FAMILY INVOLVEMENT IN THE PSYCHIATRIC PATIENT'S
HOSPITALIZATION AS RELATED TO THE
READMISSION OF PATIENTS

By

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Associate Professor of Home Economics

Nov. 24, 1971
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ABSTRACT

This study was an attempt to determine the interrelationship, if any, of family involvement in the patient's hospitalization and readmission of patients to a psychiatric hospital.

Twenty-four patients who had been admitted and readmitted to a Southern Arizona psychiatric hospital during the year 1969, and twenty-four patients who had only been admitted once during the same period, were compared to determine any difference between the two groups in the amount of family involvement. The age, sex, religion, and occupation of all 48 patients were analyzed to determine any relationship in the demographic variables to the readmission of patients.

The statistical tests used were the Chi-Square test for demographic variables, and the t test comparing the two groups' means.

The study indicated a difference at the .05 level of significance in the age distribution. The readmitted group was comprised of patients in the older group, and the non-readmitted was comprised of patients in the younger age group.

No significant difference was found among the readmitted group and the non-readmitted group in the amount of family involvement during hospitalization. A difference at the .05 level of significance was found in the amount of family involvement between the first admission and the second admission of the readmitted group. The results indicated a decrease in family involvement during the patient's second admission.
CHAPTER 1

INTRODUCTION

The rapid and often disorderly fashion of social change has created new pressures on family life and in the family structure, resulting in external and internal conflicts, greater anxieties, and all too frequently mental illness within the family constellation.

Brodey (1968) stated that the family is a living process, and family life is largely implicit. No two families are alike; there is a sameness and a difference in each family unit. As each member in the family changes, it means that everyone must change to some degree to maintain family equilibrium. The family goes through developmental stages marked by changes in structure and function, and each change in development is accompanied by a crisis within the individual member that affects the whole family unit to a greater or lesser degree. An example of some of the changes might be: the first separation in attending school, sickness, hospitalization, courtship, marriage, birth, retirement, and death.

Mental illness and family dysfunction have no respect for person, and are not limited to any one social class or economic group. The investigator, while working with psychiatric patients, found that economically well protected families are frequently involved in the trauma of mental illness, separation, divorce, alcoholism, extramarital relations, and drug abuse and misuse.
As early as 1929, Burgess indicated the importance of studying the family as a unit. His formulation described the different identities and personalities of each family member, and the need to understand the interpersonal relationships that influence the family process.

Clark (1967) discussed changes in the mental health field, and the government's role in mental health and its implications for the family. In 1961 and 1963, the Joint Commission on Mental Illness and Health submitted reports to Congress that influenced the concept of comprehensive community mental health centers. The discovery of anti-depressant and tranquilizing drugs greatly increased the number of hospitalized patients in out-patient care services.

Glasscote et al. (1966) found in their study that ex-patients constituted the largest group of psychiatric emergencies. Certain emergency situations appeared to depend on the family's tolerance level, and the degree of fear which the disturbed behavior evoked. The emergency was found to occur as a result of some shift in the family homeostasis. The study pointed to a need for aftercare services if exacerbation, recidivism, and hospitalization was to be prevented, and it recommended that follow-up services be a part of comprehensive community psychiatry.

"The entire family must be treated rather than only one component, or individual, within it. Treating the individual in artificial isolation from his social context, as in individual psychotherapy, can be compared to studying elephants by observing their behavior in a zoo" (Williams 1970). The author further maintained
that by involving the family in the hospital program, "... it is possible to extend the operation of the therapeutic field into the family and bring about very rapid change."

Goode (1959) reformulated the functions of the family in an attempt to develop a family theory. "There are usually two main reasons for lack of theoretical development in any field or subfield: (1) the right questions have not been asked; or (2) there is an insufficient empirical base or fund of knowledge, upon which to begin asking the right questions." Goode stated that theory in the field of the family has been generally neglected, and suggested a theory parallel to Durkheim's Suicide study of the relationship between the individual and the group: from the specific subfield of the family to its interrelationships with other institutions. In exploring the functions classically assigned to the family, Goode viewed emotional maintenance as the degree to which the family patterns bring comfort to the individual, and the responsibility of the family to the society for the behavior of its members.

Studies in the field of family relationships have indicated the importance of the family unit, but it appears that there is very little understanding of the role the family plays, or the family's potential, in the field of mental health.

Purpose of the Study

This study was an attempt to determine interrelationships between family involvement in the patient's hospitalization and readmission of patients to a psychiatric hospital.
Hypotheses

The following hypotheses were tested:

I. There are no significant differences in the amount of family involvement in the patient's hospitalization, measured by the average number of family contacts per week, among the readmitted group's first admission and the non-readmitted group's admission.

II. There are no significant differences in the amount of family involvement in the patient's hospitalization, measured by the average number of family contacts per week, among the readmitted group's first admission and their second admission.

Definition of Terms

Family: Any significant relative or non-relative from the patient's point of view. Significant by virtue of their relationship to the patient rather than by blood ties.

Family Involvement: A panel of judges (Appendix) agreed upon the following criteria for measurement of "Family involvement"; measurable personal contacts by the family with the patient during his hospitalization that have been noted in the clinical records.

Personal Contacts: Face to face interaction, as opposed to contact by telephone or written communication with the patient, either through visiting with the patient, taking him out on pass, or participating with the patient in any of the family therapy sessions conducted by a professional staff member.

Family Contacts per Week: Since the length of stay in hospital varied for each patient and could influence the number of
family contacts he may have, it was important to find a variable that adjusted family involvement for length of hospital stay. Family contacts per week is such a variable.
CHAPTER 2

REVIEW OF LITERATURE

Introduction

Various schools of thought in social psychiatry, sociology, anthropology, and psychology have made systematic attempts to enumerate possible factors and their relationship to mental illness within the individual and the family. The many contributory factors to mental illness still remain a challenge to current theorists.

There appeared to be no known literature published comparing the influence of family involvement during the patient's hospitalization to the readmission of patients to a psychiatric hospital. The review of literature for this study, therefore, is concerned with studies related to family influence on the patient's admission, post-hospital adjustment, and on readmission to the hospital.

The Influence of the Family on Mental Illness

Dreikurs (1968) emphasized the importance of "life styles," based on Adlerian theory, as a concept describing the psychological force in the development of the individual. He attributed the relationship between the father and mother as the determining factor in all interpersonal relationships within the family. Dreikurs supported the concept of family therapy in his principles of group discussion, and
focused on family atmosphere and family constellation as influences on the individual's life style.

Lansley and Kaplan (1968) described the significant differences between the two groups selected for their comparative study of family crisis therapy and mental hospital treatment. They stipulated the importance of family crisis therapy in reducing symptoms of acute upset within the family, and that with the reduction of tension, the family acquires a capacity for more efficient problem solving. The deleterious effects of hospitalization of a family member such as economic stress and guilt were also quoted. The collection of extensive follow-up data on a larger population is still continuing in this project, but the initial results appeared to present a strong case for family involvement in the patient's therapeutic process.

Sociological studies of the family's influence on mental illness and mental health have contributed much to a better understanding of the family's social role. Pollock, Rapoport, Vincent, Parsons, Faber, Hill, and Goode are a few of the well known writers in this field. Goode (1964) focused on the social aspects of family interactions, but cautioned that a consistently sociological approach to family behavior patterns missed the important facets of concrete family interactions. He viewed the sociological approach to family psychodynamics as interest in the impact of mental disease on the social relationship within the family unit, and also the kinds of family patterns or constellations that are more likely to produce certain types of mental illness.
Research concerning the family's influence and interaction patterns goes beyond the traditional study of the family dyads to the nuclear and extended family.

Satir (1964), in treating the family as a whole rather than the individual family member, revealed latent aspects of family life which produced symptoms of mental illness. These aspects had been largely overlooked when only the individual family member was being treated. Satir supported the findings of Ackerman (1961) and Hill (1958) in demonstrating that some particular event precipitated family dysfunction, and that when one member of the family was affected by an event, all family members were affected to some degree.

Ackerman (1961) described the influence of family members on mental illness, and the dynamics of family conflict. He suggested that any study of mental illness should include the study of the family as a unit. In his studies of family process, an attempt was made to correlate certain types of family identity, role complementarity, conflict patterns, and disturbance of family development with the emergence of psychiatric illness in a family member. Critical differences were noted in the quality of impairment of the family's growth capacity, patterns of prejudice, scapegoating, and healing. These differences were more evident in family identity, patterns of coping with conflicts, and value orientation in the content of conflict.

Mental illness and hospitalization of a family member frequently requires a relocation of the patient's roles to others, and a period of imbalance in the family homeostasis occurs while the family learns and
adapts to the new roles. In the area of family crisis, Hill (1958) showed that the source of family troubles influenced the family's reaction to the problem. "Extra-family events appeared to solidify the family, while intra-family events such as mental illness and alcoholism were usually more disorganizing because they reflect poorly on the family's internal adequacy." His studies indicated that the family's attitude towards precipitating events and the family's definition of the events are important factors in evaluating family problems. Hospitalization for mental illness is viewed by Hill as: loss of a family member (dismemberment), and loss of morale and family unity (demoralization). Hill suggested a deeper commitment by professional services to the total family concept, and a strong program of prevention and education, particularly in preventive social work and family life education. According to Hill's studies, successful modes of adjustment to family crisis appeared to be dependent upon family adaptability, family integration, affectional relations among family members, good marital adjustment of husband and wife, and previous successful experience with crises.

**Posthospitalization and Aftercare**

The increase in aftercare treatment programs is one phase of the control of mental illness that has surged ahead in the past decade, and is one of the most promising aspects both for the discharged patient and the family in the prevention of rehospitalization.

Williams (1970) emphasized that discharge planning and aftercare treatment planning should begin with the admission of the
patient. He concluded that willingness on the part of the staff to become authoritative rather than authoritarian is necessary if family involvement in the treatment process is to be achieved.

Jackson's (1970) studies indicated that communication patterns within the family revealed data concerning health and pathology. According to Jackson, future systems of studying the family will be influenced by data-processing via machines, and greater focus will be placed on systems of health, concepts of family homeostasis, family coalition, acquisition of family models, family stability, and family roles.

Many studies on the posthospital adjustment of patients indicated that the period immediately following discharge was crucial to both the patient and the family.

Michaux et al. (1969) conducted a longitudinal study on the posthospital adjustment of recently discharged patients from a state mental hospital. The study was undertaken to increase clinical knowledge concerning posthospital adjustment and rehospitalization, and to determine the course and outcome of the patient's return to the community. The results of Michaux et al. study showed that patients' relatives held inordinately high expectations regarding the patient's social performance. These unrealistically high expectations between what the patient expected of himself and what others expected of him frequently led to discrepancy between expectations and social performance and appeared to influence the course and outcome of the patient's posthospital adjustment. The authors suggested counseling of
close relatives and significant others as a means of preventing crises and attenuating inordinately high expectations.

The authors pointed out the need for closer clinical attention to the family dynamics of rehospitalization, and that patient-relative interactions merit high priority in treatment, research, and the prevention of hospitalization.

The studies of Strupp, Fox, and Lessler (1969) reported on the effectiveness of psychotherapy from the patient's point of view. Information was obtained from discharged psychiatric patients and data recorded in the hospital clinical charts. The sample tested was largely composed of young adults with a mean age of 28.3 who had some college education. Eighty-eight percent were under 45 years. The authors reported that success ratings in outpatient psychotherapy was not related to the number or length of previous hospitalizations, and that according to their data older patients achieved a greater level of therapeutic success. One of the most frequently presenting problems patients indicated was difficulty with significant others in current life situations. The data obtained in this study pointed to the importance of interpersonal relationships in emotionally disturbed patients.

The Task Force Study on Comprehensive Health Care (1967) pointed out the need for available and adequate treatment as early as possible. "Psychiatric disorder, perhaps more than any other, can be described as a stress phenomenon." It was recommended that
alternatives to hospitalization should be stressed, and that focus
should be on relieving intolerable stress before mental breakdown.

Collard (1966) and Glasscote et al. (1966), carried out studies on aftercare services. These studies supported the results of
Greenblatt et al. (1963) and Clausen and Yarrow (1955), in the need for aftercare services immediately following the discharge of the patient. Glasscote et al. viewed the delay in initiating follow-up services as an important factor in rehospitalization. Greenblatt et al. indicated that aftercare services was a means of preventing rehospitalization.

Clausen and Yarrow stated, "With the exception of a few papers, primarily by psychiatric social workers who had drawn upon an intimate experience with the problems of families of mental patients rather than upon systematic data, there is no research literature on the impact of mental illness upon the family." For the most part this statement appears to be still pertinent today. The studies carried out by Clausen and Yarrow focused on the process of family reaction and family functioning during mental illness, and the ways the family members related to each other, the patient, and society. The posthospitalization and rehabilitation of the patient appeared to be influenced by the attitudes and feelings of the family toward the patient and his illness. They stressed "the rehabilitative potential" of a much greater measure of psychological support to patient and family in the early days of his return from the hospital.

In summary, the literature reviewed appeared to suggest that the family's influence on the patient's illness, hospitalization, and
posthospital adjustment is a psychological and social phenomena that deserves high priority in the patient's course of treatment and successful adjustment to the community.
CHAPTER 3

METHODOLOGY

Selection of Subjects

The subjects for this study were 25 males and 23 females between the ages of twenty and sixty years, all of whom were married. All of the sample had been hospitalized for mental illness during the year 1969 in a Southern Arizona psychiatric hospital.

Permission was obtained from the medical, administrative, and nursing directors to review the hospital records. The total population for readmitted patients was found to be 95, and the total non-readmitted was 411 for the year 1969. The hospital records were reviewed for sample selection by the investigator. In order to qualify for selection, the patient had to meet the following criteria:

1. The patient had to be married.
2. The patient had to be between 20 and 60 years of age.
3. The patient could have no organic brain disease.

The readmitted group was defined as having had at least two admissions during the year 1969, and the non-readmitted group was admitted once during the same period.

Construction of the Instrument

Various psychiatric and psychological measurement scales were explored as possible instruments to measure family involvement. The
instruments appeared to be limited to specific fields of study or developed for particular purposes. Spitzer, Endicott, and Fleiss (1969) developed an integrated group of instruments for research comparison of groups of patients or non-patients. The Psychiatric Evaluation Form (PEF), and Social Background Record (SBR) are both designed to allow the researcher to use many sources of information to obtain data: the subject, informant, case records, and all clinical records. However, in the opinion of the investigator, none of the established instruments, tests, techniques, or rating scales adequately measured the problem being investigated, namely, family involvement.

It was decided to approach several professionals from the different disciplines within the family services field to discuss the methodology of the study, the type of data being investigated, and the need for an acceptable criterion to measure the family's involvement with the patient during the length of stay in the hospital.

Four professionals agreed to serve as a panel of judges (Appendix) to determine a criterion for the measurement of family involvement. The investigator discussed salient points of the study individually with each panel member. After a group meeting of the investigator with the panel, the study method and purpose were viewed as both feasible and appropriate. The investigator was then notified of the panel's criterion for measurement of family involvement. This criterion was measurable personal contacts by the family with the patient during his hospitalization that were noted in the hospital
clinical records. The noted family contacts were, visiting with the patient, taking him out on pass, or participating with the patient in any of the family therapy programs conducted by a professional staff member.

The length of stay in hospital varied for each patient and was considered to be an important variable in measuring the amount of family involvement in both the readmitted and non-readmitted group. All of the subjects tested remained in the hospital at least one week, therefore, in order to adjust family involvement in relationship to length of hospital stay, family contacts per week was considered the variable necessary to obtain this adjustment.

Differences in the number of family contacts in the readmitted group's first admission and their second admission was also viewed as an important variable in measuring family involvement. Therefore, the recorded personal family contacts were counted during both periods spent in hospital, to determine any difference in the level of family involvement during these two periods.

Collection of Data

Data on each of the 48 subjects were obtained from clinical hospital records. Information on age, sex, religion, and occupation was collected by the investigator from the admission records. The investigation of hospital records revealed that the psychiatrists, nurses, and social workers' records were the most reliable for the purpose of this study. The psychologists, recreational and
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occupational therapist, and psychiatric technicians' reports were not included in the collection of data.

Reliability was established on all of the sample patients who had recorded family contacts in the psychiatrists and social workers' records, through cross reference with appointment records. Personal family contacts recorded in the nursing records were verified in the hospital pass record book.

The hospital records used in this study were:
1. Psychiatrists' records
2. Psychiatric social workers' records
3. Psychiatric nurses' records
4. Admission records
5. Appointment records
6. Hospital pass records

The demographic data were obtained from the admission records to determine whether or not the sex, age, religion, and occupation of the subjects in the two groups would reveal some interrelationship to the readmission of patients. Although these data were not directly related to the hypotheses being tested, they were considered as potentially important variables in the readmission of patients.

The investigation of hospital records as a research method in the collection of data was used for the following reasons:
1. This method has been utilized in various studies; both singularly and in conjunction with other methods. Ginsburg (1963), in his study to evaluate the therapeutic results of
psychiatric clinic practice, analyzed the data obtained from the clinical records. Spitzer et al. (1969) studies indicated frequent use of clinical records as a method of research in conjunction with questionnaires and interviews.

2. The hospital records in general, and clinical notations by professional staff in particular are often presented as acceptable evidence in a court of law.

3. As a historical type of research, review of clinical hospital records was considered an acceptable method to identify the problem as stated in the study and the criterion established by the judges.

**Treatment of Data**

The data for measurement of family involvement were obtained by the investigator from the psychiatrists, nurses, and social workers' hospital records for all of the 48 subjects in the sample being tested.

Family involvement was identified in each subject's record by the stated criterion established by the panel of judges. Measurable personal contacts by the family with the patient during his hospitalization that were noted in the clinical hospital records, either visiting the patient, taking him out on pass, or participating in any of the family therapy programs conducted by a professional staff member.

The 24 subjects in the readmitted group were identified by means of their hospital case number to maintain confidentiality. Each of the 24 subjects in the non-readmitted group were treated in the same manner. The total number of personal family contacts noted on
the clinical records for each subject was tabulated by hand, and the means, standard deviation, and variance of both groups was computed.

The t test was used to determine whether there was a significant difference in the amount of family involvement, measured by family contacts per week between the two group means at the .05 level of significance.

The t test was also used to determine whether there was a significant difference in the amount of family involvement, measured by family contacts per week between the means of the readmitted group's first admission and their second admission at the .05 level of significance.

Family contacts per week was the variable used to determine if there was a relationship between family involvement and the readmission of patients.

The psychiatrist's and the admission records reported the date of admission and date of discharge. The length of hospital stay for each subject was tabulated by hand. The number of recorded family contacts was obtained from the psychiatrists, social workers, and nurses' records. The total number of recorded family contacts for each patient was divided by their length of hospital stay to determine the average number of family contacts per week in both the readmitted and the non-readmitted groups.

The demographic data on age, sex, religion, and occupation were tabulated by hand and analyzed by means of the chi-square ($X^2$) test of significance. Each variable was tested in both the readmitted and
the non-readmitted group patients to determine any relationship to
the demographic variables and the readmission of patients. The
chi-square ($X^2$) test of significance was used to determine any
significant difference between the two groups at the .05 level.
CHAPTER 4

RESULTS AND DISCUSSIONS

The readmitted group was defined as patients who had had at least two admissions to a psychiatric hospital during the year 1969. The non-readmitted group was defined as patients who had been admitted only once during the year 1969.

It is important not only to know about significant differences between the two groups in some demographic variable, but also to consider what effect the differences might have on readmission and family involvement. The non-significance of a demographic variable leads one to believe that it has no effect upon a difference in readmission and family involvement. The age, sex, religion, and occupational distribution of the sample were analyzed to see whether there was a difference between the readmitted and the non-readmitted groups.

Age: The data in Table 1 revealed a significant difference in the age distribution of the readmitted and the non-readmitted groups. It is apparent from the data that this significance is caused by the readmitted group having a higher percentage of patients in the 41-60 age group and a smaller percentage in the 20-40 age group.

The older population might have less family available to visit, or become involved with than a younger population. The significance between the age difference in the readmitted group might be related to
the disengagement theory, discussed by Cumming and Henry (1961). The theory is based on the needs of the older citizen; the need for independence and self identity, and the fear of becoming a burden or dependent on their family. This concept attempts to explain the social withdrawal of older people from their families. In this context, the older age group may view hospitalization as a solution, or it may be a mutually agreeable solution both to the patient and the family.

Table 1. Age Distribution of the Readmitted and Non-readmitted Patients*

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Readmitted</th>
<th>Non-readmitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>31-40</td>
<td>7</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>41-50</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>51-60</td>
<td>9</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>24</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>

* $X^2$, 3df = 7.984. Significant at .05 level of significance.

The study did not allow for comparison of family involvement in different age groups, but the implication may be that among the older age group there is less family involvement with the patient during his hospitalization.

The significance of age differences among the readmitted and the non-readmitted groups indicate a need for further study in this area. Research on a larger sample, tested over a longer period, and
composed of a more mixed population may bring to light pertinent factors that support or negate the findings of this investigator.

Sex: The sex distribution of the sample is shown in Table 2. The data revealed no significant difference between the sex distribution in the readmitted and the non-readmitted groups at the .05 level of significance. Michaux et al. (1969, p. 128) tested variables that might predict rehospitalization. Their study revealed no significant sex differences in the readmission of patients to hospital.

Table 2. Sex Differences of the Readmitted and Non-readmitted Patients*

<table>
<thead>
<tr>
<th>Sex Differences</th>
<th>Readmitted</th>
<th>Non-readmitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>24</td>
<td>48</td>
</tr>
</tbody>
</table>

* $X^2$, 1 df = 0.85. Not significant at the .05 level of significance.

Religion: The religious affiliation of patients in the readmitted and the non-readmitted group is illustrated in Table 3. The data revealed no significant differences at the .05 level of significance.

The investigator's review of literature pertaining to religious affiliation and rehospitalization failed to reveal any tangible association between the two factors. However, current trends in the psychiatric field indicate an awareness of the need to work with
ministers of religion in order to achieve mental health for patients under psychiatric care.

Further study might explore the influence of religious support in the prevention of readmission of patients.

Table 3. Religious Affiliation of the Readmitted and Non-readmitted Patients*

<table>
<thead>
<tr>
<th>Religion</th>
<th>Readmitted</th>
<th>Non-readmitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>17</td>
<td>16</td>
<td>33</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Unclassified</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>24</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>

* $X^2$, 3df = 1.454. Not significant at the .05 level of significance.

Occupation: Table 4 shows no significant difference between the readmitted and non-readmitted groups. However, the data revealed an increase in the proportion of homemakers, and a decrease in the proportion of professional and business population among the readmitted group.

The possibility of real differences should be investigated, and if they are real, further research must control occupation in the readmitted and the non-readmitted groups.
Table 4. Occupation Distribution of the Readmitted and Non-readmitted Patients*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Readmitted</th>
<th>Non-readmitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and Business</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Homemaker</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Technical</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Unclassified</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>24</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>

* $X^2$, 3df = 4.578. Not significant at the .05 level of significance.

Testing of the Hypotheses

The results of the study in regard to the hypotheses tested are shown in Tables 5 and 6.

Hypothesis I states: There are no significant differences in the amount of family involvement in the patient's hospitalization, as measured by the average number of family contacts per week, between the readmitted group's first admission and the non-readmitted group's admission.

Table 5 presents the amount of family involvement adjusted for length of stay, as stated in Chapter 3, and measured by family contacts per week among the readmitted group's first admission and the non-readmitted group.

The data indicated no significant difference between the two groups' means at the .05 level of significance. Therefore, the null hypothesis was accepted.
Table 5. Family Involvement and Length of Stay: Number of Individual Recorded Family Contacts per Week among the Readmitted Group's First Admission and the Non-readmitted Group*

<table>
<thead>
<tr>
<th>Patient</th>
<th>Readmitted First Admission</th>
<th>Non-readmitted One Admission Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family Contacts per Week</td>
<td>Family Contacts per Week</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
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<td>3</td>
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<tr>
<td>4</td>
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<td>5</td>
<td>6</td>
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<tr>
<td>6</td>
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<tr>
<td>7</td>
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<tr>
<td>9</td>
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<td>10</td>
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<td>21</td>
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<td>4</td>
<td>22</td>
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<tr>
<td>23</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>24</td>
<td>5</td>
<td>24</td>
</tr>
</tbody>
</table>

Means: 5.00* 4.96*

* Not significantly different at the .05 level of significance. t = -.238.
Hypothesis II states: There are no significant differences in the amount of family involvement in the patient's hospitalization, measured by the average number of family contacts per week, among the readmitted group's first admission and their second admission.

Table 6 indicates the amount of family involvement adjusted for length of stay, and measured by family contacts per week among the readmitted group's first admission and their readmission. The analysis of data revealed a significant difference between the two groups' means at the .05 level of significance, therefore the null hypothesis was rejected.

The significance of a decrease in the amount of family contacts in the second admission for the readmitted group may be attributed to strained affectional relationships between the patient and the family during the posthospital period because of the family's inordinately high expectations of the patient. This concept is supported by Michaux et al. (1969) who suggested that family dynamics during the posthospital period is a contributing factor to readmission, and therefore points to the need for family involvement in the patient's treatment. Guilt feelings, a sense of failure, and the belief that only the hospital staff is qualified to assist the emotionally disturbed person, may further decrease family involvement during the second admission. Hill (1958) supported the view that intra-family events such as mental illness creates disorganization in the family because it reflects poorly on the family's internal adequacy. This
Table 6. Family Involvement and Length of Stay: Number of Individual Recorded Family Contacts per Week among the Readmitted Group's First Admission and the Second Admission*

<table>
<thead>
<tr>
<th>Patient</th>
<th>First Admission</th>
<th></th>
<th>Second Admission</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family Contacts per Week</td>
<td></td>
<td>Family Contacts per Week</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td></td>
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<tr>
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<td>5</td>
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<td>4</td>
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</tr>
<tr>
<td>24</td>
<td>5</td>
<td>24</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Means 5.08*  3.54*  

* Significantly different at the .05 level of significance.  t = 3.027.
may account for guilt feelings, sense of failure and inadequacy on the part of the family and contribute to a decrease in family involvement during readmission.

A greater emphasis on outpatient therapy and follow-up services especially for patients in the older age group may substantiate the results of noted studies, particularly that of Strupp et al. (1969). According to the authors, success in outpatient therapy was not related to previous hospitalizations and length of hospital stay. The study indicated that older patients achieved a greater level of therapeutic success, also the importance of interpersonal relations with significant others among the emotionally disturbed.

Further research may possibly indicate other variables in relation to the significance of the decrease in family involvement during the hospitalization of readmitted patients, especially among the older age group.

The data revealed a significant difference between the two groups' means at the .05 level of significance. Therefore, the null hypothesis was rejected.
CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to determine if family involvement in the patient's hospitalization period had a relationship to the readmission of patients to a psychiatric hospital.

The readmitted patients who had been admitted twice during the year 1969, and the non-readmitted patients, admitted only once during the same period to a Southern Arizona psychiatric hospital, were compared to determine any difference between the two groups in the amount of family involvement. The age, sex, religion, and occupation of all 48 patients were analyzed to determine any association of the demographic variables with the readmission of patients.

The study indicated a significant difference at the 0.05 level between the age distributions of the readmitted and non-readmitted patients. The readmitted group was older than the non-readmitted group.

The data obtained in testing Hypothesis I yielded results which warranted the acceptance of the null hypothesis.

However, the statistical analysis of the data obtained in testing Hypothesis II warranted rejection of the null hypothesis.

The results suggested a decrease in family involvement during the patient's second admission among the readmitted group. Since the
readmitted group was comprised of the older age group, the significance of age differences becomes an important factor in relationship to readmission. Therefore, the effects of aging on family involvement during the hospitalization period merits further research.

Michaux et al. (1969, p. 156) study yielded pointed suggestions:  

... (1) the advisability of counseling close relatives against holding inordinately high and tenacious expectations as to a patient's posthospital performance, and (2) the distinct possibility that repeated hospitalization may do patients more harm than good. When relatives look to rehospitalization to relieve their growing disappointment with patients, the starting point for help should be to deal with their disappointment, and the patient-relative relationship which engendered it.

Implicit in much of the documented research on the family-patient relationship is the importance of the family dynamics, and the specific role the family plays in preventing or expediting the readmission of a family member.

In general, the results of this study indicated that family involvement in the patient's rehospitalization is an area in need of further research. Since the readmitted group was older than the non-readmitted group, specific research on the effects of aging on family involvement and hospitalization merits further study. Research in this area might explore not only the dynamics of interpersonal relationships between persons of significant importance to the patient, but the hospital milieu and the psychiatric team's approach to the aged and their family.

Zinberg (1965), in discussing geriatric psychiatry, identified the needs of the older age group, and pointed out the importance of
family counseling as a function of the geriatric psychiatrist. He indicated that psychiatrists frequently help the older person to deal with the current problem rather than to increase understanding of his psychic dynamic structure.

Limitations of the Study

The study was done on a small sample, therefore the results may not reflect the impact of family involvement for larger hospital populations.

Only personal family contacts were used to measure the amount of family involvement during the patient's hospitalization. Letters and phone calls from family members were not included as a media for measurement of family involvement.

The study only included married patients; therefore patients who were divorced, widowed, or unmarried were not measured for family involvement.

The socio-economic level of the groups was not considered in the sample studied.

The instrument used to measure family involvement needs to be refined to include many of the other variables that might influence any further research in this area.

The study was limited to patients who had been hospitalized during a one year period.
Recommendations

A longitudinal study in the relationship of family involvement to the readmission of a family member might indicate significant differences in some of the variables tested.

Study of the persons considered by the patient to be significant, and their level of importance to the patient's hospitalization.

Study of the kinds of family involvement with the patient during hospitalization that contribute to the prevention of recidivism.

Study of the hospital staff's utilization of the family's potential, in the therapeutic program, as a means of preventing readmission.

A study of a team approach among the different hospital and community health disciplines, in relation to the family's point of view in the patient's hospitalization.

Study of a more heterogeneous population that would include all age groups, all socio-economic levels, also widowed, divorced, and unmarried patients.

Additional research needs to be undertaken to determine if the findings of this study are typical or atypical of family involvement in relation to the readmission of patients to a psychiatric hospital, and to provide much needed answers to the role the family plays in achieving and maintaining the mental health of its members.
APPENDIX

PANEL OF JUDGES

Professional Data Sheet

Mrs. Betty Slaybaugh

Education and Experience:

Academic Degrees: B.A., Washburn University, 1952
M.S.W., University of Kansas, 1962

Most Recent Professional Experience:
1961 to present: Tucson Child Guidance Clinic
Present Position: Principal Investigator of NIMH
Research Grant, "Crisis Intervention in a Child Guidance Clinic."
Field Instructor (past 7 years)
Graduate School of Social Service Administration, Arizona State University.


Fields of Major Interest: Crisis intervention; parent-child relationships, group therapy.

Professional Memberships: National Association of Social Workers; Academy of Certified Social Workers; American Group Psychotherapy Association; Council of Social Work and Mental Health Services; Executive Committee of NASW; Council on Social Work Education; currently the President of the Arizona State Council of NASW.
Nicholas George Bahn

Education and Experience:

Academic Degrees: B.S., St. Louis University, 1950
M.S.W., St. Louis University, 1954

Experience:
Adams Co. Mental Health Clinic (Director and Chief Social Worker), 1956-1959, Quincy, Ill.

Tucson Outpatient Clinic (Director and Chief Social Worker), 1959-1962, Tucson, Arizona.


Palo Verde Hospital, Director of Social Service, 1967-present, Tucson, Arizona.

Institutes, Workshops, etc.:

Leadership in Group Discussion, 1955, St. Louis School of Group Dynamics.


Professional Memberships: National Association of Social Workers; Tucson, Arizona Chapter of National Association of Social Workers; Governor's Advisory Committee on Mental Health; Casework Executives Conference of Tucson; Professional Advisory Committee.

Professional Publications:


Howard P. Roush

Education and Experience:

Academic Degrees: B.A. Ed., The University of Arizona, 1953
M.Ed., The University of Arizona, 1958
Certificate of Social Work, Louisiana State University, 1959
M.S.W. (Psychiatric Social Work)
Louisiana State University, 1959

Experience:
Classroom Teacher, 1955-57, Prescott, Papago Reservation.
Special Ed. Teacher, 1957-58, Baton Rouge, La.
Clinical Social Worker, 1958-59, Gulfport, Miss.
School Social Worker, 1959-60, Phoenix, Arizona.
Psychiatric Social Worker, 1960-64, Phoenix, Arizona.
Community Mental Health Planning Consultant, 1965-68, Honolulu.

Faculty Appointments:
Sociology, Mercy School of Nursing, 1957-59, Baton Rouge, La.
Social Work, University of Hawaii, 1966-68.

Warren S. Williams, M.D.

Education and Experience:

Academic Degrees:
B.S., University of Wisconsin, 1946
M.D., University of Wisconsin, 1948
Specialty training in Psychiatry, University of Texas, 1952

Most Recent Professional Experience:
Medical Director, Palo Verde Hospital, 1960-71, Tucson, Arizona.
Assistant Director of Psychiatric Services, University of Texas, 1952-59.
Faculty Appointments:

Associate Professor of Psychiatry, University of Texas, 1958-59.
Assistant Professor of Psychiatry, University of Texas, 1955-58.
Instructor in Psychiatry, University of Texas, 1952-55.

Professional Memberships:

Hogg Foundation for Mental Health (Research Consultant), 1957-59.

Arizona Psychiatric Society (Member, Executive Council), 1960-present.

Arizona Psychiatric Society (President), 1961-63.

Tucson Psychiatric Society (President), 1962-64.

Assembly of the American Psychiatric Association (Alternate Delegate), 1963-present.

Assembly of the American Psychiatric Association (Nominating Committee), 1965-present.

Arizona League for Nursing (Chairman, Council of Mental Health and Psychiatric Nursing), 1966-present.

Community Activities:

Galveston City Association for Mental Health (President), 1958.

Tucson Community Goals Committee (Sub Committee Chairman), 1965-67.

Tucson Community Council (Chairman, Coordinating Committee for Community Mental Health Centers), 1966-present.

Tucson Community Goals Action Board (Member), 1967-present.

Private Practice:

Part-time practice of Psychiatry, University of Texas, 1952-59.


LIST OF REFERENCES


