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The family and its involvement in the hospitalization, treatment and aftercare of the psychiatric patient.

Ruth Ann. Schnarr
University of Windsor

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U N I V E R S I T Y O F W I N D S O R

The School of Social Work

THE FAMILY AND ITS INVOLVEMENT IN
THE HOSPITALIZATION, TREATMENT AND
AFTERCARE OF THE PSYCHIATRIC PATIENT.

by

Ruth Ann Schnarr

A research project presented to the School of Social
Work of the University of Windsor in partial
fulfillment of the requirements for the
degree of Master of Social Work.

September 1972

Windsor, Ontario, Canada

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412180

Research Committee

Dr. L. E. Buckley Chairman

Mr. Moti Dhar Member

Dr. Wassef Y. Wassef Member

ABSTRACT

It was the purpose of this research project to explore some family factors as they relate to psychiatric hospitalization. The project was to determine if there was a relationship between family involvement in the in-hospital and post-hospital treatment of the identified psychiatric patient and the number of readmissions to the hospital of that patient.

The researcher used an ex post facto study design with a sample of patients who at the time of first admission lived with, and at the time of discharge returned to, a "family" where family was defined as living with at least one adult person aged nineteen to sixty years. The patients in the sample were initially hospitalized in the Department of Psychiatry of the I.O.D.E. Hospitals between December 1, 1969, and October 31, 1970. The sample included thirty-six former patients who had had at least one readmission to the facility within eighteen months of their initial discharge, and thirty-six who had had no such readmission. Data was collected from the hospital records for the entire sample, using a schedule designed by the researcher. Introductory letters were sent to each subject. It was possible to interview thirty former patients and nineteen of their significant others. The structure of the interview with each was provided by two interview schedules, again designed by the researcher.

It was found that family difficulties were a prime factor in the patient's hospitalization, that quite often there was a particular worry at home, and that the problem had been developing for sometime. Both patients and significant others generally found that hospitalization helped the patient. The major form of family involvement in treatment was visiting and showing concern. However, the family of the non-readmission group was more therapeutically involved in treatment, as perceived by the patient, than was the family of the readmission group. There was no difference between the reports of the significant others of the readmission and non-readmission groups on this point. Therefore the hypothesis has received at least preliminary support and further research on the topic is necessary.

ACKNOWLEDGEMENTS

The researcher would like to express her appreciation to all those who contributed to this project, both to its completion and to its value as a learning experience for her. There are, however, some people who deserve particular mention.

She would like to thank, first of all, the people who gave of their time and shared their thoughts and opinions during the interviews. It was an interesting, at times frustrating, but rewarding experience for her. Her expression of thanks is the presentation of this report to the hospital with the hope that the findings will be utilized to further develop hospital programs.

The I.O.D.E. Hospitals, particularly Dr. David Brown, the hospital's administrator, and the Department of Psychiatry, are to be thanked for their co-operation in all aspects of the project, and most specifically, for providing the research sample. Of particular help were Mr. Moti Dhar, Chief Social Worker, who was the primary hospital consultant and who arranged for the data collection; Miss Pauline Renaud, secretary, Department of Social Work, who typed and mailed the letters to the patients, and

who arranged some of the interviews. The researcher also wishes to thank Mrs. Mary Serdowich of the Medical Records Department for her assistance in finding records and locating past inpatient statistics.

She would like to express her appreciation to the members of her research committee: Mr. Moti Dhar, who served as a reader of the report, in addition to hospital consultant; Dr. Wassef Y. Wassef, Research Director at the School of Social Work, for his specific comments regarding the preparation of the final report; and especially, her chairman, Dr. Lola Beth Buckley, for her patience, knowledge, and encouragement with a task that initially seemed overpowering. Her guidance was an essential aspect for the completion of the project.

The researcher wishes to express special thanks to her roommate, Miss Judy Lindop, for her practical help with organization, typing and suggestions. Without her patience and understanding throughout the joys and frustrations of the project, the task would have been much more difficult.

Finally she expresses her appreciation to Miss Judy Knight, her typist for the final copy of the report. She so agreeably fit the typing into her work schedule.

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CHAPTER I

INTRODUCTION

It is the purpose of this research project to explore some of the family factors as they relate to psychiatric hospitalization. The project will determine if there is a relationship between family involvement in the in-hospital and post-hospital treatment of the identified psychiatric patient and the number of readmissions to the hospital of that patient.

What initially interested the researcher in the subject of family involvement in treatment was her social work experiences at I.O.D.E. Hospitals in Windsor, in the Department of Psychiatry. The hospital was her field placement for the completion of her Bachelor of Social Work degree in the academic year 1970-1971. Though her experience was limited, two days per week for a seven month period, it suggested to her that family dynamics were a prime factor in the development of the "sickness" of one member of the family, and that often the "sickness" was an individual's reaction to stress within the family system. It thus seemed less than adequate to treat only the identified patient and then to send him back to the setting that had been influential

in the evolution of his need for hospitalization, especially when there had been little or no family intervention or family preparation for the discharge of the patient.

In the past fifteen to twenty-five years psychiatric hospitalization has undergone extensive modification. There has been a movement away from long term hospitalization toward short term stays; the emphasis is more on rehabilitation and therapy, and less on incarceration; more on problems in daily living and less on the "sickness" of an individual.¹ As the length of psychiatric hospitalization decreased, the importance of the "significant others" in the life of the patient has increased. Thompson and Wiley noted that:

Particularly in a short term hospital where most patients come from and return to their families, the family as a unit, and through its individual members, plays a key role in relation to the patient's illness, treatment, and posthospital adjustment.²

¹ See Max Silverstein, Psychiatric Aftercare (Philadelphia: University of Pennsylvania Press, 1968), p. 3; William Clayton, "Release of the Chronic Psychiatric Patient", Mental Hygiene LIV (July, 1970), p. 410; Ira Friedman, Otto von Mering, Edward Hinko, "Intermittent Patienthood: The Hospital Career of Today's Mental Patient", Archives of General Psychiatry XIV, (April, 1966), p. 390; David Rahling and John Lion, "Patients with Repeated Admissions to a Psychiatric Emergency Service", Community Mental Health Journal VI (April, 1970), p. 313; and Shirley S. Angrist, et al., Women After Treatment: A Study of Former Mental Patients and Their Normal Neighbours (New York: Appleton-Century-Crofts, 1968), p. 22.

² Richard Thompson and Elizabeth Wiley, "Reaching Families of Hospitalized Patients: A Group Approach," Community Mental Health Journal, VI (February, 1970), p. 22.

More specifically, Mezaros and Mezaros suggested that of all the factors which had influenced the process of re-adaptation of the schizophrenic patient, his relationship with his family seemed to have been of prime importance.³

Professionals began to realize the importance of the environment from which the patient came and to which he returned. What aspects of employment were problematic, and to what extent? Was living in a high-rise apartment or on a rural farm a factor in an individual's withdrawal from society? Such factors affect the individual's adjustment and his ability to remain in the community as does the support received from his church, interest groups, friends, extended family, and neighbours.

A very specific aspect of the environment of the individual is his family. The family as a primary reference group for the individual in his development⁴ has been receiving increasing emphasis in the literature.⁵ The family

³ A.F. Mezaros and E.S. Mezaros, "Integration of the Discharged Schizophrenic Patient within the Family," in Mental Patients in Transition, ed. by Milton Greenblatt, et al. (Springfield: Charles C. Thomas, 1961), p. 218.

⁴ See Hilde Bruch, "Changing Approaches to the Study of the Family," in Family Structure, Dynamics and Therapy, ed. by Irvin M. Cohen (Washington, D.C.: Psychiatric Research Reports, American Psychiatric Association, 1966), p. 5.

⁵ See Don Jackson and Virginia Satir, "A Review of Psychiatric Developments in Family Diagnosis and Family Treatment," in Exploring the Base for Family Therapy, ed. by Nathan Ackerman, Frances Beatman and Sanford Sherman (New

is described as a system. This suggests that the phenomena observed in family function or dysfunction are not random but exist within a structure of interaction and interdependence. It also implies that the family is a gestalt, the whole being larger than the sum of its parts. The family has a life that is greater than the sum of the lives of the individual members. Thus, when an individual manifests a problem, the problem often can be seen as a difficulty in family interaction.

Both current literature⁶ and the personal experience of the researcher indicate the necessity of looking at the family in its relationship to the treatment of the individual. If the family is a factor in the etiology of the symptoms manifested by the identified patient, or if the patient is the symptom carrier for a disturbed family, should the family not be involved in treatment. This seems essential since the patient most frequently leaves the hospital to live again with the "problem" family.

York: Family Service Association, 1961), pp. 37-40 for the history of the development of family work. The history indicates a gradually increasing emphasis on the family as the unit of treatment.

⁶ Thompson and Wiley, "Reaching Patients of Hospitalized Patients," p. 22; and Kalman Flomenhaft, David M. Kaplan, and Donald G. Langsley, "Avoiding Psychiatric Hospitalization," Social Work, XIV (October, 1969), p. 40.

Angrist noted:

Unless more is understood about the dynamics of post-hospital adjustment, the gains in the discharge rate will be partially and perhaps even wholly, offset by the increased rate of readmission.⁷

Along with the increased discharge rate and the decreased length of hospitalization has come a dramatic rise in the rate of readmissions. Readmission should not be seen as generally negative, since it may, in fact, be part of one type of effective aftercare program at a particular time. However, for the individual and his family, readmission can suggest lack of success, some stigma, and a sign of adjustment difficulties. The patient moves back and forth between the "sick" role and the "somewhat stable member of society" role. The family intermittently loses a member and often its prime means of financial or emotional support. In either case the family experiences stress and must reassemble its members and their roles in an effort to maintain a functioning unit. In this respect it would seem advantageous to both the family and the "sick" individual to avoid the need for readmission. Would the fact of family involvement in any of the treatment of the individual have a differential effect on the likelihood of readmission? It is the hypothesis of the researcher that a patient whose family is involved in any treatment, either during or after

7 Angrist, Women After Treatment, p. 21.

hospitalization, or both, will be less likely to be readmitted than a patient whose family has no such involvement.

The primary purpose of this research, then, is to test the above-mentioned hypothesis. In addition, the researcher hopes to provide the hospital with information regarding treatment and aftercare as experienced by former patients and their families. This information could be utilized to further develop existing hospital services and to extend them beyond the present second and third levels of prevention, namely, treatment of emerging malfunctioning, and rehabilitation. The goal should be an increased emphasis on intervention before the occurrence of pathology or malfunctioning. Primary prevention, as it is called, is an essential aspect of community mental health. A second value of the information obtained by the researcher would be to develop further hypotheses for testing, again with the long range goal of developing and extending hospital treatment and services. The final goal of the researcher is to gain knowledge, experientially, regarding family attitudes toward involvement in treatment. This will be for her own utilization in future practice.

CHAPTER II

A SURVEY OF THE LITERATURE

A comprehensive survey of the literature concerning family involvement in the treatment of the psychiatric patient and the rate of readmission to the psychiatric hospital would be a task of considerable magnitude. The development of an adequate understanding of the topic would involve reviewing the literature concerned with the family and its dynamics; psychiatric hospitalization and alternatives to hospitalization; treatment of individuals and their families, as well as the effectiveness of each; the etiology of mental disorders; dynamics of readmission; and various systems and types of aftercare. To facilitate an understanding of the project topic the researcher read some material related to each of these aspects and then divided it into three major sections for ease of presentation. The sections are:

1. Family Dynamics and Mental Disorder,
2. The Psychiatric Patient, Post-hospital Adjustment and Readmission,
3. Psychiatric Services and Aftercare.

None of these sections is distinct and complete in itself. Some overlapping or seeming lack of continuity will be

obvious but all relevant material will be covered.

FAMILY DYNAMICS AND MENTAL DISORDER

In a very real sense it may be said that the study of the family as a significant system in its own right has no history, no body of commonly accepted concepts and no established findings. This is especially true in regard to the topic of the family of the psychiatric patient.¹

"The Family of the Psychiatric Patient," from which this quote is borrowed, was probably the first inclusive work on the subject. The authors noted that there had been a strong bias against including the family in psychotherapeutic procedures because of the difficulty in handling transference with more than one person at a time. However, professionals began to view these dangers as less serious. The authors then suggested that the treatment of the family as a group had advantages, and that "some of the patterns of interaction that produced and maintained pathology in the affected person were subtle and not easily comprehended except by direct observation in interaction."²

Concurrently, Jackson and Satir outlined the factors that were influential in the development of a family

¹ John P. Spiegel and Norman W. Bell, "The Family of the Psychiatric Patient," in American Handbook of Psychiatry, Vol. 1, ed. by Silvano Arieti (New York: Basic Books, Inc., 1959), p. 114.

² Ibid., p. 136.

orientation to psychiatry. These factors can be summarized as follows:

1. Psychiatry had become less medically oriented. Since the nineteenth century it had begun to borrow from psychology, sociology, and anthropology.
2. Practitioners in the child guidance movement found that the child who was labelled by the family as the patient was not necessarily the "sickest" in the family and treating the child was not enough.
3. The psychoanalytic movement influenced family diagnosis by means of such concepts as maternal influence and the Oedipal conflict. Ego psychology took more of an interactive and transactional approach, and there was a shift in emphasis from psychiatric diagnosis to character, marital and child guidance problems.
4. Practitioners realized that health existed within the same framework as pathology and thus began to focus on the "why" of illness rather than psychopathological symptoms.
5. Studies on schizophrenia indicated important results related to the family. Brown showed that the success or failure of chronic schizophrenic patients when they left the hospital depended on the living situation to which they returned. The highest failure rate occurred with those returning to spouse and parents; and it was not related to diagnosis or prognosis. It was found, too, that the single most significant correlate with a patient's length of hospitalization was the number of visits he received, during his first two months in the hospital.
6. Two promising avenues for the exploration of family interaction became apparent. These were the field of social psychology and its study of small groups, and the field of social communication and information theory.³

³ Don Jackson and Virginia Satir, "A Review of Psychiatric Developments," pp. 31-35.

By 1958, many different researchers and authors had contributed to the wealth of knowledge included in "the family orientation to psychiatry." Freud, with his emphasis on the psycho-sexual stages of development and parental influence on the child, set the stage. He was followed by Ackerman, Richardson, Spiegel, Jackson, Bowen, and others.

Richardson, in Patients Have Families, one of the earliest works on "the family," wrote about physical disease:

The idea of disease as an entity which is limited to one person, and can be transmitted or spread from one individual to another fades into the background, and disease becomes an integral part of the continuous process of living. The family is the unit of illness, because it is the unit of living.⁴

He supported this statement with case material throughout the book and underlined the value of the country doctor of years ago who knew the family and its problems intimately, and therefore could relate to the emotional as well as the physical problems. Today, the public health nurse continues to use this concept. One of the precepts of community health nursing is: "In community health nursing the family, rather than the individual patient, is recognized as the unit of service."⁵

⁴ Henry B. Richardson, Patients Have Families (New York: The Commonwealth Fund, 1948), p. 76.

⁵ Kathleen M. Leahy, Marguerite M. Cobb, and Mary C. Jones, Community Health Nursing (2nd ed; New York: McGraw Hill Book Company, 1972), p. 27.

In 1963, A. Russell Lee suggested that in the previous ten years conceptualizations regarding mental disorders had undergone a radical transformation away from the medical illness model. He stated:

a view about the development of mental disorders has arisen which postulates that the mental disturbance within the family member is the direct result and expression of forces within the family itself.... The identified patient thereby becomes a symptom of a disturbed mental apparatus. ...the very symptoms which the family member develops are interpretable as a statement or communication about the stresses he has lived under and continues to live under within the family system.⁶

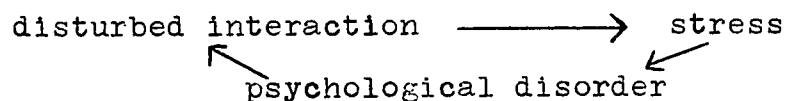
According to Lee there had been three major conceptual shifts concerning familial stress antecedent to the breakdown of one member. These shifts were: (1) from overt trauma to covert stress, (2) from past factors to here-and-now factors, and (3) from intrapsychic conflict to interpersonal conflict.⁷ Mental disorder was seen as rising out of family processes and the everyday aspects of family living. These produced stress within the family and this, in turn, caused the breakdown and further stress.

⁶ A. Russell Lee, "Psychodynamics of the Family under Stress of Ill Health," The Family is the Patient: The Group Approach to Treatment of Family Health Problems, Monograph VII, Social Work Practice in Medical Care and Rehabilitation Settings, (New York: National Association of Social Workers, 1965), pp. 12-13.

⁷ Ibid., p. 13.

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He diagrammed the situation thus:



Because the family was the setting for the individual's symptom development and manifestation, the need for family involvement in treatment became obvious.

Sampson et al. reported on a study conducted by the California Department of Mental Hygiene. The subjects were seventeen families in which the wife, mother of several small children, was hospitalized with a diagnosis of schizophrenia. It was found:

that the wife's schizophrenia episode occurred as part of a process of marital disintegration. Her manifest illness did not ordinarily precede and produce marital disintegration, rather it arose in the context of chronically conflicting or recently decayed marital family relations. Hospitalization routinely took place at a relatively late stage of both family and personal disorganization.⁹

Hospitalization tended to interrupt and neutralize the forces of marital disintegration and helped the family move toward

⁸ Ibid., p. 14.

⁹ Harold Sampson, et al., "The Mental Hospital and Marital Family Ties," in The Other Side: Perspectives on Deviance, ed. by Howard S. Becker (New York: The Free Press, 1964), p. 141. See also Harold Sampson, Sheldon L. Messinger and Robert D. Towne, "Family Processes and Becoming a Mental Patient," in American Journal of Sociology, LXVIII (February, 1962), p. 89 where the authors noted that the occasion for hospitalization was not the recognition of "mental illness by the patient or his family, but the inability to cope with the disturbed behaviour in the family."

the reintegration of their strained relationships. However, the authors do not accept hospitalization as the answer because it can weaken ties with the community and isolate the individual. Rather, they suggest family oriented psychotherapies that might change the balance of forces within the family that had initiated and sustained the individual and family pathology.

As noted previously, Jackson and Satir suggested that the work on schizophrenia facilitated the family orientation to psychiatry, and it was Bowen who did some of the early research and writing. From 1954 to 1957 he conducted a research project in which normal parents and their schizophrenic offspring lived together in the psychiatric hospital. From his previous observations he had identified "the family as the unit of illness." He elaborated that each family member was an individual on one level, but that on a deeper level the central family group was as one. He called this central family oneness the "undifferentiated family ego mass."¹⁰

Using this idea of family oneness, Bowen developed some aspects of family dynamics. Schizophrenia was described as a generalized family problem that disabled one member of the family. Both parents were equally immature, and their overadequate, inadequate reciprocity led to

¹⁰ Murray Bowen, "The Family as the Unit of Study and Treatment," American Journal of Orthopsychiatry, XXXI (January, 1961), p. 45.

functional helplessness and an intense interdependence between father, mother and patient.

Bowen expanded these ideas in a subsequent article.¹¹ Children grow up to achieve varying levels of differentiation of self from the undifferentiated family ego mass. The mature person has a well-defined ego boundary, whereas one who later becomes schizophrenic has a relatively low level of differentiation of self. People tend to marry spouses with identical levels of differentiation of self. Spouses with a low differentiation of self long for closeness, but closeness results in the fusion of two pseudo selves into a common self. To avoid the anxiety of fusion the two keep an emotional distance between them and the result is a constant struggle for dominant ego strength. Bowen concluded that "schizophrenia develops in a family in which the parents have a low level of differentiation of self and in which a high level of parental impairment is transmitted to one or more children."¹² Schizophrenia, which requires three or more generations to develop and demands that the parents transmit a major part of the parental problem to a single child in

¹¹ Murray Bowen, "Family Psychotherapy with Schizophrenia in the Hospital and in Private Practice," in Intensive Family Therapy, ed. by Ivan Boszormenyi-Nagy and James L. Framo (New York: Harper and Row, Hoeber Division, 1965), pp. 213-243.

¹² Ibid., p. 222.

each generation, is transmitted by the "family projection process."¹³ The three steps in this process are (1) feeling-thinking, (2) examining-labeling, and (3) treating. A major crisis occurs when one member collapses and there is no longer someone to absorb the family projection. Bowen found that in a family with severe schizophrenia the family projection process was never completely resolved though it could disappear for a time. He stated that it was with problems less severe than schizophrenia that avoiding the "sick-patient diagnosis" was of direct benefit in helping the family ego mass toward a higher level of differentiation of self¹⁴ and therefore, a higher level of both individual and family functioning.

The concepts discussed by Ackerman in "Family Therapy" do not differ, in essence, from those of Bowen, though each uses different terminology. Ackerman defines the homeodynamic principle as "the preservation of a certain center of self and the addition of healthy dimensions to the self in a never-ending series of group interactions,"¹⁵ and suggests that because the family is the matrix of human relationships,

¹³ Ibid., p. 224.

¹⁴ Ibid., p. 234.

¹⁵ Nathan Ackerman, "Family Therapy," in American Handbook of Psychiatry, Vol. III, ed. by Silvano Arieti (New York: Basic Books, Inc., 1966), p. 203.

whether they are healthy or sick, then the family is the natural point for intervention when the homeodynamic principle breaks down. He observed that the incentive for the referral of a patient for psychotherapy was often the outbreak of a disabling conflict in family relations rather than a clear recognition of specific psychopathological symptoms in one family member and concluded that:

Family psychotherapy...can be useful in the treatment of psychosis, neurosis, and character disorders... [it] is uniquely effective with marital disorders and with disturbances involving the relations of a child or an adolescent with the family.¹⁶

Satir¹⁷ expanded upon Bowen's concept of level differentiation of self. She noted that people with low self-esteem seemed to choose each other as mates. Each had high hopes and great fears; each expected to be disappointed. After marriage each found the other to be different from his expectations, and saw this differentness, when it led to conflict, as evidence of his being unloved. Then differentness could not be tolerated.

¹⁶ Ibid., p. 209. See also M. Wildman, "Communication in Family Therapy," The British Journal of Psychiatric Social Work, IX (Autumn, 1967), p. 79, where the author notes that there is no confirmation that family interviewing accomplishes more or less than individual therapy but that it conserves time, avoids hospitalization, utilizes resources, and appears to succeed with even long-term, chronic hospitalized patients.

¹⁷ Virginia Satir, Conjoint Family Therapy, (California: Science and Behaviour Books, Inc., 1967), pp. 1-60.

Each married "to get" without realizing that he would have "to give." The couple have a child hoping for an opportunity to feel loved, but again find that they must give. As well, each parent's wish for an extension of himself, in the child, gets blocked or challenged by the other parent's wishes. The child and parents form a triangle and each struggles against being the one who is left out. There is little opportunity for parental validation, then; and it is only with parental validation that the child learns how to influence and predict response, how to structure his world, and to esteem himself as masterful and sexual. The child becomes so entangled in his parents' struggle that he has no opportunity in or reinforcement of his differentiation of self; he comes to believe that he holds his parents together. Satir suggests that when one person has pain which shows in symptoms, all members feel the pain. The family is therefore the logical point for intervention.

In an academic lecture given in Toronto, Anthony reported the results of three years of data collection in a research project designed to discover the ways in which different families deal with the impact of illness and the changes in organization and function which ensue.¹⁸ The

¹⁸ E. James Anthony, "The Mutative Impact on Family Life of Serious Mental and Physical Illness in a Parent," Canadian Psychiatric Association Journal, XIV (October, 1969), p. 433.

family evolved an explanation for themselves and for the public, to account for the illness. With the development of this explanation, the family appeared more stable because it had made a meaningful connection between the past, present and future. The various results of the illness were growth and differentiation, breakdown and rally, or rout and disintegration. The particular outcome for a family was determined by the amount of psychologically-sound understanding and superstitious, magical thinking present in the family's explanation of the illness. Because it is the explanation that lends stability to the family, the importance of family intervention for the development of a realistic explanation of the illness is obvious.

The Committee on the Family Group for the Advancement of Psychiatry reported some interesting information from their survey of clinicians--psychiatrists, psychologists, social workers and others--who used family therapy. Family theory was defined as a combination of the theories of individual personality dynamics and multi-person system dynamics. Family therapy was not seen as a treatment method in the usual sense since there were no generally-agreed-upon set of procedures followed by practitioners. However, practitioners held in common the premise that psychopathology in the individual could be an expression of family pathology and the conviction that seeing the family together might have

advantages over seeing the members individually.¹⁹

Framo, in a recent article entitled "Symptoms from a Family Transactional Viewpoint"²⁰ discussed symptom-producing family situations, symptom choice, symptom maintenance and symptom reduction, pseudosymptoms and sharing and exchange of symptoms, and presented the formulation that symptoms are the concomitant of the universal conflict of autonomous strivings and loyalty to the family relationship system. Some of his closing remarks are of special interest since they concur with the observations made by the researcher while working at the hospital:

Despite the movement of the helping professions toward social factors, clinical practice is still overwhelmingly oriented toward the principle that there is an individual patient with a focal disorder. The alternative being offered here is that most people's problems stem from the difficulties arising from the familiar social systems in which they presently live, and that when there is family distress the symptoms may appear in any form, in any member as a function of what is going on in that system.²¹

The family approach offers a meaningful supplanter to the medical model, which, while supported financially and emotionally as a vested interest is proving increasingly inappropriate for these times of sweeping cultural changes.²²

¹⁹ See The Committee on the Family Group for the Advancement of Psychiatry, Treatment of Families in Conflict (New York: Science House, 1970), p. 38.

The importance of family factors in the etiology of mental disorders and the need for family involvement in treatment should now be obvious. One of the gaps in the literature is sufficient documentation of the effectiveness of family involvement in treatment. Some work has been done as noted above, but the etiological development of illness is more represented in the literature than is the effectiveness of treatment aspect. Perhaps more research on the effectiveness of family involvement in treatment would add credibility to the validity of a family approach to treatment.

THE PSYCHIATRIC PATIENT, POSTHOSPITAL
ADJUSTMENT, AND READMISSION

With the high rates of release from the psychiatric hospitals in the past ten years the proportion of long-stay patients had been declining. However, concomitantly, readmission rates have risen to as high as sixty-four per cent. The hospital career of the mental patient has changed from one of long-stay chronicity to intermittent patienthood.²³ Friedman, von Mering, and Hinko proposed that:

²⁰ James L. Framo, "Symptoms from a Family Transitional viewpoint," in Nathan Ackerman, Family Therapy in Transition (Boston: Little, Brown and Company, 1970), pp. 125-166.

²¹ Ibid., p. 166.

²² Ibid., p. 168.

²³ Friedman, von Mering, and Hinko, "Intermittent Patienthood," pp. 389-390. Note also that the "sixty-four

if hospital patient care is to remain effective in the face of changing conditions, extramural and intramural treatment planning cannot be separate issues. If a short intramural period makes current psychotherapeutic approaches seem less meaningful than in the past personnel can get involved in extensive programs in family therapy, therapy with relatives, environmental manipulation, vocational planning and guidance.²⁴

And Angrist suggested that any gains in the discharge rate would be offset by the increased rate of readmission unless more was understood about post-hospital adjustment.²⁵

In studying post-hospital adjustment Purvis and Miskimins noted that community aftercare programs tended to increase post-hospital community adjustment and minimize the need for rehospitalization. They found that hospitalization alone was insufficient in achieving community adjustment, and that follow-up was better than no follow-up, but

per cent" is an American statistic. No comparable statistic for the rate of readmission in Ontario could be found in the Mental Health Division of the Department of Health of the Province of Ontario, One Hundred and Fourth Annual Report (Toronto: Ontario Department of Health, 1970).

²⁴ Friedman, von Mering, and Hinko, "Intermittent Patienthood," pp. 391-392.

²⁵ Angrist, Women After Treatment, p. 21. See also Dorothy Miller, "Alternatives to Mental Patient Rehospitalization," Community Mental Health Journal, II (Summer, 1966), p. 124; The rate of rehospitalization could become a significant public health problem.

that a community-based program was most efficient since it fostered independence.²⁶ And Silverstein found that patients who left the hospital were more likely to sustain their "community tenure" if they made use of available aftercare services.²⁷

A major research project concerned with readmission was conducted by Freeman and Simmons in Massachusetts in the late 1950's. The researchers hypothesized that a differential "tolerance of deviance"²⁸ would explain the post-hospital performance of patients. However, the characteristics of family settings and family members provided only a limited understanding of the patient's success or failure in remaining in the community. The authors concluded that differential "tolerance of deviance" was useful as an explanation, primarily in range of instrumental performance and secondarily of rates of rehospitalization. The expected relationship between community tenure and performance levels was not supported. A significant finding was that patients who return to the hospital have relatives who neither expect nor insist upon a particular behaviour, and high performance

²⁶ S.A. Purvis and R.W. Miskimins, "Effects of Community Follow-up on Post-hospital Adjustment of Psychiatric Patients," Community Mental Health Journal, VI (October, 1970), pp. 376 and 380.

²⁷ Silverstein, Psychiatric Aftercare, p. 40.

²⁸ Tolerance of deviance was defined as the continued acceptance of the former patient by his family

levels most frequently occur in the settings in which relatives hold high expectations and insist upon these high performance levels.²⁹ Since the performance of the patient is congruent with the expectations of family members, the hospital should emphasize the return of patients to either productive non-kin settings or to families with high expectation systems so as to minimize readmissions.

Other important findings include:

1. Family members, rather than community agents or the patients themselves, are the principal arbiters of the patient's community tenure.
2. A key variable in predicting the post-hospital performance of successful patients is length of hospitalization. Female patients hospitalized longer tend to be rehospitalized in greater proportions. Both males and females who perform at high levels are much more likely to have been hospitalized for a short time.
3. There was no significant difference between the proportion of patients rehospitalized from conjugal and from parental families.³⁰

In 1967 Maisel set out to examine the processes underlying the social adjustment of the discharged mental patient on his return to the community.³¹ He notes that

members, even when he failed to perform in instrumental roles. See Howard E. Freeman and Ozzie G. Simmons, The Mental Patient Comes Home (New York: John Wiley and Sons, Inc., 1963), p. 6.

²⁹ Ibid., p. 142.

³⁰ Ibid., p. 70, 85 and 103 respectively.

³¹ Robert Maisel, "The Ex-Mental Patient and Rehospitalization: Some Research Findings," Social Problems, XV (Summer, 1967), p. 20.

previous studies had retained a traditional individualistic focus on psychiatry and seemed to assume that rehospitalization was merely a function of the recurrence of illness. In his own study Maisel found that sixty-one per cent of ex-patients worked or had some source of income in the first year after discharge. During this period eighty-nine per cent of those who worked as compared with forty-eight per cent of non-workers remained in the community.³² The importance of work for an ex-mental patient implies that protection of status through having a job and an income helps him retain his position in the community. Dependence on others provides only short-term security since those who are not working avoid rehospitalization for only short periods.

Schuerman's hypothesis that patients whose marital expectations at discharge were relatively unfulfilled would show greater post-hospital symptomatology after discharge than those patients whose expectations were being met was not supported. The findings were that even if the wife had all the time and affection she wanted from her husband, she was more likely to develop symptoms if he was not responsive to her emotional needs at times of difficulty. Frustration in marriage was a less important factor in causing symptomatology where needs are being met outside marriage; for

³² Ibid., p. 22.

those with no outside resources, gratification in marriage was most important.³³ In terms of service delivery this suggests the need for someone to relate to at the times of every-day crises, and the idea of encouraging the wife to seek out friends and relatives, if not her husband, who would provide support.³⁴

Clayton noted that factors important to a low rate of readmission of chronic psychiatric patients were medication, close follow-up by social workers, continued availability of the ward physician for consultation, and the level of tolerance of the patients' behaviour in the family or nursing home.³⁵ The findings of Rajotte and Denber do not differ. Reporting on a similar group, they noted that those who had readmissions had generally stopped taking maintenance medication, lived in a poor social environment and had no personal relationship with the doctor or social worker in the follow-up period.³⁶

³³ John Schuerman, "Marital Interaction and Post-hospital Adjustment," Social Casework, LIII (March, 1972), pp. 168-169.

³⁴ Ibid., p. 172.

³⁵ Clayton, "Release of the Chronic Psychiatric Patient," pp. 409-410.

³⁶ Paul Rajotte and Herman Denber, "Intensive Follow-Up Study of 50 Chronic Relapsing Psychotic Female Patients," in Mental Patients in Transition, ed. by Milton Greenblatt et al. (Springfield: Charles C. Thomas, 1961), p. 139. See also Silverstein, Psychiatric Aftercare, p. 26;

Thus, many variables related to the adjustment of the psychiatric patient in the community include aftercare, especially community-based aftercare; relatives' expectation of, and insistence upon high performance levels; length of hospitalization; employment; emotional support from husband and relatives in times of stress; medication; social work follow-up; and level of tolerance of patients' behavior in the family or nursing home. The family, then, emerges as a prime factor in community tenure.

PSYCHIATRIC SERVICES AND AFTERCARE

In Ontario the psychiatric patient population reached a peak in 1960 (25,630) and has been decreasing every year, with the exception of 1964, at the rate of 4.9 per cent per year. Reports from 1970 indicate a further development of community resources, and an increase in the number of individuals being served in their own community. This number is now fifty-nine per cent of the total number admitted to a special service for the treatment of psychiatric disorders. The increasing utilization of local services

and A.J. Mezaros and E.S. Mezaros, "Integration of the Discharged Schizophrenic Patient Within the Family," p. 218 where it is stated that the patient's relationship to his family is of outstanding importance in the process of the readaptation of the schizophrenic patient.

is also reflected by the number of patients served on an outpatient basis.³⁷ These trends are as expected from the long-term objective defined by the Mental Health Division of the Ontario Department of Health in 1966:

to make readily available a comprehensive range of services in prevention, diagnosis, treatment or training, and rehabilitation with respect to mental illness so that continuing care will be available to the patient with the least possible separation from his home and community.³⁸

The concepts of "rehabilitation" and "prevention," as well as "least possible separation from home and community" introduce the topic of aftercare.

Aftercare achieved high-priority attention in the United States beginning in 1955. This was the year of the dramatic reversal of the upward trend in the number of patients resident in mental hospitals. The discovery and widespread use of the psychopharmaceutical drugs, the increase of personnel-to-patient ratios in hospitals, the increased provision of alternative community services, including outpatient clinics, day care centres, psychiatric units in general hospitals --all contributed to this phenomena.³⁹

This summation defines the areas to be considered in this final section.

³⁷ Ontario Department of Health, One Hundred and Fourth Annual Report, p. 9.

³⁸ Committee on the Healing Arts, Report of the Committee on the Healing Arts, 1970, Vol. III (Toronto: Queen's Printer, 1970), p. 141.

³⁹ Silverstein, Psychiatric Aftercare, p. 3. Note

Aftercare, the process of providing services to assist the mental patient in the community after his in-patient psychiatric treatment,⁴⁰ includes a great variety of services. However, Silverstein observed that three after-care services, regulation of medication, counseling, and psychotherapy constituted seventy-five per cent of the after-care recommendations for his study patients,⁴¹ and that patients are successful in remaining in the community if they use available aftercare services. He noted that thirty-five and one-half per cent of the study patients who returned to the hospital did not utilize available aftercare services and concluded that aftercare services can, if used, help released patients sustain "community tenure."⁴²

One aspect of aftercare is "home care." In Saskatchewan a study was conducted with an experimental and a

that in Saskatchewan the mental hospital population dropped from 3,100 in 1963 to about 1,200 in 1968. Canada, too, was experiencing a decrease in the numbers resident in mental hospitals. See Colin M. Smith, "Measuring Some Effects of Mental Illness on the Home," Canadian Psychiatric Association Journal, XIV (April, 1969), p. 97.

40 Silverstein, Psychiatric Aftercare, p. 3.

41 Ibid., p. 14.

42 Ibid., pp. 40-41. See also Alan Sheldon and Kenneth J. Jones, "Maintenance in the Community: A Study of Psychiatric Aftercare and Rehospitalization," British Journal of Psychiatry, CXIII (September, 1967), p. 1011 where they report that aftercare resulted in a longer period outside the hospital, a shorter rehospitalization and fewer readmissions for all diagnoses except schizophrenia.

control group of patients seen at the Psychiatric Department, University Hospital, Saskatoon. One of the measures utilized was a scale "to determine the effect of having the patient at home as perceived by the person most closely associated with him."⁴³ It was administered to a significant other of the patient at the time of the patient's referral and again three months after he left the hospital. In the intervening period the experimental group received home care, the control group did not. It was found that:

the informants of home-care patients had undergone a more striking diminution of complaints than those of the control group and it was concluded that home care has been effective to a considerable extent in relieving their problems.⁴⁴

It was thus concluded that psychiatric patients should receive follow-up and be supported in the community, both for their own sake and the sake of those who live with them.

The two most recent developments in psychiatry, community psychiatry and psychopharmacology,⁴⁵ are integral aspects of aftercare. Community psychiatry is defined as a social action movement that is intended to help the patient

⁴³ Smith, "Measuring Some Effects of Mental Illness," p. 99.

⁴⁴ Ibid., p. 101.

⁴⁵ Garfield Turney, "Psychiatric Therapies: 1800-1968," in Changing Patterns in Psychiatric Care, ed. by Theodore Rothman (Los Angeles: Rush Research Foundation, 1970), p. 26.

regain positive relations to his family and the community environment through the use of drugs, and individual and group psychotherapy. Its theoretical bases are the social and behavioral sciences, and the emphasis on understanding has shifted from the individual patient to family, social and cultural milieu.⁴⁶ There has been a concomitant role shift for the psychiatrist. He has moved from the doctor-patient type of role to being a community leader and educator, and there is emphasis on prevention through health-promoting activities and consultation to caretaker agents such as teachers, nurses, clergy, and police who can give supportive care in the community.⁴⁷

What gave a real thrust to community psychiatry was President Kennedy's 1963 Message to Congress. It called for a fifty per cent reduction of the number of patients in custodial institutions. This was to be accomplished by providing better community facilities for all aspects of treatment and care for the emotionally disturbed and mentally ill, and by improving the coordination of existing resources. The United States Federal guidelines defining the nature of a comprehensive community health program indicated that the five following services would have to be provided to any

⁴⁶ Ibid., p. 26.

⁴⁷ Bernard Neugeboren, Psychiatric Clinics: A Typology of Service Patterns (New Jersey: The Scarecrow Press, 1970), p. 14.

resident residing in its geographic area: inpatient care; outpatient care; consultation and education; partial hospitalization; and twenty-four-hour emergency service.

Goldberg,⁴⁸ in discussing the community mental health centre, suggests that the experience of seeking to be of help to others and finding one's efforts helpful and appreciated is therapeutic, especially for the emotionally disturbed person who has been deprived of meaningful and significant relationships with others at home and in the community. Thus he proposes that there is a missing component in mental health, namely, self-help. His example is a school teacher who receives marital counseling and then compensates the community by tutoring students having problems in school, at low cost or no cost, instead of paying a fee to the centre. He concludes:

As mental health specialists we believe that we can contribute more to a community and to the development of its autonomous resources by providing consultation and training to the traditional caretakers and other community agents than by emphasizing⁴⁹ and specializing in direct services.

He notes, also, that in the past, mental health centres have been used both by the chronically and acutely ill, but only

⁴⁸ Carl Goldberg, "A Community is More Than a Psyche: The Concept of Community Mental Health," Canada's Mental Health, XX (May-August, 1972), pp. 15-21.

⁴⁹ Ibid., p. 21.

at the time of crisis. He suggests that a self-help component would remove the "sickness" stigma from such centres and facilitate their use for primary prevention so that hospitalization would not be a necessity.

The previous section of this chapter noted a variety of factors associated with readmission. One of these was medication. Since the 1950's the many psychopharmaceutical advancements have brought a different orientation to psychiatric treatment. They have made possible the maintenance in the community of psychiatric patients. Hankoff and Galvin noted that "the use of drugs had contributed significantly to both prevention of hospitalization and shortening of hospital stay for the psychotic patient."⁵⁰ The authors suggest that the "medication alone is often less important than the setting and the attitudes of the caregiving professionals."⁵¹ Rajotte and Denber stressed that the psychiatrist should be aware of the dynamic meaning of the physician-patient transaction in which the medium of exchange is "the pill," and concluded that the physician-patient relationship is one of the most important social adjuncts to treatment.⁵²

⁵⁰ L.D. Hankoff and John W. Galvin, "Psychopharmological Treatment and Its Implications for Social Work," Social Work, XIII (July, 1968), p. 41.

⁵¹ Ibid., p. 46.

⁵² Rajotte and Denber, "Intensive Follow-Up Study," pp. 147 and 149.

Partial hospitalization is defined as a "generic term to embrace day, night, evening, and weekend care--or treatment, or centre, or service, or hospital."⁵³ The program goals in a day hospital can be summarized as follows:

1. To provide an alternative to inpatient treatment for those to whom necessary environmental supports are available. Day hospitalization is not appropriate for those who are suicidal, those who are harmful to others, those who are agitated and need heavy sedation, and those too disoriented to travel to the program.
2. To provide a transitional facility for smoothing the patient's transition from inpatient care to release from the hospital and possibly shorten his inpatient stay.
3. To provide intermediate term rehabilitation of persons who have social and vocational deficits resulting from and related to mental illness.
4. To provide services to those patients so impaired that they would otherwise need long-term hospitalization and for those who have a long history of mental illness and extreme dependency from a very long previous hospitalization and who need considerable environmental support and give little promise of ever gaining independent functioning.⁵⁴

The program seeks to provide a variety of meaningful activities; and there is emphasis on group methods, procedures and relationships. The remainder of the time is spent in occupational therapy, recreation, working, and preparing lunch and dinner.

⁵³ Raymond M. Glasscote, et al., Partial Hospitalization for the Mentally Ill (Washington, D.C.: Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1969), p. 7.

⁵⁴ See Ibid., pp. 14-20.

Another alternative to hospitalization is the psychiatric emergency service. Rahling and Lion acknowledged that an increasing number of psychiatric treatment facilities have recognized the need to make this service readily available to the community.⁵⁵ The authors found that borderline patients repeatedly come to the emergency service. They are concerned with the present and aware of their own urgent need of relief from distress. However, they cannot cope with a future-oriented solution and so neglect referrals for continued therapy.⁵⁶

At the Colorado Psychiatric Hospital's Emergency Psychiatric Service the percentage of patients hospitalized when crisis therapy was available dropped from fifty-two per cent to twenty-six per cent.⁵⁷ When an individual was identified as sick the family was seen for collaborative work to obtain additional history and to alter the environment of the sick one. Family crisis, as opposed to individual crisis treatment, was utilized. In a later article on this same project it was reported that

six months after treatment experimentals
[received family crisis therapy] were
doing as well as controls [were hospital-
alized] on two measures of social

⁵⁵ Rahling and Lion, "Patients with Repeated Admissions of a Psychiatric Emergency Service," p. 313.

⁵⁶ Ibid., p. 317.

⁵⁷ Donald G. Langsley and David Kaplan, The Treatment of Families in Crisis (New York: Grune and Stratton, 1968), p. 21.

functioning, and that the experimentals returned to prestress functioning much more rapidly than did controls. Approximately the same number of experimentals were subsequently hospitalized as the number of controls who were re-hospitalized during the first six months following discharge.... The duration of hospitalization for control cases, however, was approximately three times as long as that for experimental cases.⁵⁸

Family therapy, not necessarily in an emergency treatment situation, is another alternative to hospitalization as well as a treatment to be offered as an inpatient or outpatient service. Bostrom noted that it was a method applicable to a variety of problems presented in a family unit including relatively chronic psychiatric illness.⁵⁹ More on the validity of the use of family therapy from the experiences of Bowen, Ackerman, Satir, and Framo was presented earlier in this chapter.

Some aspects of aftercare are home care, the community mental health centre, psychopharmacology, emergency psychiatric service, family crisis treatment and family therapy. The family has a role in all of these aspects. If not directly included in treatment it may provide the

⁵⁸ Flomenhaft, Kaplan and Langsley, "Avoiding Psychiatric Hospitalization," pp. 43-44.

⁵⁹ Dorothy Bostrom, "Objectives of Family Therapy," The Family is the Patient: The Group Approach to Treatment of Family Health Problems, Monograph VII, Social Work Practice in Medical Care and Rehabilitation Settings (New York: National Association of Social Workers, 1965), p. 61.

encouragement for the former patient's involvement in the community mental health centre or create an atmosphere conducive to the patient taking the prescribed medication. Therefore, the family's role in aftercare is of prime importance.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

The purposes of this research project were outlined briefly in the opening chapter. The specific questions that the project was designed to explore were as follows:

1. What was the level of functioning of the patient¹ in the community at the time of the interview with the researcher?
2. How well was the patient functioning before he was hospitalized?
3. What was the source or sources of the problem for which the patient was hospitalized and was it in any way related to family functioning?
4. From the patient's point of view and that of his family,² what were the merits and the deficiencies of both his in-hospital and post-hospital treatment?
5. To what extent, and in what ways, was the patient's family involved in both his in-hospital and post-hospital treatment?³

1 Patient is defined as the individual who was hospitalized and who expressed or who had expressed for him, symptoms problematic to the family.

2 Family is defined as living with at least one adult person aged nineteen to sixty years at the time of the first admission to the hospital and upon the first discharge from the hospital.

3 Family Involvement in Treatment is defined as

A descriptive study design was considered, for the purpose of exploring these questions, since

The objective [of this type of design] is a descriptive view, which may be qualitative, quantitative--or both--of a situation, agency, program, or client group. It often has value for planning, policy selection, and program implementation.⁴

The descriptive design would satisfy some of the purposes of the project. However, in order to test the hypothesis concerning the relationship between family involvement in treatment and frequency of readmission, the experimental design was chosen. The decision in favour of an experimental design does not prevent the inclusion of descriptive material collected by the researcher even though it may not pertain specifically to the hypothesis regarding family involvement.

RESEARCH DESIGN

From the broad range of experimental research designs, the ex post facto design was chosen. To test the hypothesis a longitudinal study with an experimental and a control group would have been superior. However, this would

the gamut of possible activities, under "treatment," in which the family or some of its members participate. For example, it could include the social worker or physician doing an intake interview with the patient's relatives; joint interviewing of husband and wife, or parents and child; marital counselling; or family intervention.

⁴ Alfred J. Kahn, "The Design of Research," in

have required that the researcher have a different relationship with the hospital than was possible. Conducting the study would have been difficult within the current operations of the hospital since little foundation has been developed for an extended research project. As well, the time available for the completion of a Master's thesis would not permit this type of project.

The ex post facto experimental design⁵ has been diagrammed by Kahn as follows:

| | Time 1 (Before) | | Time 2 (After) |
|---------|--------------------|-------------|-------------------|
| Group A | X | Stimulus | X_1 |
| Group B | X^1 | No Stimulus | X_1^1 |

Data is collected first to establish the equality of Group A and Group B at Time 1, and then to support the assertion that Group A was exposed to a certain stimulus while Group B was not exposed to this stimulus. Primary data collection occurs during or after Time 2, and makes possible a comparison of X_1 and X_1^1 .

The ex post facto design has two divisions: the effect-to-cause studies and the cause-to-effect studies. The latter are used to compare the effects of a situation; for example, what is the effect of being an oldest child as

Social Work Research, ed. by Norman A. Polansky (Chicago: The University of Chicago Press, 1960), p. 53.

⁵ Ibid., p. 64.

opposed to being a youngest child, on the amount of responsibility accepted for personal actions at age twenty-one. The former is employed to study relatively rare effects and their causes. The researcher chose this division of the ex post facto design and interpreted it, for the purposes of this study, as in Table 1.

TABLE 1

THE EFFECT-TO-CAUSE DIVISION OF THE EX POST FACTO
EXPERIMENTAL DESIGN AS APPLIED TO THIS
RESEARCH PROJECT

| | Before | After |
|---------|---|-----------------------------|
| Group A | - Pre-hospital functioning - Source of problem - In-hospital and post-hospital treatment - Family involvement in treatment | Readmission ⁶ |
| Group B | - Pre-hospital functioning - Source of problem - In-hospital and post-hospital treatment - Family involvement in treatment | No Readmission ⁷ |

⁶ Readmission was defined as any subsequent admission, as an inpatient, to the psychiatric facility at the I.O.D.E. Hospitals, within eighteen months of the initial discharge from that facility.

⁷ No Readmission was defined as having no subsequent admission, as an inpatient, to the psychiatric facility at I.O.D.E. Hospitals, within eighteen months after discharge from that facility. Readmission and non-readmission were not intended to imply either success or failure in the patient's adjustment in the community. An individual with no readmissions could have been referred to a larger facility such as the Ontario Hospital at St. Thomas, after a short time in the community. At the same time, as noted in Chapter

Kahn noted that the validity of the ex post facto study

...seems to hinge, most often, on its ability to assert with confidence that groups which they are comparing after the fact were, actually, comparable before the fact, i.e....before the events under study.⁸

The validity of the researcher's use of this design for this project, namely, the extent of the comparability of the two groups before the events under study, will be discussed in the chapter on analysis of data.

The Population

The population for this research project was all adult patients from the Department of Psychiatry at the I.O.D.E. Hospitals in Windsor, Ontario during the period from December 1, 1969, to October 31, 1970. The decision to use this particular population was based on the fact that the

I, readmission did not necessarily imply failure since it may have been an aspect of therapeutic aftercare.

⁸ Kahn, "The Design of Research," in Social Work Research, p. 66.

I.O.D.E. Hospitals is the major short-term psychiatric facility in Essex County. Supporting factors in the decision were the hospital's interest in being used as the setting for this research project, and the researcher's familiarity with the facility, its programs and personnel.

Department of Psychiatry of the I.O.D.E. Hospitals

In October of 1963 the adult psychiatric facility of I.O.D.E. Hospitals opened under the name of Community Psychiatric Hospital. It operated under the 1961 Community Psychiatric Hospitals Act and provided inpatient treatment for adults and outpatient services for children. When the Mental Health Act was passed in 1967 it was implemented by the hospital. Doctor Robert J. Mason, Clinical Director, cited the determining philosophies existent in the Community Psychiatric Hospital. They are as follows:

1. to treat outpatients and inpatients;
2. to be of service to the many social agencies school authorities, and courts, with respect to their clients and their inservice training programs; and
3. to participate in community planning regarding gaps and overlaps in service.

As of September 15, 1971 the Community Psychiatric Hospital came under the Public Hospitals Act, as well as the Mental Health Act, and its name was changed to the Department of Psychiatry of the I.O.D.E. Hospitals. Since its opening, the facility has served Windsor and Essex County. In 1969

the bed capacity of the facility was eighty, but this was cut to fifty-four in 1970 when one of the three wards was closed to accommodate patients for a Thoracic Unit. Two other hospitals, Hotel Dieu of St. Joseph and Metropolitan Hospital, serve the Windsor area and have psychiatric wards. Their psychiatric beds number thirty-five and twenty-three, respectively.

Table 2, below, indicates a comparison of some statistics for inpatient service from 1969 to 1971 in the Department of Psychiatry at the I.O.D.E. Hospitals.

TABLE 2

FIGURES USED TO DETERMINE AVERAGE NUMBER OF PATIENT DAYS FOR EACH INPATIENT FOR 1969, 1970, AND 1971.

| Year | 1969 | 1970 | 1971 |
|--|--------|--------|--------|
| Patient Days | 14,413 | 21,947 | 18,018 |
| Admissions | 490 | 479 | 616 |
| Patients Carried Over From Previous Year | 61 | 70 | 52 |
| Patients Served | 551 | 549 | 668 |
| Average Number of Patient Days for Each Patient | 26.1 | 40 | 27 |

The figures in Table 2 indicate a fifty-two per cent increase in patient days from 1969 to 1970. For the same time period there was an almost negligible decrease in the number of admissions, thereby giving rise to a fifty-three

per cent increase in the average number of patient days per patient.

From 1970 to 1971 there was a thirteen per cent decrease in the number of patient days, and a twenty-nine per cent increase in admissions, despite a decrease in the number of psychiatric beds. The result was a thirty-three per cent decrease in the average number of patient days per patient. This recent trend toward shorter periods of hospitalization has allowed the treatment of more patients in the year. Factors in this trend may have been the Day-Care (S.T.O.P.P.--Special Treatment Out-Patient Program) program initiated in 1971, and the opening of the Moditen Clinic in November of that year. This clinic offers injections of a long-acting anti-psychotic tranquilizer to discharged patients to prevent their recurrent admissions to the hospital, while the Day-Care program allows patients to return to the community sooner and to be maintained there with supportive therapy. In 1971 as well, the Connaught Clinic opened to offer intensive therapy to alcoholics and their families. These programs, while not in operation at the time the patients in this research sample received their initial hospital treatment, indicate that the hospital is broadening its treatment scope.

During 1970 services included in-patient treatment in the following departments: psychiatry, neuropsychology,

occupational therapy, psychology, social work, and speech therapy. Special programs included an evening drop-in centre for discharged patients, and "Recovery, Inc.," a community based self-help organization for chronically nervous patients.

The Sample

The initial design for the sample was to select subjects defined by the following criteria:

1. all subjects were to be first admissions to the Department of Psychiatry at the I.O.D.E. Hospitals;
2. all subjects were to be adults between the ages of twenty-one and sixty years of age at the time of the initial hospitalization;
3. all subjects were to live within a specific geographic area, namely, within twenty miles of the hospital; and
4. at the time of first admission all subjects were to have lived with, and at the time of discharge to have returned to, a "family."

An initial perusal of the admission and discharge books suggested that a three-month period from the discharge book might yield an adequate sample. All those who met the above criteria from the months of May, June, and July, 1970 were chosen. This choice of dates allowed an eighteen-month period for possible readmission to occur. The eighteen-month period was chosen because of its use in previous.

studies and the findings therein. Angrist noted from a study in Maryland that within eighteen months forty-five per cent of psychotics and thirty-two per cent of psychoneurotics and personality disorders from three state hospitals were re-hospitalized.⁷ Another study indicated that eighty-seven per cent of the patients admitted to the hospital in the year ending March, 1959 were former patients, thirty-seven per cent of whom were returned within a year of their release.⁸ Another factor in the choice of the eighteen-month period was the ex post facto study design; it would have been difficult to locate some of those who had not been in contact with the hospital for more than two years.

By the process of choosing all those who met the criteria in the three-month period, only a few subjects with readmissions were drawn, while there was a large number with no readmissions. It was obvious that because of the difference in the size of the two groups, comparison would have been distorted. As well, limiting the geographic area to within twenty miles of the hospital hindered the total sample size. This sample was therefore discarded.

⁷ Shirley S. Angrist et al., Woman After Treatment: A Study of Mental Patients and Their Normal Neighbours (New York: Appleton-Century-Crofts, 1968), p. 22.

⁸ See Paul Rajotte and Herman Denber, "Intensive Follow-Up Study of 50 Chronic Relapsing Psychotic Female Patients," in Mental Patients in Transition ed. by Milton Greenblatt et al. (Springfield, Illinois: Charles C. Thomas, 1961), p. 139.

For the second selection of the sample the criteria listed previously were utilized, with the modification that the geographic area was extended to within twenty-five miles of the hospital; Belle River and Kingsville became the northern and southern limits of the eastern boundary of the area. All those who met the criteria, whose discharge date fell between January 1, 1970 and September 30, 1970, and who had a readmission within the eighteen months after their first discharge were included. This yielded a total of twenty-eight subjects. Then, using a table of random numbers, a sample of twenty-eight subjects, each of whom met the criteria, whose discharge date fell between January 1, 1970 and September 30, 1970, and who had no subsequent admission to the hospital, within the eighteen-month period, was selected. The number of non-readmitted subjects randomly chosen from each month was determined by the number that had had readmissions that same month. For example, in January, 1970 only one person who had any subsequent admissions met all the criteria, so that only one person with no subsequent admission was then randomly selected. Thus the readmission group represented all subjects who met the criteria where as the non-readmission subjects were a random sample, matched in number with the readmission group. At the time of selection each subject was assigned a code number so as to preserve confidentiality.

During the process of data collection it became apparent that a number of the subjects selected were, for a variety of reasons, not available to be interviewed. To maintain the desired sample additional subjects were chosen by the same method previously described. These subjects were drawn from the months of December, 1969 and October, 1970. These particular months were utilized so that the sample would represent a continuous time period, namely, December, 1969 to October, 1970.

Method of Data Collection

For the purpose of data collection five schedules were devised:

- Schedule I - Hospital Record Data (Personal)
- Schedule II - Hospital Record Data
- Schedule III - Interview with Patient
- Schedule IV - Interview with Significant Other⁹
- Schedule V - Researcher's Comments at the Conclusion of the Interview¹⁰

⁹ Significant Other referred to those people who had the greatest influence on an individual's evaluation of himself and who had the greatest impact on his acceptance or rejection of social norms. For example, in the socialization of a child, the significant others generally include his parents, teachers, and playmates. See George A. Theodorson and Achilles G. Theodorson, A Modern Dictionary of Sociology (New York: Thomas Y. Crowell, 1969), p. 381.

¹⁰ See Appendix A.

A brief description of the content of each of the schedules is as follows:

- Schedule I - Hospital Record Data (Personal) was used to note the name, address, telephone number, case number, and assigned number of each subject. The information on this sheet was needed to mail letters of introduction¹¹ to the subjects in the sample and to arrange, by telephone, a convenient time for an interview. This sheet was destroyed when the interview was completed, and only the code number was used thereafter.
- Schedule II - Hospital Record Data was used to record the following data from individual hospital records: age; marital status; diagnosis; physician; type of inpatient treatment and aftercare; readmission information; et cetera.
- Schedule III - Interview with Patient, used as a guide during the interview, contained two types of questions: scale-type questions and open-ended questions. The latter was desirable to obtain comments from the respondents.
- Schedule IV - Interview with Patient's Significant Other was very similar to Interview with Patient in intent, design and content.
- Schedule V - Researcher's Comments at the Conclusion of the Interview was used by the researcher to record notes on the family situation and the interview, as well as relevant comments.

When Schedules I and II were completed a letter was sent to each subject in the sample to explain the project and its purposes. Within two weeks, each person was telephoned, and

¹¹ See Appendix B.

an interview was arranged. Schedules III, IV, and V were then completed at the time of the interview.

Personal interviews with each subject in the sample and a member of the family to whom each returned when discharged were chosen because they provided the opportunity to pose open-ended questions that could facilitate the development of a picture of the experience of the family with respect to the patient's hospitalization. Using only hospital records or a mailed questionnaire would have limited this aspect. Further, the hospital records did not contain sufficient information to answer the questions posed by this research design.

Analysis of Data

Analysis of data will involve the comparison of the age and sex of the study sample and the hospital population to determine how representative the sample is. Chi square will be used to test the null hypothesis of no significant difference between the population and the sample. In a similar manner those interviewed will be compared to the total sample on pertinent variables. The hypothesis of no significant difference between the total sample and those interviewed will be tested.

Chi square and the proportions test will be used to test various aspects of the major hypothesis of the differential family involvement between the readmission and

non-readmission groups. Correlations will be utilized, as they are relevant, to relate specific variables. Descriptive material from the interviewing process will be presented along with these analyzed results.

CHAPTER IV

PRESENTATION OF DATA AND FINDINGS

During the process of data collection the researcher accumulated more material than could be properly presented and analyzed within the requirements for this thesis. After considerable thought she decided that the findings from the interview process were of primary interest and importance. Therefore these findings will form the major portion of this chapter. A summary of the data collected from the hospital records with Schedule II is available in Appendix D for reference, as necessary.

For ease of presentation, this chapter is divided into the following five sections:

1. Description of the Inpatient Hospital Setting,
2. Findings Related to the Sample,
3. Findings from the Interview Process,
4. Findings from the Interviewer's Comment Schedule,
and
5. Summary of the Research Findings.

The first section, "Description of the Inpatient Hospital Setting," is presented to describe the setting in which this research took place. It outlines the physical outlay of the facility, hospital procedures, staffing, programs and the operation of the Professional Advisory Committee at the time of the hospital stay of the subjects included in the research sample.

"Findings Related to the Sample" includes a discussion of the representativeness of the sample of the population, and of respondents of the sample. This will determine if the results of the study can be generalized. Also presented is support for the validity of the use of the ex post facto design in this study, the geographic distribution of the sample, and the distribution of the sample by interview status. The information in this section is presented as background to the understanding and interpretation of the findings from the interviews.

The third section, "Findings from the Interview Process," is a presentation of the data collected during the interview with the patient and his significant other. It is organized under the five categories this research was designed to explore, as noted in Chapter III. Present level of functioning of the patient includes how the patient and his significant other feel that they get along with each other and the patient's use of time; patient's level of functioning before his hospitalization includes employment status, job satisfaction, and ability to take responsibility at home; the source of the problem for which the patient was hospitalized includes influential factors in the need for hospitalization, the presence of a particular worry at home before hospitalization, the length of the onset of the problem, and ways of coping with it; the merits and deficiencies of

hospital treatment covers the degree of help received from his hospital stay and from the hospital staff, his preparation for discharge, recommended medication after release, and suggestions from patients and significant others; and family involvement in treatment outlines family reaction to the patient after his hospitalization, home visiting, the return home, and family involvement in treatment.

"Findings from the Interviewer's Comment Schedule" includes the interviewer's appraisal of those attitudes the patient and the significant other had toward each other, those the patient and his family had toward the hospital, and those the patient and the significant other had toward the interview process; and a summary of some of the interviewer's comments at the completion of the interview.

The fifth section of the chapter will provide a summary of the important research findings.

Description of the Inpatient Hospital Setting

The following section on the inpatient hospital setting will provide a brief description of the facilities and programs at the I.O.D.E. Hospitals' Department of Psychiatry, in 1970 at the time when the subjects in this research sample were inpatients.

Facility Organization and Procedures

As noted in Chapter III in the description of the

Department of Psychiatry, until June, 1970, the psychiatric facility had eighty inpatient beds. At that time the number was reduced to fifty-four. These beds are located on two different floors in two different wings of the building. There is the third floor, the admission unit, which has twenty-nine beds, of which four are for seclusion and one is for observation. At one end of the floor is the patient dining room where meals are served, a television room, and a sunporch. At the other end is the nursing station, a small conference room, and a treatment room used for Electroconvulsive Therapy and Indoklon Convulsive Therapy. The central block contains utility and supply rooms, as well as an examination room and a consultation office. On opposite sides of both long corridors there are patient rooms--private, semi-private, and four-bed wards. The atmosphere of the ward is quite informal. Patients are dressed during the day as soon as they feel well enough, and most of the staff are dressed in street clothes.

The west wing of the building is used as a transition facility. Patients are transferred here from the third floor, before they are discharged from the hospital. The nursing station is centralized with three corridors radiating from it. In this central room there are tables and chairs, couches, a pool table (purchased by the patients with money raised during various projects), and a small,

glassed-in stereo room. The patients' rooms are off each of the three corridors. Down the hall from the entrance to this unit is the patients' dining room. Again, the atmosphere is very informal and relaxed.

According to hospital procedure, the physician is the only staff member with formal admitting privileges. However, a family doctor may refer one of his patients, some people walk in requesting their admission, or the psychologist or social worker may admit a patient with the consultation of a physician. Whoever admits the patient continues as primary therapist. Discharge is generally the decision of the attending physician, though the patient or his family may consult with him about this. Visiting hours are six to eight p.m. on weekdays, and noon to eight p.m. on weekends and holidays. The frequency of weekend passes from the hospital varies with the individual physician and patient; it depends on the need of the patient and the decision of the physician.

Staff and Programs

The paid staff, which numbered eighty-two in 1970, included seven physicians, five of whom were psychiatrists; three psychologists, one neuropsychologist and two psychometrists; three registered and one assistant occupational therapist; three social workers; one speech therapist; fourteen registered nurses and four registered nursing assistants;

and seven male attendants. The number of nursing staff is approximate and includes twenty-four hour service, seven days a week.

The programs in operation in 1970 included:

1. the Milieu Therapy Program, initiated for the west wing patients, was a form of patient self-government, with a heavy emphasis on various forms of group therapy;
2. Indoklon Convulsive Therapy, Electro-convulsive Therapy, chemotherapy and psychiatric consultation;
3. occupational therapy, which involved craft work, work assessment and the areas for job placement in the hospital, woodwork and light metal work, the regular Friday morning Coffee and Cookie Sale and luncheons for the staff and patients, as well as recreational therapy involving swimming, bowling, hiking, and campfires during the summer;
4. psychological services; namely, interviews, psychodiagnosis, individual and group psychotherapy, and clinical case conferences and consultations; and
5. social work services; namely, social history gathering, casework, and group and Milieu Therapy. There were also neuropsychology and speech therapy services available.

There were two different types of case conferences used during 1970. Initially all staff met twice per month to discuss every admission, and once a month to review the cases of those who had been in the hospital longer than two months. Later in the year it was decided that one staff from each discipline would meet with each physician once per week for a detailed interdisciplinary team conference on that physician's patients.

Professional Advisory Committee

To develop a broader scope of information, knowledge, and interdepartment co-ordination, the Professional Advisory Committee was formed. This committee participated in an advisory capacity, in the decisions of the Executive-Director and functioned somewhat the same as the Medical Advisory Committee utilized by most other hospitals except that its scope was broader than that of the Medical Advisory Committee. The prime purpose of the Professional Advisory Committee, which included the Heads of all the Departments in the Department of Psychiatry, was to advise and assist the Executive-Director in matters pertaining to the analysis, supervision, and review of all clinical work and treatment programs provided to psychiatric patients through the hospital.

Findings Related to the Sample

The research sample included seventy-two patients who had received inpatient treatment in the Department of Psychiatry of the I.O.D.E. Hospitals between December 1, 1969, and October 31, 1970. Thirty-six of these patients had at least one admission to the hospital, since their first admission, in the eighteen months following their first discharge from the facility; and thirty-six had no such subsequent admission.

The following section will present some of the

more interesting and relevant findings related to the total sample. Included will be a discussion of the representativeness of the sample on the variables of age and sex; the representativeness of patients interviewed by sex, age, and diagnosis; the validity of use of the ex post facto study design for this research; the geographic distribution of the sample; and the distribution of the sample by interview status.

Representativeness of the Sample

This section will include a discussion of the representativeness of the sample on the variables of age and sex.

Patient Population by Sex

The number of males and females in the population, sample, and the group of respondents for each month of the study period is presented in Table 3, (on following page).

As indicated in Table 3, during the period from December 1, 1969, through October 31, 1970, there were 248 males and 276 females¹ discharged from the hospital. The research sample included thirty-eight males and thirty-four

¹ See I.O.D.E. Hospitals, "I.O.D.E. Hospitals Supplement to the Annual Report 1969," Windsor, 1969, and "I.O.D.E. Hospitals Supplement to the Annual Report 1970," Windsor, 1970.

TABLE 3
DISTRIBUTION OF POPULATION, SAMPLE, AND
RESPONDENTS, MONTHLY, BY SEX

| | Males | | | Females | | | Total | | |
|-----------------|----------------------------|--------------|--------------|---------------|--------------|--------------|---------------|--------------|--------------|
| | Pop. ² (248) | Sam. (38) | Res. (16) | Pop. (276) | Sam. (34) | Res. (14) | Pop. (524) | Sam. (72) | Res. (30) |
| December, 1969 | 23 | 5 | 2 | 28 | 1 | 1 | 51 | 6 | 3 |
| January, 1970 | 13 | 2 | 1 | 21 | 0 | 0 | 34 | 2 | 1 |
| February, 1970 | 24 | 4 | 2 | 21 | 2 | 1 | 45 | 6 | 3 |
| March, 1970 | 23 | 2 | 0 | 21 | 2 | 0 | 44 | 4 | 0 |
| April, 1970 | 40 | 6 | 3 | 24 | 6 | 3 | 64 | 12 | 6 |
| May, 1970 | 29 | 1 | 0 | 32 | 1 | 1 | 61 | 2 | 1 |
| June, 1970 | 20 | 3 | 1 | 33 | 5 | 1 | 53 | 8 | 2 |
| July, 1970 | 21 | 2 | 1 | 26 | 2 | 2 | 47 | 4 | 3 |
| August, 1970 | 22 | 5 | 2 | 24 | 5 | 2 | 46 | 10 | 4 |
| September, 1970 | 13 | 1 | 0 | 20 | 7 | 3 | 33 | 8 | 3 |
| October, 1970 | 20 | 7 | 4 | 26 | 3 | 0 | 46 | 10 | 4 |

females. A chi square test indicates that there is no statistically significant difference³ between the population and the sample, in composition, by sex.

Patient Distribution by Age

With random tables, three of the eleven study

² The following abbreviations will be used in tables, henceforward: Pop.--Population, Sam.--Sample, Res.--Respondents; namely, those subjects in the sample who agreed to have an interview; () indicates "n" for each column.

³ Henceforward, unless otherwise stated, the level of significance will be .05.

months were chosen. The ages of all patients discharged during these three months, namely, June, September, and January, 1970, were recorded. The distribution is reported in Table 4 along with the age distribution of the sample and the respondents.

TABLE 4
DISTRIBUTION, BY AGE, OF POPULATION,
SAMPLE, AND RESPONDENTS

| Age Range | Population (n=120) | Sample (n=72) | Respondents (n=30) |
|-----------|-----------------------|------------------|-----------------------|
| Under 21 | 22 | 0 | 0 |
| 21 - 30 | 32 | 21 | 9 |
| 31 - 40 | 23 | 21 | 7 |
| 41 - 50 | 20 | 24 | 11 |
| 51 - 60 | 13 | 6 | 3 |
| Over 60 | 10 | 0 | 0 |

The average age of the 120 persons in the population was 35.8 years; the range was thirteen to eighty-two years. The average age of the subjects in the sample was 37.3 years, with the range from twenty-one to sixty years as defined by the sample criteria. The average ages of the population and the sample are almost equal; and a chi square test revealed no significant difference in age distribution of the population and the sample, though the population is concentrated in the twenty-one to thirty age group whereas

the sample is slightly overrepresented in the forty-one to fifty age group.

Therefore the sample is representative of the total hospital population on the variables of sex and age distribution. Other variables were not compared because of the inability to obtain such information.

Representativeness of Patients Interviewed

Respondents by Sex

As indicated in Table 3, there were thirty-eight males and thirty-four females in the research sample. The respondents included sixteen females and fourteen males. There is no statistically significant difference between the sample and the respondents, in composition, by sex.

Respondents by Age

The average age of those in the research sample was 37.3 years, while the average age of the respondents was 37.8 years. The average ages of the sample and the respondents are almost equal; testing revealed no statistically significant difference in the age distribution of the sample and the respondents. This distribution was presented in Table 4.

Therefore the respondents are representative of the sample on the variables of sex and age distribution. Since the sample is representative of the hospital population, and the respondents are representative of the sample,

then the respondents are representative of the hospital population on these two variables.

Respondents by Diagnosis

There is no statistically significant difference between the sample and the respondents by diagnosis, as indicated in Table 5, though the psychoses are overrepresented

TABLE 5
PERCENTAGE OF SUBJECTS IN SAMPLE AND
RESPONDENTS, BY DIAGNOSIS

| | Sample (N=72) | Respondents (N=30) |
|--------------------------------------|------------------|-----------------------|
| Psychosis ⁴ | 36.1 | 53.5 |
| Neurosis | 30.6 | 30.0 |
| Personality Disorder | 25.0 | 16.5 |
| Transient Situational Disturbance | 8.3 | 0.0 |

and the personality disorders are underrepresented in the respondents. Because the finding is not significant, it is assumed to have no effect on the findings from the interview process, and the respondents are representative of the sample on diagnosis.

⁴ See James C. Coleman, Abnormal Psychology and Modern Life (Chicago: Scott, Freeman and Company, 1956), p. back cover, for definitions of each of these diagnoses as prepared in 1952 and still used by the American Psychiatric Association.

Validity of Study Design

It was noted in Chapter III that the validity of the ex post facto research design was dependent upon the comparability of the two groups before the event under study occurred. In this instance the event is readmission. The researcher will now address herself to the question of the comparability of the two groups.

A perusal of "General Characteristics of the Research Sample"⁵ indicates that the average ages of the readmission and non-readmission groups, respectively, were 36.7 and 37.9 years; that there were twenty males and sixteen females in the readmission group and eighteen of each sex in the non-readmission group; and that there were twenty-four, eleven, and one from the readmission group and twenty-seven, six, and three from the non-readmission group in each of conjugal, parental, and other types of families respectively. The readmission and non-readmission groups were similar in diagnosis and marital status, as well. Therefore it can be said that the use of the ex post facto design was valid for this research.

Geographic Distribution of the Sample

The geographic area from which the sample was drawn

⁵ See Appendix D.

included Greater Windsor as well as the geographic area within a twenty-five mile radius of the city. Figure 1 illustrates the distribution of the sample by city wards, and Table 6 outlines the distribution numerically. The

TABLE 6
GEOGRAPHIC DISTRIBUTION OF THE SAMPLE, BY WARDS

| | R ⁶ | | NR | | T | Pop. |
|----------------|----------------|--------------|-------------|--------------|--------|---------------|
| | I (n=15) | NI (n=21) | I (n=15) | NI (n=21) | (N=72) | ages 21-60 |
| Ward 1 | 3 | 1 | 3 | 5 | 12 | 5788 |
| Ward 2 | 2 | 1 | 1 | 1 | 5 | 4688 |
| Ward 3 | 2 | 2 | 0 | 3 | 7 | 5262 |
| Ward 4 | 1 | 5 | 1 | 0 | 7 | 6747 |
| Ward 5 | 2 | 4 | 1 | 4 | 11 | 6519 |
| Ward 6 | 1 | 0 | 0 | 3 | 4 | 4507 |
| Ward 7 | 0 | 1 | 1 | 2 | 4 | 7228 |
| Ward 8 | 2 | 2 | 1 | 0 | 5 | 11022 |
| Other Areas | 2 | 5 | 7 | 3 | 17 | * |

* impossible to estimate this figure

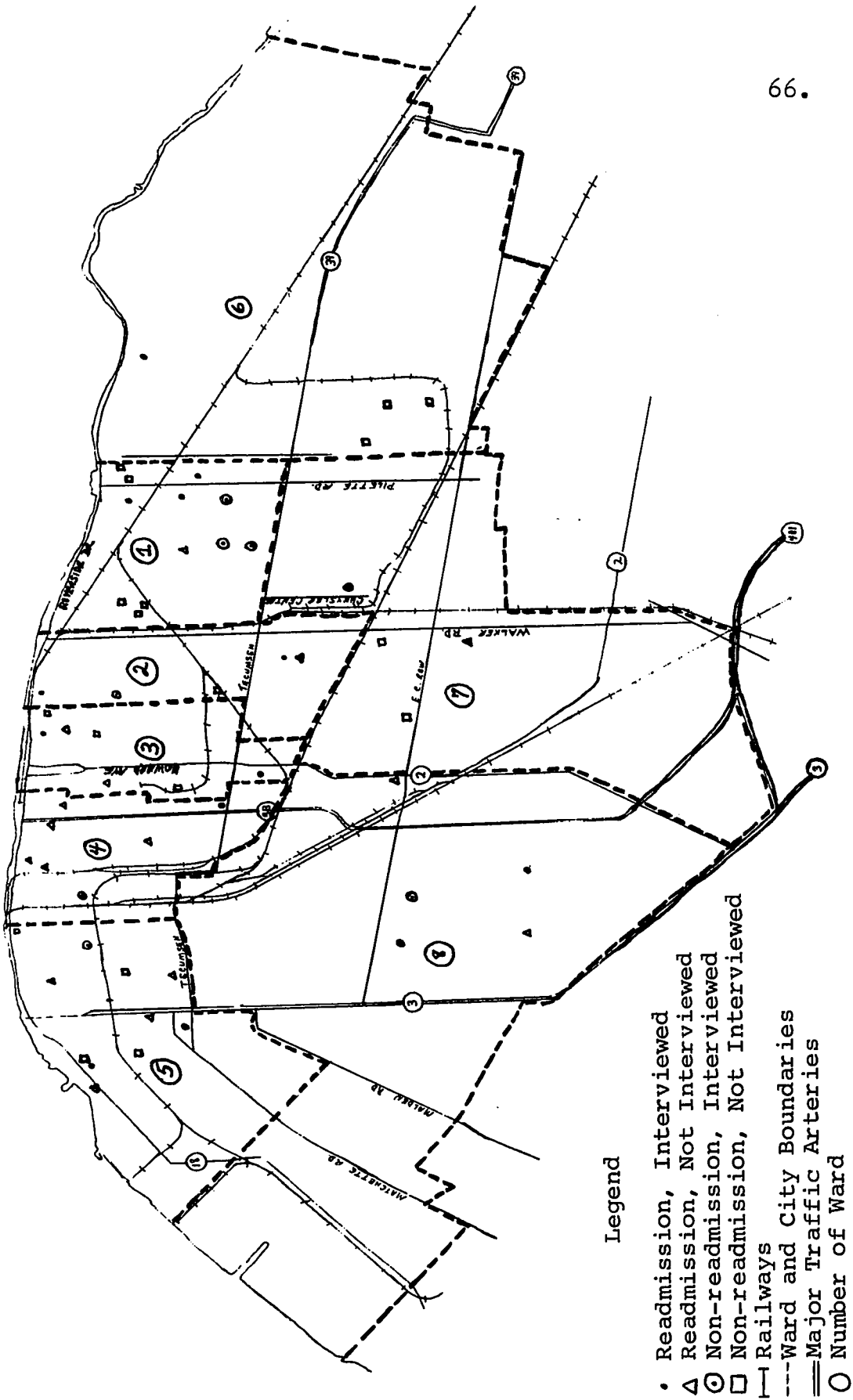
totals in each ward for the general population aged twenty-one to sixty years was taken from the 1971 City of Windsor census data.

Table 6 suggests that 76.5 per cent (55) of the sample resided in the city at the time of the first hospitalization, and that the remaining 23.5 per cent (17) lived

⁶ Henceforward the following abbreviations will be used in the tables: R--Readmission, NR--Non-Readmission, T--Total, I--Interviewed, and NI--Not Interviewed.

FIGURE 1

Geographic Distribution of Sample



outside the city limits. The null hypothesis that there was no significant difference between the distribution of the sample in the wards and the distribution of adults, ages twenty-one to sixty years, in the wards was rejected. The sample was overrepresented in Ward 1 and Ward 5 and underrepresented in Ward 7 and Ward 8. The researcher attempted to obtain other statistics, by wards, such as level of education, crime rate, standard of living, et cetera, but no figures were available from any city authority. This would be an area for further research.

Distribution of Sample by Interview Status

Of the total sample (72), 42 per cent (30) were interviewed; the remaining 58 per cent (42) fall into the categories noted in Table 7, on the following page.

As indicated in Table 7, one subject had died since her hospitalization. Twenty per cent (14) of the total sample refused to be interviewed. Of these, twelve subjects gave a definite verbal refusal when first contacted by telephone. Reasons for the refusal included trying to forget the whole matter, not living in a suitable neighbourhood, and not wishing to be bothered. For two of the fourteen refusals, the researcher phoned at different times and on a variety of days and did not find the subject at home, so she left a message. There was no response when the researcher

TABLE 7
DISTRIBUTION OF SAMPLE BY INTERVIEW STATUS

| | R | | NR | | T | |
|---|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=36) | Per Cent | No. (n=36) | Per Cent | No. (N=72) | Per Cent |
| Interviewed | | | | | | |
| Patient | 7 | 19.5 | 4 | 11.1 | 11 | 15.3 |
| Patient and Family | 8 | 22.2 | 11 | 30.6 | 19 | 26.4 |
| Not Interviewed | | | | | | |
| Deceased | 0 | 0 | 1 | 2.8 | 1 | 1.4 |
| Refusal | | | | | | |
| -in conversation with interviewee | 7 | 19.5 | 5 | 13.9 | 12 | 16.7 |
| -no return call | 1 | 2.8 | 1 | 2.8 | 2 | 2.8 |
| Letter Returned | 3 | 8.3 | 6 | 16.7 | 9 | 12.5 |
| Letter Not Returned | | | | | | |
| -no reply to second mailed note | 2 | 5.6 | 1 | 2.8 | 3 | 4.2 |
| -not at address or in directory | 2 | 5.6 | 2 | 5.6 | 4 | 5.6 |
| -wrong phone number and not in directory | 3 | 8.3 | 4 | 11.1 | 7 | 9.7 |
| -moved | 2 | 5.6 | 1 | 2.8 | 3 | 4.2 |
| -disappeared | 1 | 2.8 | 0 | 0 | 1 | 1.4 |

left telephone messages on several occasions. In one instance an interview was arranged by the subject who then ignored any subsequent calls and messages. A refusal rate of 19.5 per cent (14) of the sample may seem high, but taken in the context of the subject matter of the interview and given the fact that some people would find such inquiries quite threatening, the refusal rate is understandable. Fifty per cent (7) of those who refused to be interviewed had a diagnosis of psychoneurosis, the diagnosis that is characterized by anxiety.

This would lend support to the idea of the threatening nature of the topic for some of the subjects.

The remaining 37.5 per cent (27) of the sample is broadly classified as "unlocatable." The introductory letter was returned by the post office for 12.5 per cent (9) of the sample. When letters were returned the addresses were checked at the hospital and in the city directory and remailed, when appropriate. For 25 per cent (18) of the sample, or 67 per cent (18) of the "unlocatables," the letter was not returned. This suggested that the post office may have had a forwarding address for the subject; however they are not allowed to release this information. For the three subjects who had no telephone and were not at home when a personal visit was made by the researcher, a note was left at the time of the second call, asking the subject to call the researcher if he were willing to be interviewed. Four subjects or 5.6 per cent of the total subjects in the sample were not at the address listed in the hospital records or at the one listed in the city directory; 9.7 per cent (7) were not at the phone number recorded and they were not listed in the city directory; 4.2 per cent (3) had definitely moved; and 1.4 per cent (1) had definitely disappeared. In the case of the disappearance, the mother phoned to ask if I had seen her daughter who had attempted suicide twice before leaving home; she had not been seen for some time.

Lack of Interview with Significant Other

It will be noted from Table 7, that of the thirty subjects interviewed, it was possible to interview a "significant other" for 63 per cent (19) of the subjects. The reasons for no interview of the "significant other" of the remaining 37 per cent (11) of the sample are listed in Table 8.

TABLE 8

DISTRIBUTION FOR LACK OF INTERVIEW
WITH SIGNIFICANT OTHER

| | R (n=7) | NR (n=4) | T (N=11) |
|--------------------------|------------|-------------|-------------|
| Refusal -by patient | 5* | 1* | 6 |
| -by significant other | 1 | 1 | 2 |
| Moved from Windsor | 1 | 0 | 1 |
| Deceased | 0 | 2 | 2 |

* $z=2.54$ Statistically Significant

It is statistically significant that more of the readmission than the non-readmission group refused to have a significant other interviewed. Where it was the patient who refused that his "significant other" be interviewed, this was in some instances a factor on which the interview with the patient himself was dependent. The prospects of having a family member asked questions about the personal experiences of the patient, related to his illness, are obviously very threatening.

Findings from Interview Process

This section will include the material collected during the interview with both the patient and his significant other, as well as the researcher's comments at the conclusion of the interview. The following section is essential as background to the understanding of the findings.

Type of Family and Number of Children of Respondents

The number of patients and significant others interviewed, by readmission status and type of family with which the patient is living presently, is outlined in Table 9.

TABLE 9

NUMBER OF PATIENTS AND SIGNIFICANT OTHERS INTERVIEWED
BY TYPE OF FAMILY AND READMISSION STATUS

| | Patient | | | Significant Other | | |
|----------|-------------|--------------|-------------|-------------------|--------------|-------------|
| | R (n=15) | NR (n=15) | T (N=30) | R (n=8) | NR (n=11) | T (N=19) |
| Conjugal | 7 | 9 | 16 | 4 | 8 | 12 |
| Parental | 7 | 4 | 11 | 4 | 3 | 7 |
| Alone | 1 | 2 | 3 | 0 | 0 | 0 |

As indicated in Table 9, seven respondents of the readmission group lived with their parental family. Three of these seven were single and had always or intermittently lived at home, while four were married. Three of the four returned home because of marital problems and subsequent hospitalization, and the remaining one moved home after his

wife's death. The respondent who lived alone had done so since his wife moved out of town. Of the four living with parental families in the non-readmission group, one was married and moved home after his wife left him while the other three had always been at home. The two respondents of this group who lived alone had done so since the death of their significant other. Of the eleven who lived with parental families, 45 per cent (5) did so because of marital problems. There is not a significant difference between eight and eleven, the numbers of significant others from the readmission and non-readmission groups, respectively, who were interviewed.

Table 10 indicates the number of children of those respondents who had children. There is no appreciable

TABLE 10
NUMBER OF CHILDREN LIVING WITH CONJUGAL
FAMILIES, BY READMISSION STATUS

| Number | R (n=8) | NR (n=9) |
|---------|------------|-------------|
| 1 | 4 | 2 |
| 2 | 1 | 1 |
| 3 | 2 | 4 |
| 4 | 1 | 1 |
| 7 | 0 | 1 |
| Average | 2 | 3 |

difference between the readmission and non-readmission groups. Non-readmission families have, on the average, one more child,

than do readmission families.

The Present Level of Functioning of the Patient

To consider the present level of functioning of the former patient the researcher posed questions⁷ concerning the former patient's feelings about the quality of his present relationship with his mate or parental family, and the amount of time he spent with his family, his friends and alone, as well as the kinds of activities in which they participated together. Questions of this nature were directed to both the patient and his significant other.

How the Former Patient and his Family Get Along

How Patient Gets Along with his Mate

As indicated in Table 11, with few exceptions, patients from both groups see themselves as getting along "very well" or "quite well," with their mates. In fact,

TABLE 11

HOW WELL COUPLE GETS ALONG WITH EACH OTHER, GENERALLY AND SEXUALLY, AS EXPRESSED BY THE FORMER PATIENT

| | Generally | | | Sexually | | |
|-----------------|-------------|--------------|-------------|--------------|---------------|-------------|
| | R (n=15) | NR (n=15) | T (N=30) | R (n=15)* | NR (n=15)* | T (N=30) |
| Very Well | 2 | 2 | 4 | 0 | 3 | 3 |
| Quite Well | 4 | 7 | 11 | 2 | 3 | 5 |
| Adequately | 0 | 0 | 0 | 1 | 2 | 3 |
| Quite Poorly | 0 | 0 | 0 | 1 | 0 | 1 |
| Very Poorly | 1 | 0 | 1 | 2 | 0 | 2 |
| Not Appropriate | 8 | 6 | 14 | 8 | 6 | 14 |

* one response was lost from each because of the use of a translator.

⁷ See Appendix A: Schedules III and IV, henceforward,

94 per cent (15) of those subjects living with conjugal families felt that they get along at least "quite well." This is a statistically significant finding since $x^2=12.25$.

Respondents, in commenting on their choice, said: "After thirty years of living together she's used to my ways: we can live with each other's idiosyncracies."; "We agree on most things. What arguments we have soon blow over."; "We have the same likes, we share the same goals, we think along the same lines."; "He beats me up less. He has become a cub leader, and spends more time with the family."

The woman who chose "very poorly" cited her husband's drinking and non-support of the family as important factors. At the time of the interview she was planning to place her four children with the Children's Aid Society and to live on her own until she made some money to support them. The husband's behavior pattern of drinking and non-support was constant and had been known to the Children's Aid Society for several years.

Though both groups felt generally that they get along positively with their mate, sexual compatibility presented a different pattern. Fifty per cent (3) of the readmission group, as opposed to 100 per cent (8) of the non-readmission group felt that they get along "adequately" or

for the questions used to collect the stated information.

better. Using a proportions test a significance of 2.45 was found. Therefore the readmission and non-readmission groups differ significantly on how well they get along with their mates sexually.

Few respondents chose to make responses of explanation for their choices on the quality of their sexual relationship. Comments included: "Since he's stopped running around and has changed, we get along very well."; "There are no problems."; "My husband was disabled in a car accident. His disability presents certain difficulties, but we manage satisfactorily within these limitations."; "My wife and I decided on once a week and that suits me fine since we're both not so young as we used to be."; "Sexual relations have been a problem since I had a hysterectomy over a year ago."; "He drinks and doesn't give us any money."; and "My wife isn't interested in sex anymore."

How Mate Gets Along with the Former Patient

When the significant other was asked how well he gets along generally and sexually with the former patient, responses were as categorized in Table 12 on the following page.

From Table 12, 92 per cent (11) of the significant others felt that they get along "adequately" or better generally with their mates, the former patients. This is a statistically significant finding. There is not a statistically significant difference between the 75 per cent (3)

TABLE 12

HOW WELL COUPLE GETS ALONG WITH EACH OTHER, GENERALLY
AND SEXUALLY, AS EXPRESSED BY THE SIGNIFICANT OTHER

| | Generally | | | Sexually | | |
|-----------------|------------|--------------|-------------|------------|---------------|-------------|
| | R (n=8) | NR (n=11) | T (N=19) | R (n=8) | NR (n=11)* | T (N=19) |
| Very Well | 0 | 3 | 3 | 1 | 4 | 5 |
| Quite Well | 2 | 4 | 6 | 0 | 1 | 1 |
| Adequately | 1 | 1 | 2 | 2 | 1 | 3 |
| Quite Poorly | 0 | 0 | 0 | 0 | 0 | 0 |
| Very Poorly | 1 | 0 | 1 | 1 | 1 | 2 |
| Not Appropriate | 4 | 3 | 7 | 4 | 3 | 7 |

* one response was lost because of the use of a translator.

of the readmission group and the 100 per cent (8) of the non-readmission group that chose "adequately" or better. The response pattern is similar to that of the patients on the same question.

Significant others made the following comments regarding their general relationship with the former patient: "We have no problems."; "We've worked out a mutually-satisfying system of subordinate-dominant roles and give-and-take."; "We never fight though we do have some arguments. She looks after the house."; "My husband and I have had no major problem in fifteen years."; "He has a lot of different ideas. He's strong so there is no use arguing. I just let it go in one ear and out the other."; and "He drinks, he beats me and the kids, he walks out on us for days at a time, and sometimes the police have to come to get things straightened out."

In the area of sexual compatibility, 75 per cent (3) of the mates of the readmission group and 86 per cent (6) of the mates of the non-readmission group felt that they get along "adequately" or better with the former patient. This is quite different from the responses of the patient group. This is accounted for by the fact that two of the three patients who stated that they get along less than adequately with their mate, refused to have the mate interviewed, while for the third person, husband and wife agreed that they get along "very poorly."

The comments of significant others on sexual compatibility included: "We have no problems in that area."; "Before she went to the hospital she was on pills and so doped up that she did not respond, but now she is almost too much for me."; "I keep putting it off as long as I can. He drinks and I don't want to play second to the bottle."; "I'm often tired and go to bed early. He never misses the eleven o'clock news so that we don't get together too often."; "He's in the change of life and impotent now." and "My wife is past that now."

How Patient and Parental Family Get Along

How well the patient and his parental family get along is presented in Table 13 on the following page. Eighty per cent (8) of the patients get along "adequately" or better

TABLE 13

HOW WELL PATIENT GETS ALONG WITH PARENTAL FAMILY AND
HOW WELL FAMILY GETS ALONG WITH PATIENT

| | Patient | | | Significant Other | | |
|-----------------|-------------|----------------|-------------|-------------------|--------------|-------------|
| | R (n=15) | * NR (n=15) | T (N=30) | R (n=8) | NR (n=11) | T (N=19) |
| Very well | 2 | 1 | 3 | 2 | 1 | 3 |
| Quite Well | 3 | 0 | 3 | 0 | 0 | 0 |
| Adequately | 0 | 2 | 2 | 2 | 1 | 3 |
| Quite Poorly | 1 | 1 | 2 | 0 | 1 | 1 |
| Very Poorly | 0 | 0 | 0 | 0 | 0 | 0 |
| Not Appropriate | 8 | 11 | 19 | 4 | 8 | 12 |

* one interviewee felt that he could not respond.

with their parental family. Using a proportions test a significance of 3.32 was found. Eighty-three per cent (5) of the patients in the readmission group and 75 per cent (3) of the patients in the non-readmission group felt that they get along "adequately" or better. This is not a statistically significant finding, so that the two groups are not differentiated on this variable. The pattern is that of both patients and significant others in the conjugal situation.

The comments of the patients included: "we have no fights or arguments."; "My parents allow me my independence."; "My mother is a good cook." "We just seem to get along with each other."; "I have it pretty good at home. My parents have tried their best."; "Sometimes I'm resentful. I think that my parents love my sister more than me." and "Sometimes my mom is on my back and sometimes she's not."

From Table 13, 86 per cent (6) of the significant

others in parental families stated that they get along "adequately" or better with their son or daughter who is a former patient. This is a statistically significant finding. Most parents get along at least adequately with the former patient. This is similar to the response pattern for the conjugal situation and for the patient in the parental family. It is not statistically significant that 100 per cent (4) of the significant others in parental families of the readmission group and 67 per cent (2) of those in the non-readmission group felt that they get along adequately or better with the former patient.

Some of the explanations of parents for their choice of response are as follows: "We have no trouble."; "We have no reason to think otherwise."; "My wife and I did not spend enough time with our daughter. We didn't talk things out with enough openness." and "We have our problems but they get straightened out eventually as they do in most families." The mother who chose "quite poorly" gave her son's drinking as the reason. At the time of the interview she was upset about the problem, thus the researcher arranged counseling at the hospital for her and her son.

Former Patients' Use of Time

Table 14 shows the patient's impression of how time is spent. Most patients spend at least some time with

family, friends and alone. There are few differences between the readmission and non-readmission groups. However, one trend does emerge. A larger per cent of the non-readmission group spend "a good deal" of time with the family than do the readmission group.

TABLE 14

PATIENT'S IMPRESSION OF THE AMOUNT OF TIME
SPENT WITH FAMILY, FRIENDS, AND ALONE,
EXPRESSED IN PERCENTAGES (n=15)

| | Family | | Friends | | Alone | |
|-------------|--------|------|---------|------|-------|------|
| | R | NR | R | NR | R | NR |
| A Good Deal | 26.7 | 60.0 | 13.3 | 33.3 | 26.7 | 26.7 |
| Some | 40.0 | 26.7 | 46.7 | 40.0 | 33.3 | 40.0 |
| Very Little | 26.7 | 6.6 | 26.7 | 26.7 | 33.3 | 33.3 |
| None | 6.6 | 6.6 | 13.3 | 0.0 | 6.6 | 0.0 |

* these patients no longer have family in the immediate vicinity

** z=1.94 No. Statistical Significance

Former patients indicated a broad range of activities that they engaged in with their families. Watching television, visiting friends and relatives, and playing cards were activities consistently shared, no matter what time the family spent together. Those who spent "a good deal" of time together emphasized working in the house and yard together and sharing sports activities, while those who spent "very little" time with the family generally ate and slept together.

With friends, as with the family, cards and table games were a favorite pastime. Several respondents mentioned dinner, drinking and dancing as activities shared,

and casual chats were also suggested. A few said that they watched television and participated in or watched various sports.

As with activities with family and friends, so it was with activities alone--no definite pattern emerged to differentiate the readmission and non-readmission groups. Activities when alone included housework, hobbies and reading. Those who spent more time alone seemed to spend more time watching television.

The Patient's Functioning Before His Hospitalization

To consider the patient's functioning before his hospitalization two variables were utilized: employment and ability to take responsibility at home.

Employment Status and Job Satisfaction

The employment status of each of the patients in the sample is outlined in Table 15. The table indicates

TABLE 15

EMPLOYMENT STATUS OF PATIENT AT THE TIME OF HOSPITALIZATION

| | R (n=15) | NR (n=15) | T (N=30) |
|-------------------|-------------|--------------|-------------|
| Fulltime | 13 | 7 | 20 |
| Partime | 0 | 1 | 1 |
| Unemployed: | | | |
| Housewife | 2 | 4 | 6 |
| Seeking Job | 0 | 1 | 1 |
| Attending School | 0 | 1 | 1 |
| Mentally Retarded | 0 | 1 | 1 |

that only one person who was unemployed actually wanted a job. The remainder of the sample was employed or satisfied with the status of housewife.

From Table 16, 85 per cent (17) of those who were employed before their hospitalization, felt that they got along "okay" or better with the people where they worked. This is a statistically significant percentage. Also, 75

TABLE 16

HOW WELL THE PATIENT FELT HE GOT ALONG
WITH THE PEOPLE WHERE HE WORKED

| | R | | NR | |
|--------------|-------|----------|-----------|----------|
| | No. * | Per Cent | No. (n=8) | Per Cent |
| Very Well | 3 | 25.0 | 1 | 12.5 |
| Quite Well | 5 | 41.7 | 2 | 25.0 |
| Okay | 1 | 8.3 | 5 | 62.5 |
| Quite Poorly | 1 | 8.3 | 0 | 0.0 |
| Very Poorly | 2 | 16.7 | 0 | 0.0 |

* one interviewee did not respond.

per cent (9) of the readmission group and 100 per cent of the non-readmission group felt that they got along "okay" or better with the people where they worked. With the proportions test a significance of 2.00 was found. This is statistically significant. Thus the non-readmission group feel that they got along better with their fellow employees and the management than do the readmission group.

From Table 17, on the following page, 84.5 per cent (11) of the readmission group and 75 per cent (6) of

TABLE 17
HOW THE PATIENT FELT ABOUT HIS JOB

| | R | | NR | |
|--------------|---------------|-------------|--------------|-------------|
| | No. (n=13) | Per Cent | No. (n=8) | Per Cent |
| Liked Job | 5 | 38.5 | 3 | 37.5 |
| It Was Okay | 6 | 46.0 | 3 | 37.5 |
| Disliked Job | 2 | 15.5 | 2 | 25.0 |

the non-readmission group felt that their job was "okay" or better. This is not a statistically significant difference between the two groups. It should be noted that most of the subjects in the sample were satisfied with their jobs.

Responsibility Assumed by Patient for his Home and Family

Both the patient and his significant other answered a scale-type question concerning how much responsibility the patient assumed for his home and family before his hospitalization. The responses are presented in Table 18 and Table 19 (on the following page).

TABLE 18
HOME RESPONSIBILITY ASSUMED BY PATIENT PRIOR TO HIS
HOSPITALIZATION, AS REPORTED BY PATIENT

| | R | | NR | | T | |
|---------------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Sole Responsibility | 5 | 33.3 | 8 | 53.3 | 13 | 43.3 |
| Responsibility Often | 3 | 20.0 | 4 | 26.7 | 7 | 23.4 |
| Occasional Responsibility | 3 | 20.0 | 1 | 6.7 | 4 | 13.3 |
| No Responsibility | 4 | 26.7 | 2 | 13.3 | 6 | 20.0 |

As obvious from Table 18, 53.3 per cent (8) of the readmission group and 80 per cent (12) of the non-readmission group took responsibility for the home and children at least often. Though this finding is not statistically significant, it does suggest that the non-readmission group took more responsibility at home than did the readmission group.

TABLE 19

HOME RESPONSIBILITY ASSUMED BY PATIENT PRIOR TO HIS HOSPITALIZATION, AS REPORTED BY SIGNIFICANT OTHER

| | R | | NR | | T | |
|---------------------------|------------|----------|------------|----------|------------|----------|
| | No. (n=8)* | Per Cent | No. (n=11) | Per Cent | No. (N=19) | Per Cent |
| Sole Responsibility | 1** | 14.3 | 6** | 54.5 | 7 | 39.0 |
| Responsibility Often | 1 | 14.3 | 2 | 18.2 | 3 | 16.6 |
| Occasional Responsibility | 2*** | 28.6 | 2*** | 18.2 | 4 | 22.2 |
| No Responsibility | 3 | 42.8 | 1*** | 9.1 | 4 | 22.2 |

* one made no response because of recent move

** z=2.16 Statistically Significant

*** z=1.97 Statistically Significant

From Table 19, significantly more of the significant others of the non-readmission group than of the readmission group stated that the patient functioned at the highest level before hospitalization, while significantly more of the readmission group than the non-readmission group stated that the patient functioned at the lowest level before hospitalization. This would support the trend from the patients' responses as seen in Table 18. There are two possible

explanations for these findings: 1) The functioning of the patient who has subsequent admissions to the hospital may have been more impaired at the time of initial hospitalization than that of a patient who has no subsequent admissions; or 2) Because of subsequent admissions the patient and the significant others of the readmission group may see the previous functioning of the patient as being more negative than it actually was.

Table 20 presents a correlation of Table 18 and Table 19. As indicated, 56 per cent (10) of patients and significant others agreed upon the amount of responsibility assumed by the patient. And in six of the remaining eight combined ratings there was a one point difference between the rating given by the patient and that of the significant others. For the two other combinations, there was a two-point

TABLE 20

PATIENTS' AND SIGNIFICANT OTHERS' IMPRESSIONS
OF HOME RESPONSIBILITY ASSUMED BY PATIENT

| Rating of Patient | Rating of Significant Other | | | |
|-------------------|-----------------------------|------|------|------|
| | S.R. | R.O. | O.R. | N.O. |
| S.R. | 5 | 2 | 0 | 0 |
| R.O. | 1 | 1 | 0 | 1 |
| O.R. | 1 | 1 | 1 | 1 |
| N.O. | 0 | 0 | 1 | 3 |

S.R.--Sole Responsibility; R.O.--Responsibility Often;
O.R.--Occasional Responsibility; N.O.--No Responsibility.

difference, so that in 11 per cent (2) of the combinations then, there was a noticeable amount of disagreement on level

of responsibility. The 89 per cent of almost complete agreement lends reliability to the findings that the non-readmission group accept more responsibility at home.

The Source(s) of The Problem For Which The Patient Was Hospitalized, and It's Relationship To Family Functioning

To consider this aspect of the project the researcher posed questions concerning what was most influential in the development of the problem for which the patient was hospitalized, the presence of any particular worry at home just previous to hospitalization, the length of the onset of the illness, and other possible ways of coping with the problem without hospitalization. Questions were directed to both the patient and his significant other.

Influential Factors in the Patient's Need for Hospitalization

The responses of the patients and their significant others to what was the most influential factor in the development of the problem for which the patient was hospitalized are presented in Table 21 and Table 22 (on the following page), respectively.

From Table 21 it is obvious that there is little difference between the readmission and the non-readmission groups on this variable. In terms of this research it is important to note that 40 per cent (6) of the readmission group and 33 per cent (7) of the non-readmission group saw

TABLE 21
 PROBLEMS THAT HOSPITALIZED PATIENTS,
 AS REPORTED BY PATIENTS

| | R | | NR | | T | |
|---------------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Work | 2 | 13.3 | 1 | 6.7 | 3 | 10.0 |
| Individual | 6 | 40.0 | 7 | 46.6 | 13 | 43.0 |
| Family | 6 | 40.0 | 5 | 33.3 | 11 | 37.0 |
| Friends and Neighbours | 1 | 6.7 | 0 | 0.0 | 1 | 3.3 |
| Other | 0 | 0.0 | 2* | 13.3 | 2 | 6.7 |

* "other" includes a car accident, and insurmountable financial problems for a father of seven children.

family difficulties as the single most influential factor in the development of the problem. This represents 37 per cent (13) of the sample, and family difficulties are seen as the second most frequent prime factor in psychiatric hospitalization.

TABLE 22
 PROBLEMS THAT HOSPITALIZED PATIENTS,
 AS REPORTED BY SIGNIFICANT OTHERS

| | R | | NR | | T | |
|---------------------------|--------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=8) | Per Cent | No. (n=11) | Per Cent | No. (N=19) | Per Cent |
| Work | 1 | 12.5 | 2 | 18.2 | 3 | 15.6 |
| Individual | 3 | 37.5 | 4 | 36.3 | 7 | 37.0 |
| Family | 4 | 50.0 | 3 | 27.3 | 7 | 37.0 |
| Friends and Neighbours | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Other | 0 | 0.0 | 2* | 18.2 | 2 | 10.4 |

* "other" includes a car accident, and insurmountable financial problems for a father of seven children.

Similar to Table 21, Table 22 indicates little

difference between the readmission and the non-readmission groups on the most influential factor in the development of the problem. And 37 per cent (7) of the total sample of significant others saw family difficulties as the prime factor in hospitalization. Therefore it ranked as equally important as individual difficulties. This finding of the importance of family difficulties as a prime factor in the development of the problem for which the patient was hospitalized is as expected.⁸

Particular Worry at Home Before the Patient
Was Hospitalized

As the percentages in Table 23 indicate, both patients and significant others of the readmission group, more often than the non-readmission group, stated that there was a special problem at home before the patient was

TABLE 23

PRESENCE OF SPECIAL WORRY AT HOME, AS REPORTED
BY PATIENT AND SIGNIFICANT OTHER

| | R | | NR | | T | |
|-------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Patient | | | | | | |
| Yes | 8 | 53.0 | 6 | 40.0 | 14 | 46.5 |
| No | 7 | 47.0 | 9 | 60.0 | 16 | 53.5 |
| Significant Other | (n=8) | | (n=11) | | (N=19) | |
| Yes | 4 | 50.0 | 3 | 27.2 | 7 | 37.0 |
| No | 4 | 50.0 | 8 | 72.8 | 12 | 63.0 |

⁸ See Sampson, "The Mental Hospital and Marital Ties," p. 12 in Chapter II.

hospitalized, though the finding is not statistically significant. For the total sample of patients, 46.5 per cent (14) of the patients and 37 per cent (7) of the significant others stated that there was a particular worry at home just before the patient was hospitalized. This is as expected, given the etiology of mental problems within the family as described in Chapter II.

Worries Cited

For an outline of the worries mentioned by patients and significant others see Table 24.

TABLE 24

WORRIES AT HOME AS CITED BY PATIENTS AND
SIGNIFICANT OTHERS, BY PERCENTAGES

| | Patient | | | Significant Other | | |
|--|------------|-------------|-------------|-------------------|-------------|------------|
| | R (n=8) | NR (n=6) | T (N=14) | N (n=4) | NR (n=3) | T (N=7) |
| Marital Problems | 25.0 | 16.7 | 21.4 | 0.0 | 33.3 | 14.3 |
| Separation and Needed Adjustment | 25.0 | 16.7 | 21.4 | 0.0 | 0.0 | 0.0 |
| Fear of Physically Hurting Family | 0.0 | 16.7 | 7.2 | 0.0 | 0.0 | 0.0 |
| Difficulties with Parent | 0.0 | 16.7 | 7.2 | 0.0 | 0.0 | 0.0 |
| Terminal Illness of a Family Member | 37.5 | 16.7 | 28.6 | 50.0 | 0.0 | 28.6 |
| Death of a Partner | 12.5 | 0.0 | 7.2 | 0.0 | 0.0 | 0.0 |
| Financial Problems | 0.0 | 16.7 | 7.2 | 25.0 | 0.0 | 14.3 |
| Threatened Family Court | 0.0 | 0.0 | 0.0 | 25.0 | 0.0 | 14.3 |
| Husband's Working Situation | 0.0 | 0.0 | 0.0 | 0.0 | 66.7 | 28.6 |

In Table 24 the patient's category with the highest

percentage was "Terminal Illness of a Family Member," indicating, perhaps, an inability to cope with life's crises. The responses of 50 per cent (7) of the total sample of patients, five readmissions and two non-readmissions, were specifically related to marriage;⁹ namely, marital problems and separation and death. The loss of a significant other, either emotionally or physically, seems to leave no recourse for some people, except hospitalization, as the individual tries to learn to cope with his loss. Terminal illness of a family member and a husband's working situation were the worries cited most often by the significant other. Fifty-seven per cent (4) of the worries cited by the significant other were related to marriage and the family, namely, marital problems, threatened family court and husband's working situation.

Length of Onset of Problem and Ways of Coping With It.

As indicated by Table 25, 93.3 per cent of the patients and 89.5 per cent of the significant others felt that the problem had been developing for sometime. This is

⁹ See Appendix C, for a letter to support the idea of hospitalized patients having poor relationships with mates and parents.

TABLE 25
 LENGTH OF ONSET OF PROBLEM AS EXPRESSED
 BY PATIENT AND SIGNIFICANT OTHER

| Patient | R | | NR | | T | |
|-------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Suddenly | 0 | 0.0 | 2 | 13.3 | 2* | 6.7 |
| For Sometime | 15 | 100.0 | 13 | 86.7 | 28* | 93.3 |
| Significant Other | (n=8) | | (n=11) | | (N=19) | |
| Suddenly | 1 | 12.5 | 1 | 9.1 | 2*** | 10.5 |
| For Sometime | 7 | 87.5 | 10 | 90.9 | 17*** | 89.5 |

* $\chi^2=22.6$ Statistically Significant

** $\chi^2=11.82$ Statistically Significant

a statistically significant finding. In almost every instance the problem had been developing for sometime. Table 26 expands upon this finding.

Patients and significant others agreed that there was no other way to have coped with the problem; hospitalization

TABLE 26
 WERE THERE OTHER WAYS OF COPING WITH THE PROBLEM,
 WITHOUT THE PATIENT'S HOSPITALIZATION?

| Patient | R | | NR | | T | |
|-------------------|---------------|--------------|---------------|--------------|---------------|-------------|
| | No. (n=15) | *Per Cent | No. (n=15) | *Per Cent | No. (N=30) | Per Cent |
| Yes | 3 | 21.2 | 3 | 21.2 | 6*** | 21.2 |
| No | 11 | 78.8 | 11 | 78.8 | 22*** | 78.8 |
| Significant Other | (n=8) | | (n=11)* | | (N=19) | |
| Yes | 2 | 25.0 | 2 | 20.0 | 4*** | 22.2 |
| No | 6 | 75.0 | 8 | 80.0 | 14*** | 77.8 |

* one subject in each felt that he could not respond

** $\chi^2=9.15$ Statistically Significant

*** $\chi^2=5.55$ Statistically Significant

was the only answer at that point. This finding is statistically significant. Seventy-nine per cent of the patients and 77.8 per cent of the significant others saw hospitalization as essential.¹⁰ When people cannot cope with a problem after an extended period of seeking answers on their own, they turn to the hospital.

The 21 per cent (6) of the patients who gave alternatives to hospitalization made these comments: "Getting away from my husband; his drinking is the problem."; "My family should not have bothered me."; "Suicide." and "My sister and her family should have visited more often and helped me when Mother was dying." Thus one person felt family support would have helped while another found it detrimental. Another subject saw the hospital as his salvation.

The twenty-two per cent (4) of the significant others who saw alternatives to hospitalization commented: "He would have gotten over it at home."; "The doctor should have kept her off those pills. She was too doped up for sex so I ran around. She was nervous and the pills didn't help that." and "The family doctor could have looked after it. She just needed time and interviews."

¹⁰ See Sampson et al. Chapter II, page 12. The authors suggest that hospitalization is not the result of the recognition of the mental illness of a family member but rather the inability to cope with the behavior within the family. Therefore this research project supports the findings of Sampson et al.

Merits and Deficiencies of Hospital Treatment

To consider the merits and deficiencies of in-hospital and post-hospital treatment, as experienced by the patient and his significant other, the researcher asked questions related to how helpful the stay in the hospital was, how the hospital staff was helpful, how they could have been more helpful, preparation of the patient and family for the patient's discharge, maintenance medication to be taken at home, and suggestions for service development.

Helpfulness of Hospital Stay and Hospital Staff

The patients' responses to "How helpful was your stay in the hospital?" are presented in Table 27. Table 28 has the responses of the significant others to the same question.

TABLE 27

HELPLEFULNESS OF PATIENT'S HOSPITAL STAY, AS EXPRESSED BY PATIENT

| | R | | NR | | T | |
|------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Very Helpful | 7 | 46.7 | 10 | 66.7 | 17 | 57.0 |
| Somewhat Helpful | 7 | 46.7 | 5 | 33.3 | 12 | 40.0 |
| Not Helpful | 1 | 6.6 | 0 | 0.0 | 1 | 3.0 |

As indicated in Table 27, 97 per cent (29) of the patients thought that their hospitalization helped them at least somewhat. This is a statistically significant finding. It indicates that patients generally perceive their

hospitalization as a positive experience.

When asked "In what ways was your stay helpful or not helpful?" the comments of the patients who chose 'helpful' included: "It gave me an opportunity to get away from the situation, and time to mature."; "I realized that I wasn't the only one with a problem and that other people's problems are even worse."; "I had a social worker and nurses to listen to me."; "The structure of the hospital forced me to live each day, namely to eat and sleep, and I hadn't been before."; "I shared my problems with the other patients and they shared theirs."; "I didn't drink for awhile."; and "I got a rest but didn't solve my problem." The subject who chose "not helpful" said: "I couldn't sleep. The more erratic patients were not separate from the rest. There should be more occupational therapy so that not so much time is left to the individual. I didn't like being herded and I felt watched by tours of student nurses."

TABLE 28

WAS PATIENT'S STAY IN HOSPITAL HELPFUL,
AS REPORTED BY SIGNIFICANT OTHER

| | R | | NR | | T | |
|-----|--------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=8) | Per Cent | No. (n=11) | Per Cent | No. (N=19) | Per Cent |
| Yes | 5* | 62.5 | 11* | 100.0 | 16** | 84.0 |
| No | 3 | 37.5 | 0 | 0.0 | 3** | 16.0 |

* $z=2.18$ Statistically Significant

** $\chi^2=8.9$ Statistically Significant

As shown in Table 28, 84 per cent of the significant others thought that the patient's stay in the hospital helped him and 16 per cent felt that it did not. This is statistically significant and in agreement with the findings from the patient's responses that they themselves found their hospitalization helpful.

Also, 62.5 per cent (5) of the readmission group and 100 per cent (11) of the non-readmission group said that the hospitalization of the patient helped him. There is a statistically significant difference between these two groups so that significantly more of the significant others of the non-readmission group than the readmission group thought that the initial hospitalization of the patient had been helpful.

Significant others who indicated "yes" in response to the "helpfulness of stay" question commented: "He saw the doctor more often than at St. Thomas."; "He seems to understand himself better."; and "The doctor helped pin down the problem to my job and moving so I got another job and things are fine now." Those who said "no," that the hospital did not help, noted: "He was too drugged." and "His stay in the hospital was good for nothing. He still drinks. Nothing was changed."

Helpfulness of Hospital Staff, as Reported by Patient

As shown in Table 29 (on the following page) 42

per cent (13) of the patients felt that it was the physician who helped them the most during their stay in the hospital. Fellow patients were found to be the most helpful with the second greatest frequency. The readmission group cited the physician and fellow patients as most helpful almost equally as often, while the non-readmission group said that the

TABLE 29

PATIENT'S IMPRESSION OF WHO WAS MOST HELPFUL
TO HIM DURING HIS HOSPITALIZATION

| | R | | NR | | T | |
|-----------------|----------------|-------------|-----------------|-------------|---------------|-------------|
| | No. (n=15)* | Per Cent | No. (n=15)** | Per Cent | No. (N=30) | Per Cent |
| Physician | 6 | 37.5 | 7 | 46.6 | 13 | 42.0 |
| Nurse | 2 | 12.5 | 1 | 6.7 | 3 | 9.7 |
| Social Worker | 2 | 12.5 | 2 | 13.3 | 4 | 12.9 |
| Fellow Patients | 5 | 31.3 | 2 | 13.3 | 7 | 22.6 |
| Orderly | 1 | 6.2 | 0 | 0.0 | 1 | 3.2 |
| Psychologist | 0 | 0.0 | 1 | 6.7 | 1 | 3.2 |
| All | 0 | 0.0 | 2 | 13.3 | 2 | 6.4 |

* one subject in each mentioned both nurse and Social Worker

** one subject could not respond

physician was the most helpful three times as often as they cited fellow patients. When asked in what ways they found the physician helpful, eight subjects stated that it was his ~~talking to~~ talking to them, his reassurance and straightforward approach. Four found the drugs the physician prescribed most helpful, while one patient stated: "He gave good advice."

Patients who said that the nurses were "most helpful" stated: "They talked to me, tried to help, and

were understanding."; and "It was fun playing pool with the pretty Oriental nurses."

The comments of those who found the social worker most helpful included: "I liked the way he talked to me," and "He asked me to take some leadership position in the patient's group. I didn't but it made me feel good to be asked."

Some remarks of those who thought that fellow patients were the most helpful to them were: "Seeing others with the same problem or worse gave me the desire to get better."; "I liked sharing advice and realized that I would have to help myself."; "I enjoyed group therapy. It gave me a chance to relate to other patients." and "Seeing others with worse problems made me want to get out." While the patient who chose the psychologist noted, "He helped by talking to me and working out with me in the gym. I got physically active and had the chance to release my pent-up emotions. He saw my wife and I together about one half of the time." And the one who selected the orderly commented: "He explained hospital procedure and ward life to me. When I knew what was going to happen I could relax and start to get better."

In answer to the question, "In what ways could others have been more helpful?" there were a great variety of answers. Some of the more general comments were: "The

staff should talk to you more...They should ask more personal questions to get us to open up more."; "There was too much supervision. We felt watched."; "It would be nice to be asked to do something rather than be ordered to do it."; "The staff did not seem interested in us and made fun of some of the patients in front of them."; and "The Council of Patients should be continued."

Specific comments follow: "O.T. was awful. It really seemed unpleasant. It's difficult to get gratification when you're told to do something."; "Some professional should explain what it means to have a nervous breakdown and how long you're going to be in the hospital."; "Someone should explain about meals and visiting and all that as soon as someone is admitted."; "There should be someone to listen to you--a father confessor sort of person."; "The more disturbed people should be kept separate."; and "There should be some discussion with patients about adjustment in society and the stigma of mental illness." Two patients found their communication in the hospital severely limited because they spoke little English.

Numerous statements were related to the physician: "I would have liked to see him oftener--three times a week instead of twice."; "He should have seen me sooner. I was in for five days before I saw a doctor." and "He should try to understand deeper problems rather than just superficial

ones." One subject wanted to change physicians but was not allowed to do so, while another said, "I couldn't talk to the doctor; he didn't seem to listen; I couldn't communicate. I wanted another doctor but I didn't ask."

Some of the patients could think of no ways that the staff could have been more helpful and made the following comments: "Everything was good."; "I have no complaints." and "It was adequate."

Helpfulness of Hospital Staff, as Reported by
Significant Others

TABLE 30

SIGNIFICANT OTHER'S IMPRESSION OF WHO WAS MOST HELPFUL
TO PATIENT DURING HIS HOSPITALIZATION

| | H | | NR | | T | |
|-----------------|--------------|-------------|----------------|-------------|---------------|-------------|
| | No. (n=8) | Per Cent | No. (n=11)* | Per Cent | No. (N=19) | Per Cent |
| Physician | 3 | 37.5 | 5 | 54.5 | 8 | 47.0 |
| Nurse | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Social Worker | 2 | 25.0 | 1 | 11.1 | 3 | 17.7 |
| Fellow Patients | 3 | 37.5 | 1 | 11.1 | 4 | 23.6 |
| Psychologist | 0 | 0.0 | 1 | 11.1 | 1 | 5.9 |
| All | 0 | 0.0 | 1 | 11.1 | 1 | 5.9 |

* two subjects could not say

The results presented in Table 30 are very similar to those in the preceding Table. Both the patients and the significant others said the physician was the one who helped the patient the most during the patient's hospitalization. In both instances fellow patients were cited as the most helpful, after the physician. As with the patients, the

significant others of the readmission group cited the physician as the most helpful, equally as often, while the non-readmission group said that the physician was the most helpful five times as often as they cited fellow patients.

When the significant others were asked in what ways others could have been more helpful, their comments included: "The doctor gave too many pills and I could never get hold of him."; "I wanted to talk to the doctor to give him some background. My husband came home on weekends, drank and scared my kids. When he was back I called the doctor and left messages, but he never called back. It is easier to go to Moscow to the Kremlin, get tickets and see Stalin than to see a psychiatrist." and "As soon as one person is admitted, get someone to the home to get the facts of his life and childhood and to see how the family is managing without one member. There should also be some follow-up to check progress after discharge."

Preparation for Discharge

Readiness for Discharge

Table 31 (on the following page), indicates that there is little difference, between the readmission and non-readmission groups on feeling of readiness to go home; 77 per cent (23) felt ready to leave the hospital when discharged. Comments on this question included: "I wanted to get back to

TABLE 31

HOW READY PATIENT WAS TO GO HOME, AS REPORTED
BY PATIENT AND SIGNIFICANT OTHER

| Patient | R | | NR | | T | |
|-------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Very Ready | 11 | 73.5 | 12 | 80.0 | 23 | 77.0 |
| Somewhat Ready | 3 | 20.0 | 3 | 20.0 | 6 | 20.0 |
| Not Ready | 1 | 6.5 | 0 | 0.0 | 1 | 3.0 |
| Significant Other | (n=8) | | (n=11) | | (N=19) | |
| Definitely Ready | 4 | 50.0 | 8 | 72.7 | 12 | 63.0 |
| Seemed Ready | 2 | 25.0 | 2 | 18.2 | 4 | 21.0 |
| Not Ready | 2 | 25.0 | 1 | 9.1 | 3 | 16.0 |

my family and the routine."; "I felt able to look after the kids."; "Some of the new patients were starting to bother me."; and "I was still disturbed and went to St. Thomas after my second hospitalization at I.O.D.E."; "I was apprehensive about being accepted."; "I wanted to go back to apply for a job promotion. I did, but I didn't feel well enough."

As shown in Table 31, 63 per cent (12) of the total significant others felt the patient was ready to come home. Fifty per cent (4) from the readmission group and 72.7 per cent (8) of the non-readmission group felt the patient was ready to come home. This is not a statistically significant finding but it does indicate a trend. As an afterthought, more of the significant others of the readmission group feel the patient was not ready to come home.

Comments of the significant others included: "He

seemed better and more relaxed."; "She could take care of the kids."; "It was proven; she never went back." and "She stayed five days longer than the doctor said, till she knew she was ready." "She was alright for awhile, but then got worse and had to go back."; and "It took her awhile to adjust to living with the family."; "He went back to drinking soon so he wasn't better." and "He was still sick; he should have gone to the clinic from the hospital rather than from the home."

Person Suggesting Discharge

As indicated in Table 32, it is the physician who suggests the patient's discharge in 60 per cent (18) of the discharges. This is a statistically significant finding.

TABLE 32

PATIENT'S REPORT OF WHO SUGGESTED HIS DISCHARGE

| | R | | NR | | T | |
|-----------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Self | 6** | 40.0 | 3** | 20.0 | 9* | 30.0 |
| Physician | 7 | 46.5 | 11 | 73.0 | 18 | 60.0 |
| Mutual | 2 | 13.5 | 1 | 7.0 | 3 | 10.0 |

* z=2.50 Significant

** z=1.25 Not Significant

The physician suggests the discharge twice as often as the patient suggests it for himself. The physician was the only staff person recommending discharge. Of the 30 per cent (9) of the patients who suggested their own discharge, 40 per cent

(6) were readmissions and 20 per cent (3) were non-readmissions. This is not statistically significant but suggests perhaps that readmissions are anxious to get out, possibly because they had been hospitalized for a longer time.¹¹

Staff Preparation of Patient for Discharge

In Table 33 below 46.5 per cent (14) of the patients had some discussion regarding their discharge with the physician. An almost equal percentage, 43.5 per cent (13) had no discussion with anyone. Of the readmission group, 33.3 per cent (5), and of the non-readmission group, 60 per cent

TABLE 33

STAFF DISCUSSION WITH THE PATIENT REGARDING DISCHARGE

| | R | | NR | | T | |
|---------------|----------------|-------------|----------------|-------------|---------------|-------------|
| | No. (n=15)* | Per Cent | No. (n=15)* | Per Cent | No. (N=30) | Per Cent |
| Physician | 5** | 33.3 | 9** | 60.0 | 14 | 46.5 |
| Social Worker | 2 | 13.3 | 2 | 13.3 | 4 | 13.3 |
| Group Therapy | 1 | 6.7 | 0 | 0.0 | 0 | 0.0 |
| Staff | 0 | 0.0 | 1 | 6.7 | 2 | 6.7 |
| None | 9*** | 60.0 | 4*** | 26.7 | 13 | 43.5 |

* Subjects in both groups cited both Physician and Social Worker.

** z=1.59 Not significant

*** z=1.94 Not significant

(9) had some discussion with the physician. This is not a statistically significant difference, but it suggests an

¹¹ See Appendix D.

important trend. Would more preparation of the patient for discharge, on the part of the physician, increase the likelihood of the patients remaining in the community?¹² What reinforces this suggestion is the fact that nine of the readmission group and four of the non-readmission group got no preparation whatever for discharge. This finding approaches statistical significance and is deserving of consideration.

Those patients who discussed their discharge with a staff person covered such topics as job, home, marital partner and children, medication, the desire for discharge and day-care.

Preparation of Family for Patient's Discharge

When the former patient was asked what discussions the staff had had with his significant other before his discharge, four said the physician talked to his family; seventeen said there was no discussion and eight did not know. There was no statistical difference between readmission and non-readmission group reporting of family involvement in the discharge process. For the four who saw a physician and the seventeen who had no discussion, $z=4.4$. It is therefore statistically significant that fourteen per cent (4) of significant others spoke to a physician while fifty-seven

¹² See Chapter II for several references lending support to the idea that aftercare helps to sustain community tenure.

per cent (17) of the significant others received no preparation or instructions regarding the patients' discharges.

When significant others were asked what consultation they were given regarding the patients' discharges, seven of the readmission group and eight of the non-readmission group said they received none; namely, 79 per cent (15) received no preparation or instruction, while 21 per cent (4) did receive some. This is a statistically significant difference. Most families received no preparation for the patients' discharges. When the physician did speak to the significant other, he discussed medication, going home, and the family helping more at home.

Medication at Home

When they returned home, 90 per cent (27) of the patients were given some medication. This is found to be statistically significant with a proportions test. Most patients are given medication to help them in their adjustment to home and society.

As indicated in Table 34, one person did not take the prescribed medication; all the rest took what was suggested. Of those who took the medication, 33.3 per cent (9) discontinued it of their own accord while 63 per cent (17) took it as long as they were supposed to. There was a

TABLE 34

HOW LONG THE PATIENT CONTINUED TO TAKE MEDICATION

| | R | | NR | | T | |
|------------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=14) | Per Cent | No. (n=13) | Per Cent | No. (N=27) | Per Cent |
| As long as supposed to | 10 | 71.5 | 7 | 54.0 | 17 | 63.0 |
| As long as needed | 4 | 28.5 | 5 | 38.5 | 9 | 33.3 |
| Not at all | 0 | 0.0 | 1 | 7.5 | 1 | 3.7 |

greater percentage of readmissions than non-readmissions who continued to use the medication.

From Table 35 of those who took medication, 73.3 per cent (19) felt that the medication was at least somewhat helpful; 26.7 per cent (7) felt the medications were not helpful. This is statistically significant.

TABLE 35

HOW HELPFUL THE PATIENTS FOUND THE MEDICATION

| | R | | NR | | T | |
|------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=14) | Per Cent | No. (n=12) | Per Cent | No. (N=26) | Per Cent |
| Very Helpful | 6 | 43.0 | 5 | 41.7 | 11 | 42.5 |
| Somewhat Helpful | 4 | 28.5 | 4 | 33.3 | 8 | 30.8 |
| Not Helpful | 4 | 28.5 | 3 | 25.0 | 7 | 26.7 |

Thus a significant number of patients find the medications helpful in adjusting to home. There is no difference between the readmission and non-readmission groups. The comments of those who took the medication included:

"It helped me to relax so it was easier for the family to be with me; and I felt I was doing what the doctor asked and

this gave me confidence that I would get better."; "I'm high-strung without it."; "I felt I was in another world. It was a cop out but I did rely on them."; "I got a shot one day and felt sick for four days, but then was fine for a week. It gave me some bad side effects, and ups and downs."; "There's a lot you have to do for yourself. Medication can't do everything."; "They had no effect on my condition. They relaxed me physically rather than mentally."; "You can't take a pill to feel happy."

Of the significant others, 84 per cent (16) said that the patient took some medication at home. This figure agrees with the percentage of patients who said that they were taking medication. Those who said the patient was taking medication made these comments: "It helped to keep her relaxed and calm."; "It made him drowsy so he slept during the day and then couldn't sleep at night."; and "The drugs mean she can stay at home, and not in the hospital."

Patients' and Significant Others' Suggestions

The final question asked of both the patient and his significant other was: "As you look back on it now, do you think that there are other services or instructions that might have been helpful to you when you were leaving the hospital?"

Patients gave the following suggestions: ¹³

¹³ See also Appendix C.

- "Day-care should have been available at the hospital sooner."
- "The doctor should see a patient as soon as he comes in rather than wait two or three days." and "I only saw the doctor twice a week. It was not enough. He should talk to you longer and three times per week."
- "Passing time was a problem. Occupational therapy is not enough to fill the time. Working outside on the grounds was good for me."
- "My problem was that I didn't think my parents loved me as much as my sister. Wouldn't the family therapy that they talk about in psychology books have helped us?"
- "The staff should have given us more encouragement."
- "I would have liked to talk to the doctor when I was leaving."
- "There should be some follow-up during and after hospitalization. The social worker should get to the family as soon as the patient is admitted to the hospital."

Suggestions of the significant others included:

- "There should be more follow-up so the patient does not end up going back a second time. They should be able to see the doctor sooner and more often."
- "They should continue group therapy."
- "There didn't seem to be any follow-up. I thought someone would have asked to talk to me [sister who admitted patient]. The doctor spoke to me only once on the phone. There should be more family involvement."
- "There should be persons on staff rather than a doctor or a nurse, who are authority figures, in whom the patient can confide."
- "No follow-up is needed. He would have felt sick

if someone from the hospital had called."

Family Involvement in Treatment

To consider family involvement in the in-hospital and post-hospital treatment, as experienced by the patient and his significant other, the researcher asked questions about how the family reacted toward the patient after his hospitalization, visiting home and returning home, the presence of other emotional problems in the family and family involvement in treatment.

Family Reaction to the Patient After his Hospitalization

Both the patient and his significant other were asked if the family reacts any differently toward the patient now, as compared to before his hospitalization. The responses are reported in Table 36.

TABLE 36

DOES FAMILY REACT ANY DIFFERENTLY TO PATIENT NOW?

| Patient | R | | NR | | T | |
|-------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Yes | 7 | 47.0 | 6 | 40.0* | 13 | 43.0** |
| No | 8 | 53.0 | 9 | 60.0 | 17 | 57.0 |
| Significant Other | (n=8) | | (n=11) | | (N=19) | |
| Yes | 3 | 37.5 | 2 | 18.0* | 5 | 26.0** |
| No | 5 | 62.5 | 9 | 82.0 | 14 | 74.0 |

* z=1.29 Not Statistically Significant
 ** z=1.21 Not Statistically Significant

Of the patients, 57 per cent said "No," the family did not react differently, while 74 per cent of the significant others said the same. It seems that the significant others see themselves as reacting less differently than did the patients, though it is not a statistically significant difference. The idea that more of the significant others of the non-readmission group see themselves as reacting no differently to the patient, relates to the fact that more (72.7% versus 50%) of the significant others of the non-readmission than the readmission group, as an afterthought, felt that the patient had definitely been ready to come home and so would react to him with this in mind.

The researcher observed with interest, some of the reactions of the interviewees when this question was asked. Some patients and significant others said, "Yes" with pride, while others gave a very defensive "No." Some of the comments of those patients who said "Yes" included: "They show more concern and understanding."; "We get along better and the family doesn't preach anymore."; "Arguments start easier but pass more quickly."; "They treated me like a stranger." and "They seemed to resent me and lectured me." Significant others said: "We're more friendly and like him more now that he doesn't drink so much."; "We're more careful to avoid friction and criticism of each other."; "I consciously avoid suggesting doing things with him."; and "We have to

change our ways and attitudes so that it won't happen again."

Visiting Home and Returning Home

Frequency of Visits Home

There is no statistically significant difference between the groups on the frequency of visits home. However, more non-readmissions make no visits whatever. This is

TABLE 37

FREQUENCY OF PATIENT'S VISITS HOME

| | R | | NR | | T | |
|--------------------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| One Day Per Week | 2 | 13.3 | 2 | 13.3 | 4 | 13.3 |
| One to Two Days Per Week | 11 | 73.4 | 7 | 46.7 | 18 | 60.0 |
| More Than Two Days Per Week | 0 | 0.0 | 1 | 6.7 | 1 | 3.4 |
| Not At All | 2 | 13.3 | 5 | 33.3 | 7 | 23.3 |

partially explained by the shorter hospitalization of the non-readmission group, and the fact that those who are in for five to ten days do not usually come home because the time is too short.

Helpfulness of Visits Home

As shown in Table 38, 87 per cent (20) of the patients who visited home during their hospitalization found these visits helpful to them. This is a statistically significant finding. There was no difference between the readmission and non-readmission groups on whether or not they found the

TABLE 38
WERE THE VISITS HOME HELPFUL?

| | R | | NR | | T | |
|-----|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=13) | Per Cent | No. (n=10) | Per Cent | No. (N=23) | Per Cent |
| Yes | 11 | 84.5 | 9 | 90.0 | 20* | 87.0 |
| No | 2 | 15.5 | 1 | 10.0 | 3* | 13.0 |

* $\chi^2=15.7$ Significant

visit home helpful. Those who found the visits home helpful made the following statements: "It made me aware of what living outside the hospital was like."; "I could see the differences in the relationships at home." and "I realized that I was more happy at home with my family than in the hospital." One subject who said "No," that the visits were not helpful, stated: "I felt that going home was going back to a trap and I wasn't ready to go back."

Consideration of Living Arrangements

Table 39 indicates a very statistically significant finding. Without exception the significant others stated that they did not consider alternate living arrangements for the patient. A further point is that there was almost perfect agreement between the patient and the significant other. Three out of four patients who said that they had considered other arrangements did not have a significant other interviewed, so that only in one instance did the patient and significant other disagree. The fact that little consideration

TABLE 39

DID PATIENT CONSIDER LIVING ANYWHERE BUT AT HOME?

| Patient | R | | NR | | T | |
|-------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Yes | 3 | 20.0 | 1 | 6.7 | 4 | 13.0 |
| No | 12 | 80.0 | 14 | 93.3 | 26 | 87.0 |
| Significant Other | (n=8) | | (n=11) | | (N=19) | |
| Yes | 0 | 0.0 | 0 | 0.0 | 0 | 0.0* |
| No | 8 | 100.0 | 11 | 100.0 | 19 | 100.0* |

* Statistically Significant

was given to alternate living arrangements suggests that any family problems were not extreme enough to cause family disintegration.

Presence of Other Emotional Problems in Family

As indicated in Table 40, 77.8 per cent (14) had no other emotional problems in the family that required that

TABLE 40

PRESENCE OF EMOTIONAL PROBLEM IN FAMILY,
BESIDES IN IDENTIFIED PATIENT

| | R | | NR | | T | |
|-----|--------------|-------------|----------------|-------------|---------------|-------------|
| | No. (n=8) | Per Cent | No. (n=11)* | Per Cent | No. (N=19) | Per Cent |
| Yes | 3 | 37.5 | 1 | 10.0 | 4*** | 22.2 |
| No | 5 | 62.5** | 9 | 90.0** | 14*** | 77.8 |

* no response from one subject

** z=1.42 Not Significant

*** $\chi^2=5.55$ Statistically Significant

person to have professional help. This is a statistically

significant finding. Of the readmission group, 37.5 per cent (3), and of the non-readmission group, 10 per cent (1), had another member of the family, besides the patient, who had an emotional problem. This finding is not statistically significant but suggests a higher degree of disruption in the families of those who have admissions to the hospital subsequent to the first hospitalization.

Family Involvement in Treatment

Of the patients, two from the readmission group and one from the non-readmission group said that their family was not at all involved in their treatment, while of the significant others, one of the readmission group and three from the non-readmission group said that they were not involved in the patient's treatment.

Patients' Perceptions of Family Involvement in Treatment

As indicated in Table 41, (on the following page), 89.5 per cent (17) of the readmission group and 52.9 per cent of the non-readmission group saw involvement in treatment as visiting, showing concern, offering encouragement, and sending cards or bringing gifts. Such activities are expected aspects of life and are not defined as therapeutic in a strict "treatment" sense, though they are necessary to develop and maintain the patient's positive attitude toward life, and his relationships. We visit, send cards, and offer

TABLE 41
WAYS IN WHICH PATIENT FELT FAMILY
WAS INVOLVED IN TREATMENT

| | R | | NR | | T | |
|-----------------------------------|----------------|-------------|----------------|-------------|---------------|-------------|
| | No. (n=15)* | Per Cent | No. (n=15)* | Per Cent | No. (N=30) | Per Cent |
| Visited | 12 | 63.0 | 8 | 47.0 | 20 | 55.5 |
| Showed Concern | 5 | 26.5 | 1 | 5.9 | 6 | 16.7 |
| Saw Physician or Social Worker | 2 | 10.5** | 7 | 41.2** | 9 | 25.0 |
| Joint Sessions | 0 | 0.0 | 1 | 5.9 | 1 | 2.8 |

* each patient stated all ways

** $z=2.13$ Statistically Significant

encouragement on many occasions besides when a friend or relative is hospitalized. The most important statistically significant finding from Table 41 is that 41.2 per cent (7) of the significant others of the non-readmission group saw the physician or social worker, while 10.5 per cent (2) of the significant others of the readmission group did this. And further, in one case an interviewee from the non-readmission group and his wife were seen jointly for a series of sessions. The significant others of the non-readmission group were more involved in treatment.

Significant Others' Perceptions of Family Involvement in Treatment

The pattern in Table 42 (on the following page) is not so striking as that in Table 41. Visiting was again the major means of involvement. And more significant others of

TABLE 42

WAYS IN WHICH SIGNIFICANT OTHER FELT FAMILY
WAS INVOLVED IN PATIENT'S TREATMENT

| | R | | NR | | T | |
|-----------------------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Visited | 4 | 44.7 | 8 | 57.0 | 12 | 34.7 |
| Showed Concern | 1 | 11.1 | 1 | 11.1 | 2 | 8.7 |
| Saw Physician or Social Worker | 3 | 33.3 | 5 | 36.0 | 8 | 34.9 |
| Attended Clinic Meetings | 1 | 11.1 | 0 | 0.0 | 1 | 11.1 |

the non-readmission group than of the readmission group saw the physician or the social worker, though this is not a statistically significant finding.

Desire for Increased Family Involvement

A statistically significant number of the patients (66.6%) did not want their family more involved in their

TABLE 43

SHOULD FAMILY BE MORE INVOLVED IN PATIENT'S TREATMENT?

| Patient | R | | NR | | T | |
|-------------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | No. (n=15) | Per Cent | No. (n=15) | Per Cent | No. (N=30) | Per Cent |
| Yes | 4 | 26.5* | 3 | 20.0 | 7 | 23.4** |
| No | 9 | 60.0 | 11 | 73.4 | 20 | 66.6** |
| Did Not Know | 2 | 13.3 | 1 | 6.8 | 3 | 10.0 |
| Significant Other | (n=8) | | (n=11) | | (N=19) | |
| Yes | 5 | 62.5* | 4 | 36.4 | 9 | 48.0 |
| No | 2 | 25.0 | 4 | 36.4 | 6 | 31.6 |
| Did Not Know | 1 | 12.5 | 3 | 27.2 | 4 | 20.4 |

* z=1.72 Not Significant

** z=2.75 Statistically Significant

treatment. However, there was no statistically significant difference, for the significant others, on whether or not they wanted to be more involved in the patient's treatment. Forty-eight per cent of the significant others wanted to be involved in the patient's treatment, while only 23.4 per cent of the patients wanted family to be involved in treatment. This was especially true for the patients and significant others in the readmission group. The fact that 48 per cent of the significant others wanted to be more involved in the patient's treatment suggests this is an untapped resource that should be further explored for its potential usefulness.

Use of Aftercare by Patient and his Family

As indicated in Table 44, the readmission group used the aftercare services more frequently than did the

TABLE 44

AFTERCARE AS SUGGESTED TO AND USED BY PATIENT (n=15)

| | R | | NR | |
|------------------------------------|---------|------|---------|------|
| | Offered | Used | Offered | Used |
| Day Care | 2 | 3 | 2 | 1 |
| Visits to Physician | 7 | 8 | 6 | 5 |
| Social Work Services | 1 | 1 | 2 | 0 |
| Group Sessions | 8 | 6 | 3 | 1 |
| Family Counseling | 0 | 0 | 2 | 0 |
| Referral to Community | | | | |
| Agency | 0 | 0 | 2 | 0 |
| Home Visits | 0 | 0 | 1 | 0 |
| Outpatient Occupational Therapy | 0 | 0 | 1 | 1 |
| Public Health Nurse | 2 | 2 | 0 | 1 |
| Family Doctor | 0 | 0 | 2 | 2 |
| See Psychologist | 0 | 0 | 1 | 1 |
| TOTAL | 20 | 20 | 22 | 12 |
| None | 3 | 3 | 6 | 6 |

non-readmission group who seem to try to manage more on their own. The services offered and used were almost entirely individual services rather than family services. When the significant others were asked what aftercare services were offered to the family, twelve replied that there had been nothing, while two gave the public health nurse, and one each said the family doctor, the Connaught Clinic, and the psychologist. Two significant others were offered visits to the physician and one was offered social work services. The public health nurse, the psychologist, the Connaught Clinic, and the family doctor were the only services used. Thus, the family was not involved in the patient's aftercare.

Findings from the Interviewer's Comment Schedule

This section will include a brief report of the interviewer's appraisal at the conclusion of the interview with the patient and his significant other. The researcher feels that this appraisal is relatively unbiased on the readmission-non-readmission variable since she did not consult her information from Schedule II before each interview and so had no idea whether she was interviewing a person who had any subsequent admissions. It will be noted that the questions in the interview schedules with the patient and his significant other referred only to initial hospitalization so that in most instances readmission was not mentioned during the interview.

Interviewer's Appraisal of Patient's and Significant
Other's Attitude toward Each Other

From Table 45, most of the patients and significant others in both the groups were seen, by the researcher, to have at least somewhat positive feelings toward one another. There are no statistically significant differences between the readmission and non-readmission groups. However it seems

TABLE 45

INTERVIEWER'S APPRAISAL OF INTERVIEWEE'S FEELING

| | Patient Toward Significant Other | | Significant Other Toward Patient | |
|-------------------|-------------------------------------|----|-------------------------------------|----|
| | R | NR | R | NR |
| Very Positive | 2 | 6 | 2 | 5 |
| Somewhat Positive | 7 | 7 | 2 | 6 |
| Neutral | 1 | 2 | 4 | 0 |
| Somewhat Negative | 2 | 2 | 0 | 0 |
| Very Negative | 2 | 0 | 0 | 0 |
| No Indication | 1 | 0 | 7 | 4 |

that the researcher perceived both patient and significant other in the non-readmission group as more often having positive feelings toward one another than was the case with the readmission group. The findings, then, are similar to those reported under the present functioning of the patient.

Attitude of Patient and Family Toward Hospital

Under attitude of patient and his family toward the hospital the researcher felt that 46.5 per cent (14) respected and appreciated the hospital function; 40 per cent (12) respected the hospital and personnel in general, but had some

criticisms; 6.7 per cent (2) were not impressed with the hospital but accepted its potential usefulness; and 6.7 per cent (2) gave no indication whatever. There were no significant differences between the readmission and non-readmission groups. It would, however, be statistically significant that 86.5 per cent (26) respected the hospital, with or without criticism.

Attitude of Patient and Significant
Other Toward Interview

Most of the patients and their significant others were friendly toward the interviewer and answered the questions with interest. The rest agreed to the interview with

TABLE 46

ATTITUDE OF PATIENT AND SIGNIFICANT
OTHER TOWARD INTERVIEW

| | Patient | | Significant Other | |
|----------|-------------|--------------|-------------------|--------------|
| | R (n=15) | NR (n=15) | R (n=8) | NR (n=11) |
| Friendly | 7 | 9 | 5 | 9 |
| Neutral | 7 | 5 | 3 | 2 |
| Hostile | 1 | 1 | 0 | 0 |

hesitation, but answered most of the questions and were, at the conclusion, quite surprised at how non-threatening the experience had been. Only two patients were quite hostile toward the interviewer during the interview, and the hostility was confined to subtle remarks and refusal to answer some questions.

Interviewer's Comments

In the process of interviewing the researcher happened upon some interesting thoughts, some of which follow:

-There were several people in the sample who spoke almost no English. The interview was possible with an interpreter. There were, however, requests for some staff to interpret for them in the hospital. Discussion with the physician was limited because of the language barrier, and the idea of the therapeutic milieu is lost.

-There were several people who were either in a crisis situation at the time of the interview or felt that a crisis was approaching. The researcher made two definite referrals, aided in the placement of four children with the Children's Aid Society at the time of crisis, and offered referrals in three more situations. These last three offers were refused because of other agency involvement and a sense of frustration with the problem.

-There seemed to be quite a few people employed in factories and "on the line" at the car plants. How is this related to problem development, and to the number of "unlocatables" who might be very transient? How does the type of work and keeping that type of job effect the family and the problem for which the patient was hospitalized?

-My definition of family presents some difficulties. For example, if it was on the record that a patient who was thirty-five years old returned to live with his mother, there was no way of knowing whether the woman was fifty-five or seventy-five years old. In the case that she was the elder, the possibility of her involvement in treatment would be more limited.

-One subject of the non-readmission group was interviewed in the hospital. He had been in the community for two years and was hospitalized about the time of the study.

-The purpose of the research was difficult to explore because of the limited amount of family work done during or after hospitalization.

-The researcher noted that she seemed to be driving to one part of the city more often than the others, and so prepared the map presented in this chapter.

Summary of Research Findings

This summary is presented in the same format as was the information in the body of the chapter.

Findings Related to the Sample

Because the sample is representative of the population and the respondents are representative of the sample on the variables of age and sex, then, the respondents are representative of the hospital population at least on these variables. The researcher has therefore assumed that her findings can be generalized.

Comparison of the general characteristics of the readmission and non-readmission groups in the sample indicated that the use of the ex post facto research design was valid for this study.

It was found that the sample was not evenly distributed throughout the eight wards in the city. There was a concentration of the sample in Ward 1 and Ward 5. This suggests that these may be "high risk" areas for the development of problems necessitating hospitalization.

Findings from Interview Process

Present Level of Functioning of the Patient

Both patients and significant others, in general, feel that they get along with each other, both in the conjugal and parental family situations.

The area of sexual compatibility clearly differentiates the readmission and non-readmission patients. More of the non-readmission patients get along adequately or better, sexually, with their mates. The pattern for significant others responses to this question is not so distinct but it is interesting that two of the three patients who said they get along less than adequately, sexually, with their mate, refused to have that mate interviewed.

Most patients spend at least some time with their families; the non-readmission group does so more often than the readmission group. In spending more time together the non-readmission families share working and playing, while readmission families often only eat and sleep in the same house.

Therefore the non-readmission group is functioning somewhat better on one variable, sexual compatibility, and somewhat better on enjoying time and activities with the family. In all other aspects reported in this section the two groups are similar.

The Patient's Functioning Before his Hospitalization

The significant finding under employment was that significantly more of the non-readmission group got along okay or better with the people where they worked.

More of the patients from the non-readmission group said that they took responsibility at home at least

often. Though not statistically significant it indicates a strong trend that is supported by the responses of the significant other. Significantly more of the significant others of the non-readmission group said that the patients functioned with sole responsibility for their roles in the family before hospitalization; while significantly more of the readmission group said that the patients functioned with no responsibility for their roles in the family before their hospitalization. Correlating patient's and significant other's responses indicated agreement, within one point, most of the time. This lends reliability to the finding that the non-readmission group takes more responsibility at home, before hospitalization.

Source of Problem for which Patient was Hospitalized
and It's Relationship to Family Functioning

The most influential factor in the patient's hospitalization, as stated by the patient, was individual difficulties. The second most influential factor was family difficulties. Significant others gave individual difficulties and family difficulties equally often. Thus family difficulties is an important factor in hospitalization, though not a statistically significant one.

Approximately one-half of the patients and one-third of the significant others said that there was a special worry at home before the patient was hospitalized. Though

not statistically significant it underlines the fact that family difficulties are definitely a factor in psychiatric problems.

Most patients and significant others said that the problem had been developing for sometime and that by the time of hospitalization there was no other way of coping with the problem.

Merits and Deficiencies of Hospital Treatment

Most of the patients and the significant others felt that the patient's hospitalization was helpful. Significantly more of the significant others from the non-readmission group said this.

Both patients and significant others felt that the physician was the person most helpful to the patient. Fellow patients ranked second as most helpful.

Most patients and significant others felt that the patient was ready to come home. Of the significant others, however, the readmission group was less certain than the non-readmission group about the patient's readiness. Most often it was the physician who suggested discharges; in fact, he was the only one, besides the patient himself, to do so.

The physician discussed discharge with the patient for one-half of the subjects interviewed. And more of the readmission group than the non-readmission group received no

preparation for discharge. The patients reported that very seldom did the family see the physician and that more often than not the family received no preparation for the patient's discharge. The significant others agreed that most often none of the hospital staff discussed the patient's discharge with them.

Most patients were given medication to use at home, and they took the medication given to them, at least for awhile. Most of those who took medication found it helpful.

The suggestions of the patients and their significant others regarding treatment and the hospital were related to the topics covered in this section, and can be referred to as necessary.

Family Involvement in Treatment

Patients and significant others agreed that more often than not the family reacted no differently toward the patient after his hospitalization. The significant others said this more often than did the patient, but the finding was not statistically significant.

Most patients visited home at least one day per week during the last half of their hospitalization. Of those who visited home most found that the visit was helpful.

It is statistically significant that most of the patients and none of the significant others considered no

alternate living arrangements for the patient when he was leaving the hospital. Where there was a family problem, it was not great enough to cause family disintegration.

Both patient and significant other saw the family's major form of involvement in treatment as visiting and showing concern. However, there is a statistically significant difference between the readmission and non-readmission group of patients on the number of times that they said the family talked to the doctor or social worker. This differentiation is not supported by the significant others, to a significant degree. Most patients did not want their family more involved in their treatment, while many significant others wanted to be more involved in treatment. The family was not involved in the patient's aftercare.

Findings from the Interviewer's Comment Schedule

Though the findings of the researcher from Schedule V were not statistically significant in differentiating the readmission and non-readmission groups; they supported the trends from the interviews with the patient and his significant other. And, it was indicated that most of the sample was neutral, if not friendly, during the interview.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The researcher began this research in order to seek support for her hypothesis that a patient whose family is involved in any treatment, either during or after the patient's hospitalization, or both, will be less likely to be readmitted than a patient whose family has no such involvement; as well as to gather material about the hospital experience as perceived by the patient and his significant other. Two groups of fifteen former patients each, one with subsequent admissions to the psychiatric facility, and one with no such subsequent admissions within eighteen months after the initial discharge, were interviewed. Where possible a significant other was interviewed as well.

The Major Findings

The major findings are reviewed under the same organization as they were presented in Chapter IV.

Present Level of Functioning of Former Patient

Most patients and significant others, in both conjugal and parental families, indicated that they got along adequately or better with one another. However, the more intimate variable of sexual compatibility differentiated the readmission and non-readmission patients. The non-readmission

ones get along better with their mates now, than do the readmission ones. There is no significant difference between the two groups on the amount of time spent with family, with friends and alone. However, it does seem that the non-readmission group spends more time with the family, and that they spend this time sharing more closely.

Patient's Functioning Before his Hospitalization

The questions related to employment did not differentiate the two groups, except on how well the patient got along with the people where he worked prior to his initial admission. Significantly more of the non-readmission than the readmission group got along okay or better with the people where they worked.

There was a trend for more of the patients from the non-readmission than the readmission group to indicate that they took responsibility for their role at home at least often before their initial hospitalization. This trend was supported by two statistically significant findings from the significant others. More of the significant others of the non-readmission group said that the patient functioned with sole responsibility for his role, while more of the readmission group said that the patient functioned with no responsibility for his role in the family before he was hospitalized.

It would seem that on the variables of getting along

with fellow workers and taking responsibility at home for one's role, the functioning of the readmission group was more impaired at the time of hospitalization than was the functioning of the non-readmission group.

Sources of Problem for which Patient was Hospitalized and Their Relationship to Family Functioning

Family difficulties was given as the most influential factor in the patient's hospitalization by both patient and significant other only slightly less frequently than were individual difficulties. Thus family difficulties emerge as an important factor in hospitalization. As well, one-half of the patients and one-third of the significant others said that there was a particular worry at home just before the hospitalization. Their worries included marital problems, and death and illness in the family. The problems had most definitely been developing for sometime, as reported by both the patient and his significant other.

Merits and Deficiencies of Hospital Treatment

Both patients and significant others said that they felt that the patient's hospitalization helped him. Significantly more of the significant others of the non-readmission group said this. Physicians and then fellow patients were cited by patients and significant others as most helpful. Most of the patients and the significant others felt that the patient was at least somewhat ready to come home when he left

the hospital. However, the significant others of the readmission group were somewhat less certain about the patient's readiness to come home. More of the readmission than the non-readmission group said that they received no preparation for discharge, in terms of discussing adjustment, job and home with a member of the staff. The patients and significant others agreed that in most cases the staff did not discuss the patient's discharge with the family.

Family Involvement in Treatment

Both patients and significant others stated that more often than not the family reacted no differently toward the patient after his hospitalization. Patients found visiting home during their hospitalization helpful. Only infrequently was a living arrangement, alternate to coming home, considered for or by the patient.

Both the patient and his significant other saw the major form of the family's involvement in treatment as visiting and showing concern. However, significantly more of the significant others of the non-readmission group talked to the physician or social worker, as reported by the patient. Therefore, the family of the non-readmission group was more therapeutically involved, as perceived by the patient, than was the family of the readmission group. There is no difference between the reports of the significant others of the readmission

and non-readmission groups on this point.

Original Research Hypothesis

Research Hypothesis:

A patient whose family is involved in any treatment, either during or after the patient's hospitalization, or both, will be less likely to be readmitted than a patient whose family has no such involvement.

The hypothesis proved to be difficult to test because of the limited amount of family involvement in treatment. However the findings related to what limited involvement there was are summarized below.

Both the patient and the significant other perceived their major form of involvement as visiting and showing concern. The only finding in this area that statistically differentiates the readmission and non-readmission groups was that more of the patients in the readmission group reported that their significant other saw the physician or social worker. Therefore the hypothesis is supported by this finding. There was no difference between the readmission and non-readmission groups when it was the significant other reporting on his involvement.

The lack of agreement between the patient and his significant other is difficult to explain. Of the readmission group, in one instance the two agreed that the significant other had seen the physician or social worker, while one

patient and two significant others reported that they had seen the physician or social worker when the other did not. Of the non-readmission group, three patients and significant others agreed, while two patients and one significant other said that they had seen the physician or social worker when the other did not mention it. One of the readmissions and two of the non-readmissions, who had no significant other interviewed, said that a member of the family had seen the physician or social worker.

These findings suggests that in order to more accurately test the hypothesis, very distinct measures of family involvement should be defined. Therefore the researcher presents these findings as an exploratory base on which to develop further studies of family involvement in treatment.

The Readmitted Patient and his Family

The patient with a readmission presents a picture somewhat different from that of the patient with no readmissions. For the patient with subsequent admissions, personal relationships are sometimes problematic. He got along less well with his fellow workers before his hospitalization than the patient with no readmissions. And even now, he gets along less than adequately, sexually, with his mate; and he spends less time with his family. Also he refused, more often, to allow his significant other to be interviewed.

Just before the time of his hospitalization the patient took little responsibility for his role at home and he reported, more often than did the non-readmission patient, that there was a particular worry at home. He also considered alternate living arrangements when leaving the hospital more frequently than did the patient who had no subsequent admissions, and he was also hospitalized for a longer time.

During his hospitalization he found the physician and fellow patients the "most helpful" almost equally as often. It is interesting to note that fellow patients were considered most helpful when it seems that personal relationships were problematic. From comments during the interviews it is obvious that the patients shared much in terms of mutual problems. However, this sharing was not constructive enough to sustain the patient in the community, and therefore it would seem necessary that this be supplemented with professional support. Group therapy would allow the mutual sharing but the purpose and program would add the therapeutic element.

Despite the fact that more frequently there were particular worries at home and that more frequently other family members had experienced emotional problems, the patient with readmissions definitely did not want the family more involved in his treatment. Visiting and showing concern was the expected and acceptable extent of involvement.

Though he was hospitalized for a longer time, the patient with readmissions received less preparation for discharge. He made more extensive use of aftercare. In spite of this he was rehospitalized within eighteen months.

The significant other of the patient with subsequent admissions noted that prior to hospitalization the patient took almost no responsibility at home and that most frequently it was a family problem that hospitalized the patient. Twice as often as did the significant other of the patient with readmissions said that there was a worry at home. They perceived the patient as less ready to come home when he was discharged and saw the patient's stay in the hospital as less helpful. The significant other wanted to be more involved in the patient's treatment, almost twice as often as did the significant other of the patient with no readmission.

A Possible Explanation

The researcher proposes, then, that patients are admitted to the hospital with various levels and degrees of personal and family dysfunction, and that for those with subsequent admissions this degree is higher. For this reason the family member identified as the patient bears a greater degree of guilt or anxiety, and the stigma of being the "problem" is much greater. The patient accepts this label and the guilt, and thus he does not want the family involved. Hospitalization

provides a rest from the problem situation but gives no solution; despite the longer initial hospitalization, the patient was readmitted.

It is not surprising that the patient is not able to remain in the community. His hospitalization removed him from an environment that, in many cases, was problematic for him. Removal from and return to an environment, when no change has occurred in that environment, cannot be expected to reinforce the gains of hospital treatment, especially when neither the patient nor his family were prepared for the patient's return. The problem still exists; the patient is eventually again hospitalized in search of a solution for the family.

The family sees that there is a problem and a family worry; they see their own involvement in it. Therefore they want to be involved in the treatment. At the same time there are hopes and fears and uncertainties. The patient was hospitalized for his own sake and that of the family. However his hospitalization is not the solution to the family problems; it merely changes roles and interaction for a time. Thus the family is not certain that the patient should come home; the idea that the patient "was not ready" would be a more acceptable rationalization to the significant other than would the thought of unmanageable problems in the home situation. Also, the family did not see the hospitalization

as very helpful, possibly because the patient did not maintain his tenure in the community.

The researcher sees this as a plausible explanation of her findings in view of past research and writing on the family as presented in Chapter II.

Recommendations

As a result of the findings of this research project the researcher makes the following recommendations:

- Certain areas of the city seem to be "high risk" areas, in terms of the development of problems that eventually require hospitalization. The researcher suggests that this be the subject of further research to determine some of the factors contributing to the "high risk" nature of the areas, and that the hospital or other community resources consider and explore the possibilities of doing some preventive work in the community, particularly in these areas.
- The fact that problems had been developing for sometime again underlines the need to reach families in trouble sooner, before the problem becomes a crisis requiring hospitalization. Primary prevention in the community is essential.
- Because relationships are problematic, particularly to some patients, treatment programs should place more emphasis on developing interpersonal relationship skills. This could include marital and family counseling and patient group sessions.
- The value of sharing with fellow patients, as expressed by the former patient, suggests that group programs would be a very acceptable

and effective form of treatment. Well-programmed group sessions would facilitate patient sharing in an environment that is defined by the constructive professional input of physician, social worker, nurse, psychologist and occupational therapist.

- The nature of the problems for which patients were hospitalized underlines the need for a family orientation toward treatment. The initial support given to the research hypothesis emphasizes the importance for the professional staff to involve the family of the patient in treatment. Family involvement should be more extensively utilized while the patient is in the hospital as well as in aftercare treatment; the desire of significant others to be involved in treatment is a definite resource that the hospital should utilize. Involvement could include many combinations or variations as the needs of the individual and his family suggest, and could range from an interview with the primary therapist to family therapy with the entire family.

- Although patients indicated that they did not wish their families more involved in their treatment, the researcher sees this as a lack of understanding of what assistance this could be in their treatment progress. In order to effectively utilize family involvement patients would need to be convinced that this form of treatment would aid their recovery and readjustment. Therefore the professional staff of the hospital should add this preliminary educational aspect to the treatment program.

- Although patients indicated that the physician was the most helpful person in their treatment it was evident that other personnel and patients contributed to helping the patient. This would suggest the need to strengthen all areas of the therapeutic milieu so as to provide maximum treatment possibilities.

- Preparation of the patient and his family for the patient's discharge must become a

program priority. without it, use of readmission becomes the patient's only means of obtaining the continuing help he wishes and needs.

- Patients did not indicate any negative feelings about the hospital as the arena for treatment. This should encourage the hospital in its continuation and increase of aftercare programs directed toward both patients and their significant others.

- The value of family involvement in treatment requires more research. The development of specific measures of family involvement would provide a more conclusive method of testing the research hypothesis.

- The number of people found to be "unlocatable" in this particular research population suggests that a concurrent study might be better than the ex post facto design. A concurrent study would have the advantage that patients could be prepared for follow-up, and therefore less suspicious and anxious when approached.

- The finding that those with subsequent admissions to the hospital were experiencing a higher degree of personal and family dysfunction at the time of the initial admission suggests that this should be an area for further research. Degree of impairment of functioning should be related to a variety of treatment programs to ascertain the most effective means of facilitating the patient's improvement and thereby reducing the number of his readmissions.

APPENDIX A

HOSPITAL RECORD DATA (PERSONAL): SCHEDULE I

Assigned Number: _____

Case Number: _____

Name: _____

Address: _____

Telephone Number: _____

Name of person patient was
released to live with when
first discharged: _____

HOSPITAL RECORD DATA: SCHEDULE II

1. Data of record reading: _____
2. Assigned number: _____
3. Date of first discharge: _____
4. Date of first admission: _____
5. Length of first hospitalization:
(in days) _____
6. Age (in years): _____
7. Sex: _____
8. Marital Status: Single _____
Married _____
Divorced _____
Widowed _____
Separated _____
9. Diagnosis (if any): _____
10. Diagnostic Person (if any) _____
11. Profession of Diagnostic Person: _____
12. Patient's relationship to person
who admitted him to hospital: _____

INTERVIEW WITH PATIENT: SCHEDULE III

Assigned Number:

Date:

Time:

1. The first thing that I would like to know is who lives in the house with you. (Record this)
And then I would like to know their approximate ages.

| Relationship to you | Age |
|---------------------|-----|
|---------------------|-----|

2. (a) (If living with mate). How do you and your (husband/wife), as a couple, get along, compared to most other couples?

| | | | |
|-------|------------|-------|-----------------|
| _____ | very well | _____ | quite poorly |
| _____ | quite well | _____ | very poorly |
| _____ | adequately | _____ | not appropriate |

- (b) What makes you feel this way?

3. (a) (If living with mate). How do you and your (husband/wife), get along sexually?

| | | | |
|-------|------------|-------|-----------------|
| _____ | very well | _____ | quite poorly |
| _____ | quite well | _____ | very poorly |
| _____ | adequately | _____ | not appropriate |

- (b) What makes you feel this way?

- 4 (a) (If living with parental family). How do you get along with your parents, compared to how most other people get along with their parents?

| | | | |
|-------|------------|-------|-----------------|
| _____ | very well | _____ | quite poorly |
| _____ | quite well | _____ | very poorly |
| _____ | adequately | _____ | not appropriate |

- (b) What makes you feel this way?
5. (a) How much time do you usually spend with the members of your family?
- _____ a good deal
_____ some
_____ very little
- (b) What kinds of things do you do with your family or some members of your family?
6. (a) How many friends would you say that you have?
- _____ lots of friends
_____ some friends
_____ no friends
- (b) How much time do you spend with your friends?
- _____ a good deal
_____ some
_____ very little
- (c) What kind of things do you do when you are with your friends?
7. (a) How much time do you spend by yourself?
- _____ a good deal
_____ some
_____ very little
- (b) What do you usually do when you are alone?
8. (a) Before your hospitalization, what was your employment status?
- _____ employed fulltime
_____ employed part-time
_____ unemployed

- (b) (If unemployed). Why were you unemployed?
- (c) (If unemployed). For how long were you unemployed?
9. (a) If employed, which of the following best describes how you got along with the people where you worked?
- | | | | |
|-------|------------|-------|--------------|
| _____ | very well | _____ | quite poorly |
| _____ | quite well | _____ | very poorly |
| _____ | okay | | |
- (b) If employed, which of the following would you say best describes how you felt about your job?
- | | |
|-------|-------------------------|
| _____ | I liked it very much |
| _____ | It was okay |
| _____ | I disliked it intensely |
10. (a) How many relatives live within a half-hour's drive of your home?
- (b) Of these, how many have you seen
- | | |
|-------|------------------------|
| _____ | in the past month |
| _____ | in the past six months |
| _____ | in the past year |
- (c) How helpful were these relatives to you during and after your hospitalization?
- | | | | |
|-------|------------------|-------|--------------------|
| _____ | very helpful | _____ | not very helpful |
| _____ | somewhat helpful | _____ | not helpful at all |
| _____ | moderately | _____ | did not see them |
- (d) What did they do that was helpful or not helpful to you?
11. As you remember now, before your first hospitalization, which of the following best describes you in relation to those with whom you live:
(To be written out and handed to respondent).

- _____ I had almost sole responsibility for the care of the house and the children, if any. I took responsibility for maintaining family affairs or acted as head of the house.
- _____ I often had a share in the care of the house and the children. I often took responsibility for maintaining family affairs or acted as head of the house.
- _____ I occasionally had a share in caring for the house and children, if any. I sometimes took responsibility for maintaining family affairs or acted as head of the house.
- _____ I took no responsibility for the care of the house and the children, if any. I took no responsibility for maintaining family affairs nor acted as head of the house.
12. (a) Do you feel that your family reacts any differently to you now, say as compared to before you were hospitalized?
- _____ yes
_____ no
- (b) In what ways do they react differently?
- (c) Are there other ways that you would like to be reacted to?
13. Which of the following would you say was most influential in the development of the problem for which you were hospitalized?
- _____ work
_____ very personal, individual difficulties
_____ family difficulties
_____ relationships with friends or in your neighbourhood
_____ others (specify)
14. (a) Did you have any special worry at home just before you went to the hospital?
- _____ yes
_____ no

- (b) What was it?
- (c) Did the problem develop quite suddenly or do you feel that it had been developing for sometime?
- _____ suddenly
 _____ for sometime
15. (a) Do you think there may have been any other ways to have coped with the problem without your hospitalization?
- _____ yes
 _____ no
- (b) What would these ways have been?
16. (a) Of all those with whom you were in contact while you were in the hospital, whom did you feel was most helpful to you? (Do not read list. Allow respondent to make suggestions).
- | | |
|---------------------|-----------------------|
| _____ physician | _____ O.T. staff |
| _____ nurses | _____ fellow patients |
| _____ social worker | _____ other (specify) |
- (b) In what ways was this person helpful?
- (c) In what ways could the others have been more helpful?
17. How did you come to go to the hospital in the first place?
18. (a) How helpful was your stay in the hospital?
- _____ very helpful
 _____ somewhat helpful
 _____ not helpful
- (b) In what ways was it helpful or not helpful?

19. (a) How involved was your family in your treatment at the hospital?

_____ moderately
 _____ very little
 _____ not at all

(b) In what ways were they involved?

(c) Would you have liked your family to have been more involved in your treatment?

_____ yes
 _____ no

(d) In what ways do you think they should have been involved?

Next, I would like to ask some questions about leaving the hospital the first time.

20. (a) How ready to go home did you feel when you were discharged?

_____ very ready
 _____ somewhat ready
 _____ not ready at all

(b) Why did you choose that response?

21. Who suggested your discharge from the hospital?

_____ you
 _____ your family
 _____ your physician
 _____ other (specify)
 _____ do not know

22. To what extent did you and your family agree that you should return home when you were discharged?

_____ strongly agree
 _____ mildly agree

_____ mildly disagree
 _____ strongly disagree
 _____ not a consideration

23. Before your discharge, did you consider going any place else, rather than home to your family?
24. (a) How often did you visit home during the last half of your stay in the hospital?
- _____ less than one day per week
 _____ one to two days per week
 _____ more than two days per week
 _____ other (specify)
- (b) Were these visits helpful?
- _____ yes
 _____ no
- (c) In what ways were they helpful or not helpful?
25. (a) While you were in the hospital, what kinds of discussions regarding your discharge and aftercare did you have with the people in the hospital?
- | Kind of Discussion | With Whom? |
|--------------------|------------|
| | |
- (b) What kinds of discussions regarding discharge and aftercare did members of the staff have with your family?
- | Kind of Discussion | With Whom? |
|--------------------|------------|
| | |
26. (a) When you left the hospital were you given any medication?
- _____ yes
 _____ no
- (b) How long did you continue to use the medication?
- _____ as long as I was supposed to
 _____ as long as I thought I needed it
 _____ I did not use it at all

(c) How helpful was the medication as you adjusted to living at home?

- very helpful
 somewhat helpful
 not helpful

(d). Why did you choose the preceding answer?

27. (a) What types of aftercare services were offered to you and your family?

- day care
 visits to the physician
 social work services
 group sessions
 family counselling
 referral to a community agency
 home visits
 out-patient occupational therapy
 other (specify)

(b) Which of the aftercare services did you and your family use?

- day care
 visits to the physician
 social work services
 group sessions
 family counselling
 referral to a community agency
 home visits
 out-patient occupational therapy
 other (specify)

28. As you look back on it now, do you think that there are other services or instructions that might have been helpful to you when you were leaving the hospital?

INTERVIEW WITH PATIENT'S SIGNIFICANT OTHER:
SCHEDULE IV

Assigned Number: Patient's Name Designated: ***

Date: Time:

Relationship of respondent to patient:

First of all I would like to ask some questions about the family living here in the house.

1. (a) How much time do you usually spend with the members of your family?

_____ a good deal
 _____ some
 _____ very little

- (b) What kinds of things do you do with your family or some members of your family?

2. (a) (If living with mate). How do you and your (husband/wife), as a couple, get along, compared to most other couples?

| | |
|------------------|-----------------------|
| _____ very well | _____ quite poorly |
| _____ quite well | _____ very poorly |
| _____ adequately | _____ not appropriate |

- (b) What makes you feel this way?

3. (a) (If living with mate). How do you and your (husband/wife), get along sexually?

| | |
|------------------|-----------------------|
| _____ very well | _____ quite poorly |
| _____ quite well | _____ very poorly |
| _____ adequately | _____ not appropriate |

- (b) What makes you feel this way?

4. (a) (If living with parental family). How does *** get along with you, as compared to how most other children get along with their parents?

| | | | |
|-------|------------|-------|-----------------|
| _____ | very well | _____ | quite poorly |
| _____ | quite well | _____ | very poorly |
| _____ | adequately | _____ | not appropriate |

- (b) What makes you feel this way?

5. As you remember now, before *** was first hospitalized, which of the following best describes *** in relation to those with whom he/she lived:
(To be written out and handed to the respondent).

_____ He/she had almost sole responsibility for the care of the house and the children, if any. He/she took responsibility for maintaining family affairs or acted as head of the house.

_____ He/she often had a share in the care of the house and the children, if any. He/she often took responsibility for maintaining family affairs or acted as head of the house.

_____ He/she occasionally had a share in caring for the house and the children, if any. He/she sometimes took responsibility for maintaining family affairs or acted as head of the house.

_____ He/she took no responsibility for the care of the house and the children, if any. He/she took no responsibility for maintaining family affairs nor acted as head of the house.

6. (a) Do you feel that you and the rest of the family react any differently toward *** now, as compared to before he/she was hospitalized?

_____ yes
_____ no

- (b) In what ways do you react differently?

Now we can move on to consider *** first hospitalization.

7. Which of the following would you say was most influential in the development of the problem for which *** was hospitalized?

work
 very personal, individual difficulties
 family difficulties
 relationships with friends or in your neighbourhood
 other (specify)

8. (a) Did you and the family or *** have any special worry at home just before he/she went to the hospital?

yes
 no

- (b) What was it?

- (c) Did the problem develop quite suddenly or do you feel that it had been developing for sometime?

suddenly
 for sometime

9. (a) Do you think that there may have been any other ways to have coped with the problem without *** hospitalization?

yes
 no

- (b) What would these ways have been?

10. (a) Of all those involved in the treatment of *** in the hospital, whom do you feel was most helpful to him/her?
(Do not read list. Allow respondent to make suggestions).

physician
 nurses
 social worker
 O.I. staff
 fellow patients
 other (specify)

- (b) In what ways was this person helpful?

- (c) In what ways would the others have been more helpful?
11. (a) Do you feel that *** stay in the hospital helped him/her?
- _____ yes
 _____ no
- (b) In what ways was it helpful or not helpful?
12. (a) How involved were you and the family in *** treatment at the hospital?
- _____ somewhat
 _____ a little
 _____ not at all
- (b) In what ways were you involved?
- (c) Would you have liked to be more involved in his/her treatment?

Next I would like to ask some questions about leaving the hospital the first time.

13. (a) Which of the following statements best describes, as you remember now, your thoughts about *** leaving the hospital?
 (To be written out and handed to respondent).
- _____ He definitely was well enough to come home.
 _____ He seemed better, but I had some doubts about whether he was well enough to come home.
 _____ He should not have come home yet.
- (b) Why did you choose that response?
14. (a) Before *** discharge, did you and the family consider any different living arrangements for him/her, other than coming home?
- _____ yes
 _____ no

- (b) For what reasons did you consider alternate living arrangements?
15. (a) What kinds of discussions regarding *** discharge and aftercare did members of the staff at the hospital have with you and the family?
- | Kind of Discussion | With Whom? |
|--------------------|------------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
16. (a) What types of aftercare services were offered to the family?
- day care
 - visits to the physician
 - social work services
 - group sessions
 - family counselling
 - referral to some community agency
 - home visits
 - other (specify)
- (b) Which of the aftercare services did the family use?
- day care
 - visits to the physician
 - social work services
 - group sessions
 - family counselling
 - referral to some community agency
 - home visits
 - other (specify)
17. (a) Was *** given any medication to use at home, after his/her discharge?
- yes
 - no
- (b) In what ways was it helpful or not helpful?
18. Often relatives of patients receive or want help and advice regarding the patient's problem. Have you or any family member received advice?

Problem Who Gave Advice? Was it Useful?

Before
Hospitalization

During
Hospitalization

After
Hospitalization

19. (a) Since *** was first hospitalized has any other member of the family gone to the hospital, seen a professional person, or visited a community agency regarding an emotional problem?
- _____ yes
 _____ no
- (b) Why?
- (c) Whom did they see?
20. As you look back on it now, what other services or instructions might have been helpful to *** and to the family when *** left the hospital?

RESEARCHER'S COMMENTS AT THE CONCLUSION OF THE INTERVIEW:
SCHEDULE V

Assigned Number:

Date:

Time:

1. (a) Interviewer's evaluation of the patient's feeling toward his family: (Check one).
- | | | | |
|--------------------------|-------------------|--------------------------|-------------------|
| <input type="checkbox"/> | very positive | <input type="checkbox"/> | somewhat negative |
| <input type="checkbox"/> | somewhat positive | <input type="checkbox"/> | very negative |
| <input type="checkbox"/> | neutral | <input type="checkbox"/> | no indication |
- (b) Interviewer's evaluation of significant other's feeling toward the patient: (Check one).
- | | | | |
|--------------------------|-------------------|--------------------------|-------------------|
| <input type="checkbox"/> | very positive | <input type="checkbox"/> | somewhat negative |
| <input type="checkbox"/> | somewhat positive | <input type="checkbox"/> | very negative |
| <input type="checkbox"/> | neutral | <input type="checkbox"/> | no indication |
2. Attitude of patient and his family toward the hospital:
- | | |
|--------------------------|---|
| <input type="checkbox"/> | respects and appreciates the hospital function |
| <input type="checkbox"/> | respects hospital and personnel in general, but has some criticisms |
| <input type="checkbox"/> | not impressed with hospital but accepts its potential usefulness |
| <input type="checkbox"/> | resents hospital, including personnel and policy |
| <input type="checkbox"/> | other (specify) |
3. (a) Attitude of patient toward interview:
- | | |
|--------------------------|----------|
| <input type="checkbox"/> | friendly |
| <input type="checkbox"/> | neutral |
| <input type="checkbox"/> | hostile |
- (b) Attitude of significant other toward interview:
- | | |
|--------------------------|----------|
| <input type="checkbox"/> | friendly |
| <input type="checkbox"/> | neutral |
| <input type="checkbox"/> | hostile |
4. Any further comments:

APPENDIX C

LETTER FROM AN INTERVIEWEE
FOLLOWING THE INTERVIEW

Dear Miss Schnarr:

As you know, my *** and myself have had an interview with you. After you left our place, my *** and I had a talk about what we felt would help us the most concerning the hospital treatment we both have had in the past.

As a hospital patient, have several weekly group therapy meetings with patients who have the "same problem."

Direct criticism or direct ridicule is the worst thing for a patient or for anyone, in fact. If this action is used frequently by a nurse, psychiatrist or the head psychiatrist, by any employee who works at a Psychiatric hospital towards a patient they should be fired! This is fair!! Whatever job a person has, if they are only interested in good pay and don't care enough about doing an honest, sincere job then they don't deserve to be in that profession!! We need agreement or compassion. Of course we can't have this all the time but instead of direct criticism or ridicule why not ask us criticism in the way of "questions." This way a patient feels (for example, that his doctor accepts him and a patient can therefore criticize his own actions, not criticized by his doctor).

Whether a hospital or out-patient, wouldn't interviews with their families with the patient's psychiatrist, help? One interview at least wouldn't hurt! At least the psychiatrist could tell them, the patient's problems and possible solutions. If my relationship with my parents were improved I think it would help me a lot!! But of course this is only my opinion! However, one thing I had in common with almost all the patients I met at the hospital; our biggest common problem was husbands or wives! (In most cases we had lots of discipline, or parents didn't care, or mainly the lack of love. A lot of the patients have agreed on this-that we have had a lack of love. We may love others but are rarely loved back! In fact many have never known what love really is! I was very fortunate. I met a young man who loved me and I likewise, love him! I will always be grateful for this.

Why isn't there more, for example Recovery Inc. meetings which some are held in various churches in Windsor? These meetings as you know are for persons who think or act upon taking their own lives ie. suicide. Why couldn't there be more centres held by the Mental Health Association? In ***, I'm trying to get Recovery meetings to be held in a church or some place. *** is a small town but you'd be surprised how many people seek psychiatric help! Suicide is the third greatest "killer" among college and high school students.

P.S. I have written you what I feel is the truth and very valuable to me. I hope it is of some value to others!

Thank you for everything!

Yours sincerely,

APPENDIX D

GENERAL CHARACTERISTICS OF THE RESEARCH SAMPLE¹

I - Interviewed
 NI - Not Interviewed
 T - Total

| | Readmission | | | No Readmission | | | Total |
|-------------------------------------|-------------|------|------|----------------|------|------|-------|
| | I | NI | T | I | NI | T | |
| | n=15 | n=21 | n=36 | n=15 | n=21 | n=36 | N=72 |
| Length of Hospitalization (in days) | | | | | | | |
| 1 - 21 | 5 | 9 | 14 | 9 | 8 | 17 | 31 |
| 22 - 42 | 2 | 5 | 7 | 3 | 7 | 10 | 17 |
| 43 - | 8 | 7 | 15 | 3 | 6 | 9 | 24 |
| Average length | 49.7 | 63.1 | 57.3 | 44.2 | 33 | 37.6 | 47.5 |
| Age at time of admission (in years) | | | | | | | |
| 21 - 30 | 5 | 8 | 13 | 4 | 4 | 8 | 21 |
| 31 - 40 | 3 | 6 | 9 | 4 | 8 | 12 | 21 |
| 41 - 50 | 6 | 6 | 12 | 5 | 7 | 12 | 24 |
| 51 - 60 | 1 | 1 | 2 | 2 | 2 | 4 | 6 |
| Average Age | 37.8 | 35.5 | 36.7 | 37.7 | 38.2 | 37.9 | 37.3 |
| Sex | | | | | | | |
| Male | 9 | 11 | 20 | 7 | 11 | 18 | 38 |
| Female | 6 | 10 | 16 | 8 | 10 | 18 | 34 |
| Marital Status | | | | | | | |
| Single | 2 | 3 | 5 | 3 | 0 | 3 | 8 |
| Married | 9 | 16 | 25 | 10 | 16 | 26 | 31 |
| Divorced | 1 | 1 | 2 | 0 | 3 | 3 | 5 |
| Widowed | 1 | 0 | 1 | 0 | 0 | 0 | 1 |
| Separated | 2 | 1 | 3 | 2 | 2 | 4 | 7 |

¹ See Appendix A, Schedule II for the data collection instrument.

| Variables | Readmission | | | No Readmission | | | Total |
|--|---------------------|----|----|----------------|----|----|----------------|
| | I | NI | T | I | NI | T | |
| Diagnosis | | | | | | | |
| Brain Disorders | 0 | 0 | 0 | 1 | 0 | 1 | 1 ² |
| Mental Deficiency | 0 | 0 | 0 | 1 | 0 | 1 | 1 ³ |
| Psychoses | 8 | 7 | 15 | 5 | 4 | 9 | 24 |
| Psychosomatic Disorders | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychoneuroses | 4 | 7 | 11 | 5 | 6 | 11 | 22 |
| Personality Disorders | 3 | 5 | 8 | 2 | 8 | 10 | 18 |
| Transient Situational Disturbance | 0 | 2 | 2 | 0 | 4 | 4 | 6 |
| Diagnostic Person | | | | | | | |
| M.D. 1 | 3 | 0 | 3 | 2 | 3 | 5 | 8 |
| M.D. 2 | 2 | 3 | 5 | 0 | 0 | 0 | 5 |
| M.D. 3 | 2 | 3 | 5 | 5 | 4 | 9 | 14 |
| M.D. 4 | 5 | 5 | 10 | 3 | 4 | 7 | 17 |
| M.D. 5 | 1 | 1 | 2 | 1 | 1 | 2 | 4 |
| M.D. 6 | 0 | 3 | 3 | 1 | 1 | 2 | 5 |
| M.D. 7 | 2 | 6 | 8 | 3 | 8 | 11 | 19 |
| Profession of Diagnostic Person | All were physicians | | | | | | |
| Relationship of Person Admitting Patient | | | | | | | |
| Husband | 3 | 2 | 5 | 3 | 6 | 9 | 14 |
| Wife | 2 | 7 | 9 | 3 | 6 | 9 | 18 |
| Daughter or Son | 0 | 1 | 1 | 0 | 0 | 1 | 1 |
| Parent | 4 | 2 | 6 | 4 | 1 | 5 | 11 |
| Other | 4 | 6 | 10 | 2 | 5 | 7 | 17 |
| Unknown | 2 | 3 | 5 | 3 | 3 | 6 | 11 |
| Type of Therapy | | | | | | | |
| Individual | 14 | 21 | 35 | 15 | 21 | 36 | 71 |
| Family | 0 | 0 | 0 | 0 | 0 | 0 | 0 ⁴ |
| Other | 1 | 0 | 1 | 0 | 0 | 0 | 1 |

² Complete diagnosis was schizophrenia due to chronic atrophic brain syndrome. Thus, this will be included with the psychoses.

³ Complete diagnosis was catatonic schizophrenia, mental retardation. This, too, will be included with the psychoses.

⁴ Other is "no therapy" since in this one instance the patient left the hospital, against advice, after one day.

| Variables | Readmission | | | No Readmission | | | Total |
|---|-------------|----|----|----------------|----|----|-------|
| | I | NI | T | I | NI | T | |
| Number of Days Patient visited Home per week | | | | | | | |
| Less than one | 6 | 10 | 16 | 9 | 8 | 17 | 33 |
| One to two | 7 | 4 | 11 | 2 | 8 | 10 | 21 |
| More than two | 2 | 7 | 9 | 4 | 5 | 9 | 18 |
| Relationship of Person to whom Patient was released | | | | | | | |
| Husband | 4 | 7 | 11 | 7 | 7 | 14 | 25 |
| Wife | 5 | 8 | 13 | 3 | 10 | 13 | 26 |
| Daughter or Son | 0 | 1 | 1 | 0 | 0 | 0 | 1 |
| Parent | 6 | 3 | 9 | 5 | 1 | 6 | 15 |
| Other | 0 | 2 | 2 | 0 | 3 | 3 | 5 |
| Type of Family | | | | | | | |
| Conjugal | 9 | 15 | 24 | 10 | 17 | 27 | 51 |
| Parental | 6 | 5 | 11 | 5 | 1 | 6 | 17 |
| Other | 0 | 1 | 1 | 0 | 3 | 3 | 4 |
| Suggestions regarding Aftercare | | | | | | | |
| In-hospital | 7 | 8 | 15 | 4 | 8 | 12 | 27 |
| Outside Hospital | 3 | 3 | 6 | 2 | 5 | 7 | 13 |
| None | 5 | 10 | 15 | 9 | 8 | 17 | 32 |
| Frequency of Use of Aftercare | | | | | | | |
| Not at all | 9 | 13 | 22 | 9 | 14 | 23 | 45 |
| One to five | 2 | 8 | 10 | 2 | 6 | 8 | 18 |
| More than five | 4 | 0 | 4 | 4 | 1 | 5 | 9 |

BIBLIOGRAPHY

Books

- Ackerman, Nathan W. Family Therapy in Transition. Boston: Little, Brown and Company, 1970.
- Ackerman, Nathan; Beatman, Frances; and Sherman, Sanford, editors. Exploring the Base for Family Therapy. New York: Family Service Association of America, 1961.
- Ackerman, Nathan; Beatman, Frances; and Sherman, Sanford, editors. Expanding Theory and Practice in Family Therapy. New York: Family Service Association of America, 1967.
- Angrist, Shirley S.; Lefton, Mark; Dinitz, Simon; and Pasa-manick, Benjamin. Woman After Treatment: A Study of Former Mental Patients and Their Normal Neighbours. New York: Appleton-Century-Crofts, 1968.
- Arieti, Silvano., ed. American Handbook of Psychiatry. Vol. 1. New York: Basic Books, Inc., 1959.
- Arieti, Silvano., ed. American Handbook of Psychiatry. Vol. 3. New York: Basic Books, Inc., 1966.
- Becker, Howard S. The Other Side: Perspectives on Deviance. New York: The Free Press, 1967.
- Boszormenyi-Nagy, Ivan; and Framo, James L. Intensive Family Therapy. New York: Harper and Row, 1965.
- Cohen, Irvin M., ed. Family Structure, Dynamics and Therapy. Washington, D.C.: American Library Association, 1966.
- Coleman, James C. Abnormal Psychology and Modern Life. Chicago: Scott, Foresman and Company, 1956.
- Committee on the Family Group for the Advancement of Psychiatry. Treatment of Families in Conflict. New York: Science House, 1970.
- Freeman, Howard E.; and Simmons, Ozzie G. The Mental Patient Comes Home. New York: John Wiley and Sons, Inc., 1963.

- Geismar, Ludwig L. Preventive Intervention in Social Work. Metuchen, New Jersey: The Scarecrow Press, Inc., 1969.
- Glasscote, Raymond M.; Kraft, Alan M.; Glassman, Sidney M.; and Jepsen, William W. Partial Hospitalization for the Mentally Ill. Washington, D.C.: Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1969.
- Greenblatt, Milton; Levinson, Daniel J.; Klerman, Gerald L.; and Ewalt, Jack R., editors. Mental Patients in Transition. Springfield, Illinois: Charles C. Thomas, 1961.
- Heiss, Jerold., ed. Family Roles and Interaction: An Anthology. Chicago: Rand McNally & Co., 1968.
- Howells, John G. Theory and Practice of Family Psychiatry. New York: Brunner/Mazel, Inc., 1971.
- Langsley, Donald G.; Kaplan, David. The Treatment of Families in Crisis. New York: Grune & Stratton, 1968.
- Leahy, Kathleen M.; Cobb, M. Marguerite; and Jones, Mary C. Community Health Nursing. 2nd ed. New York: McGraw-Hill Book Company, 1972.
- Messer, Alfred A. The Individual in His Family. Springfield: Charles C. Thomas, 1970.
- Neugeboren, Bernard. Psychiatric Clinics: A Typology of Service Patterns. Metuchen, New Jersey: The Scarecrow Press, Inc., 1970.
- Polansky, Norman A., ed. Social Work Research. Chicago: University of Chicago Press, 1960.
- Richardson, Henry B. Patients Have Families. New York: The Commonwealth Fund, 1948.
- Rothman, Theodore., ed. Changing Patterns in Psychiatric Care. Los Angeles: Rush Research Foundation, 1970.
- Satir, Virginia. Conjoint Family Therapy. California: Science and Behaviour Books, Inc., 1967.
- Selltiz, Claire; Jahoda, Marie; Deutsch, Morton; and Cook, Stuart W. Research Methods in Social Relations. Chicago: Holt, Rinehart and Winston, 1959.

- Silverstein, Max. Psychiatric Aftercare. Philadelphia: University of Pennsylvania Press, 1968.
- Spitzer, Stephan P.; Denzin, Norman K., ed. The Mental Patient: Studies in the Sociology of Deviance. New York: McGraw-Hill Book Company, 1968.
- Theodorson, George A.; and Theodorson, Achilles G. A Modern Dictionary of Sociology. New York: Thomas Y Crowell, 1969.

Articles

- Anthony, E. James. "The Mutative Impact on Family Life of Serious Mental and Physical Illness in a Parent." Canadian Psychiatric Association Journal, XIV (October, 1969), 433-453.
- Bergen, Helen M., and Kris, Anton O. "Services to Parents of Adolescent Mental Patients." Social Casework, 53, (2), (February, 1972), 85-90.
- Caron, Paul. "Obstacle to Reform: Compulsion in Mental Hospitals." Canada's Mental Health, XX (May-August, 1972), 28-31.
- Clayton, William. "Release of the Chronic Psychiatric Patient." Mental Hygiene, 54, (3), (July, 1970), 407-16.
- Flomenhaft, Kalman; Kaplan, David M.; and Langsley, Donald G. "Avoiding Psychiatric Hospitalization." Social Work, 14, (4), (October, 1969), 38-45.
- Friedman, Ira; von Mering, Otto; and Hinko, Edward. "Intermittent Patienthood: The Hospital Career of Today's Mental Patient." Archives of General Psychiatry, 14, (April, 1966), 386-92.
- Giordano, Joseph, and Lurie, Abraham. "Social Work in a Psychiatric Hospital." Canada's Mental Health, XVII, (6), (November-December, 1969), 13-18.
- Goldberg, Carl. "A Community is More Than a Psyche: The Concept of Community Mental Health." Canada's Mental Health, XX (May-August, 1972), 15-21.
- Hankoff, L.D., and Galvin, John W. "Psychopharmacological Treatment and Its Implications for Social Work." Social Work, 13, (3), (July, 1968), 40-47.

- Hornstra, Robin K., and McPartland, Thomas S. "Aspects of Psychiatric Aftercare." The International Journal of Social Psychiatry, IX, (2), (Spring, 1963), 135-42.
- Maisel, Robert. "The Ex-Mental Patient and Rehospitalization: Some Research Findings." Social Problems, 15, (Summer, 1967), 18-24.
- Miller, Dorothy. "Alternatives to Mental Patient Rehospitalization." Community Mental Health Journal, 2, (2), (Summer, 1966), 124-128.
- Miller, Dorothy., and Blanc, Esther. "Concepts of Moral Treatment for the Mentally Ill: Implications for Social Work with Posthospital Mental Patients." Social Service Review, 41, (1), (March, 1967), 66-74.
- Purvis, S.A., and Miskimins, R.W. "Effects of Community Follow-up on Post-hospital Adjustment of Psychiatric Patients." Community Mental Health Journal, 6, (5), (October, 1970), 374-82.
- Rahling, David L., and Lion, John. "Patients with Repeated Admissions of a Psychiatric Emergency Service." Community Mental Health Journal, 6, (4), (April, 1970), 313-318.
- Sampson, Harold; Messinger, Sheldon L.; and Towne, Robert D. "Family Processes and Becoming a Mental Patient." American Journal of Sociology, LXVIII, (February, 1962), 88-96.
- Schuerman, John. "Marital Interaction and Posthospital Adjustment." Social Casework, 53, (3), (March, 1972), 163-72.
- Schulberg, Herbert C. "Community Mental Health: Fact or Fiction?" Canada's Mental Health Supplement, 63, (November-December, 1969), 1-9.
- Sheldon, Alan, and Jones, Kenneth J. "Maintenance in the Community: A Study of Psychiatric After-care and Rehospitalization." British Journal of Psychiatry, 113, (September, 1967), 1009-1012.
- Smith, Colin M. "Measuring Some Effects of Mental Illness on the Home." Canadian Psychiatric Association Journal, 14, (April, 1969), 97-104.

- Thompson, Richard, and Wiley, Elizabeth. "Reaching Families of Hospitalized Patients: A Group Approach." Community Mental Health Journal, 6, (1), (February, 1970), 22-30.
- Weissman, Myrna M. "Casework and Pharmacotherapy in treatment of Depression." Social Casework, 53, (1), (January 1972), 38-44.
- Wildman, M. "Communication in Family Therapy." The British Journal of Psychiatric Social Work, IX, (2), (Autumn, 1967), 75-79.
- Yarrow, Marian Radke; Schwartz, Charlotte Green; Murphy, Harriet S.; and Deasy, Leila Calhoun. "The Psychological Meaning of Mental Illness in the Family." Journal of Social Issues, XI, (4), (1955), 12-24.

Encyclopedia Article

- Margolis, Philip M., and Favazza, Armando R. "Mental Health and Illness." Encyclopedia of Social Work. 16th Issue. Vol. 1.
- Michelson, William. "Social Adjustment to Environment." Encyclopedia of Social Work. 16th Issue. Vol. 1.
- Sussman, Marvin B. "The Family." Encyclopedia of Social Work. 16th Issue. 1970. Vol. 1.

Reports

- Committee on the Healing Arts. Report of the Committee. Report of the Committee on the Healing Arts 1970. Toronto: Queen's Printer, 1970.
- One Hundred and Fourth Annual Report. Mental Health Division of the Department of Health of the Province of Ontario. Honourable Richard T. Potter, Minister. Toronto: Ontario Department of Health, 1970.

Unpublished Materials

- I.O.D.E. Hospital. "The I.O.D.E. Hospitals Supplement to the Annual Report 1969," Windsor, 1969. (Photostatic Copy).

I.O.D.E. Hospital. "The I.O.D.E. Hospitals Supplement to the Annual Report 1970," Windsor, 1970. (Photostatic Copy).

I.O.D.E. Hospital. "The I.O.D.E. Hospitals Supplement to the Annual Report 1971," Windsor, 1971. (Photostatic Copy).

VITA AUCTORIS

Ruth Ann Schnarr was born on February 20th, 1948 in Kitchener, Ontario, Canada. She attended elementary school at St. Clements Separate School in St. Clements, Ontario and Our Lady of Lourdes Separate School in Waterloo, Ontario. In 1962 she began her high school education at St. Mary's Senior Girls' School in Kitchener and in 1967 she graduated from Grade XIII. She then attended the University of Waterloo for one year before transferring into the undergraduate social work program at the University of Windsor, Windsor, Ontario. In 1971 she received her B.S.W. from that institution, and in September of that year enrolled in the M.S.W. program at the University of Windsor, School of Social Work. In the fourth year of her B.S.W. work her field placement was the Department of Psychiatry of the I.O.D.E. Hospitals in Windsor, Ontario. Her graduate field placement was with an experimental field unit at the Downtown Action Centre, again, in Windsor, Ontario. During both these academic years the researcher was employed as a teaching assistant for the first year social work class at the University of Windsor, Windsor, Ontario.