

RESPONSES OF FAMILIES TO THE TREATMENT SETTING

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Families of psychiatric patients have many problems and concerns as a result of their relatives' mental illness and subsequent hospitalization. Living with a mentally ill relative for months or even years prior to treatment may result in disruption of social and personal routines; it may create physical and emotional stress; and it may cause financial and occupational difficulties (Robin, Copas & Freeman-Browne, 1979). Their initial encounters with the psychiatric hospital occur at a time of crisis, when they may be feeling guilty and ashamed for having contributed to the illness, and they may be apprehensive about the future (Leavitt, 1975). They may also feel inadequate and helpless because they lack information about the illness and its treatment (Lewis & Zeichner, 1960). The hospitalization presents families with the task of acknowledging the relative as "mentally ill", a task which is a major component of the crisis (Clausen & Yarrow, 1955; Mechanic, 1967). Families therefore try to make sense of events and people encountered during the hospital experience in order to help them with this task (Perelberg, 1983).

Families often arrive at a psychiatric hospital following a circuitous and frustrating route of seeking help from various agencies and professionals. The families' views of the hospital as a last resort, as well as their attitudes about mental illness, contribute to their feelings of guilt with the result that the family is "thrown out of balance" by the hospitalization (Fleck, 1965; Zwerling & Mendelsohn, 1965). Anderson (1977) noted that families felt isolated from the hospital, they experienced few opportunities to express their feelings or request support, and often they appeared resistant to therapy because of their fears and anxieties about the illness. Leavitt (1975) found that families maintained their feelings of confusion and fear throughout the hospitalization, and concluded that hospital staff had not been effective in supporting the family.

The lack of attention paid to the needs of families of psychiatric patients during hospitalization, both in research and clinical practice has been noted (Harbin, 1979). The development of an understanding of those needs involves an examination of the families' responses to the setting in which treatment occurs, since many of the problems that families encounter in dealing with the illness may be related to the hospital itself. The author of this article will discuss the results of a recent study designed to explore families' perspectives of their experience of the psychiatric hospitalization of a relative. A major finding of the study has

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indicated that families were actively involved in making sense of the hospital experience - a process that was influenced by their desire to understand and become a part of the treatment. The problems they experienced related to the hospital setting will be identified, and the relationship of these problems to the cultural elements of the psychiatric hospital will be shown.

Theoretical Perspective

The objective of the study was to elicit the families' perspectives of their experiences of mental illness and its treatment. Their subjective responses to events and situations encountered in the treatment setting were considered important to the development of an understanding of the meaning of the experience for them, and to its subsequent influence on their behaviour. The perspective of phenomenology as developed by Schutz (1962) was seen as appropriate to the study objective and was therefore chosen as the basis for the qualitative research design.

Qualitative methods based upon phenomenology go beyond the objective observation of behaviour that are typically done in quantitative studies, and attempt to explain phenomena by eliciting the subjective, inner experience of the participants (Rist, 1979). The phenomenological approach precludes the use of hypotheses or other preconceived notions, biases, or assumptions, and the researcher is open to all reports from the participants that might constitute "data" (Omery, 1983). Reality of the situation under study is therefore socially constructed by those within it (Davis, 1978). Methods of data collection are guided by the aim of the researcher to understand how the participants "make sense of" or construct this reality, based upon their subjective interpretations (Cicourel, 1968; Schutz, 1962). If interviews are chosen as the method of data collection they are usually unstructured, to allow the participant to focus on aspects of the experience important to them, and to encourage description of individual interpretations and meanings (Omery, 1983).

It should be noted that when the method of data collection is in-depth interviewing, the number of participants is in part determined by the extent of the data obtained, and the degree to which the researcher is satisfied that the participant's perspective is understood. The aim is not to determine cause and effect, but rather to glean the essence of each participant's unique experience (Colazzi, 1978; Omery, 1983).

Method

Families of adult psychiatric patients whose duration of hospitalization was likely to be four to six weeks during the time allotted for the study, were asked to participate. It was felt that such a period was representative of the average length of stay of patients in an acute care psychiatric setting. Families had to be able to converse in English in order to articulate their experience to the researchers, and they had to reside in the local metropolitan area. The basis for these criteria was the desire for a homogenous group, in terms of length and quality of hospital contact, as well as to allow the researcher ample time to conduct the in-depth interviews in the families' homes during the hospitalization period.

Data Collection.

Initial contact with families meeting the criteria was made by the researcher after receiving consent from the patients and hospital staff to do so. Two interviews were conducted with families during the hospitalization period. These interviews were essentially open-ended and unstructured, although as phenomenology directs, the initial interview was guided by the review of the literature, the researcher's personal experience, and the work of other researchers (Colazzi, 1978). For example the families were asked to describe their reactions to admission, the treatment process, their involvement in treatment, and the impending discharge (Anderson, 1977; Harbin, 1979; Kleinman, 1978; Leavitt, 1975). The purpose of the initial interview was to discuss events leading up to and including hospital admission. As well, the researcher tried to elicit families' perceptions of the hospital environment and the effect of the hospitalization on their everyday lives. The timing of the initial contact varied, but, as much as possible, occurred during the first two weeks of the patient's hospitalization. An important methodological consideration within the phenomenological perspective, this schedule aided the families and the researcher in "exploring the meaning of that experience as it unfolds for the participants" (Omery, 1983, p.54).

While conducting these interviews, the researcher was actively involved in identifying her own subjectivity, and attempting to recognize its influence on the research process. Possible assumptions or biases were recognized, and every effort was made to examine them and to set them aside in order to be completely open to the families' view (Davis, 1978). Words and phrases that might have different meanings, or for which there was a danger of assuming shared meaning, were clarified with the families in the subsequent interviews.

Ten family members of seven patients participated in the study, representing various relationships to the patients: wives

(2), parents (3), siblings (1), daughters and sons (3), and grandmother (1). They ranged in age from twenty to seventy, and could broadly be described as lower- to upper-middle class. One family was Hungarian, another Chinese, and the remainder were Canadian. Patients represented a variety of diagnostic categories but all were experiencing their first hospitalization.

Data Analysis

The qualitative research design, based upon the phenomenological perspective, involved an inductive and interpretive approach to data analysis (Anderson, 1981). It is closely related to the methodology of grounded theory research in which content analysis of data, such as that gained through in-depth interviewing, results in the emergence of dominant themes descriptive of the participants' experience (Glaser & Strauss, 1967). To use this qualitative approach to data analysis is to engage in a process of "living with" the data, reflecting upon its meaning, pulling out the salient categories or themes, and attempting to conceptualize them to represent the participant's experience. Thus, the emerging theory of a phenomena is "grounded" in the data of the participant's experience (Stern, 1980). The process was further enhanced through constant comparison of all data; as interviews were completed and transcribed, they were simultaneously compared and contrasted with other data, to support or refute themes tentatively identified (Glaser & Strauss, 1967). Since the basic tenet of the phenomenological approach is validity of the client's perspective, an important component of data analysis was the follow-up interview, or contact with study participants, to "check out" the researcher's interpretations. Sharing conceptualizations with colleagues who were familiar with the method and area of study also helped to reduce the erroneous interpretations of a single researcher.

The Families' Accounts

Through the inductive analysis of the interview data just described the concept of assimilation was identified as describing the families' experiences in the hospital setting. The process of assimilation is offered by the researcher as a way of explaining one source of families' problems and concerns. Analysis of their accounts of personal experiences in the psychiatric unit highlighted the families' wish to become active participants in their relatives' treatment, and their need to determine their role within the setting.

As families engaged in the assimilating process, they seemed to be involved in several activities; first, they were learning to identify and adjust to necessary changes in their relationship to the ill relative, particularly when visiting the patient in hospital;

secondly, they were involved in identifying the role of various staff in the setting, for example nurses, psychiatrists, psychiatric assistants and clerks; thirdly, they were using informal methods of gathering information about the hospital routine, philosophies and such; and finally they were continually evaluating the reasons and methods concerning treatment as it applied to their relative. For the purpose of clarity these activities can be viewed separately, but in actuality they occurred more or less simultaneously and influenced each other; for example, the families' view of the staff role affected their own information gathering behaviours.

Identifying Families' Roles

The ease of assimilating into the setting was affected by the degree of uncertainty families felt about their own roles. Families' beliefs about the causes of mental illness, and their concerns about their own contributions, created feelings of uncertainty during their initial visits with the patient. Questions they had about their role in relation to the patient in the hospital setting were focused on their verbal responses and general attitudes toward the patient. They asked questions about resuming a parent role, or assuming responsibilities normally fulfilled by the patients. One family decided that, "You just have to treat them like small children," while another family was confused about their role: "I don't know what to say to him, I don't know how to handle it."

Families were also confused about their role in relation to the staff on the unit. They looked for rules in the setting that might direct their actions, and none were clearly evident. Families described feelings of guilt and remorse for their possible contributions to the patient's illness, and expressed a need to be involved in the patient's care because of these feelings. They were hesitant to request such involvement however, and questioned its acceptability from the staff's point of view. Should they call the unit, for example, and request a progress report? Others asked questions about what was expected of them when the patient returned home for a temporary pass, or whether they were expected to volunteer information about the patient's past. Such concerns, and the lack of help they received in dealing with them, made their assimilation into the setting more difficult. The unanswered questions affected their ability to interact comfortably and assertively while in the hospital setting. As one family described, "I suppose you're groping; you don't really know what you're to ask." But the belief in the importance of a clear role for families was evident, as one family member expressed, "It's my life too."

Identifying Roles of Others

The families' prior beliefs and assumptions about the roles and functions of various health professionals, developed in other, more "medical" settings, further affected their attempts to assimilate this new experience. Staff were initially viewed as "experts" who would be able to answer clearly their questions about the cause, prognosis, and treatment of mental illness. One family member described her initial notion that professionals "know how to handle people, talk to people because they know what goes on in people's minds." Families consistently reported that their preconceived notions did not apply in the psychiatric unit. Experiences in the setting resulted in disappointment for many when concrete, definitive answers to their questions were not offered. They were uncomfortable in the day-to-day interactions with staff, as evidenced by uncertainty and insecurity in identifying and approaching the "right person" or the staff member "in charge" of their relative's care. "I'm sometimes a little doubtful about the right person to talk to," one family admitted. Assumptions that they used to govern their actions resulted in the decision that nurses were not allowed to provide any information about the relative's progress. Families who lacked clear directives about the roles of staff expressed feelings of isolation from the hospital.

Information Gathering

An inability to define their roles in the unfamiliar surroundings was most apparent when families described their circui0ous methods of information gathering. Information was gained through their observations of staff interacting with patients. Patients were questioned about ward events or treatment modalities such as group therapy or medications. Other patients were observed in informal encounters and compared to a family's relative in order to help them make some judgement about the severity of the illness. Making sense of the physical environment was important to their decisions about how they should act. The presence of a "lounge" or common area, for example, meant for some that they should spend time there with other patients and families. "We go there because we don't want to appear separate from the others," one family explained. Such a sensitivity to cues in the environment highlighted the families' efforts to understand the norms and values of the unit.

Treatment Issues

Families had difficulty understanding and accepting the treatment plans when the values on which they were based were not easily identified, or were in conflict with their own value system. They described their surprise and doubt when they realized the staff expected more of a patient than they did.

Other patients were judged as "worse", or their relative was viewed as "different" in some way and therefore, families concluded, required different treatment. As one family observed, "I couldn't really see where there was very much that's going to be able to happen for him, because he isn't psychotic, like a lot of the people there." They examined how the patients "looked" or responded to them during visits and made their own judgements about their progress, which they did not always share with staff.

Communication between families and staff was further hampered when families were not committed to the treatment methods and goals. Few families could specifically describe what the therapies were designed to do for their relative. One family that was informed by staff that the relative was participating in group therapy, had no notion of what that was or how it was supposed to help. Other families voiced skepticism about the relevance of the group approach to their relative's problems. They hesitated to disagree with or question staff treatment methods however, and instead patients were asked to describe what had transpired. As one family concluded: "I don't think that it helped him to stay there. I came out of there feeling quite depressed, because I thought, to be in that environment all day... I couldn't really see where it would do anybody any good."

While "improved communication" or "getting along with others" was acknowledged as important, other aspects of treatment, such as "forced" interactions between their relative who was "not up to it" and others were not. The experiential techniques used were viewed critically, and staff lost credibility because they valued them more highly. "It was funny, some of the things they picked up on," one family observed, while another concluded that the hospital was "a place where you just talked with other patients, and ate and slept." A third family stated: "I thought they would have more individual discussions, to see if they couldn't get to the bottom of things." Another family described the home and hospital as "two different worlds", and did not place any value on her relative's responses in group therapy since they were "out of context" of the patient's home environment.

Discussion

Among psychiatric hospitals there may be a variety of treatment philosophies which influence organization. The choice of an overall treatment philosophy, such as a therapeutic community model, determines the nature of the unit as a social system. Kraft (1976) emphasizes the importance of considering the socio-cultural elements of a unit when he describes how the values and norms governing behaviour, the distribution of power among staff, and the beliefs about mental illness upon which treatment is based must influence one another. These factors which highlight the social nature of the system are sources of

problems and concerns for families in their initial exposure to the psychiatric unit, when they see little that is familiar or easily understood. While staff and patients become aware of their role through the legitimacy given to them, families do not enjoy such a benefit in settings where no formal structure exists for their involvement.

In this study, families described feelings of discomfort, insecurity and isolation from the hospital because they were unsure of their role or the role of the staff, and they had many doubts and questions about the therapies used with their relatives. They realized that they never felt a part of the setting, and as Leavitt (1975) described in an earlier study, they concluded that the hospital was only concerned about the patient (p.38). This attitude seemed to be a result of failure of the staff to involve the family in the patient's treatment plan.

While the issue of the family's desire or lack of desire for involvement has been argued by other researchers (Krajewski & Harbin, 1982), and indeed the families' motives for involvement have been questioned (Greenley, 1972), it seems clear from the accounts of the families in this study that they wanted to understand what was happening to their relative and to be included in planning for the future. They wanted to become assimilated into the social system of the psychiatric unit, so that they could help their relative during and after the hospitalization. A consequence of a failure of families to become a part of the setting -- to obtain the necessary information and support -- is that they may experience alienation from the system (McFarlane, 1982, p.105). Feelings of powerlessness, a lack of meaning attached to events they encounter, and isolation seem to summarize the problems that these families had in their attempts to become assimilated into the social system.

Families felt powerless when they perceived a lack of control over events in the setting, such as the treatment of their relative, or when they were uncertain that their requests for involvement would be acknowledged and met. The lack of assistance from professionals in understanding the illness, or in providing directions for how to act toward their relative hampered their ability to see meaning in the experience. They lacked confidence in their own actions and decisions in the setting. This was accentuated when the patient's treatment seemed to have little relevance to the family's life outside the hospital.

Differing beliefs and values of families and professionals about mental illness and how it should be treated can be a source of conflict, contributing to families' feelings of isolation from the system. As families evaluated staff expectations of the ill relative and interactions and this interaction with them, they were struggling with their own belief system, which often

involved a lack of trust of of the patient, decreasing expectations, and a cautious approach in interactions. The differences in approaches to mental illness were noted by families but not immediately understood.

The families in this study, then, clearly identified their sense of isolation from the hospital, and went on to describe their emotional responses of sadness and helplessness. Their lack of involvement in treatment resulted in little or no new knowledge about how to deal with the patient or the illness -- which they perceived as contributing to a pervading sense of pessimism about the future.

Families arrived at the psychiatric setting with emotional burdens of guilt and shame. The lack of a clear message from professionals, that they were not to blame for the relative's illness, increased the burden. They actively sought ways in which they could now positively influence the patient's recovery and expressed a strong desire to be involved in this way.

Implications for Nursing

The families in this study have illustrated the extent of the impact of the social system of the psychiatric unit on their lives and on the difficulties they experienced in understanding its characteristics. The families' accounts of the problems they encountered in becoming assimilated into the system suggests several directives for nursing practice, to improve the quality of the experience for families.

A comprehensive family orientation has been suggested as a means of reducing the families' anxieties and developing a working alliance among staff, patient, and family (Anderson & Reiss, 1982). Rather than hastily dismissing a family as resistive or uninterested, an exploration of their feelings and attitudes toward the setting is needed. During an orientation, discussion of the overall unit philosophy and specific goals of treatment could occur. Their input, questions, and evaluative statements should be encouraged. Ideally this first contact should be made by the nurse who will be most closely involved with the patient, and who will then serve as a contact person for the family for the remainder of the hospitalization. Roles of the various professionals on the unit could be explained, and support staff that families will encounter when visiting could be introduced.

On-going involvement with families is important to alleviate their feeling of isolation. Multiple family groups can be effective mechanisms for meeting families' needs for support and involvement (Atwood & Williams, 1978; McFarlane, 1982) as well as providing an opportunity to re-evaluate their own feelings of guilt and shame and thus decreasing feelings of self-blame. Such groups would also provide a legitimate role for families in the

hospitalization of their relative. The legitimization however, needs to be continually reinforced through individual contacts with families, both formal and informal. Encouraging them to voice their attitudes and beliefs about mental illness, and to discuss their relationship with the patient in a non-punitive manner, may help to increase the meaning of the hospitalization for them. Giving them permission and encouragement to approach staff would help to clarify their role as valuable members of the unit.

Before any of these interventions could be instituted, however, an analysis of attitudes of staff toward family involvement should occur on all levels. How do nursing staff on the unit, for example, respond to an anxious or even hostile relative during visiting hours? An understanding of the family's feelings of powerlessness and isolation might help the nurses to respond more therapeutically to those families, instead of dismissing them as "problems". Further research could focus on such staff attitudes and interactions; additionally the questions could be asked: Does the development of a formal program for family involvement decrease family concerns? Or do family groups only occur for those obviously in need of family therapy? Nurses should be given the time and support to be actively involved in family programs. In a recent involvement with such a support group by this author, it was apparent that its on-going success was dependent upon administrative support.

Conclusions

The increasing complexity of the health care system can create feelings of alienation for any consumer of its services. While the effect of dependency and passivity on patients has been acknowledged, less consideration has been given to the responses of families. Particularly for families in psychiatric hospital settings, the lack of a legitimate role and a poor understanding of treatment contributes to feelings of isolation and hampers their ability to support the patient. For these families, feelings of alienation from the hospital are increased because of their emotional responses to the illness, the nature of the mental illness and its treatment, and the families' strong desires to become a part of the treatment process. Their assumptions that they must be part of the solution if indeed they were part of the problem create turmoil when they are not included.

The families' experiences of alienation were discussed in this article as a way of understanding the responses of families to the psychiatric hospitalization of a relative. Assessment of families' needs and the development of family-oriented treatment units can be greatly facilitated by the consideration of factors that hamper assimilation, and that contribute to their feelings of powerlessness, isolation, and lack of meaning. We can

effectively address these concerns of families, if we are sensitive to their needs to understand the norms and values governing behaviour in the setting. It is ultimately a benefit to the patient to include the family in treatment if the family can share the treatment goals. If families can find relevance and meaning in the therapeutic approaches used and in the changes made by patients during hospitalization, they will then be better equipped to support the patient in the crucial post-hospital adjustment.

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