THE PSYCHIATRIC PATIENT'S HOSPITALIZATION AND DISCHARGE

FROM THE FAMILY'S PERSPECTIVE

by

Sandra Dale Barnes

A Thesis Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF SCIENCE

In the Graduate College

THE UNIVERSITY OF ARIZONA

1977
STATEMENT BY AUTHOR

This thesis has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgment of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: [Signature]

APPROVAL OF THESIS DIRECTOR

This thesis has been approved on the date shown below:

[Signature] GLORIA DI CENSO
Assistant Professor of Nursing

Date: November 16, 1977
ACKNOWLEDGMENTS

The author wishes to express her appreciation to her thesis committee members: Dr. Gloria Di Censo, chairman, Dr. Jan Atwood and Georgia Hudson from the College of Nursing, University of Arizona, for their guidance, assistance, and patience during this study.

Appreciation is also expressed to the staff in the Department of Psychiatry at the University Health Sciences Center who allowed the researcher to use their facility and who assisted during the data collection.

The author is grateful to the National Institute of Mental Health for a stipend which helped make this study possible.

The author is also grateful to the patients and their families who consented to participate in this study.

A special note of thanks to John, Margaret, Terry, and Mindy for their encouragement and support during the entire project.
TABLE OF CONTENTS

LIST OF TABLES ........................................ vi

ABSTRACT ............................................. vii

1. INTRODUCTION ....................................... 1
   Purpose of the Study ................................. 2
   Statement of the Problem ............................ 3
   Significance of the Problem ........................ 4
   Theoretical Framework ................................ 6

2. REVIEW OF LITERATURE .............................. 10
   Effects of Psychiatric Hospitalization upon the Family 10
   Attitudes and Interventions of Hospital Staff ........ 16
   Summary ............................................... 19

3. DESIGN OF THE STUDY .............................. 20
   Setting and Population Studied ....................... 20
   Protection of Subject's Rights ....................... 22
   Method of Data Collection ............................ 23
   Tool .................................................. 23
   Data Analysis ........................................ 27

4. ANALYSIS AND DISCUSSION OF DATA ............... 28
   Demographic Data of Relative Subjects ............. 28
   Summary .............................................. 31
   Demographic Data of Patients ....................... 31
   Summary .............................................. 36
   Families' Response to Patients' Hospitalization ..... 36
   Summary .............................................. 41
   Discharge Planning ................................... 42
   Summary .............................................. 45
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. DISCUSSION AND CONCLUSIONS</td>
<td>47</td>
</tr>
<tr>
<td>Relationship of Theoretical Framework to the Study</td>
<td>47</td>
</tr>
<tr>
<td>Findings in Relation to the Review of Literature</td>
<td>49</td>
</tr>
<tr>
<td>Effects of Psychiatric Hospitalization upon the Family</td>
<td>49</td>
</tr>
<tr>
<td>Attitudes and Interventions of Hospital Staff</td>
<td>50</td>
</tr>
<tr>
<td>Implications for Nursing</td>
<td>53</td>
</tr>
<tr>
<td>APPENDIX A: IDENTIFYING DATA</td>
<td>55</td>
</tr>
<tr>
<td>APPENDIX B: INTERVIEW SCHEDULE</td>
<td>57</td>
</tr>
<tr>
<td>APPENDIX C: HUMAN SUBJECTS CONSENT FORM FOR RELATIVE SUBJECT</td>
<td>60</td>
</tr>
<tr>
<td>APPENDIX D: HUMAN SUBJECTS CONSENT FORM FOR THE PATIENT</td>
<td>62</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>64</td>
</tr>
<tr>
<td>Table</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>1. Number and Percent of Relative Subjects Interviewed</td>
<td>29</td>
</tr>
<tr>
<td>2. Relationship of Relative Subject to Patient by Number and Percent</td>
<td>29</td>
</tr>
<tr>
<td>3. Employment Status of Relative Subjects by Number and Percent</td>
<td>30</td>
</tr>
<tr>
<td>4. Highest Level of Educational Attainment of Relative Subjects by Number and Percent</td>
<td>30</td>
</tr>
<tr>
<td>5. Religious Preference of Relative Subjects by Number and Percent</td>
<td>31</td>
</tr>
<tr>
<td>6. Patient's Age and Gender by Number and Percent</td>
<td>32</td>
</tr>
<tr>
<td>7. Marital Status of Patients by Number and Percent</td>
<td>32</td>
</tr>
<tr>
<td>8. Highest Level of Educational Attainment by Patient by Number and Percent</td>
<td>33</td>
</tr>
<tr>
<td>9. Religious Preference of Patient by Number and Percent</td>
<td>33</td>
</tr>
<tr>
<td>10. Family Size of Patient by Number and Percent</td>
<td>34</td>
</tr>
<tr>
<td>11. Occupation of Patient by Number and Percent</td>
<td>34</td>
</tr>
<tr>
<td>12. Previous Psychiatric Hospitalizations of Patient by Number and Percent</td>
<td>35</td>
</tr>
<tr>
<td>13. Family Member's Response to Patient's Hospitalization by Number and Percent</td>
<td>37</td>
</tr>
<tr>
<td>14. Change in Responsibility of Relative Interviewed by Number and Percent</td>
<td>38</td>
</tr>
<tr>
<td>15. Change in Responsibility of Other Family Members by Number and Percent</td>
<td>39</td>
</tr>
<tr>
<td>16. Most Helpful Family Interaction with Staff Regarding Treatment Plans by Number and Percent</td>
<td>40</td>
</tr>
<tr>
<td>Table</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>17. Least Helpful Family Interaction with Staff Regarding Treatment Plans by Number and Percent</td>
<td>41</td>
</tr>
<tr>
<td>18. Family Member's Perceptions of Patient's Readiness for Discharge by Number and Percent</td>
<td>43</td>
</tr>
<tr>
<td>19. Family Member's Readiness for Patient's Discharge in Relation to Patient's Length of Hospitalization by Number and Percent</td>
<td>44</td>
</tr>
</tbody>
</table>
ABSTRACT

The purpose of this study was to gather information regarding the concerns and problems of the families of psychiatric patients who were being discharged. The exploration focused on (1) the family's perceptions of the patient's readiness for discharge, (2) the family's views concerning their involvement in the treatment program, (3) the effects of the hospitalization on the family system, and (4) the implications for the psychiatric nurse to consider when giving care.

The sample was composed of fifteen selected family members from thirteen families of inpatients in a university hospital acute care psychiatric unit. The age range of the subjects was 22 to 65 years of age. The data were collected by interview and from the medical records of the hospitalized family member. The interview was held with the family member prior to the patient's discharge.

Responses to the interview questions supported the belief that families can benefit from being included in the treatment and discharge planning while the patient is hospitalized.
INTRODUCTION

With the 1963 passage of the community mental health centers legislation and subsequent growth of the community facilities for outpatient care, psychiatric patients are being discharged sooner from hospitals and are frequently still symptomatic at discharge. The average length of stay in an acute care psychiatric unit in a general hospital is 13.9 days (Commission on Professional and Hospital Activities 1975).

The contemporary policy of short-term hospitalizations means that the old patterns of chronic hospitalization in which the patient each year becomes further removed from his family is becoming a thing of the past. Hospitalizations are as "brief as possible" and follow-up care is taking a more active role (Ruesch 1967). The family is becoming involved in plans and care for the patient (Kreisman and Joy 1974).

According to statistics from the National Institute of Mental Health (1973) the resident population in public psychiatric hospitals has declined each year since 1955 with the expansion of community-based service programs. In spite of the change in resident population, traffic in and out of hospitals has increased from 280,000 in 1962 to 415,000 in 1971 with a corresponding increase in the discharge rate.

Prior to the release of the statistics from the National Institute of Mental Health (1973), Harrington (1966) reported similar findings. He found that the rate of psychiatric hospitalizations has increased, the
discharge rate has increased, and patients are being released who formerly would not have returned to the community. Social problems following the patient's discharge are becoming more visible. These are problems such as vocational and social inadequacies.

Patients who go from their families to the hospital usually return to their families at discharge (Cumming and Cumming 1966). This fact has been identified by Braceland (1966) as a major block to rehabilitation. Families who have experienced considerable stress due to the patient's behavior prior to admission, may resist the patient's discharge. They may not have had sufficient opportunity to vent their concerns and fears.

The recognition of the importance of the patient's family as reported in the literature has opened a critical area for investigation—the articulation between the hospital and the patient's family. It would seem that in order for the patient's discharge to be least disruptive to the family system, the family needs to be included in the discharge planning for the patient.

Purpose of the Study

The purpose of this study was to gather information regarding the concerns and problems of the families of psychiatric patients who were being discharged. The exploration focused on (1) selected family member's perceptions of the patient's readiness for discharge, (2) selected family member's views concerning their involvement in the treatment program, (3) the effects of the hospitalization on the family system, and (4) the implications for the psychiatric nurse.
Statement of the Problem

In viewing the family as a system and the impact of hospitalization upon the family, Williams (1974) describes the family as a system made up of people who are interdependent on one another. Each person in the family has certain roles and depends on his role relationship to establish and maintain his identity and self-esteem. When one person leaves a system, each member of the system is affected. When one family member is hospitalized, each member experiences stress.

According to Satir (1967) many therapists have found it useful to call the family member who carries the symptom the "Identified Patient" or "I. P." rather than to join the family in calling him "the sick one" or the "one who is to blame." The therapist sees the identified patient's symptoms as serving a family system function as well as an individual function.

The relationships within the family, as a result of the identified patient's illness have been studied (Spiegel and Bell 1959; Leavitt 1975; Kreisman and Joy 1974). Spiegel and Bell found that families are disorganized and disintegrated by the stress of their relative's illness. Leavitt reported major family life disruptions and turmoil before the patient was hospitalized, but that the family had difficulty recognizing that their relative was ill and in need of professional help. Kreisman and Joy reported on the 1965 study of Rogler and Hollingshead. This study described striking differences in the response of the family when the spouse was the identified patient.

The successful use of the social and therapeutic milieu of the hospital with the identified patient (Cumming and Cumming 1966) brings
into focus the importance of the family as the social milieu to which the patient returns. Good psychiatric inpatient care must provide a therapeutic experience for the patient's family. Results from research in family studies and investigations of the psychiatric hospital milieu (Lidz, Fleck, and Cornelison 1965) revealed that patients whose families are ignored or rejected by the hospital have less chance of recovering than patients whose families become actively involved with them during the hospitalization. If the family is to be effective in the patient's continued progress, it appears that they need to be included in the treatment focus. In order to do this effectively, the problems and concerns of the family need to be elicited and identified. Decisions about discharge and the disposition of the patient after discharge can involve family members in conflicts about readiness for discharge. There may be problems in the family regarding adjustment of attitudes toward mental problems and the family's perceptions of the problem.

**Significance of the Problem**

Viewing the family as a system has implications for social, psychological, and health oriented interventions. The individual incorporates the fundamentals of the social system through his experiences in the family. The personalities of the individuals who constitute the family markedly influence the structure and nature of the family and its ability to meet the needs of the broader society (Lidz et al. 1965).

There is a need for more research in the area of family relationships involving an identified patient. Hymovich (1974) says we must recognize the values, attitudes, and feelings of the family units. Most
nurses have received little theoretical information about family dynamics and development. Clinicians tend to involve the family only when their cooperation is necessary for treatment procedures.

Reading and hearing about successful family-oriented nursing interventions provides a foundation for awareness. It seems that if our nursing practice is to be based on theory, exploration of the family's concerns is needed in order to implement our knowledge in the most therapeutic manner. Opportunities for discussion between nurses and family members about family situations or difficulties can provide the chance to explore feelings. Family education concerning mental health could be included in the hospital treatment plan for the patient. Including the family in the discharge planning and understanding their common concerns may help alleviate some of their anticipatory anxiety regarding the future.

Nursing decisions or actions based on the knowledge obtained from research could contribute significantly to the patient's and family's well-being. An example of research which resulted in nursing actions being initiated, based upon the data collected, is Atwood's Perimortality Study at Arizona Medical Center (1975). Eight problem areas, six involving patients' families were defined and nursing action was initiated in order to improve patient care and the family's well-being. One problem area defined was that the family did not know who was in charge of the patient or who the staff were. In reviewing this problem, the staff considered the use of calling cards and compiling a list of the people on the staff including a short job description of each staff member.
Theoretical Framework

According to Waxler and Mishler (1970), the trends in research show a shift from theories and studies on dyadic relationships to those in which the family structure is central. The focus is on the family system using sociological concepts such as family role, power structure, norms, and sanctions as guiding concepts.

The study of the psychiatric patient's family as a social system is based on General Systems Theory as described by Bertalanffy (1968). It is a general science of "wholeness" which consists of a set of related definitions, assumptions, and propositions which deal with reality as an integrated hierarchy of organizations of matter and energy.

Using Bertalanffy's general systems theory as a basic approach to studying relationships, Miller (1965) describes a system as a set of units with relationships among them. The state of each unit is constrained by, conditioned by, or dependent on the state of other units.

One example of a system, as used in this study, is the family system. This system is composed of a group of two or more individuals, or units, living together. The units are interdependent on one another through mutually defined roles. A change in one unit results in change in the other units, thus affecting the whole system.

General systems theory is of particular interest to those engaged in therapy with individuals, peer groups, single families, multiple families, or larger groups of people because it helps them to a better understanding of how the individual fits into his environment (Gray, Duhl, and Rizzo 1969).
The concept of family structure is basically the idea that the family group is an organized system in which two or more status levels exist, roles are differentiated, and norms or internalized rules for behavior have developed about who may take each status position and what kind of role behavior is appropriate. The structure of the family is maintained through adherence to the norms and because the family members believe that it is appropriate to apply certain sanctions to members who deviate from the norms (Waxler and Mishler 1970).

The family process involves changing patterns of interaction within the family that may occur as a result of the changing family situation. Whenever maladaptations or pathological conditions prevail in the function of an individual or a family, or in the family's social relationships, general systems theory permits us to analyze where the primary focus of disturbance lies in the family process and to devise methods for better adaptation and integration of individuals and families in the surrounding community (Gray et al. 1969).

An example of a role change which may involve conflict in a family is the situation in which the father leaves the system. The mother may expect her teen-age son to replace the husband in various areas such as being a host for social gatherings. The son may expect the mother to be a sports companion and a firm disciplinarian (Polak 1971).

After studying the unique family system of schizophrenic patients, family theorists including Lidz, Wynne, and Jackson have been impressed by the fact that symptoms appear in other family members when the identified patient begins to improve (Anderson 1969).
According to Smoyak (1975), the study of families as systems departs radically from the historical trend of psychiatry and psychology in which the family has often been viewed as disruptive, irrelevant, or benign. The new view is that symptoms are signals of distress in the family system. Mental illness is a family, not an individual phenomenon. The identified patient emerges as a signal of family distress.

After the identified patient enters the hospital, the family may reorganize itself and establish new patterns of relationships. The organization established may be so efficient that the family's ability to cope with problems is quite high. Subsequent problems may arise when the patient tries to reenter the family system in which the ranks have been closed (Spiegel and Bell 1959).

According to Gralnick (1969) the notion that the family or the parents are to blame for mental illness is being discarded. The more realistic and current trend recognizes mental illness as a social process, emphasizing the need to treat the patient and the family as a total unit. The fact that the family members are not seen as mere bystanders in the patient's illness constitutes the rationale for a therapeutic approach which seeks the family's participation and collaboration.

This investigator views the family as a system in this study. Since the patient's departure and return to the family system is believed to affect the family process, or changing patterns of interaction within the family, this investigator believes it is important to include the family in the discharge planning. The patient can then be treated as a whole with considerations for his home environment. It permits a
broader awareness of the patient and the system in which he operates, one to which he will return, and which may be a critical factor in determining his prognosis.
CHAPTER 2

REVIEW OF LITERATURE

The literature was reviewed in the two following areas: (1) the effects of psychiatric hospitalization upon the family, and (2) the attitudes and interventions of the hospital staff in relation to families.

Effects of Psychiatric Hospitalization upon the Family

The effects of psychiatric hospitalization upon the family is reviewed to determine how families explain and react to the behavior of a relative who may be labeled "mentally ill." The family's attempt to understand the meaning of the behavior they observe is thought to follow a predictable course that shows both acceptance and denial, certainty, and uncertainty.

The family's attitudes were examined in the following areas: reaction to hospitalization, reaction to illness of the patient, role relationships in the family, family process, and discharge of the patient.

Kreisman and Joy (1974) report on a British study by Hoenig and Hamilton who interviewed 179 families of inpatients. Fifty-six percent of these families experienced great relief when the patient was hospitalized. Sixty-three percent stated they felt at least "some" burden in coping with the patient's illness. The families reported a high degree of satisfaction with the hospital and the treatment of the patient.
Spiegel and Bell (1959) acknowledge that family relationships rupture when the patient is hospitalized. The patient may feel rejected by the family. This produces guilt in the family with consequent defenses of various forms. This may accentuate official and public recognition of illness causing the family to feel disgraced and to withdraw from social contacts.

Gralnick (1969) reports on observations by the medical staff of Highpoint Hospital, a 45 bed private psychiatric hospital in New York. Interviews were held with patients' families as part of the treatment plan. Anxiety at the prospect of mental illness in the family and a defensiveness as a response to this anxiety were frequently observed in the relatives. Gralnick suggests that the sources of the family's anxieties are shame with regard to mental illness, guilt regarding family's causation of the patient's illness, fears regarding whether mental illness is hereditary or incurable, financial burdens and the threat to the symbiotic balance of the family as a result of the withdrawal of the patient from the family system when hospitalized. Gralnick suggests that these anxieties of the family create the various problems a therapist encounters and must work with in order to insure that the relative's participation in the treatment program will prove beneficial rather than detrimental to the patient.

One of the earliest studies that examined family attitudes was done by Yarrow, Clausen, and Robbins (1955). Questionnaires were sent to 33 wives of men who had been hospitalized for the first time. Most of the responses indicated that they characteristically showed feelings of underprivilege, marginality, extreme sensitivity, and self-hatred.
One-third of the wives demonstrated a pattern of aggressive concealment, for example friends were dropped or avoided and occasionally there was a move to another section of the town. Two-thirds of the wives deliberately concealed information regarding their spouse's illness. All respondents had told at least one other person outside the family, usually a personal friend, about their relative.

Lewis and Zeichner (1960) studied 109 families approximately three weeks after a family member was hospitalized. They found that 50 percent of the sample expressed a sympathetic understanding of the patient. Only 17 percent expressed hostility or fear toward the patient, and the remainder were either ambivalent or puzzled at their relative's illness.

Rose (1959) interviewed family members in a sample of 100 hospitalized patients at a Veterans' Administration Hospital in Massachusetts. Unlike Yarrow's study, few reported avoiding friends. The majority of relatives spoken with claimed that they felt no stigma and that they had discussed the illness with other people. The difference may be explained by the sample used in the study. These were relatives of long-term patients, and it is likely that experience with mental illness plays a role in the eventual reaction of the family to the patient and society.

Hollingshead and Redlich (1958) examined social-class differences in the family response to mental illness using the "Two Factor Index of Social Position." In this measurement the number of years of school completed and occupation are scored on educational and occupational scales. The scores range from 11 to 77 with 11 representing the highest
score by combination of outstanding educational and occupational achievements and 77 assigned to individuals with less than seven years schooling and unskilled laborers. Scores grouped into five clusters so the study divides the sample into five social classes with the highest being Class I and the lowest Class V. Results of the study show that in response to mental illness in the family, resentment and fear were prevalent reactions in lower-class families and shame and guilt were more pronounced in the upper-classes. The researchers found that during the hospitalization, resentment in the lower-class families was replaced by feelings of helplessness and apathy. In the three upper classes, such feelings were less marked, and there was more interest in the sick member. The researchers believe that the attitude of the family toward its sick member is responsible for the determination of who goes to the hospital, who improves, and who deteriorates and ends up as a chronic patient.

A more intensive study by Myers and Roberts (1959) with a sample of 25 families with a schizophrenic member indicated that shame at having a mentally ill person in the family was a common reaction in the lowest social class.

Freeman (1961) used a standardized interview schedule to study attitudes of mothers and spouses of psychiatric patients. He found that better educated relatives tended to have more enlightened attitudes about mental illness than did those relatives with less education, but that social class was not a significant factor. There was a correlation between education and attitudes. He also found that relatives' attitudes
were not influenced by duration of hospitalization, number of hospitalizations, or diagnosis of the patient.

Kreisman and Joy (1974) report the results of a study by Dunigan which examined the effect of multiple hospitalizations on the role the patient plays within the family. In the sample were 66 husbands of patients with varying numbers of hospitalizations. Results indicated that there is a critical point at which expectations and tolerances change. Husbands seemed to cope with one or two hospitalizations by making temporary role adaptations to the deviant behavior of the patient. With three or more hospitalizations the husband withdrew from the wife, lowered his role expectations, and made other more permanent arrangements for the functioning of the household. These events tended to isolate the wife within the family setting and to strain the marital relationship. Dunigan concluded that families eventually exhaust their resources to adapt to keeping the wife as a contributing member of the family system.

Another study on role relationships was reported by Kreisman and Joy (1974). The 1965 study by Rogler and Hollingshead reported striking differences in the responses of husbands and wives to the hospitalized patient. When husbands were ill, the wife frequently added his work role to hers and the family was maintained as a functioning unit. Illness on the part of the wife had a destructive influence on the family organization, since the husbands were unable or unwilling to take on the female role. This study was done in a traditional society (Puerto Rican) in which roles are very clearly defined, but it does signify modes of
adaptation to a stressful situation that may occur as a result of sex-role differences.

Families' reactions to the discharge of the patient have been studied. Rose (1959) observed that most families were verbally agreeable to the idea of discharge, but became resistant once the likelihood of discharge was a reality. Rose saw this as a form of social rejection of the patient. Reluctance to take the patient home increased with the number of years the patient had spent in the hospital.

Leavitt (1975) interviewed the families of 16 patients prior to their discharge. The study was done in five acute inpatient services in Boston and San Francisco. Using a semi-structured interview schedule, relatives were asked questions including reactions to the patient's discharge. When asked if they thought the patient was ready for discharge, nine of the 16 families did not think so. The majority of the families indicated they did not have the opportunity to discuss their concerns with the hospital staff. Most of the families expressed uncertainty and lack of direction about the future. In six cases the family indicated they were unaware of the follow-up plans for the patient. These findings were the basis for some of the questions asked the subjects in this investigator's study.

Hollingshead and Redlich (1958) noticed a reluctance to have the patient return home in some of the families they studied, similar to the findings of Rose. They offered a social-class explanation for this behavior. Classes I and II explained the patient's deviant behavior on the basis of nerve strain, fatigue, or overwork. Classes III, IV, and V tended least often to have a psychological explanation for the deviant
behavior of the patient and relied on "somatic theories, heredity, or the evil eye" to explain the patient's behavior. They discovered in their study that many patients in Class V were not discharged because nobody wanted to take them home. This last finding was confirmed and explored by Myers and Bean (1968), who interviewed 387 of the 1,563 relatives of patients who were in Hollingshead and Redlich's sample. They found that, with each successive hospitalization, more lower-class families cut ties with the patient.

Results of these studies tend to be somewhat contradictory, especially as related to attitudes and social class and attitudes versus number of hospitalizations. Shame and social rejection appear to be among the most studied aspects of family attitudes and behavior. This appears to be a limited focus due to the wide range of possible responses to deviance in the family. Most investigators have concentrated on women's perceptions as they relate to male patients, and there is meager knowledge about the perceptions and expectations of males and the differential effect on the family of the illness of men and women.

**Attitudes and Interventions of Hospital Staff**

The literature on the attitudes of the hospital staff in relation to families was reviewed to determine if there is evidence of an awareness of the need for interactions with the family system of the identified patient.

Rabkin (1972) states that the impact of attitudes of clinicians and administrators responsible for treating patients is recognized as important to the experiences of the patients who are exposed to them.
Cohen and Struening (1965) reported that the overall atmosphere of a given hospital is largely determined by the attitudes of nurses and aides and that authoritarian restrictive atmospheres were negatively correlated with discharge rates. For a sample of 12 Veterans Administration Psychiatric Hospitals whose patient population consisted largely of chronic schizophrenics, it was found that hospitals characterized by an authoritarian restrictive atmosphere had lower rates of early discharge. Staff attitudes were thus related to staff decisions regarding patients' length of hospital stay.

Pavenstedt and Bernard (1971) in a study of the crisis of hospitalization found that many of the hospital staff do not seem to know that a family exists. The staff see the patient as he functions in the hospital and assume that he will carry on after discharge without any help. The investigators found that hospital staff sometimes fail to understand mental illness as seldom merely an acute episode that will "clear up and go away." "Even those who should know it best--the doctors in the hospital--don't do their discharge planning as if they did." The investigators suggested family-centered continuity of care which consisted of continuous support with psychiatric supervision, homemaker service, day care for young children, and day hospital care, when indicated, for the patient.

In Leavitt's study (1975), the results indicated a lack of staff-family interaction. The staff discharged the patient when he was ready by their standards. The fact that these standards were not shared with the family left the families with uncertainty about the future. Responses from most of the 16 families indicated that they had not
experienced an opportunity to express their views or participate in
decision making. They did not consider the staff as a resource for themselves.

Ruesch (1967) states that the psychiatrist recommends discharge of a patient when he believes that the family and the community once more can tolerate the patient's behavior. Discharge does not imply that the abnormal behavior has subsided. He suggests that the tolerance of people for pathology in others can be strengthened by hospital staff by the following: instructing others that ordinary means of communication and actions are not likely to be observed by the patient, lowering expectations of quick recovery, and exposing the family to other patients so they can accept the fact that they are not unique.

Beaudry (1975) states that an effective discharge plan considers the patient's needs, the resources available, the cost to the patient, the plan of action, and thorough follow-up. He states that the plan should begin when the patient is admitted.

According to the literature, it appears that the attitudes of the hospital staff toward the patient's family and the interventions which occur are dependent upon the importance attached to the family system. Investigators have determined that the attitudes of the hospital staff are a factor in the length of hospitalization for the patient. There does appear to be an awareness in the literature of the need for interactions with the family system of the identified patient.
Summary

The studies as reviewed in this section explain how the relatives react to the behavior of the identified patient. Their attitudes were explored and show both acceptance and denial of their relative's illness. According to the literature, the ideal hospital treatment plan includes discharge planning which begins when the patient is admitted.
CHAPTER 3

DESIGN OF THE STUDY

The purpose of this exploratory study was to gather information regarding the concerns and problems of the families of psychiatric patients at the time of discharge. The design chosen included interviews with a purposive sample of selected family members of hospitalized psychiatric patients. In purposive sampling the investigator selects some special group because there is good evidence that it is representative of the total population he wishes to study. One can hand-pick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one's needs (Sellitiz, Deutsch, and Cook 1965). In this investigator's study, the sample chosen was consistent with this criterion. The family subjects were obtained by self-selection after securing permission from each patient to contact his family. This chapter includes the selection of the setting and population, protection of human subjects, the method of data collection, and techniques for analyzing data.

Setting and Population Studied

The sample consisted of 15 selected family members of 13 in-patients in an acute care psychiatric unit of a hospital in the southwestern United States. Requirements for inclusion in the study were (1) the patient lived with the family prior to admission, (2) the patient
agreed to have his family contacted, (3) the family member was English speaking, and (4) the family member agreed to be interviewed.

The design attempted to control for a number of extraneous variables. In order to control for a difference in the milieu therapy between institutions, the sample was limited to the population of one institution. To control for a difference in the presentation of the questions during the interview, the interviews were made by one rater. Uncontrolled variables included length of hospitalization, number of hospitalizations, age, sex, and education.

Sampling bias may have resulted from inaccessibility of certain families. The investigator was unable to contact some families and there were some who were unavailable for the interview. One patient's spouse was working the evening shift and this investigator was working during the day. A mutual interview time could not be arranged. A sister of one patient was going on vacation and therefore not available for an interview. The wife of one patient failed to keep her appointment stating it was raining too hard. She stated that her husband told her not to drive because it was too dangerous. One patient refused to give permission to this investigator to contact his wife. According to Johnson (1976) the percentage of inaccessibles may be as low as three percent or as high as 20 percent. In this study the rate of inaccessibles was 33.3 percent. This unusually high rate may have been due in part to the short discharge notice given by the doctors in some cases. When the order was written less than 24 hours prior to discharge, this investigator was unable to make the necessary contacts for the interview before the patient left the hospital.
Protection of Subject's Rights

The procedure followed in this investigation for the protection of rights of the human subjects was in accordance with the Department of Health, Education, and Welfare guidelines on human subject experimentation (University of Arizona 1975).

In order to protect the subject's rights to confidentiality, a number coding system was used to identify responses. The subject's name was not used on the Identifying Data sheet (Appendix A) or the Interview Schedule (Appendix B). The subject's name was not accessible to anyone other than this investigator.

All subjects were advised as to the nature of the study in written form and orally. They were asked to read the Human Subject Consent Form before signing. The patient's consent to contact his family was obtained in writing (Appendix D).

The patients and family subjects were assured that all information would be kept confidential to the extent that no names would be revealed in the study. They were told orally and in writing that participation was voluntary, and that they could refuse to participate or they could withdraw from the study without affecting the relationship they had with the doctor or hospital staff.

The information this investigator elicited from the interviews was not shared with the staff prior to the patient's discharge. This was to eliminate the possibility of risk to the patient involving any change in the treatment plan as a result of the data collected.
Method of Data Collection

After permission was granted for the Human Subjects Committee to begin the research, the investigator contacted the head nurse of the designated psychiatric unit to present the format and purpose of the study. Arrangements were made by the investigator for daily contacts with the inpatient unit assistant to obtain names of patients with planned discharges. The investigator then contacted the patient in person to obtain his written consent to contact his family for the purpose of obtaining an interview. The families were contacted at the hospital or by telephone and an interview arranged at the hospital. Data were collected for the Identifying Data (Appendix A) from the patient's medical record. Data for the Interview Schedule (Appendix B) were elicited during the family subject interview.

Tool

An exploratory design was chosen for this study. This type of design is a good source for providing data about the present such as what people are thinking, doing, anticipating, and planning. Its usefulness comes from the presentation of insights and effective practices. Its disadvantages are that there is a low degree of control over extraneous variables, verbal behavior is unreliable, and people may not express their true reactions to questions (Hinshaw 1975).

The interview was chosen by this investigator as the method for collecting data instead of a questionnaire. The advantages of the interview are that data from each interview are usable, depth of response can be assured, no items are overlooked, and a higher proportion of responses
are obtained from potential respondents. The major disadvantage in selecting the interview is the time element involved in carrying out the procedure (Treece and Treece 1973).

The validity of the investigator's results may have been distorted by the respondent misreporting data. Johnson (1976) lists three different factors responsible for this: simple forgetting, a misunderstanding of the question, or a distortion of the response in order to make one's self-image more acceptable or to minimize the factors due to the involvement of the individual in the data he is reporting. Since interview bias may result from differences in question order, the question order was kept as consistent as possible by the interviewer. The presence of the interviewer creates another possible bias. The interviewee may answer the questions differently than he would if filling in a questionnaire by himself.

A semistructured interview schedule was chosen as the tool for the interview. In this type of interview specific major questions are asked but the interviewer is free to probe as he chooses. The tool used in this study was developed by the investigator and included an Identifying Data sheet (see Appendix A) and an Interview Schedule (see Appendix B).

In developing the tool, the literature was reviewed to determine the questions most likely to elicit the attitudes and concerns of the family. Content validity was determined by the investigator and members of the thesis committee who estimated validity on the basis of their experience. The tool is believed to have concurrent validity as the data resulting from its use are related to behaviors in the current situation. Concurrent validity is important when there is concern for adjustment,
judgment, and attitudes. Various aspects of the topic under study may be broken down for in-depth investigation, but there is always association with the present behavior of the individual (Treece and Treece 1973). In this investigator's study, the family subjects answered the interview questions prior to the patient's discharge. Their responses were based on the behavior of the patient at the time of the interview.

Since one of the basic sources of inaccuracy of a measuring instrument is created by inconsistency in different individuals taking readings from the instrument, only this investigator coded the data from this study.

The Identifying Data sheet was designed to collect identifying data relating to the patient. These variables, including age, sex, number of hospitalizations, and length of stay, were gathered to indicate possible influences on the family's readiness for the patient's discharge. The Interview Schedule was designed to gather information about the family's perceptions of the patient's hospitalization, including role changes occurring within the family system.

A pretest on the tool was conducted by the investigator using volunteer subjects. Two subjects were interviewed. Each subject had a family member recently hospitalized for psychiatric problems. One subject was the mother of an adolescent daughter with behavior problems. The other subject was a wife whose husband was hospitalized with an acute psychotic episode. The average length of the interviews was 20 minutes. This was less time than anticipated by the investigator. No changes were made in the questions as a result of the pretest.
The data obtained from the interview were used to answer the questions as stated in the Purpose of the Study. The family's perceptions of the patient's readiness for discharge were assessed by asking:

Do you think ______ (patient) is ready to go home?
Are you ready for ______ (patient) to come home?
If you think ______ (patient) is ready, what helped most to prepare you? What helped least to prepare you?
If you think ______ (patient) is not ready, what are your concerns?

The family's views concerning their involvement in the treatment program was assessed by asking:

Did your family get a chance to talk with the staff regarding the plans for ______ (patient)?
What was the most helpful?
What was the least helpful?
Did you help to make the plans for ______ (patient) to leave the hospital?

To explore the effects of the hospitalization on the family system the following questions were asked:

What was it like for your family to have ______ (patient) in the hospital?
How did your responsibilities change?
How did the responsibilities of other family members change?
What do you think it will be like having ______ (patient) home?
Data Analysis

The data were divided into two main parts: identifying data and responses to open-ended questions. The data were examined for possible relationships or associations among certain sample descriptors and responses to interview questions. Patterns of responses are presented in narrative and descriptive statistics. Interview notes were surveyed for dominant issues and concerns of families as well as reactions to the interview itself. No inferences were made because it is not a representative sample.
CHAPTER 4

ANALYSIS AND DISCUSSION OF DATA

The findings and the analysis of the data are presented in this chapter.

The purpose of this study was to elicit and identify the problems and concerns of the families of hospitalized psychiatric patients who were being discharged. The discussion focused on (1) selected family members' perceptions of the patient's readiness for discharge, (2) selected family members' views concerning their involvement in the treatment program, (3) the effects of the hospitalization on the family system, and (4) the implications for the psychiatric nurse.

Demographic Data of Relative Subjects

Fifteen selected family members from 13 families were interviewed. The sample consisted of nine female and six male subjects. The age range was from 22 to 65 years of age with a mean age of 46 (see Table 1).

The relationship of the relative interviewed to the patient can be seen in Table 2. Relatives interviewed included six spouses and six parents.

At the time of the study all of the sample were old enough to work, 60 percent were employed with 33.3 percent employed in managerial, professional, or clerical positions (see Table 3).
Table 1. Number and Percent of Relative Subjects Interviewed

<table>
<thead>
<tr>
<th>Age of Subject</th>
<th>21-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>61-70</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Percent</td>
<td>20.0</td>
<td>20.0</td>
<td>6.7</td>
<td>40.0</td>
<td>13.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 2. Relationship of Relative Subject to Patient by Number and Percent

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Father</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Husband</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Wife</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Niece</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Daughter</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 3. Employment Status of Relative Subjects by Number and Percent

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housewife</td>
<td>5</td>
<td>33.0</td>
</tr>
<tr>
<td>Skilled laborer</td>
<td>2</td>
<td>13.4</td>
</tr>
<tr>
<td>Unskilled laborer</td>
<td>2</td>
<td>13.4</td>
</tr>
<tr>
<td>Managerial</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Professional</td>
<td>2</td>
<td>13.4</td>
</tr>
<tr>
<td>Clerical</td>
<td>2</td>
<td>13.4</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The educational attainment of the participants is shown in Table 4. The level ranged from seven to 20 years with an average of 13 years. Sixty-seven percent had between 12 and 20 years of education.

Table 4. Highest Level of Educational Attainment of Relative Subjects by Number and Percent

<table>
<thead>
<tr>
<th>Years of Education</th>
<th>7</th>
<th>8-11</th>
<th>12-15</th>
<th>16-20</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Percent</td>
<td>6.7</td>
<td>26.7</td>
<td>40.0</td>
<td>26.7</td>
<td>100.1</td>
</tr>
</tbody>
</table>
The religious preference of the participants can be seen in Table 5. Twenty percent stated they had no religious preference.

Table 5. Religious Preference of Relative Subjects by Number and Percent

<table>
<thead>
<tr>
<th>Preference</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>11</td>
<td>73.4</td>
</tr>
<tr>
<td>Catholic</td>
<td>1</td>
<td>6.6</td>
</tr>
<tr>
<td>No Preference</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Summary

In this section the demographic data of the family subjects were presented. Fifteen subjects ranging in age from 22 to 65 were interviewed. The majority of the family subjects were spouses or parents. The subjects had an average of 13 years education and had a religious preference. All but one were housewives or employed outside the home.

Demographic Data of Patients

The patients whose relatives were interviewed included eight white females and five white males admitted voluntarily to the psychiatric unit. The age range was from 15 to 79 years with a mean age of 41 years (see Table 6).

The marital status of the patients can be seen in Table 7. Over half of the patients were married.
### Table 6. Patient's Age and Gender by Number and Percent

<table>
<thead>
<tr>
<th>Patient's Age</th>
<th>11-20</th>
<th>21-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>61-70</th>
<th>71-80</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Percent</td>
<td>15.4</td>
<td>30.8</td>
<td>0</td>
<td>15.4</td>
<td>23.0</td>
<td>7.7</td>
<td>7.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 7. Marital Status of Patients by Number and Percent

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>4</td>
<td>7</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Percent</td>
<td>30.8</td>
<td>53.8</td>
<td>15.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The educational attainment of the patients ranged from eight to 20 years with an average of 13 years. Sixty-two percent had between 12 and 20 years of education (see Table 8).

The religious preference is indicated in Table 9. Twenty-three percent stated no preference.

Table 8. Highest Level of Educational Attainment by Patient by Number and Percent

<table>
<thead>
<tr>
<th>Years of Education</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-11</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>High school graduate</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Some college or technical school</td>
<td>4</td>
<td>30.7</td>
</tr>
<tr>
<td>College graduate</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Graduate education</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 9. Religious Preference of Patient by Number and Percent

<table>
<thead>
<tr>
<th>Preference</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>8</td>
<td>61.6</td>
</tr>
<tr>
<td>Catholic</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>No preference</td>
<td>3</td>
<td>23.0</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The family size of the patients ranged from two to six members with a mean of 2.8 (see Table 10).

Prior to hospitalization, 30.8 percent of the patients were employed, 30.8 percent were housewives, and 23 percent were full-time students. None were without occupation (see Table 11).

### Table 10. Family Size of Patient by Number and Percent

<table>
<thead>
<tr>
<th>Size of Family</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>23.0</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### Table 11. Occupation of Patient by Number and Percent

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>3</td>
<td>23.0</td>
</tr>
<tr>
<td>Housewife</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Clerical</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Own business</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
The number of previous psychiatric hospitalizations of the patient can be seen in Table 12. This was the first psychiatric admission for 38.6 percent of the patients.

Table 12. Previous Psychiatric Hospitalizations of Patient by Number and Percent

<table>
<thead>
<tr>
<th>Number of Prior Hospitalizations</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
<td>38.6</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>23.0</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>23.0</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The length of hospitalization for patients in this study ranged from seven to 48 days with a mean of 24.4 and a standard deviation of 14.4. This compares with a mean of 13.2 days for the total population of the unit. This investigator offers several possible reasons for this difference. Since those patients included in this study's sample had been living with their families, it is possible that mental illness is more visible when the patient is part of the family system. Depending upon the family's tolerance of deviance, patients may be admitted sooner and remain longer than those without families. Another possible explanation is that those patients without families have a need to return to work as soon as possible and therefore have shorter stays once hospitalized.
Summary

In this section the demographic data of the patients were presented. Relatives of 13 patients were interviewed. The patients ranged in age from 15 to 79 years of age. More than half of the patients were married. Patients tended to be close to 40 years old, at best high school educated, from a relatively small family, had a religious preference, and were in school, a housewife, or employed outside the home.

The average length of hospitalization for patients in this study was 24.4 days. This was considerably longer than the average for the total population of the unit. This investigator suggests that mental illness is more visible when the patient is part of the family system. The patient may be admitted sooner and discharged later than those patients without families.

Families' Response to Patients' Hospitalization

The responses to the question "What was it like for your family to have (name) hospitalized?" are summarized in Table 13. Sixty percent of those interviewed stated they were relieved to have their relative in the hospital. Comments included "I was exhausted mentally and physically and was so relieved to have someone else caring for her;" "I was so tired;" "My children were feeling neglected because she took so much of my time;" "After she went in the hospital it took our family several days to adjust and relate to one another again;" "I hate to see her in the hospital, but I feel tense and nervous when she is around. I want a divorce;" "I was relieved to know where she is--when she was home I could never be sure if she would stay during the night. Sometimes the police would call and
Table 13. Family Member's Response to Patient's Hospitalization by Number and Percent

<table>
<thead>
<tr>
<th>Response of Family Member</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A relief</td>
<td>9</td>
<td>60.0</td>
</tr>
<tr>
<td>Lonesome</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Difficult adjustment</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Change in responsibility</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Ambivalent feelings</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Did not like it</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.1</td>
</tr>
</tbody>
</table>

had picked her up;" and another stated, "I was relieved but also wondered if I had done something to cause her illness." Most of those interviewed indicated they felt the hospital was a safe place and they were relieved that someone else temporarily had the responsibility of their relative.

The response to the question "How did your responsibilities change?" can be seen in Table 14. Slightly over 66 percent stated there was a change in their responsibilities. Slightly over 33 percent stated their responsibilities were lessened. Comments regarding a lessened responsibility included "I had more time to spend with my children" and "I no longer had the burden of caring for him." Those indicating their responsibilities increased included "I had to do the yard work;" "I had to cook my meals and do the housework;" "We have our own business and I
Table 14. Change in Responsibility of Relative Interviewed by Number and Percent

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No longer had to care for him</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Assumed her household duties</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Assumed his duties at home and work</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Could spend more time with children</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>No change</td>
<td>5</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

had to do his work and mine to keep it running smoothly;" and "I just did what had to be done until he gets home." Slightly over 33 percent indicated their responsibilities did not change. One wife stated that she did all the work around the house and yard anyway so nothing was different.

One husband stated his wife's illness was a complete surprise and he felt somewhat guilty about it. Another expressed financial concerns. One participant stated she felt the other family members were not willing to accept any responsibility for their relative and she felt "dumped on." One participant stated she felt she understood or could empathize with her relative's illness but other family members did not seem to understand and it was a definite strain on the family prior to hospitalization.
In response to the question "How did responsibilities of other family members change?" 46.7 percent stated there was no other family member in the household, 46.7 percent indicated there was no change, and 13.3 percent reported that it was a relief to have their relative in the hospital. It is possible that the relative feeling the most responsibility was also the one willing to be interviewed (see Table 15).

Table 15. Change in Responsibility of Other Family Members by Number and Percent

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>7</td>
<td>46.7</td>
</tr>
<tr>
<td>A relief</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>No other family member</td>
<td>6</td>
<td>40.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

All of the participants stated they had a chance to talk with a member of the staff regarding the treatment plans for their relative. The participants' perceptions of the most helpful of their interactions can be found in Table 16. Almost half of the participants (46.6 percent) stated talking with the doctor was the most helpful interaction.

The family group session was a weekly group conducted by the nursing staff. It included the patients and their families.

The participants' perceptions of the least helpful of their interactions with staff regarding treatment plans for the patient can be
Table 16. Most Helpful Family Interaction with Staff Regarding Treatment Plans by Number and Percent

<table>
<thead>
<tr>
<th>Most Helpful Interaction</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>7</td>
<td>46.7</td>
</tr>
<tr>
<td>Family therapy</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Nursing staff and doctor</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Family group session</td>
<td>1</td>
<td>6.6</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

seen in Table 17. Over half (53.3 percent) stated they could think of nothing which they considered to be least helpful. One participant had attended two family therapy sessions and stated he found one helpful and the other not helpful.

The participants who stated the nursing staff was not helpful admitted that their family did not initiate any interaction with staff so therefore did not receive any help from them. One participant said she did not want to interfere with the treatment so just stayed as uninvolved as possible letting the patient interact with the staff regarding treatment plans. Two of the participants stated they would like to have had some information regarding the medication the patient was receiving. One subject said she had asked about the medication during a group session for the families but was not satisfied with the answer she received. One subject felt a lack of information regarding what she should expect after the patient's discharge.
Table 17. Least Helpful Family Interaction with Staff Regarding Treatment Plans by Number and Percent

<table>
<thead>
<tr>
<th>Least Helpful Interaction</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Family therapy</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Nothing</td>
<td>8</td>
<td>53.3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Summary

In this section the families' responses to the patients' hospitalization were presented. Over half of the families felt relief when the patient was hospitalized. The patient's behavior prior to hospitalization appears to have been a strain on the family system. Slightly over 66 percent of those interviewed experienced a change in their responsibilities after the patient was hospitalized. Two of the three wives interviewed expressed that they assumed their husband's role by taking over work duties in addition to maintaining their own roles as homemakers. The third wife stated that she already did all the work around the house and yard so nothing was changed. Slightly over 33 percent of those interviewed indicated there was no role change due to the patient's hospitalization. It is possible that the patient had given up his role in the family some time before hospitalization as a result of his emotional difficulties.
Discharge Planning

The amount of notice given families about their relative's discharge ranged from one to seven days with a mean of 3.6 days and a standard deviation of 2.1 days. Eight families received notification of the pending discharge from the patient himself, four from the doctor, and one from other staff. Forty-seven percent of the participants stated that they had not been included in the discharge planning.

In response to the question "Do you think (name) is ready for discharge?", 60 percent answered "yes", 13.3 percent said "no", and the remaining 26.7 percent stated they were uncertain (see Table 18).

Relatives who indicated they felt the patient was ready for discharge stated this was a result of the patient's progress in five of the nine cases. One felt that talking with the doctor reassured him that the patient was ready to come home, two stated talking with the nursing staff and doctor gave them confidence that the patient was ready, and one participant stated no preparation was necessary because she did not think her husband should have been hospitalized.

Five of the six participants who stated they were uncertain if the patient was ready for discharge or did not think he was, stated the patient's behavior was their main concern. One participant stated he was afraid that the patient's presence at home would cause emotional imbalance in the family.

When asked "Are you ready for your relative to come home?" 53.3 percent answered "yes" and 46.7 percent answered "no".
Table 18. Family Member's Perceptions of Patient's Readiness for Discharge by Number and Percent

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>60.0</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Uncertain</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

There appears to be a correlation between the family member's readiness for the patient to return home and the length of the patient's hospital stay (see Table 19). Of those family members indicating a readiness for the patient to return home, 75 percent of the patients had a stay of five to 20 days. Fifty-seven percent of the patients whose relatives indicated they were not ready for the patient to return home had a stay of 36 to 50 days, significantly above the mean stay of 24.4 days for the total sample.

In response to the question "What helped least to prepare you for your relative's discharge?" 89 percent stated they could not think of anything. One participant stated he had no interaction with the staff but admitted that he did not initiate any contact with anyone nor take advantage of the weekly group for relatives. Two participants stated although they found the staff generally helpful, they would have liked some information about the patient's medication. They had questions about the importance of taking the medication, side effects to be aware
Table 19. Family Member's Readiness for Patient's Discharge in Relation to Patient's Length of Hospitalization by Number and Percent

<table>
<thead>
<tr>
<th>Family Member's Readiness for Patient's Discharge</th>
<th>Length of Stay in Days</th>
<th></th>
<th></th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6 1 1 8</td>
<td></td>
<td></td>
<td>53.3</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2 1 4 7</td>
<td></td>
<td></td>
<td>46.7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8 2 5 15</td>
<td></td>
<td></td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

of, and other related questions. Is it possible that these family members saw the medication as a way of controlling the patient's behavior?

When asked "What do you think it will be like having your relative home?" seven out of 15 stated they thought things would be "back to normal" at home. Five of the participants said the patient would not be returning home. Two participants stated they would be very happy to have their relative return home, and one stated he was uncertain how he felt about it. Uncertainty and concern for the future was expressed by comments such as "I don't feel confident to handle the situation;" "I'm afraid his past behavior problems may recur;" "The children are resenting her;" "I'll be nervous;" "I'm concerned that she will try to do too much and won't pace herself;" "I'm concerned about the future for him;" and "I'm concerned about the type of follow-up care that is available and what she needs."

Of the five participants who indicated their relative would not be returning home, one parent stated his daughter had been a behavior problem for a number of years, and he felt all resources had been
exhausted in trying to keep her at home. Another participant stated the patient would be going to a nursing home and the relative was concerned about alternatives if the nursing home was unable to cope with the patient. A parent stated his son would be better off in a residential treatment center than at home because he felt that part of his son's problem was the isolation of their home.

Additional comments made by the participants included their feelings about the hospitalization. One subject stated she appreciated the way the nursing staff encouraged independence, but she felt that her relative was so regressed that she needed more supervision and some help with her personal hygiene. Most of the participants made favorable comments about the philosophy of the psychiatric unit. All of the participants were quite willing to be interviewed. Almost all of them wished the investigator good luck with the study.

Summary

The average length of discharge notice given families was about four days. Some were given as little as one day's notice. About half of the families received notification of pending discharge from the patient. Nearly half of the families had not been included in the discharge planning. Thirteen percent of the families felt the patient was not ready for discharge and 27 percent were uncertain. Nearly half of those interviewed stated they were not ready for the patient to come home. The patient's behavior was their main concern. It appears that many of the families did not feel confident in dealing with the patient again. It is possible that more interaction between the families and
the staff might have helped to alleviate some of the family's concerns. The ideal hospital treatment plan needs to include a vehicle for the family to discuss their concerns, explore attitudes, and ventilate in a safe environment. Since the psychiatric unit utilized in this study did have a weekly group for all patients and their families, it provided the family with a vehicle. Perhaps more families would have taken advantage of this group if the nursing staff had initiated contact with the family. It is suggested that discharge planning include the family in order to ease the social adjustments necessary and to reduce the family's concerns for the future.
CHAPTER 5

DISCUSSION AND CONCLUSIONS

Included in this chapter is a discussion of the relationship of the theoretical framework to the study. The findings as they relate to the review of the literature are also discussed. The conclusions, nursing implications, and the recommendations are presented.

Relationship of Theoretical Framework to the Study

General Systems Theory (Bertalanffy 1968) provided the framework for this study. The family system, based on General Systems Theory, is an example of a system in which individuals live together with mutually defined roles. In the concept of family structure, the roles are differentiated and norms for behavior have developed. According to General Systems Theory, the whole system is affected by a change in one unit, therefore the hospitalization of a family member creates a change in the family system.

In this study there was evidence of a change in the family structure. Slightly over 66 percent of the family subjects interviewed stated there was a change in their responsibilities when their relative was hospitalized. Slightly over 33 percent stated their role in the family changed due to additional responsibilities. With these subjects, there was a role change—either the wife taking over the husband's responsibilities or the husband assuming the wife's household tasks. In these
families, the male-female roles were differentiated by tasks. Thirty-four percent of those interviewed stated their responsibilities lessened as they no longer had the burden of the patient. Thirty-three percent stated they did not think there was any noticeable change in the family. This lack of change is inconsistent with system's theory. In these cases it is possible that the patient had given up his role responsibilities some time prior to hospitalization due to his emotional difficulties.

In some families once the identified patient is labeled as mentally ill, he is treated differently within the family system. He may no longer be expected to have the same responsibilities as he had prior to his illness. His responsibilities may be considerably lessened within the family.

According to Spiegel and Bell (1959), after the identified patient enters the hospital the family may reorganize itself and subsequent problems may arise when the patient tries to reenter the family system in which the ranks have been closed. Five of the 15 family subjects interviewed by this investigator stated the patient would not be returning home. This supports the notion that these families may have closed their ranks to the patient. One of the subjects stated that he was afraid the patient's presence would cause emotional imbalance in the family. He further explained this by stating that things were going along smoothly at home while the patient was in the hospital, and if he returned home there would just be trouble. One parent stated he and his wife had exhausted their resources in trying to keep their daughter at home. In these families there were obviously internalized rules for behavior that were appropriate and the patient did not meet the family's
expectations. In one family interviewed, the parents stated their son was not returning home. They felt that he would be better off in a residential treatment center as they thought that the location of their home was a contributing factor in their son's problems.

Findings in Relation to the Review of Literature

Throughout the literature review various studies were reported and these served as the basis for the structure of the Identifying Data Form (Appendix A) and the Interview Schedule (Appendix B). These findings are compared to this study's data in two sections: (1) Effects of Psychiatric Hospitalization upon the Family, and (2) The Attitudes and Interventions of the Hospital Staff in Relation to Families.

Effects of Psychiatric Hospitalization upon the Family

Contrary to the findings of Gralnick (1969) the results of this study do not show guilt to be a major component of the family's feelings in relation to the hospitalization of the patient. Guilt was not explicitly sought in this study. Because it is not generally socially acceptable, the family member may not have volunteered the information. One family member mentioned that she had some anxiety regarding whether she had in any way contributed to her relative's illness.

This investigator found that the most frequent response to the patient's hospitalization by the family was one of relief. This is consistent with the British study by Hoenig and Hamilton as reported by Kreisman and Joy (1974) who found that 56 percent of the families interviewed experienced great relief when the patient was hospitalized. They reported that 63 percent of the families had felt the patient to be a
burden. This investigator found that 60 percent of the relative sub-
jects reported feeling relieved when the patient was hospitalized and
34 percent felt the relief from the responsibility of caring for the
patient.

Leavitt's study (1975) found that nine out of 16 subjects, when
asked if they thought the patient was ready for discharge, answered "no".
This investigator found that nine out of 15 answered "yes". In Leavitt's
study the majority of the families indicated they did not have the oppor-
tunity to discuss their concerns with the hospital staff. This was con-
trary to this investigator's study in which all the families indicated
they had talked with at least one member of the staff regarding the plans
for their relative, although 47 percent indicated they had not been in-
cluded in the discharge planning. In Leavitt's study 37 percent indi-
cated they were unaware of the follow-up plans for the patient.

Rose (1959) found that the families' reluctance to have the patient
back home increased with the time the patient had spent in the hospital.
This investigator found that the patients who were not returning home had
an average stay of 36 days as compared to the average stay of 19 days for
those patients who were returning to their families.

Attitudes and Interventions of Hospital Staff

Pavenstedt and Bernard (1971) found that many of the hospital staff
were unaware that the family exists. This investigator found that this
was not the case in this study. Weekly family groups were held by the
nursing staff. This group included all interested family members and
discussed issues of concern to the patients and families. All of the
subjects interviewed had not attended these groups, but all were aware that the group was available.

In Leavitt's study (1975), the results indicated a lack of staff-family interaction. Of the relative subjects interviewed by this investigator, 20 percent indicated they felt a lack of information regarding the patient. Questions included the patient's medication and what to expect from the patient after discharge. Leavitt found that the amount of notice given families about their relative's discharge tended to correlate positively with their knowledge of discharge plans. The amount of notification ranged from same day to one month. The range in this investigator's study was one day to seven days. The range of discharge notice to those families who were involved in the discharge planning was one to six days. The range of notice to those families who were not included in the planning was three to seven days.

This investigator found evidence that the nursing staff was aware of the patient's family as demonstrated by the weekly group session the nursing staff held for the patients and their families. During the time of this study, this group was not well-attended by the family members. The subjects in this study most frequently were informed by the patient about the family group. Perhaps if the nurses had made it a point to contact each family about the group the participation would have been better.

Apparently the nursing staff was not recognized by the families as a resource for help. Forty-seven percent of those interviewed stated talking with the doctor was the most helpful interaction they experienced. Twenty percent stated the doctor and nurse together were the most helpful.
There are several suggested explanations for the nursing staff's lack of impact on those interviewed. The staff apparently did not initiate contact with the family members but waited for them to make the first contact. The staff may believe that the family is incapable of changing its patterns and to attempt any kind of intervention would be futile.

Since 47 percent of the families interviewed had not been included in the discharge planning, these families apparently experienced no opportunities for expressing their concerns or participating in the decisions regarding discharge. Forty-seven percent of the subjects interviewed stated they did not feel ready for the patient to be discharged, and 40 percent felt the patient was not ready or it was questionable. In almost all cases, they did not discuss their views with the staff or protest the decision for discharge. Since they did express concern during the interview with this investigator, perhaps they just needed the opportunity to share their concerns.

The following conclusions were derived from the data presented in the preceding pages. The contribution to nursing made by this study is the exploration of the concerns and problems of the families of psychiatric patients. The subjects expressed uncertainty and concern for the future. They had questions about the patient's medications, follow-up plans, expected behavior of the patient, and what to do if the alternative placement did not work out.

The study offers the staff an opportunity to review their present way of handling the discharge planning. The present procedure is to have a discharge interview which includes the patient and a nurse. This investigator suggests that the family be included in the discharge interview.
By providing the relative subjects an opportunity to express their anxieties and concerns, it is likely that their anxieties may have been reduced. According to Rosenbaum and Beebe (1975, p. 301), "Catharsis is a time-honored way of helping troubled people." Although this was not a goal of this investigator, it may have been an unexpected benefit for the subjects.

The subjects generally appreciated the opportunity to talk with this investigator about their concerns and expressed this to the investigator at the end of the interview.

**Implications for Nursing**

The investigator suggests that there are several implications for nursing as a result of this study. The patient has the right to expect supportive nursing care which includes awareness by the staff of the importance of family. Since the patient has the right to expect supportive care, this requires that the nurse be knowledgeable and understand the concerns of the family. To best support the family members during the patient's hospitalization and at the time of discharge, this investigator recommends that the nurse initiate contact with the patient's family as soon as possible after the patient's admission. This would give the family a vehicle to discuss their concerns as they arise. Once the initial contact is made, the families could be encouraged to attend the weekly family group session. This investigator also recommends that the family and patient be included in a discharge interview with a nurse to alleviate some of the family's anxiety about the future.
The investigator believes that families should be provided help with decision making, with directive family guidance, and with support. Guidance could include early recognition of mental problems, intervention in the event of recurrence, and familiarization with community resources for referral.
APPENDIX A

IDENTIFYING DATA
Identifying Data

Patient

Study Case Number ___________ Date _________

Age ______

Sex ______

Marital Status: S M Sep Wid Div Cohab

Date of Admission

Expected Date of Discharge

Length of Stay

Family Size

Family Constellation

Occupation

Number of Prior Hospitalizations for Present Problem

Status of Admission: Voluntary Involuntary

Religion

Ethnic Origin

Years of Education: 1-8 10-11-12-13-14-15-16+
APPENDIX B

INTERVIEW SCHEDULE
Interview Schedule

Family Subjects

What is your relationship to ________ (patient)? Date ________

What kind of work do you do?

How old are you?

What was the last grade you completed in school?

Is there any religion you favor?

Who let you know ________ (patient) would be coming home?

When was that?

I. What was it like for your family to have ________ in the hospital?
   a. How did your responsibilities change?
   b. How did the responsibilities of other family members change?

II. Did your family get a chance to talk with the staff regarding the plans for ________?
   a. What was the most helpful?
   b. What was the least helpful?
   c. Did you help to make the plans?

III. Do you think ________ is ready to go home?
   a. Are you ready for ________ to come home?
   b. If you think ________ is ready, what helped most to prepare you?
   c. What helped least to prepare you?
   d. If you think ________ is not ready, what are your concerns?
IV. What do you think it will be like having _______ home?

V. Is there anything else you would like to tell me?
APPENDIX C

HUMAN SUBJECTS CONSENT FORM

FOR RELATIVE SUBJECT
Human Subject Consent Form

TO: Relative Subjects

You are being asked to participate in a study concerned with the effects that your relative's hospitalization have had upon your family. The aim of the study is to determine the concerns of the families of psychiatric patients for the purpose of gathering information to use in improving the quality of care given to the patient and his family. The study consists of an interview in the hospital requiring about 30 minutes of your time. You will be asked to respond to questions regarding your views of your relative's hospitalization. There are also several questions asking for some biographical facts about yourself.

In order to assure confidentiality, you are not identified by name on the interview guide. All information you give will be coded by number for analysis. Your participation in this project will result in no medical legal risks, public embarrassment, or invasion of privacy. The results of the study will be made available to you by the investigator upon request.

If you decide you do not wish to participate, or if you do consent but wish to withdraw from the study later, your relationship will not in any way be changed with your relative's doctor or other staff members. You are free not to answer particular questions and to withdraw from the study at any time. If you consent to participate in this study as outlined above, please sign in the space provided below.

"I have read the above Subject's Consent. The nature, demands, risks, and benefits of the project have been explained to me. I understand that I may ask questions and that I am free to withdraw from the project at any time without ill will."

Subject's Signature ____________________________ Date ___________

Parent or Guardian (if appropriate) ____________ Date ___________

Investigator's Signature (as witness) ____________ Date ___________
APPENDIX D

HUMAN SUBJECTS CONSENT FORM

FOR THE PATIENT
Human Subject Consent Form

TO: Patient

You are being asked for permission for this nurse researcher to contact your family for the purpose of requesting an interview with them. The purpose of the interview is to obtain information for a graduate study to determine the effects on the family when a member is hospitalized. The information obtained will be used in improving the quality of care given to the patient and his family.

In order to assure confidentiality, you and your family will not be identified by name. All information received will be coded by number for analysis. Your participation in this project will result in no medical legal risks, public embarrassment, or invasion of privacy. The results of the study will be made available to you by the investigator upon request.

If you decide you do not wish to participate, or if you do consent but wish to withdraw from the study later, your relationship will not in any way be changed with your doctor or other staff members. You are free to withdraw from the study at any time. If you consent to have this researcher contact your family for the purpose of requesting an interview with them, please sign in the space provided below.

"I have read the above Subject's Consent. The nature, demands, risks, and benefits of the project have been explained to me. I understand that I may ask questions and that I am free to withdraw from the project at any time without ill will."

Subject's Signature ______________________________ Date _________
Investigator's Signature (as witness) ______________ Date _________
REFERENCES


