.

7. Do you also feel that there was outside pressure from other people for your family to come to grips with your illness? yes no. IF YES-Which of the following groups put pressure on them? Relatives. Employers. Family friends. Others. PLEASE ELABORATE.

8. Did frustration from your immediate family members cause you to do one of the following? Become withdrawn from them. Become mad at them. Cut off your relationship with them. Try to get along with them. Other. PLEASE ELABORATE. IF NO HOSTILITY WAS SHOWN, SKIP TO NEXT SECTION.

9. Can you tell me which family member showed the most hostility toward you? PLEASE ELABORATE.

10. Do you feel that within time, your relationship with your immediate family may improve and there will be less hostility? yes no. PLEASE ELABORATE.

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11. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

A.2.5 EXPRESSION OF SPONTANEITY-

1. Does your family react differently to you now? yes no. PLEASE ELABORATE.
2. Are these changes in behaviour any one of the following? Did they show an understanding of your illness and adjustment to it. Did they show a lack of understanding during your illness and patterns of getting your life bcak together. Did they put a lot of pressure on you to get better. Were they confused because they had no information about your illness. PLEASE ELABORATE.

3. Do you feel that change in behaviour coming from your immediate family has caused you to become socially distant from them? yes no. PLEASE ELABORATE.
4. Do you feel that your immediate family was unconcerned for you during this difficult period in your life? yes no. PLEASE ELABORATE.
5. Do you feel that you were an embarrasement to your immediate family during this period while you were getting your life back together? yes no. PLEASE ELABORATE. IF YES-Can you tell me which immediate family member put pressure on you to cause this type of reaction? (READ LIST #1). IF YES-Which family member did not cause this type of reaction? (READ LIST #1). PLEASE ELABORATE.

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6. Does your immediate family put pressure on you to develop outside relationships? yes no. PLEASE ELABORATE.

7. Which relationship would you say gave you the most encouragement during this period in your life? Male friends. Female friends. Friends at work. Friends at school. Belonging to social groups. PLEASE ELABORATE.

8. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

A.2.6 PASSING-

1. Do you hide certain aspects of your illness from your immediate family? yes no. IF NO-SKIP TO QU. 3. IF YES-Were you unhappy that you had to hide these things? yes no. IF YES-Because you were unhappy did you sometimes feel you needed to hide this information that may have helped your immediate family understand your illness better? yes no. PLEASE ELABORATE.

2. Did you feel embarrassed at any time by hiding this information? yes no. PLEASE ELABORATE.

3. Do you feel that your immediate family expects you to tell them everything about your illness? yes no. PLEASE ELABORATE. IF DID NOT HIDE, SKIP TO QU 7.

4. Do you feel in your opinion that it was necessary to hide information about your illness in order to maintain a good relationship with your immediate

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family? yes no. Did not care. Would try if I could without hiding anything. PLEASE ELABORATE.

5. Did you feel by hiding this information you were getting back at certain members of your immediate family? yes no. PLEASE ELABORATE.

6. Were you unhappy that you had to react in this way? yes no. IF YES- Because you were unhappy and reacted this way, did you feel you had to withdraw from your immediate family in any way? yes no. PLEASE ELABORATE.

7. Can you tell me which immediate family member put pressure on you to withdraw information about your illness? (READ LIST #1). PLEASE ELABORATE.

8. Do you feel that your immediate family understood all the mood changes attatched to an illness such as manic-depression? yes no. PLEASE ELABORATE.

9. Do you feel that at this time it is necessary to inform your immediate family about all aspects of your illness in order not to withdraw from them? yes no. OR-Do you feel that it would not make a difference? yes no. PLEASE ELABORATE.

10. Do you think that a mental illness like manic-depression should be hidden from people outside your immediate family? yes no. PLEASE ELABORATE.

11. Do you feel that mental illness in general causes embarrassment to you and your immediate family? yes no. PLEASE ELABORATE.

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12. Do you feel that your immediate family felt that you were an embarrassment to them? yes no. PLEASE ELABORATE.
13. Could you describe the types of social groups you feel mental illness should be hidden from? (READ LIST #3). PLEASE ELABORATE. IF SHE OR HE HID-
14. Do you feel that there were certain outside groups that you could confide in so that hiding information about your illness was not a problem? yes no. IF YES-Which ones? (READ LIST #3). PLEASE ELABORATE.
15. Do you feel that being open with certain aspects of your illness allowed you to gain special attention from your immediate family? yes no. IF YES-Was this true for outside groups also? yes no. PLEASE ELABORATE.
16. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

A.2.7 DISSOCIATION

IF HE OR SHE WAS NOT SEPARATED FROM FAMILY, SKIP TO QU 5.

1. Do you feel that being separated from your immediate family was necessary for you to get your life back toether? yes no. PLEASE ELABORATE.
2. What does isolation mean to you in respect to being separated from your immediate family?
3. Was it important for you to maintain contact with them? yes no. PLEASE ELABORATE.

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4. Was it important in getting your life back together? yes no. PLEASE ELABORATE.

5. Do you feel that pressures from your immediate family caused you to become withdrawn from them while you were getting your life back together? yes no. PLEASE ELABORATE. IF HE OR SHE DID NOT WITHDRAW SKIP TO QU 12.

6. Do you feel it was your own choice to withdraw from your immediate family? yes no. IF YES-Was this because they expected too much from you? yes no. PLEASE ELABORATE. IF NO-Was this because you felt you could do better on your own? yes no. PLEASE ELABORATE.

7. Do you feel that this separation from your immediate family was caused by your feelings toward their negative behaviour about your illness? yes no. PLEASE ELABORATE.

8. Can you tell me which immediate family member applied the greatest pressure to cause you to withdraw from them? (READ LIST #1).

9. Can you tell me which immediate family member did not apply any pressure to cause you to withdraw from them? yes no. PLEASE ELABORATE.

10. Do you feel that pressure from your immediate family caused you to withdraw from them? yes no. PLEASE ELABORATE.

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11. Could you describe the types of factors that caused you to withdraw from them? For example: High expectations for your recovery. Demanding that you get a job. Demanding that you go back to school. Asking you to leave because they could not handle the pressure of your illness. PLEASE ELABORATE. IF HE OR SHE WAS ON THEIR OWN (IF NOT GO TO NEXT SECTION).
12. While you were out on your own getting your life back together did you have any contact with your immediate family? yes no. PLEASE ELABORATE.
13. Could you tell me which immediate family member you felt you were most comfortable in contacting? (READ LIST #1). PLEASE ELABORATE.
14. Which immediate family member were you least comfortable in contacting? (READ LIST #1) PLEASE ELABORATE.
15. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

A.2.8 MEMBERSHIP IN A HUMAN GROUP-

1. Do you feel that acceptance of your illness such as manic-depression helped you improve your relationship with your immediate family? yes no. PLEASE ELABORATE.
2. Do you feel that acceptance of your illness caused problems for you in improving your relashionship with your immediate family? yes no. PLEASE ELABORATE.

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3. Do you feel that understanding and acceptance of your illness by your immediate family allowed you to feel that you were a member of the family? yes no. IF YES-Did this help you get your life back together faster? yes no. PLEASE ELABORATE. IF NO-Did you feel that this caused set backs for you in getting ahead? yes no. PLEASE ELABORATE.

4. Which member of your immediate family made you feel part of the family during this difficult period? (READ LIST #1). PLEASE ELABORATE.

5. Do you feel it is necessary that you develop outside relationships rather than improve your relationship with your immediate family? yes no. For example: Belonging to social groups. Improving relations with outside relatives. Making friends at school. Developing relationships with the opposite sex. Other. PLEASE ELABORATE. OR-Do you feel that it is necessary to develop a strong relationship with your immediate family only? yes. no. PLEASE ELABORATE.

6. Could you tell me which relationships you feel are important in getting your life back together? For example: Immediate family. Relationships at school. Relationships at work. Relationships with the opposite sex. Improving relations with outside relatives. Others. PLEASE ELABORATE.

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7. Do you feel that isolating yourself from anyone of these groups was a positive step in your overall recovery? yes no. PLEASE ELABORATE.

8. Does your immediate family put pressure on you to develop outside relationships with other social groups? yes no. IF YES-Do you feel that your immediate family understood your need to develop these associations, even though they may have felt withdrawn from you at this time? yes no. PLEASE ELABORATE. IF YES-Which member of your immediate family put pressure on you to develop outside relationships? (READ LIST #1).

9. Could you tell me which group you felt gave you the most encouragement and understanding during this period in your life? (READ LIST #3). PLEASE ELABORATE.

10. Can you tell me which group was less encouraging and caused you to withdraw from them during this period in your life? (READ LIST #3). PLEASE ELABORATE.

11. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADDD HERE?

A.2.9 NORMALIZATION-

1. Do you feel that the relationship with your immediate family can improve over time with understanding and encouragement while you are getting your life back together? yes no. PLEASE ELABORATE.

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2. Do you feel that people who suffer from manic-depression have a hard time getting their lives back together? yes no. PLEASE ELABORATE.
3. Do you feel that you can talk to your immediate family about every aspect of your illness? yes no. PLEASE ELABORATE.
4. Do you feel that in some way society has put pressure on you not to accept and understand your illness? yes no. PLEASE ELABORATE.
5. What is your opinion of societal attitudes in relation to manic-depression while you are getting your life back together? It causes great problems for me. I have accepted my illness. I am constantly battling with this problem. No one uderstands my problems. PLEASE ELABORATE.
6. Do you feel that negative pressures and reactions from society caused you problems no matter how long it took you to get your life back together? yes no. PLEASE ELABORATE. IF YES-Can you tell me which social groups maintained these types of attitudes and reactions? (READ LIST #3).
7. Can you tell me which of these groups gave you the most trouble while you were trying to get your life back together? (READ LIST #3).
8. Keeping this in mind, which groups do you feel understood your problems the most and allowed you to talk about them? (READ LIST #3). PLEASE ELABORATE.

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9. In trying to get your life back together what did you do to develop balanced relationships with people in your life? For example: I had to hide my illness and problems from them. I had to withdraw my illness and problems from them. I was honest and revealed openly my illness and problems to them. PLEASE ELABORATE.

10. In accepting and understanding your own illness and problems, which social groups accepted you the most? (READ LIST #3).

11. Do you feel that your immediate family played a role in you accepting and understanding your illness? yes no. IF NO-Do you feel that it was frustration that caused you to be unable to communicate with them? yes no. PLEASE ELABORATE.

12. If they did help you, do you feel it was one of the following? Tried to help me accept my problems. Tried to help me understand my problems. Allowed me to cope without putting to much pressure on me. Tried to obtain information about my illness so that I could get my life back together. PLEASE ELABORATE.

13. Do you feel that lack of patience and understanding was a positive step in your coming to grips with your illness and the problems associated with it? yes no. PLEASE ELABORATE.

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14. Can you tell me which immediate family member showed you the most patience while you were getting your life back together? (READ LIST #1). PLEASE ELABORATE.

15. Can you tell me which approach you felt most comfortable with in trying to get your life back together and develop normal living patterns? Hiding certain aspects of your illness. Withdrawing from most people in order to get my life back together. Accepting my illness in order to function and go on with my life. PLEASE ELABORATE.

16. Do you feel that you needed help from other people than your immediate family in order to function on a daily basis? yes no. PLEASE ELABORATE. IF YES-Was this because your immediate family did not show patience and understanding during this difficult period? yes no. IF NO-Was this because your immediate family did not have the necessary information in order to help you get your life back together? yes no. PLEASE ELABORATE.

17. In trying to get your life back together could you tell me which immediate family members forced you to seek out other people for support and encouragement during this period in your life? (READ LIST #1). PLEASE ELABORATE.

18. In trying to function and develop normal living patterns, can you tell me which outside relationships

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lent support and encouragement during this period? (READ LIST #3).

19. Do you feel that at any time, your immediate family put pressure on you not to reveal any aspect of your illness in order to protect their standing in the community? yes no. IF YES-Which of the following did they do: Denied that you suffered from manic-depression. Did not allow you to talk about your illness in front of other relatives and friends of the family. Did not allow you to talk to your friends about it. They instructed other immediate family members not to talk about it. They simply ignored your illness completely. Other. PLEASE ELABORATE.

20. In trying to function and get your life back together, did you do one of the following? When developing friendly relations with the opposite sex I used it as a positive approach in order to make an impression. When joining social groups I told them of my experiences in order to show them that I was experienced at life. PLEASE ELABORATE.

21. Do you feel that being open and honest about your illness helped you to get your life back together? yes no. PLEASE ELABORATE.

22. Do you feel it is important to feel "normal" according to definitions that are created by others in society? yes no. PLEASE ELABORATE. OR-

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23. Do you feel that definitions of being "normal" are different for every person who suffers from manic-depression? yes no. PLEASE ELABORATE.

24. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD HERE?

25. THANK YOU FOR YOUR COOPERATION!!!

A.2.10 ORDERED LISTS AS A GUIDE FOR RESPONDENT-

1. HUSBAND, WIFE, MOTHER, FATHER, SISTER(S), BROTHER(S), CHILD, CHILDREN.

2. LOOKING FOR A JOB, GOING TO SCHOOL, MAKING FRIENDS, GETTING USE TO MEDICATION, GETTING YOUR LIFE BACK TOGETHER.

3. IMMEDIATE FAMILY, MALE FRIENDS, FEMALE FRIENDS, FRIENDS AT WORK, EMPLOYERS, OUTSIDE RELATIVES, SOCIAL ORGANIZATIONS, RELATIONSHIPS WITH THE OPPOSITE SEX, OTHERS.

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Appendix B

INFORMED CONSENT

B.1 WHAT IS A SOCIOLOGIST AND WHAT DOES HE DO?

A sociologist is a person who studies the interaction between individuals on a social basis. A sociologist is neither a psychologist, psychiatrist, social worker or other type of medical doctor. Sociologists usually confine their studies to totally social interaction between human beings and how they react to different social situations. In this case the attitudes and perceptions of the respondent are important here. Personal information given by the respondent will be anonymous and strictly confidential. It is not mandatory that any personal information be given.

B.2 WHAT THIS RESEARCH IS ABOUT.

This study tries to determine the relationship between immediate family support and the perceptions of the ex-patient(manic-depressive) in giving and receiving this support. Questions will be asked about personal perceptions of support and general attitudes about mental illness itself. A personal interview will be conducted either by the researcher Robert Ostrow, or his wife Margot.

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B.3 RIGHTS OF THE RESPONDENT.

The respondent should know that all of the questions are not earth shattering and will not cause the respondent pain.

If the respondent feels after reading the consent form that he/she does not want to take part, he or she may leave for any reason without question.

If a respondent consents to take part, he/she may terminate the interview at any time, if any section of the study presents a problem to the respondent and he/she may leave without question.

During the interview, if a respondent wishes not to answer any question, he/she may skip the question and go to the next one.

All names of respondents who participate will be kept confidential and are not included in the study.

All consent forms are extremely confidential and will be kept in control by the primary support organizations in the research.

If a respondent wishes to consult with his physician about taking part in this research, he/she may do so without question.

The objectives of this study are to contribute to the sociological knowledge of ex-patient perceptions and immediate family support.

RESPONDENT SIGNATURE_________

WITNESS SIGNATURE____________

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Thank you for your participation.

Robert Ostrow

University of Windsor

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VITA AUCTORIS

Robert Ostrow was born in Detroit, Michigan in 1950. He graduated from Oakland Community College in 1971 with an Associate in Arts degree. He attended the University of Windsor and received his Bachelor of Arts degree in Sociology in 1983. He graduated from the University of Windsor again in 1986 with a Masters of Arts degree in Sociology. He will begin study towards the Ph.D. degree in Sociology at York University in September 1986.

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