RESPONSE PATTERN OF THE FAMILIES OF THE MENTALLY ILL

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

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DENTON, TEXAS

DECEMBER 1985

ACKNOWLEDGEMENTS

I wish to acknowledge the support and encouragement of the many people who added meaning to this research project. I express my appreciation to Dr. Margaret T. Beard, for her inspiration and guidance, to my committee members, Dr. Anne Gudmundsen, Dr. Glen Jennings, Dr. David Marshall, and Dr. Virginia Smith, for their help through the project, to Dr. Patracia Mahon and Dr. Margie Johnson, for their advice during my studies, and to a special friend, Mrs. Jean Halbert for her consistent concerns. I wish to express special gratitude to my school, the National Defense Medical Center, for making it possible for me to pursue advanced study. I also wish to express appreciation to Dr. Jo Church and Mrs. Bobbye Gilbert for their assistance in the editing of this paper. And most importantly, thanks to my parents, my husband, and my children for the love, patience, support, and understanding that enabled me to complete this dissertation.

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December, 1985

ABSTRACT

Thirty Chinese adults, in Taiwan, Republic of China, were interviewed in the summer of 1985 for the purpose of exploring their experiences as relatives of mental patients. The concept of pre-crisis was selected as the framework. A descriptive qualitative research methodology and content analysis were used. The results revealed five different aspects in relatives' responses toward the occurrence of mental illness in their family members. The aspects were subjective and objective sufferings, blame and anger, grief versus hope, resentment versus confusion, and constructive suffering versus anger.

This study also indicates the importance of qualitative research in concept clarification. Based on the findings of this investigation, the concept of pre-crisis is defined as a state of thinking, feeling, and acting following the occurrence of a stressful event. The attributes include worry and anxiety, grief and depression, anger and frustration, strong teachable moment, and high probability of achieving a good health level.

With the information obtained from this study, several

potentially useful findings may be extrapolated. A clear understanding and a more accurate description of relatives' responses to the occurrence of mental illness in their family members are noted. By extending the current knowledge about relatives' needs and about their reactions to the mentally ill patients and the mental illness, mental health professionals may come closer to developing a more practical plan for serving these people, such as public awareness of the mental health/illness and the care of the mentally ill, promotion of advocacy for the relatives and the patients of the mentally ill, and organization of self-support groups made up of the patient's families.

The hypotheses generated from the findings of this study include: a) education concerning mental illness, including a knowledge of the disease and practical information about its management, to the relatives of the mentally ill reduces families' degree of worry, grief, and anger and b) self-support groups made up of the relatives of the mentally ill provide opportunities for sharing sufferings and methods of problem-solving with group members.

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CHAPTER 1

INTRODUCTION

During World War II a transformation in the mental health service system began. Deinstitutionalization of mentally ill patients was implemented and development of community service was strongly recommended. Patients were admitted to general hospital psychiatric units for short-term treatment and then returned to the community. As a result, the post hospital care of mentally ill patients and its impact upon the families become a major concern for psychiatric-mental health professionals such as psychiatrists, nurses, psychologists, and social workers. Studies of the relatives of the mentally ill patient become a trend for health care professionals during the late 1950's (Kreisman & Joy, 1974).

Even though there is no generally accepted definition of mental illness for all kinds of people, mental illness is a difficult experience for the patient as well as for the family. From the patient's point of view, mental illness has been described as "losing one's mind" and "aftermath" (Reid, 1979). The families of mentally ill patients have also suffered physically, psychologically, and socially because of their close relationship with the patients (Creer & Wing, 1974; Doll, 1976; Goldman, 1982; Grad & Sainsbury,

1963; Hatfield, 1978, 1979; Kint, 1978; Potasznik & Nelson, 1984; Reid, 1979; Raymond, Slaby, & Lieb, 1975). The burden placed on family members by mental illness and the mentally ill patients has been assessed. However, the family problems of coping with mental illness have been neglected and studies in conceptualizing, defining, and measuring the burden which the family bears have not developed (Kint, 1978; Reynold & Hoult, 1984).

Problem

Although the burden of the family of the mentally ill patient has been widely studied in the western countries, this author did not find many studies concerning family members' adaptation to the occurrence of mental illness in Chinese society. The problem of this study is stated as: What is the nature of the experience of having a family member diagnosed as mentally ill in Taiwan, Republic of China?

Background

One of the nurse's roles has been identified as assisting individuals whose activities and demands of daily living are actually or potentially out of balance with the resources available (Mitchell & Loustau, 1981). Traditionally, nurses have studied anatomy and physiology and the changes in structure and function of the human body

which occur in illness; nursing activities have focused on physically ill patients (Clarke, 1984). However, a change in roles has evolved because of the accumulation of knowledge. For example, the holistic approach of nursing care emphasizes that the intrapersonal (or physiological), interpersonal (or psychological), and extrapersonal (or sociocultural) factors all have impact on the individual's health. The total impact on the individual is much more than the sum of isolated impacts; the holistic approach can be viewed as a gestalt.

A human's health is a balance of the three dimensions: physical, psychological, and social aspects. Nursing care encompasses not only the individuals but also the group, family, and community that the individual is a part of. The holistic approach also includes the idea of prevention which translates into the fact that the nurse should deal not only with the patients who already have signs and symptoms of illness, but also with those who have disabilities after illness, and those who even have no signs nor symptoms except under certain conditions. Caplan (1964) identified the above mentioned ideas of prevention as primary prevention, secondary prevention, and tertiary prevention in the community mental health program. In a developed society, the idea of primary prevention is more emphasized

then secondary prevention and tertiary prevention in terms of reduction of cost and suffering.

There are many factors which have been thought to have bearing on the occurrence of mental illness such as heredity, biochemical factors, environmental pressures, and constitutional make-up. These factors make it more difficult to deal with the preventive aspects of mental health/illness. At present, medical science which treats mental illness has been well developed; chemotherapy is a great help in a patient's treatment; the so-called therapeutic environment also has been very helpful to the treatment and rehabilitation of the psychiatric patient. Nevertheless, when mental illness occurs, the patient is not the sole person who suffers; the family members who are under the immeasurable burden of his illness also experience suffering (Doll, 1976; Goldman, 1982; Grad & Sainsbury, 1963; Hatfield, 1978; Reid, 1979; Rose, 1959; Swingle, 1965). How to prevent burnout in the family is the concern of primary prevention. For only a healthy family can accept and deal with the patient to set the atmosphere for a healthier adjustment after being diagnosed as mentally ill.

According to a study which has been done by the Department of Psychiatry of the National Taiwan University Hospital, the instance of mental illness is about 30% in

Taiwan including a 1% diagnosis of schizophrenia; nonpsychotic diseases such as psychoneurosis, personality disorder, and mental retardation account for 15% of the diagnosis. In other words, with 18,000,000 people in Taiwan, there are about 55,000 people who have psychotic problems and about 250,000 people who have non-psychotic diseases (Huang, 1984). With such a large diagnosed population, the psychiatric professionals have an obligation to take care of mentally ill patients. The patients' families also have unavoidable responsibilities in caring for the patients because of the close relationship with the patients. Accordingly, the psychiatric professionals are obligated to support and help those people who have suffered indirectly because of the mental illness.

What kind of problems do the family of mentally ill patients experience? More basically, how do relatives feel when they are faced with the occurrence of mental illness in their family, and how do they respond to the event? According to Lazarus' (1981) paradigm of stress and coping, an individual's feelings and responses toward a stressful event can be described in cognitive responses, emotional responses, behavioral responses, and physiological responses. Therefore, the cognitive, emotional, behavioral, and physiological responses are the rudimentary concepts to

be identified in investigating the phenomenon in families' coping with the occurrence of mental illness in a family member.

Purpose

The purpose of this study is to generate theoretical constructs that explain human behavior in response to the occurrence of mental illness in the family and to provide baseline qualitative data concerning a relative's experience of having a family member diagnosed as mentally ill. This knowledge should be beneficial in helping and supporting family members to cope with the occurrence of mental illness in their relatives afterwards.

Significance

As a science, nursing needs specific knowledge to direct its practice. This knowledge should be able to describe, explain, predict, and control phenomena in the nursing field. In other words, theory is needed in nursing science, and construct/concept is the basic element for theory. The growing emphasis on primary prevention in community mental health programs demands that nursing continue to identify the constructs/concepts which describe the domain of potential harm to the mental health of individuals, groups, and communities.

The family has been considered as a basic social unit.

One member's illness has absolute impact on the other members and may bring about crises for the whole family system. The term "crisis" was defined by Caplan (1961) as follows:

> when a person faces an obstacle to an important life goal that is, for a time, insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made. (p. 18)

According to Brownell (1984), a generally agreed on definition of crisis is "a response state characterized by high levels of subjective discomfort with temporary inability on the part of the person to modify the stress of the environment." In brief, an individual in crisis is viewed as living in a state of disequilibrium (Aguilera & Messick, 1974). However, as a living system, man's equilibrium in its bio-physiological, psychological, and sociocultural systems is constantly maintained even though it fluctuates sometimes in the health-illness continuum. The complete idea of primary prevention should start with pre-crisis and focus on the instability of the living

system. Exploration of pre-crisis will identify individuals who are in need of better coping skills to avoid a crisis and to reach a higher level of health.

Some studies (Barzilay, 1984a; Brownell, 1984;) have considered pre-crisis. Yet there remains a paucity of knowledge and understanding of the phenomenon. A need for an in-depth understanding of pre-crisis is underscored by recommendations that interdisciplinary research be undertaken to generate data which will better clarify the concept. Since no specific theory currently exists which illuminates the concept of pre-crisis clearly, it appears appropriate to conduct an inductive investigation to generate qualitative data which may contribute to the development of theoretical knowledge.

Nature of Study

A descriptive qualitative research method was utilized for this study. The qualitative research approach involves the generation of empirical indicators in the natural environment through detailed descriptions of the individual's beliefs, attitudes, and behaviors. Such an approach offers an open, nonprescriptive method to the study of the phenomenon of pre-crisis in the mentally ill patient's family.

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Conceptual Framework

The term "crisis" has been defined by Lindemann (1944), Erikson (1959), Caplan (1961), and Aguilera & Messick (1974). These definitions occur in the professional literature. Lindemann (1944) developed an early definition of crisis from observation of bereavement in persons experiencing the loss of relatives or friends in Boston's Coconut Grove Fire. Strong similarities in individual responses to this loss were noted. Lindemann hypothesized that numerous threatening situations might arise in a person's life and that the person either adapts to the situation or fails to adapt and has impaired functioning. Lindemann and Caplan developed the basis of crisis intervention framework in the 1940's. Utilizing a systematic approach, Caplan theorized that a crisis was a disturbance of the steady state or homeostasis. Perhaps, Caplan's concept of homeostasis should be extended to include such dynamic aspects of human behavior as growth, development, and change. The idea of homeostasis leaves little room for discussion of important psychological processes related to crisis, namely emotion, perception, and learning.

Erikson in his psychological theory of development expanded the notion of crisis to include maturational

events, beginning with the normative identity crisis of adolescence. The theory proposes several periods of life when successful adaptation is critical for future psychological adjustment. Rapoport (1965) suggested that specific tasks arise during the critical periods and that their completion is necessary for movement to the next developmental stage. The crisis is a catalyst that disturbs old habits, evokes new responses, and becomes a major factor in charting new developments. Rapoport (1965) emphasized the potential for a strengthened adaptive capacity and improved level of mental health. Aguilera and Messick (1974) similarly focus on the "turning point" aspect of a crisis. They differentiate more explicitly than Rapoport the situational and maturational types of crises based on the work of Erikson and Caplan. These definitions continue to incorporate the reactive and adaptive concept of man, although attempts are clearly made to incorporate the notions of growth and development by describing maturational or normative crisis.

A commonality emerges in these loose definitions of crisis from the fields of psychiatry, mental health nursing, sociology, and psychology. Each focuses on crisis as a turning point, a crucial aspect of a person's life that will influence future capacity to cope with problems. However,

clinicians, researchers, and theorists tend to define crisis inconsistently by describing, first, the stressful event that occurs prior to the onset of the crisis state; second, the perception of the event; or third, the responses to the event (cognitive, perceptual, and behavioral factor). Although these areas are related conceptually, many theorists believe that the actual concept of crisis refers to the state of the reacting individual in a hazardous situation (Aguilera & Messick, 1974; Caplan, 1961; Lindemann, 1944; Rapoport, 1965).

The concept of crisis is vague because it includes almost any developmental event or any unexpected situational event such as problems, threats, losses, and challenges. The concept is even more elusive when the state of mind produced by the event is considered. The person's state of mind, including perceptions and cognitions, is a critical component of the crisis concept, and information relative to perceptions and cognitions is necessary to define the concept. Perhaps it is the subjectivity of such information that leads to an imprecise definition of the term. Often, personal feelings and cognitions are inferred through behavioral observation. To a limited extent, these inferences become an acceptable method of determining whether a crisis state exists (Brownell, 1984).

In order to be applicable in a theoretical framework, the concept of crisis requires further clarification. Caplan defines crisis by outlining the stages through which an individual passes in response to some traumatic event rather than defining the term. There are four stages in the process: a) tension increases from exposure to a threatening stimulus that calls on the person's habitual problem-solving capacities; b) there is a further increase in tension as the usual problem-solving mechanisms fail and the stressful stimulus remains; c) a third rise in tension becomes an internal stimulus to use all possible resources to reach a resolution. At this point, the problem may be redefined, certain aspects of it neglected, or new problem-solving techniques called into play; and d) if the problem is not resolved in stage 3 and cannot be avoided, the tension mounts beyond a further threshold or its burden increases to a breaking point. Major disorganization of the individual with drastic results often occurs. The process approach makes it more difficult to define crisis as serious disorganization or as the sequence of events that leads to disorganization, or to understand how a person has reached the state of disorganization.

The focal point of the crisis theory is the highly stressful event (or threatening stimulus). No single event

is stressful to every person; a crisis occurs when an event surpasses some level of stress. When such a dramatic situation occurs, extreme tension results because the person has not learned effective ways to cope. In brief, there are shortcomings in the crisis concept: a) it refers variously to the precipitating event, the process of reacting to the event, or the end phase of major emotional disorganization, b) it is not defined except as an event for which crisis intervention is prescribed, and c) the categories proposed to define crises (situational or developmental crisis) define the precipitant rather than the estimated state (Brownell, 1984).

Conceptualization of Pre-crisis

A crisis may be viewed as existing on a continuum (Brownell, 1984) (see Figure 1). The potential for a crisis state exists within every human by virtue of living and experiencing life. The potential crisis state represents the one end of the continuum and possesses no distinct characteristics. In the pre-crisis state, exposure to a stressful event has occurred and is accompanied by perception of the event as highly stressful. The behavioral manifestations of this stage depend on the nature of the event and the person's usual response to stress. Beyond the pre-crisis state, the crisis continuum is adapted from

Caplan's state, through which an individual progresses to major disorganization. However, if at least one of the four factors occurs, a) poor history of handling stress, b) lacking in coping abilities, c) inadequate support, and d) high probability of exposure to stressful event, then, there is the occurrence of the pre-crisis state (Brownell, 1984).

Potential crisis state	Pre-crisis	Crisis
Potential exists for all.	Person who 1) has exposure to stressful event. 2) perceives current situation as very stressful. 3) has inadequate situational supports. 4) has poor history of handling stress.	Person who 1) has tension increased from exposure to stressful event that calls on the person's habitual problem-solving capacities. 2) has failed to resolve problems. 3) has continued to draw on inner resources. 4) has failed at all attempts to solve problems. 5) believes that all resources have been used and lacks relief of stress.

Figure 1. Crisis continuum: A scheme for conceptualizing pre-crisis and crisis.

Adapted from: Brownell (1984), p. 17.

Utilizing primary prevention in a community mental health program, health care professionals work on either the potential crisis or the pre-crisis state. Working on the pre-crisis or potential crisis state has more positive meaning than working on the crisis state, even though crisis intervention has been thought of as a technique of primary prevention. Barzilay (1984b) developed a paradigm for nursing intervention for the family in pre-crisis. Its original roots appear in Aguilera and Messick's (1974) paradigm for crisis intervenion.

Barzilay's (1984b) paradigm (see Figure 2) involves factors which are either helpful toward a healthful resolution of the pre-crisis or hindering a healthful resolution of pre-crisis. The paradigm consists of a perception of the event, situational support, and development of coping mechanisms. The schematic model of Barzilay's paradigm is a structural representation of the relationship among the various results of pre-crisis.

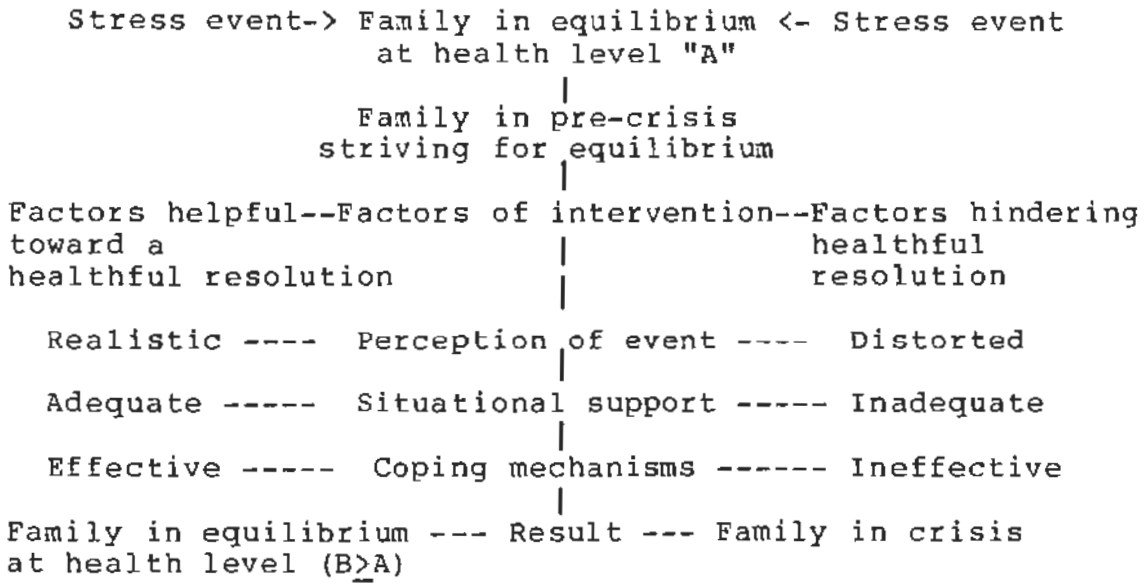

Figure 2. Paradigm for nursing intervention in the family in pre-crisis.

Adapted from: Barzilay (1984b), p. 51.

Definition of Terms

Pre-crisis is a process as well as a phenomenon. The pre-crisis is characterized by the actual reactions to a stressful event (Barzilay, 1984b). The stressful event (or stressor) is a stimulus which is perceived by the individual as requiring an adaptive response (Clarke, 1984). The demands can be of several types, physiological, psychological, or social, but basically each represents a change in balance between the demands and the sources of dealing with it. Stressors, or stimuli that produce stress, are different in quality and intensity for each individual,

and they may act together to augment, intensify, or reduce the total effects. Stress threshold and tolerance levels differ with each person and are determined partially by genetic and constitutional make up, past experience, self-concept, and other factors (Clarke, 1984; Scott, Oberst, & Dropkin, 1980). Stress is important in health because it serves two functions. On the one hand, it has the potential of impairing human functions; on the other hand, it is instrumental in learning about and improving the individual's coping ability. Certainly, the time duration of stress, severity of stressor, and vulnerability of the individual are critical factors (Clarke & Driever, 1983; Siomopoulos & Crawford, 1983).

Coping is a process with goal directed strategies which link the stressor impact with adaptation. Ultimately, coping brings about adaptation and growth--the maintenance of integrity. There are two elements of coping, problem solving and emotional regulating, but the total coping response is comprised of cognitive responses, emotional responses, behavioral responses, and physiological responses in interaction (Brownell, 1984; Lazarus, 1981; Scott, Oberst, & Dropkin, 1980).

Cognitive response is the primary appraisal of the stress situation. It is mainly the brain's work. Stressors

are differentiated as irrelevant, benign, or stressful. If the stimuli are appraised as stressful, further differentiation occurs and includes: a) harm or loss, injury or damage already done, b) threat, anticipated trauma has not yet occurred, assuming a hostile environment with the self as lacking in resources to master it, or c) challenge, an opportunity for growth, mastery, or gain, assuming the demands are difficult but not impossible to manage by using existing or acquirable skills.

The cognitive phases of the primary appraisal determine the intensity and quality of emotional responses to the stressor. Because affect and cognition are closely related, different emotions are initiated by cognitive processes. Current understanding of emotions includes: a) an emotion occurs as a consequence of the person's evaluation of the environment, b) an emotion is a feeling state with physiological parameters such as a change in hormone level, c) an emotion is experienced initially in global form and later refined into specific basic emotions, and d) emotions may be classified according to type, duration, and intensity. Emotion of too long duration becomes mood and attitude (Scott, Oberst, & Dropkin, 1980).

Following the cognitive evaluation of a stressor, a person determines the degree of threat and the resources

available to meet the demand and a fluctuation in general anxiety takes place; then, a refinement of the energy into one or more specific emotion takes place. The resultant response is a translation of the emotion into a behavior. Therefore, emotional response will be considered as an intervening variable having a powerful and direct effect on behavioral responses.

The physiological response involves a) hormonal stimulation, b) sympathetic activation, and c) end-organ response. All of these are interrelated and interdependent. According to Selye (1956), psychological events may elicit pituitary-adrenal cortical responses, and in his GAS (general adaptive syndrome), he lists a sequence of three stages: a) the stage of alarm reaction--adrenocortical hormone secreted to the blood stream, b) the state of resistance--secretion of ACTH by the pituitary stimulates the adrenal cortex to produce more corticoids, and c) the stage of exhaustion--excessive or insufficient production of corticoids damage the end organ such as the heart and the kidney. The GAS is the same general response regardless of the nature of the stressor, and the adaptive hormones are analogous to brain neurotransmitters in mediating physiological changes of GAS and psychological responses to various psychological stressor. The physiological responses

enable the individual to face the stressor. Adaptation is a "state of fit" resulting from an individual's adequate and appropriate responses to challenges in person-environment transaction.

Assumptions

1. A human's health is a harmonic interplay of physiological, psychological, and social-cultural components.

2. A person's illness influences the homeostasis of the entire family.

3. Having a family member being diagnosed as mentally ill can constitute a pre-crisis state.

4. Pre-crisis occurs in generally healthy people and is not equated with psychopathology.

5. Pre-crisis is time limited.

6. Pre-crisis contains a potential for psychological growth or psychological crisis.

7. The seriousness of stress events is found in the individual's experience rather the magnitude of the event itself.

Provisional Criteria for the Concept of Pre-crisis

1. Anxiety and worry

Anxiety is the ego reaction to the threat of loss, either of objects or of satisfaction of integrity. Two

stages of anxiety can be differentiated quantitatively. First, "signal anxiety" (or a small amount of anxiety) is a primitive biological mechanism. The signal has not only psychological implications, but also physical manifestation in putting the body rapidly into a state of readiness. The heart rate changes, the body vessels on the skin constrict, and those in the muscle enlarge, the sugar in the blood goes up, et cetera, and the body is mobilized to deal with danger (Caplan, 1961. p. 44). This is the same as the alarm stage at Selye's general adaptive syndrome.

If the threat is not relieved, if the danger continues or increases, and if there is no adaptation or adjustment by coping, the anxiety increases and reaches the level of "actual anxiety" which becomes a burden instead of a call to action. On the other hand, actual anxiety elicits a new level of ego reaction, namely the reaction of regression and disintegration. Instead of being a stimulus to fight or to flight or to adjust in an active way, after anxiety passes a certain threshold, it becomes a force that squashes the ego into a regressed state of increasing use of fantasy and magic and irrational methods, and then eventually disintegration and alienation, leaving behind a neurosis, a psychosomatic illness, or a psychosis.

The worry process is the work of internal adjustment

stimulated by signal anxiety. Worry is important when an individual faces a difficulty because it stimulates individuals to do the necessary work of adjustment and adaptation. As long as it is within a controlled range even the anticipatory worry is quite useful because it releases the future burden.

The success of worry work is influenced by three factors operating in the current situation of the threat and of the attempts to grapple with it: a) the state of the external reality threat, b) the type and degree of environmental support, and c) the ego strength which includes physical health, constitutional toughness, and a repertoire of coping responses plus the ability to withstand frustration. The outcome of worry work is a result of the interaction of all these different factors (Caplan, 1961. p. 46).

2. Depression and grief

Depression is another ego reaction to actual loss, either of objects or of individual integrity. Like anxiety, there are two levels: First, signal depression which stimulates the ego to do grief work and to adjust and adapt to the loss; second, the actual depression. If the grief work is not satisfactory and the sense of loss continues, then the depression becomes an ego burden and leads to

ego-weakening, to regression, to disintegration, and to alienation.

As with worry work, grief work is interfered with by previously unsolved problems, especially those relating to the conflict of love and hate in relation to a love-object. If the love-object is a person, the solution of this conflict is a very essential part of the development of one's feelings in relationships with other people.

Anticipatory grieving can exist in the same way as anticipatory worrying, and to some extent its influence is positive by lightening the subsequent load of the impending loss. But at times, it leads to difficulty if the anticipated loss does not occur. Healthy grieving lasts from about 4 to 6 weeks and it possesses certain characteristic signs and symptoms such as insomnia, loss of interest in the surroundings, loss of appetite, constipation, a painful feeling of emptiness, weeping, sighing, and preoccupation with the loss. In contrast, the unhealthy grieving is demonstrated by false happiness or a simple denial. This leads almost inevitably to disorder such as psychosomatic illness (Caplan, 1961. p. 60).

3. Anger and frustration

When the occurrence of the stress event is perceived as blocking important life goals, the individual responds to

such perception with anger and frustration. The ego responses or psychological operations which occur here are hostility work, which may be directed toward oneself or toward one's surroundings. Disorganized behaviors may become apparent in aggressiveness either toward one's self, such as self-destructive behavior or isolating one's self, or toward others and one's normal environment.

4. Strong teachable moment

Even though the syndromes of worry, grief, and hostility exist in the pre-crisis period, it is not necessary to view the pre-crisis as a failure in the achievement of the desired goal, but it can be seen as a period during which the individual becomes aware of the new coping mechanisms which are required; old patterns may be ineffective in the present situation. After realizing the intense change in his/her life situation, an individual seeks information, new abilities, and new skills. At such times, this individual may be easily influenced, learning takes place quickly. Therefore, this is the "teachable moment."

5 High probability of achieving a good health level

During the teachable moment, the individual will usually ask for help from those resources available and acceptable in the community, such as teachers, clergies,

physicians, or nurses. These are the first agents to whom the individual usually turns or who reach out to the individual in the pre-crisis (Caplan, 1964). Therefore, short-term and uncomplicated intervention may be very effective. The individual can then end the pre-crisis having acquired equilibrium at a new and higher health level.

Antecedents and Consequences

The antecedents to pre-crisis include: First, the individual's current perception of the seriousness of the stressful event. It also explains why few stimuli reliably cause strain in all individuals and why an identical stimulus may have a different effect on the same individual on different occasions. Second, the perceived individual's capabilities for coping are that individual's characteristics and potential behaviors. The consequences of pre-crisis are that it motivates and mobilizes an individual to acquire a new coping mechanism and finally to either reach a higher health level or to become a crisis case.

Relationships between Variables

1. Stressful event (SE) = f[Physiological demands (PH) + Psychological demands (PS) + Sociocultural demands (SC)]. The higher the sum of demand, the higher the severity of the

stress event.

2. Coping process (CP) = f[Cognitive response (RC) & Emotional responses (RE) & Behavioral responses (RB) & Physiological responses (RPH)]. There are reciprocal relationships among RC, RE, RB, and RPH. The sum of Ri and the result of the interaction of Ri lead to individual's adaptation or individual's vulnerability which leads to pre-crisis. A positive coping process links the stress impact with adaptation.

3. Individual's strength (S) = f(Ego strength or personality + stage of family life cycle + individual's expectation + previous experiences + individual's value + cultural norm + others).

4. Vulnerability (V) = f(Individual's stress threshold + stressful event). According to Clarke and Driever (1983), an individual's stress threshold can be evaluated by the perceived personal capabilities, the individual's characteristics and his/her potential behavior; the stressful event can be evaluated by the environmental situation and stressful characteristics.

An overall relationship among the variables can be shown by the following:

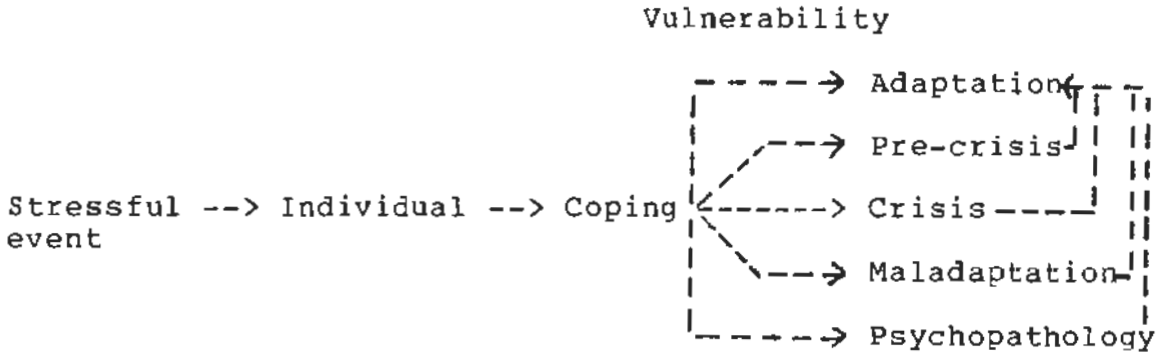

Figure 3. Paradigm: effect of vulnerability in a stressful event.

Scope and Limitation

The scope of this study is delineated by the ability of the subjects to describe their experiences in dealing with the occurrence of the mental illness of their relatives and the ability of the researcher to extract the meaning of the subject's responses toward the occurrence of mental illness in the family. A limitation of the study is the fact that pre-crisis, which is by nature an abstract concept, cannot be directly measured.

Summary

The concept of pre-crisis has been identified as an important variable in community mental health nursing. Five critical attributes of pre-crisis are anxiety and worry, depression and grief, anger and frustration, teachable moment, and high probability of achieving a good health level. The research problem includes family's cognitive,

emotional, behavioral, and physiological responses toward the relative's mental illness. Assumptions and definition of terms for this study have been identified.

CHAPTER 2

REVIEW OF LITERATURE

The problem of mental illness has existed as long as human history. The suffering of the mentally ill patient's family is unquestionable. The review of literature has two major parts. The first deals with the mentally ill patients and their families and the second deals with Chinese families and their attitudes toward mental illness.

Mentally Ill Patients and Their Families

Family burden resulting from mental illness was noted when Sullivan (1927) first suggested links between schizophrenic behavior and family interaction. Since World War II, the length of a patient's stay in the mental hospital has decreased steadily with the thrust of deinstitutionalization promoting community care of mentally ill patients. Moreover, in recent years, clinicians have emphasized the need to incorporate family members into the treatment process if the progress made in therapy sessions or in therapeutic environments is to be maintained in the daily life of the patient (Arey & Warheit, 1980). The family is becoming more involved in the long-term interaction with and for the care of the "former" patient, whether the patient returns to the family home on discharge or moves to sheltered living.

From the onset, the theoretical interest of researchers was in deviance and social control, social perception, and the origin or outcome of the mental illness (Clausen & Yarrow, 1955a, 1955b, 1955c; Goffman, 1963; Grad & Sainsbury, 1963; Mayo, Havelock, & Simpson, 1971). Soon after, the practical needs of hospital psychiatry to assess the effects of the innovative programs of community care for mentally ill patients turned the attention of researchers to the families of patients as agents of rehabilitation and bearers of the burden (Anderson & Meisel, 1976; Arey & Warheit, 1980; Creer & Wing, 1974; Doll, 1976). The most recent studies (Christ, 1984; Hatfield, 1979, 1981; Potasznik & Nelson, 1984; Reiter & Plotkin, 1985; Reynold & Hoult, 1984) focus on a growing need for advocacy for mental patients and their families, public education and awareness, and the development of community support systems.

Although the role of the family in the etiology of mental disorder is still uncertain (Arey & Warheit, 1980; Creer & Wing, 1975; Kint, 1978; Mosher & Gunderson, 1973), family members who have a psychiatric disorder can and frequently do have profound effects on other family members. The ambiguous nature of mental disorder and the consequent episodic eruptions of deviant behavior require a) an adjustment in the family that is itself stressful--an

adjustment that includes definition along with help to accept the responsibility for the continuing care of the patient, and b) family roles must shift to accommodate the behavior or deficiencies of the sick member; the strain of this accommodation is often chronic (Kreisman & Joy, 1974; Potasznik & Nelson, 1984).

In the early 1970's, researchers changed their perspectives to incorporate a view of the family as a reactor to the mental illness of a member instead of viewing the family as purely a causal agent. This change is important for its own sake because a) it permits the specification of the kind of adaptation that occurs when a functioning family interacts over time with a mentally ill patient for whom it feels and is considered responsible, b) it permits a fuller description of the system in which the patient operates, to which the mentally ill person may return, and which will be a critical factor in determining the patient's prognosis (Arey & Warheit, 1980), and c) it may help clarify issues of causality by isolating the part of the family's reaction to the patient that is operative in the family's current interactional pattern. The inclusion of the patient's family system as a respondent as well as stimulus has immeasurably broadened the conception and has permitted an important first step to be taken toward the

development of a true interactional approach (Kreisman & Joy, 1974). However, after an exclusive review of the literature, Kreisman and Joy (1974) concluded that the burden placed on family members by a patient's mental illness had been poorly assessed and that, as a consequence, the mental health community was not meeting the needs of these families. Since then, the role that relatives play and the burden that they carry have been increasely acknowledged, but it appears that their needs are still often not met (Hatfield, 1981; Potasznik & Nelson, 1984). Furthermore, despite the increased emphasis on psychiatric treatment in the community, family problems of coping with mental illness have been neglected and studies in conceptualizing, defining, and measuring the burden which the family bears have advanced little (Kint, 1978; Reynold & Hoult, 1984).

According to Kreisman and Joy (1974), the pioneer research that dealt specifically with the problems and attitudes of the families of mentally ill patients was done by Clausen and Yarrow in 1955. Their results showed that the consequence of having a family member being diagnosed as mental ill were costly to the wives and children of the patients and also to their extended families (Clausen & Yarrow, 1955a, 1955b, 1955c; Calusen, Yarrow, Deasy, &

Schwartz, 1955). The findings of Clausen and Yarrow reflected mainly the natural history of the wife's reaction to her husband's deviant behavior. Psychological explanations of deviant behavior were rarely invoked by the family during the early stages of mental illness. The most frequently given explanations tended to be those attributing the behavior to character weakness, physical ailments, or situational factors. For instance, only 24 percent of the mainly middle-class wives in Yarrow, Clausen and Rabbins' (1955) study felt something was seriously wrong when their husband first displayed overt symptoms. When such interpretations were made, anger was occasionally used as a means of social control in an attempt to bring the husband's behavior into line. By the time successive redefinitions had taken place and hospitalization was imminent, slightly less than one-third of the total sample of the wives of neurotic and psychotic patients and one-fifth of the wives of psychotic patients still denied that their husbands were mentally ill.

Similarly, in an interview done approximately three weeks after a family member's hospitalization, 18 percent of Lewis and Zeichner's (1960) sample of the 109 families of first admissions patients denied the patients' mental illness. In 40 percent of the cases, the illness was first

recognized by a physician or someone outside the family. Mayo, Havelock, and Simpson (1971) reported that 19 nonpsychotic men in a mental hospital and their wives tended to accept a physical view of the husband's illness and that this general disbelief in the psychological determinants of the patient's state was at variance with the mental health professionals' view of the nature of the illness.

Research discloses that the closer the relationship to the patient, the greater the perceived threat and anxiety of the family resulting from a psychological definition of mental illness. When variables such as social class, age, and educational level were controlled, studies (Goffman, 1963; Schwartz, 1957) revealed that the closeness of the family relationship resulted in delay or in outright denial; the closer the tie of the relatives, the less ready the family was to perceive mental illness. Distance appears to facilitate a diagnosis of psychological disturbance. Sakamoto (1969) speculated that a particular type of closeness, the symbiotic tie between parent and child, functioned to impede early parental recognition of a child's schizophrenia. However, both the type of symptom and aspects of the patient-family relationship have also been shown to be related to the recognition of mental illness.

When hospitalization occurs, most families have come to

believe that the individual member is mentally ill. The possible consequence of such a belief can be theoretically represented by a wide range of affective and behavioral responses. On the one hand, families could show increased support and tolerance for their ill member and, because of their concern, be more aware ties of affection. On the other hand, quite different responses may occur. When the patient's symptoms are unpredictable or bizarre, the family may become fearful. Anger may occur because of patient's disruptiveness, or because of family's resentment due to increased strain (Schwartz, 1956). In some instances, the occurrence of mental illness arouses guilt, or when the illness is evaluated in moral terms, attitudes of shame and rejection might be expected (Kreisman & Joy, 1974; Potasznik & Nelson, 1984; Raymond, Slaby, & Lieb, 1975).

Despite the wide range of possible responses to deviance in the family, professional interest seems to have concentrated on the negative responses to the patient and particularly on the issue of stigma, with the consequence that shame and social rejection have been among the most studied aspects of family attitudes and behaviors. Such a limited focus is probably the result of two factors: a) a realization by the family of the negative opinions that the general public holds (Rabkin, 1972), and b) the commonly

held assumption shared by many mental health professionals that mental illness is indeed shameful (Creer & Wing, 1975; Hatfield, 1979; Kreisman & Joy, 1974). According to Goffman's (1963) essays on stigma, the assignment of stigma or nonhuman quality to the mentally ill patient permits the environment to discriminate against the patient and encourages those who interact with him to behave as if the stigma were the essence of the patient. The inevitable outcome of this process is generally believed to be rejection of the patient.

However, the more intimate the relationship between the stigmatized and the other, the less the stigma is attached to the person; thus, closeness permits one to see qualities other than the flaw. But association with a stigmatized person brings with it its own dilemma. Since a close relationship results in being "tainted" oneself, a relative can choose either to embrace the fate of the stigmatized person and identify with him or to reject sharing the discredit of the stigmatized person by avoiding or terminating the relationship. There is no clear conclusion about the relationship between the stigmatization and closeness with the patient.

The family's affective response is generally assessed either through direct questioning or by the use of a

semistructural interview that maximizes the probability of the occurrence of affective responses. Occasionally, the affect is inferred from behavioral measures too, such as in the case of shame in which withdrawal from friends or the concealment of the patient's illness is considered sufficient to justify the inference.

Yarrow, Clausen, and Rabbins' (1955) study revealed that the sample family behaved as if they were minority-group members and characteristically showed feelings of being underprivileged, of marginality, of extreme sensitivity, and of self-hatred. One-third of the wives demonstrated a pattern of aggressive concealment; friends were dropped or avoided, and occasionally respondents moved to a different part of town. Another third of the wives had a few favored people to whom they talked--people who would understand the problem or who had been in a similar plight. The remaining third of the wives could be described as communicating extensively and as expressing few fears of dire social consequences.

Fear of the patient was reported by Waters and Northover (1955), who interviewed the wives of long-term schizophrenic patients two to five years after discharge. Wives were often found to be frightened of their husbands and experienced long periods of tension in the home.

Schwartz (1956) reported a considerable amount of anger and resentment on the part of husband and wives toward their mentally disordered spouses prior to hospitalization.

Despite the anticipations of common sense, the general trend is for families to report little fear, shame, and anger or guilt. For instance, according to Lewis and Zeichner's (1960) report, 50 percent of the sample expressed a sympathetic understanding of the patient; only 17 percent expressed hostility or fear, and the remainder were either ambivalent or puzzled at their relatives' illness. In Rose's (1959) study, relatively little stigma and shame were evident in the feelings of family members.

Theoretically, feelings of shame and stigma should particularly be aroused in situations in which a public display of deviance makes the label obvious to others. When unusual behavior is not evident, then it is less likely that shame will be a salient aspect of the attitude toward the patient. For instance, when families worry little about embarrassing behaviors or behaviors that cause trouble to the neighbors, as in Grad and Sainsbury's (1963) study, one might think that symptoms are neither bizarre nor easily noticeable. In that case little shame would be expected.

According to Grad and Sainsbury (1963), among the surveyed family, nearly two-thirds of all the families had

experienced some hardship because there was an ill person at home. In a fifth of the families the burden was severe; more than half of the surveyed subjects felt excessive anxiety due to worry about the patient. A fifth of them attributed neurotic symptoms (insomnia, headache, excessive irritability, and depression) to their concern about the patient's behavior. The social and leisure activities of a third of the families had been restricted; nearly a third had had their domestic routine upset (housekeeping, shopping, and so on), and about a quarter had had their income reduced by at least 10 percent. In a quarter of the families someone had to stay away from work. In more than a third, the children were disturbed.

The aspect of the patient's behavior which families found most troublesome was constant harping on bodily complaints. Second, was the family's fear that the patient might harm himself--commit suicide or have an accident. Equally upsetting was the patient who made excessive demands. Nearly a third of the patients needed nursing care or supervision at home; half of these needed constant attention and could seldom be left alone. Dangerous and socially embarrassing behavior, and behavior conspicuous enough to provoke comment from neighbors were the items mentioned least often (Grad & Sainsbury, 1963).

Almost fifteen years later, Hatfield (1979) had similar findings. Families were asked to identify behaviors of their patients most difficult to live with. Most frequently reported were gross failures in task functioning: failure to take care of personal needs, inability to handle money, and failure to plan for the future. Second, the families reported disturbances at the intrusion of strange personal habits into family life: unusual eating and sleeping habits, argumentativeness, and negligence and destruction in the use of things in the home. Families were frequently kept on edge by manifestations of bizarre psychiatric symptoms: paranoia, voices, talking to themselves. Suicide threats were frequent. Ability to cope with these behaviors was complicated by their quixotic nature, keeping families constantly on guard. The families spoke of bewilderment about patient's lack of motivation; they were unable to tell if this was part of the illness or an unnecessary "cop out."

Living with these behavior on a daily basis had a profound effect on family members. The management of the illness caused discord; spouses often disagreed and blamed each other. Often a single family member bore the total burden. There was concern for the neglect of other children and for sharply curtailed social life. Time for personal life was nearly nonexistent. Emotional responses such as

chronic stress, anxiety, grief, depression, and unexpressed resentment, were high (Hatfield, 1979).

Phillips (1963) and Scheff (1963) both believe that symptoms of mental illness are not easily identifiable by the lay public and that other cues are therefore necessary to define the behavior as mental illness. One such cue is the source of help that is sought to deal with the problem. They found that the rejection score was less when no help source was mentioned, and the hightest score was found when the mental hospital was mentioned as the help source. Overall, respondents with family members who had been mentally ill were less critical than those who had a friend or knew no one with emotional problems. Swanson and Spitzer's (1970) study also indicated that the significant others were less critical of the mentally ill than the patients themselves; they were also considerably more stable in attitude from phase to phase. This tolerance was unaffected by age, sex, social class, or diagnosis of the patient. Swanson and Spitzer (1970) concluded that the family had embraced the patient's fate rather than the alternatives of avoiding or terminating the existing relationship.

However, in Swingle's (1965) study concerning the acceptance of the discharged patient, relatives expected

approximately 50 percent of all mental patients to be incapable of returning home after treatment. Nonrelatives expected fewer patients (40%) to be unable to return home. Swingle also reported trends that relatives believe that more patients would remain patients and few number of patients would be able to conduct themselves properly in town on a 1-day pass. In other words, relatives and nonrelatives did not differ in their perception of the friendliness or violence of mental patients.

There is no clear-cut conclusion about whether the rejection of patients derived logically from either a consideration of stigma or from the practical realities of life. In Grad and Sainsbury's (1963) study, for instance, 81 percent of the rejecting and negative relatives had realistic problems, whereas only 62 percent of the "accepting" group were rated as having such problems. In any case, when the family ceased to interact with the patient because they believed that the patient's condition was irreversible or when discharge plans were met with theoretical approval but actual reluctance, then one had to speculate that the issue of the cost and burden to the family of maintaining ties with the mentally ill patient such as living arrangement of the patient and the needs for community mental care played an important role (Goldman,

1982).

Recent studies (Christ, 1984; Lurie, 1982) did show that the mentally ill patient's discharge was likely to be delayed by lack of outside living arrangement, unavailability of needed resources, regression in the patient's condition, and financial assistance to pay for ongoing medical or psychological support services. The major problems for family members were finding effective treatment for and worry about their patients (Kint, 1978). The needs of families included understanding of the illness, practical guidance in patient management and community resources (Hatfield, 1979).

Chinese Families and Their Attitudes toward Mental Illness

A paucity of studies exist regarding the Chinese' responses toward mental illness and the mentally ill person. However, sociocultural factors have had an intensive effect on the field of psychiatry (Lin, Kreinman, & Lin, 1981). Chinese families are unique in regard to relatives' attitude toward mental illness. On the one hand, Chinese culture has characteristics which are different from the Occidental culture, such as pragmatism and intrafamilial hierarchy. These factors influence the family's choice of treatment for the mental illness (Lin, 1981). On the other hand, Chinese have various views of mental illness and its etiology. The

concern of the Chinese family for conformity in the conduct of its individual members is deep-rooted in Confucian ethics and even further in ancient history (Metzger, 1981). Mental illness, with the attendant irrational behavior, arouses a family's responses of tender loving care combined with attempts at correction. The multifaceted Chinese view of the etiology of mental illness includes moral, religious or cosmological, physiological, psycological, social, and genetic factors (Lin & Lin, 1981). The weight of each component varies from one individual to the other. Even for the same individual the weight may vary over time, depending on changing circumstances. In most Chinese families living in contemporary society, the various components usually coexist because of the mixed composition of the inclusive family system. Each family member holds individual view emphasizing one or two facets of the etiological factors.

The moral view, a commonly held etiology of mental illness, emphasizes "misconduct" as a cause of mental illness, deviation from socially prescribed behavior especially in neglecting the respect due to ancestors. Mental illness is regarded as a punishment for violating Confucian norms governing interpersonal relations, especially filial piety. The Chinese family used to lecture to or exhort the mentally ill person by drawing upon

Confucian teaching about the virtue of good conduct in the hope of correcting the mentally ill person's misbehavior. Often, community leaders or teachers are called in to help the head of the family in preaching about proper conduct to the individual. The indigenous view is that, like other forms of immoral behavior, mental illness necessitates "correct" thinking and therefore requires "rectification" of personal errors.

The intensity of such exhortation is related to the degree of shame held by the family for their failure to control the behavior of their individual members. One effect of this preaching is that the patient is made to feel guilty about his/her own conduct, a factor which sometimes further complicates his/her problem.

The religious or cosmological view regards mental illness as the wrath, incurred by the patient or his/her family member, of gods and ancestors in either present or former lives. Then, the belief of reincarnation and supernatural spirit play an important part in the Chinese view of the etiology of mental and other illness. Prayers and offerings at temple and calling priests to perform religious rituals for curing mental patient are common practices of Chinese families (Lin, 1981; Tseng, 1972).

Physiological or medical theory plays an important role

in the Chinese view of both etiology and treatment of mental illness. However, this view has its roots in the Yin and Yang theory, a theory of homeostasis. All illness is caused by an imbalance of nature's opposing yin and yang forces. Excess or deficiency of physiological functions, such as breathing, eating, bowel movement, sexual activities, physical exercise or exhaustion, can upset the yin-yang balance, thus leading to mental illness or rendering the person susceptible to forces that give rise to mental illness. Remedies are sought by the family, often in consultation with traditional herb doctors, for restoring the balance of yin and yang in the patient. This usually includes herbs and a special diet. Such popular medical treatment seems to offer a high degree of psychological relief to the family from shame or guilt over the patient's condition, perhaps because the negatively valued personal or family responsibility for the disorder has been replaced by a sanctioned impersonal organic etiology (Lin & Lin, 1981).

The Chinese share views similar to the Westerns regarding the importance of psychological factors in the etiology of mental illness, such as failure in love affairs, finance and career, death and mourning, loss of face through public humiliation or failure in examination, and family break-up. But the Chinese seem to give more weight to the

breakdown of the family relationship as a specific psychogenic factor than do other cultures (Lin, 1981).

Finally, there is not only a popular biological belief in genetic transmission, but also belief in the inheritance of the "disturbance" by virtue of parental/ancestor's "misconduct" that serves as a nucleus for future problems. This set of beliefs underlies the traditional marriage prohibition for those suffering mental illness and sometimes even for their siblings (Lin, 1981). However, the pressure on the family to arrange the marriage of a mentally ill youth is great indeed. Marriage may bring back the harmonic state of yin and yan. Besides, the family wishes the male patient to marry in order to produce a son and carry on the family name, hoping, or even believing, that his mental illness will not be passed on to the new born son. In the case of a female patient, the dominant motivation seems to be getting rid of the potentially embarrassing and burdensome problem of keeping a psychiatric patient at home (Lin & Lin, 1981).

As a rule the family, not the affected individual, makes the decision concerning treatment modality and assumes the whole responsibility of providing the necessary means and support to carry out the treatment. The process in reaching this decision seems to be determined by factors

which are peculiar to the Chinese family such as intrafamilial hierarchy and pragmatism (Lin & Lin, 1981).

Each member in the family has his/her own views of the etiology of the mental illness. Sometimes these views coincide, but often they differ. The male-dominated and age-oriented family system, ascribes a certain priority and weight to the views of particular individuals based on age, sex, ordinal position and role, social status, experience, and knowledge (Metzger, 1981). After weighing the pros and cons of the various views expressed, the head of the family assumes the responsibility for the final decision on the treatment modality and also for its implementation. The process of intrafamilial decision-making consists usually of informal discussion. Once a decision is arrived at, the whole family participates in its implementation.

The pragmatism of the Chinese in dealing with their lives in general and in everyday problem solving also applies in the search for an effective treatment for the mentally ill member. With utmost diligence and vigilance the head and members of the family proceed with trial and error in carrying out treatments. If and when a treatment proves to be ineffective, then another round of selecting a treatment method starts with renewed effort to implement it. In this manner, the family applies all the efforts,

resources, and time until the family obtains the desired effect on the patient's illness. The family will bring in outsiders only when they find that their own material or knowledge resources and skills have not proved effective in problem solving. However, this process of seeking outside help is a cautious one and expands in concentric circles to include relatives, elders of the community, school teachers, and other trusted friends whom the family regard as equal (Chen, 1970). The views of these outsiders on the etiology of mental illness are considered and their advice on treatment is valued. The weight of such consultation increases with time in selecting treatment modalities and is in inverted relationship to the failure of the efforts of intrafamilial coping (Lin & Lin, 1981)

Shame and Guilt

The shame the family feels about the presence of a mentally ill member is intense and pervasive (Sue & Mckinney, 1975). This feeling is rooted in cultural views of the etiology of the mental disorder. The moral view implies that someone in the family has not behaved correctly, and thus the family should be ashamed of having failed in performing its duty of teaching or controlling its member's proper behavior. Similarly, but perhaps in

somewhat lesser degree, the psychological etiological view of mental illness causes the family to feel ashamed. For failure in love affairs or business or other psychological difficulties of the individual that have presumably precipitated or caused the mental illness reflect the failure, in the minds of the family, of performing their duty in guiding or protecting the individual in order to avoid such disaster. The religious etiology implicates the family as having had ancestors who committed some kind of misconduct.

According to the genetic theory, mental illness tarnishes the family name, making it difficult for its young people to marry. Furthermore, extreme disgrace comes to all those connected with the family. Fear of exposing its own shame to outsiders is the origin of the stigma that attached to mental illness in Chinese society (Lin, Tardiff, & Donetz, 1978). The stronger the wish of the family to protect the "disgrace" from being exposed, the more intense the stigma attached to mental illness becomes (Lin, 1981).

Feeling of guilt plays an important role in emotional responses to mental illness. The fear that the family might not have fulfilled its duties in controlling the behavior of the afflicted member and, as a result, has tarnished the family name in the eyes of the outsiders, evokes a sense of

guilt toward ancestors. Disgrace results from such an act against filial piety, a most essential virtue demanded of every Chinese family. The feeling of guilt of the family increases with time and with its repeated failure in attempting to restore the sanity of the afflicted member. Resorting to religious healing becomes an increasingly frequent treatment modality during the protracted course of family coping with the mental illness in its midst (Lin, 1981; Lin & Lin, 1981).

Denial and Somatization

The burden on the family seems to be least when the mental illness is viewed as medical or physiological in nature. To understand and accept the cause or the mechanism of mental disturbance based on the age-old yin-yang theory is easier for Chinese family. The prescribed methods for restoring the sanity of the patient are generally simple and concrete, mostly consisting of using herbs or certain dietary measures which can be managed within the family without the risk of exposing the patient to the outsiders (Lin, Tardiff, & Donetz, 1978). Most significant of all, the medical view implicates the family least and thus relieves the family of the painful burden of shame and guilt as well as the fear of the stigma of mental illness (Lin,

1981; Lin & Lin, 1981).

Denial of psychological factors that induced mental illness resulted in patient's resistance to attempts at psychotherapy or psychosocial intervention, especially by outsiders, including mental health professionals. To the Chinese, the family is a sacred bastion to be shielded from the eyes of outsiders, to be protected from the meddling of strangers. When the quality of family control is being questioned in the case, this phenomenon becomes more obvious. The family's reputation and social status are at stake, and the prospects of marriage of the younger generation are endangered (Lin & Lin, 1981). Chen (1970) has reported that, whereas the "silent Chinese" may have a large number of problems, their strong sense of shame and pride has precluded and hindered their use of community health programs and services. Sue and Mckinney (1975) also observed that an admission of emotional problems and the inability to work out one's problems would cause shame and reflect poorly on the family name. These factors result in the Chinese resistance to the use of professional services.

Help-seeking Behavior

According to Lin and Lin (1981), the distinct pattern of help seeking behavior of the Chinese family from the

onset of a mental illness to the point when the afflicted individual ends up in a public institution or a mental health agency can be depicted as following: a) exclusively intrafamilial coping, b) inclusion of certain trusted outsiders in the intrafamilial attempt at coping, c) consultation with outside helping agencies, physicians, and finally a psychiatrist while keeping the patient at home, d) labeling of mental illness and subsequent series of hospitalizations, e) scapegoating and rejection.

The first three phases can be grouped together as a protracted intrafamilial and "pre-psychiatric" stage which may last from several to over twenty years (Lin & Lin, 1981). Dominant in attempting to restore the sanity of the afflicted individual in this stage is the tender loving care of family members to the sick and their intense effort to mobilize intrafamilial resources with minimal assistance from outside resources. Strong feelings of shame and guilt contributed to shield the patient from the outside world, except for a few trusted friends, community leaders or herbalists. Only when all these efforts have failed to effect change in the behavioral pathology of the individual, does the family seek outside help such as agencies or physicians, and finally, a psychiatrist or other mental health workers to assist in restoring the patient's mental

condition. At this stage, attempts to help are still within family boundary.

Labeling of the condition of the ill person as mental illness seems to introduce a radical change in the family's attitude toward the afflicted individual and the family's approach to intervention (Lin, Tardiff, & Donetz, 1978). To the family the occurrence of mental illness in one of their family members is a "shock". They may resist accepting the notion and keep denying the mental illness by continuing the previously ineffective intervention. Gradually, the family members accept the diagnosis and sometimes do so with a feeling of relief as they had already suspected and dreaded the presence of mental illness all along. In any case, the label has a profound effect on the family. Subsequently, the family becomes less tolerant of the ill individual, because the labeling is usually done to the Chinese by an outsider. This poses an added psychological threat to the family as it entails public exposure of the family's shame with attendant loss of face (Lin, 1981).

The label of mental illness almost instantly and drastically affects the patient and alters his/her status in the family. The patient becomes a "crazy" person with the attendant stigma. The shame and guilt of the family will begin to focus more on the patient along with frustrations,

fears, and eventually anger. The friendly and warm atmosphere in the family, including tender concern for the sick, is gradually replaced by one of tension, worry, and desperation. The attitude to the patient becomes less cordinal and more distant (Lin & Lin, 1981).

Consulting with outside agencies, physicians, or psychiatrists sooner or later leads to the admission of the patient into a mental hospital. Despair and exhaustion of the family's tolerance and resources end the long struggle to contain the patient within family. This is replaced by a sense of relief and new hope for "cure" of the patient. The patient's recovery and return from the hospital brings back, at least temporary, the family's old atmosphere of warmth and mutual concern. Relapse of the psychiatric condition, however, again sets in motion the process of family response and intervention described above. The duration of intrafamilial coping in this second episode is usually shorter. The process of intrafamilial coping and extrafamilial coping becomes shorter and shorter and hospitalization becomes longer as the patient's course of illness becomes more chronic. The family's visits to the hospital are in inverse relationship with the number of hospitalizations and also their duration. Rejection is complete when all family contacts cease. Sometimes the

hospital finds no one who is willing to accept the patient for home care even though the patient's condition is sufficiently improved to warrant return home. However, the above mentioned pattern of help seeking and family intervention primarily applies to psychotic patients with such symptomatology as psychomotor excitement, bizarre behavior, delusions, or hallucinations. Other types of mental illness such as depression and neurosis seldom come to the attention of psychiatrists or mental health agencies because either these are not regarded as mental illness, or they are easily treated at home as physical illness by other physicians (Lin & Lin, 1981).

The multifaceted view on etiology of mental illness results in different interpretations of the mental illness and varying explanations of the behavior of the mentally ill patient. Chinese culture continues to influence the way psychotic symptoms are perceived, expressed, and reacted to (Lin, 1981). According to Lin and Lin (1981), Chinese families responded to the occurrence of mental illness in their relatives with shame, guilt, denial, somatization, and rejection. However, in Chinese society the mentally ill person seems to be better tolerated at home. The deviance of the mentally ill patient is contained in the family, even in oversea Chinese community, for much longer periods than

among Western groups (Lin, Kleinman, & Lin, 1981). Chin (1981) also reported that Chinese families shouldered the major responsibility for the care of insane members.

These phenomena should not be judged as good or bad. Nevertheless, the overall prevalence rate of mental disorder, as well as the rate for psychosis among Chinese, is roughly similar to those reported from other cultures (Lin, Kleinman, & Lin, 1981). The Chinese probably comprise one-fourth of the world's population, making them the planet's largest ethnic group. On one hand, the Chinese could not avoid the attack of mental illness. On the other hand, the Chinese family usually has a high tolerance for keeping the mentally ill patient at home (Lin, Tardiff, & Donetz, 1978). Their sufferings are predictable. A fundamental knowledge of relatives' responses toward the occurrence of mental illness in Chinese population is imperative for planning the community mental health program.

Summary

Literature regarding Western attitudes toward mental illness and Chinese attitudes toward mental illness has been reviewed. Even though the interpretations of mental illness and its attendant behavior are different in the Occidentals and the Chinese population, the psychological responses toward mental illness and the mentally ill, guilt, shame,

stigma, worry, resentment, and anger, are similar.

The problem of mental illness is one of ever-enlarging health and social significance in North American society. In 1978, the President's Commission on Mental Health (PCMH) reported that, at any one time, an estimate of between 10% to 15% of the American population needs some form of mental health care. The Commission noted that, of this estimate, more than five million people have serious mental health problems, which includes schizophrenia, profound depressive disorders, and other permanent disabling mental conditions. The overall prevalence rate of mental disorder as well as the rate for psychosis among Chinese is roughly the same (Lin, Kleinman, & Lin, 1981). According to Kreisman and Joy (1974), the studies of the family's early reaction to the mental illness of a relative provide a first step in understanding the initial perception of the patient's behavior, attempts at explanation, and responses to the patient. The fundamental knowledge about relatives' responses toward the occurrence of mental illness within the family is also the prerequisite for the development of useful community mental health service in terms of offering the multipurpose services to the mentally ill patients and their families both in the Occidentals and the Chinese population.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The investigation of pre-crisis in the families of mentally ill patients was a descriptive research methodology. The qualitative descriptive approach fits the stated purpose of proposed investigation by describing the event of pre-crisis in the mentally ill patient's family in the form of either narrative description or formal concepts with properties and formal definitions which further conceptualize the event of pre-crisis in the mentally ill patient's family.

Setting

The data collection was carried out in a psychiatric ward. The subjects were selected from a Provincial General Hospital in the northern part of Taiwan, Republic of China.

Sample and Sampling

The target population of the investigation consists of all families of mentally ill patients. A non-random sample includes thirty adult relatives of the patients who have been recently diagnosed as mentally ill excluding alcoholism, drug addiction, and mental retardation. The investigator personally approached the potential subjects and elicited their written agreement to participate before the interview was taken.

The selection of non-probability sampling meets the feasibility criterion of the three month time period allocated for completion of the investigation. No other limiting factors for sample selection are identified. It was assumed that the subjects selected were relatively healthy both mentally and physically.

The units of sampling are the individual subjects who are determined as representative of the target population in the sense that they experience the pre-crisis and are rich sources of data. The data sources were limited to:

a) subjects' experiences about pre-crisis including cognitive responses, emotional and behavioral responses, and physiological responses toward the stressful event, that is, having relatives diagnosed as mentally ill.

b) the investigator's observations of the subjects' non-verbal responses during the face to face interview.

Protection of Human Subject

To provide appropriate protection for the rights of the subjects, the investigator performed the following activities.

1. Approval of study by Human Subjects Review Committee at Texas Woman's University (see Appendix A).

2. Volunteer participants--the subjects were asked to sign the consent forms agreeing to participate in the study.

3. Rights of human subjects participating in the study were explained to each subject.

4. Each subject was informed that he/she may withdraw from the study at any time, prior to, during, or after data were collected.

5. Anonymity was guaranteed. All tapes were erased at the end of the study.

Data Collection

Data were collected through the use of unstructured interviews and through the investigator's observation of subject's non-verbal responses during the interview. An interview guide (see Appendix B) includes areas on:

a) subject's demographic data and relationship with the mentally ill patient,

b) the meaning of mental illness,

c) effect of mental illness on the patient, the subject, and other members in the family, and

d) management of the problems which were caused by having a family member being diagnosed as mentally ill and the resources available for helping in problem solving.

e) other questions posed by the family members.

The principal source for question contents in the interview guide is from a review of the literature concerning the concept of pre-crisis. The interview guide

was pilot tested with a particular member of the patient's family in the psychiatric ward. The interview of the subjects was conducted for an half hour and was audio tape recorded. After the interview the audio taped record was transcribed into written form for further analysis.

The unstructured nature of the interview and the questions permits flexibility in data generation and allow for leads to emerge and for elaboration upon.

Data Analysis

For consistency with the research design of the investigation, the content analysis was used for data analysis. According to Polit and Hungler (1983), a content analysis is a procedure for analyzing written, verbal, or visual materials in a systematic and objective fashion.

According to Wilson (1985), the content analysis involves three steps: First, select the unit of analysis. The whole response of the subjects in the interview was used as the unit of analysis in this study. The researcher wrote out all information obtained during the interview. Each individual subject had a summary sheet of data. Second, develop the set of categories. From each subject's interview data the cognitive, emotional, behavioral, and physiological responses were extracted. The researcher made a conscious attempt to deal only with the data collected and

not contaminate the interview information with preconceived ideas. However, the existing categories in the study are: worry and anxiety, grief and depression, frustration and anger, strong teachable moment, and high probability of achieving a higher level of health. The researcher read through the data and coded them into those categories and reported the frequency with which responses appeared in the various categories. Pearson correlation coefficient, factor analysis, t-test, and one way analysis of variance were used for further data analysis. Third, develop the rationale and illustrations to guide the coding of data into categories. The researcher judged the categories for each response or unit of analysis. For the purpose of being objective, the categorizing process was carried out with the help from an experienced psychiatric nurse with doctoral qualifications.

Pilot Study

The study evolved over a 12 month period from the work the researcher had done with patients and their families in a psychiatric ward. Relatives of the newly admitted patients had more questions about dealing with care of the patients than do relatives of chronic cases, and they have become angry easily with the staff workers on the floor. Based on this information the development of a pilot study was undertaken. The interview guide was developed and

refined.

Interviews were held with ten families of the newly admitted patients (4 males and 6 females) were conducted in a Provincial General Hospital in the northern part of Taiwan from December, 1984 to January, 1985. The subjects' ages ranged from 21 to 75 years, with two subjects being 45. The median age was 44.5 years. The educational level ranged from none to college student. Occupations include college student, high school teacher, housewife, businessman, labor worker, and retired. The relationship with the patient included: father, 1; mother, 4; husband, 3; and sister, 2. All of the interviewed subjects were living in the same household with the patients. (The demographic data of the subject and the patients are shown in the appendix C)

Interview Data Analysis

Question 1: How would you describe your family member's mental disorder?

The answer included: a) description of patient's behavior such as: patient had insomnia, headache, hot-temper, incoherent speech, depression, slow motions, and immature thinking; patient heard voices (hallucination); patient did not groom himself, did not talk, and patient had strange behavior; patient worried too much; patient was very

talkative; patient was dependent; patient's behavior was intolerable; patient was unreasonable; patient was very emotional; patient was stupid. Three out of the ten subjects verbalized that the patient had experienced behavioral change. Nine out of the ten subjects' answers fell into this category.

b) confusion about the patient's mental disorder. The answers included: "I don't know what is the matter with his/her disorder." "I don't know how to help the patient." and "I cannot imagine the patient has mental illness." The frequency of the aboved mentioned answers was 6, 3 and 1 out of the ten subjects accordingly. Seven out of the ten subjects' answers fell into this category.

c) revealment of psychological stress or physical trauma before the onset of patient's mental disorder. One patient had glaucoma and failed his college-entrance examination twice in sequential years; one patient had a poor relationship with in-laws; two patients had hard times at school; one patient had fever convulsions when he was little; and one patient had a history of a fall from a second level bed ten years ago.

d) complaints about changing family life patterns and financial burden which were caused by the occurrence of mental illness in their families. Three out of the ten

subjects had former complaints. One subject had latter complaints.

e) worry about personal ability in taking care of the patient. One subject answered the question as "I am afraid I do not have enough energy to take care of the patient and the whole family. One subject expressed that she brought the patient to a temple and did rituals for the patient. One subject said that every body should have some commitment to his/her family.

Question 2: How does your relative's mental disorder affect you and your family?

The answers included various kinds of burdens to the subjects and their families such as: One subject said that he had to watch for the patient's safety as did all his family. Another subject verbalized that the patient's illness made her mother feel guilty because her mother thought she was responsible for her son's mental disorder. Concerning the physical burden, three subjects complained that they had to come and visit the patient while the patient was hospitalized. As to the psychological burden, five subjects express that they and their families worried about not only how to deal with the patient's problem but also how the patient was progressing. About the social burden, one subject worried about how others considered the

problem in his family. Concerning the financial burden, two subjects stated that they were worried about the hospital expense. Nonverbally, frowns, sad facial expressions, and tears were noticed during the interview period.

Question 3: How do you manage the problems which are caused by that (from question 2).

Except for one subject who said that he was just too worried and that no one was able to help. There were patterns of responses such as: a) accepting the problem passively as the first subject said "I either listen to her (the patient) or ignore her." The second patient said "We just have to be patient with the mentally ill person." The third subject said "Do I have another choice? He is my son."

b) getting help from the doctor or sending the patient to the hospital. One subject expressed that he had consulted with the doctor before he sent the patient to the hospital. The second subject said he would talk with the doctor or nurse if he had time. The third subject said his family had sought help from hospital to hospital; the patient's condition got better while the patient stayed at the hospital. The fourth subject said he sent the patient to the hospital immediately when he was unable to handle the problem.

c) seeking help from religion. Two subjects expressed that they had been seeking help from Buddha, that is, they prayed.

d) keeping away from the stressful situation. One subject said she took a walk when she developed a headache after dealing with the patient.

Question 4: Is there anything that you would like to share with me?

Four subjects did not have any questions. One burst out crying. One subject mentioned something unrelated to the subject under investigation. Two subjects asked the researcher about the researcher's opinion concerning the religious "rituals" for curing mental illness. One subject asked the researcher to spend time with the patient and help the patient talk out her problems. One subject repeatly prosed the question, "Can the mental disorder really be cured?" Conversely, one subject consciously mentioned the financial burden, however it may have been concern for making advance plans for the patient's medical care.

In the summary analysis, the subjects had anxiety and worry syndrome; they expressed their worry directly by verbally expressing it; they felt perplexed about the situation which they faced; and they had many complaints which were deemed as common symptoms of anxiety (see

Appendix C, Table C-3). Also, the subjective and objective data showed that the subjects had grief and depression syndrome such as using denial as a defense mechanism, feeling of helplessness and hopelessness, and sad expressions (see Appendix C, Table C-4). In addition, the subjects had anger syndrome: The subjects expressed their anger verbally or their anger could be read from their facial expressions and behavior such as to avoid sharing more with the researcher (see Appendix C, Table C-5).

Regarding the teachable moment on the families of the mentally ill, subjects had awareness of the ineffectiveness of old coping pattern such as questioning about the coping method which they have used in problem solving. Meanwhile, the subjects seeked information about whether "religious ritual" do any good for patient's mental health/illness from the researcher (see Appendix C, Table C-6). High probability of achieving a good health level was shown by the subject's help-seeking behaviors such as asking help from various resources that include medical personnel, hospital, family members, and friends (see Appendix C, Table C-7).

From the pilot study, five critical attributes as stated under concept analysis of pre-crisis were supported by the empirical data. Worry and anxiety, grief and

depression, anger, strong teachable moment, and high probability of achieving a good health level were themes in the clue groupings of relatives' responses toward the occurrence of mental illness in their family members.

In summary, the pilot study affirmed the usefulness of the interview questions, validated the methodology, and served to further define and describe the nature of the experience of having a family member being diagnosed as mentally ill.

CHAPTER 4

DATA ANALYSIS

The interview data from the thirty subjects were analyzed by the approach proposed by Wilson (1985). The clinical indicators of the five critical attributes of pre-crisis were extracted from each interview with the subject and presented below. Pearson correlation coefficient, factor analysis, t-test, and one way analysis of variance were also used for further analysis.

Description of the Sample

Of the thirty selected subjects for this study, fifteen were female and fifteen were male. The ages ranged from twenty-three to sixty-five years of age, with five subjects being 52. The median was 46.5 years. The mean was 44.57 years, with the standard deviation, 11.21 years. All participants were Chinese. Twenty-six subjects were married, three subjects were single, and one was a widow. The subjects' education levels ranged from none to college graduates. They worked as bookkeepers, businessmen, farmers, housewives, labor workers, and managers. The relationships of the subjects to the mentally ill patients included: father, 7; mother, 13; husband, 4; wife, 2; son, 1; and brother, 3. Twenty-nine of the interviewed subjects were living in the same household with the mentally ill

patients. The average number of members in the same household was 4.67, with the standard deviation, 1.71. The mode was 5. Six subjects had more than one patient at home.

Regarding the patient's demographic data, sixteen were male and fourteen were female. All of these patients were inpatients. The patients' ages ranged from sixteen to sixty-four years, with five patients being nineteen years. The mean was 26.07 years with standard deviation, 10.94 years. Eighteen patients were in the hospital for the first time, eight for the second time, and three for the third time. Nineteen patients had been diagnosed within the past six weeks or less. Eleven patients had been diagnosed more than six weeks before the study. The patients' education ranged from none to graduate school. They worked as bookkeepers, businessmen, housewives, labor workers, vocational nurses, salesmen, soldiers, and students. Eight patients had no job.

The raw demographic data for each of the subjects and their mentally ill families are presented in Table 1 and Table 2.

Table 1

Demographic Data of the Interviewed Family Members

Name	Classification	Subtotal		Total	
Sex	Male	15	(50.0%)		
	Female	15	(50.0%)		
				30	(100%)
Age	21-30	4	(13.3%)		
	31-40	8	(26.7%)		
	42-50	5	(16.7%)		
	51-60	11	(36.6%)		
	61-70	2	(6.7%)		
				30	(100%)
Marital status					
	Single	3	(10.0%)		
	Married	26	(86.7%)		
	Widow	1	(3.3%)		
				30	(100%)
Education level					
	None	4	(13.3%)		
	Primary school	12	(40.0%)		
	Junior high	5	(16.7%)		
	Senior high	3	(10.0%)		
	Vocational school	2	(6.7%)		
	Junior college	3	(10.0%)		
	College	1	(3.3%)		
				30	(100%)
Number of members in the household					
	2-4	12	(40.0%)		
	5	9	(30.0%)		
	6-8	9	(30.0%)		
				30	(100%)

Table 1 (Cont.)

Demographic Data of the Interviewed Family Members

Name	Classification	Subtotal		Total	
Relationship to the patient					
	Father	7	(23.3%)		
	Mother	13	(43.3%)		
	Husband	4	(13.3%)		
	Wife	2	(6.7%)		
	Brother	3	(10.0%)		
	Son	1	(3.3%)		
				30	(100%)
Living in the same household with the patient					
	Yes	29	(96.7%)		
	No	1	(3.3%)		
				30	(100%)
More than one patient at home					
	Yes	6	(20.0%)		
	No	24	(80.0%)		
				30	(100%)
Occupation					
	Businessman	4	(13.3%)		
	Farmer	2	(6.7%)		
	Housewife	9	(30.0%)		
	Labor worker	8	(26.7%)		
	Manager	1	(3.3%)		
	Public officer	1	(3.3%)		
	Salesman	2	(6.7%)		
	Soldier	1	(3.3%)		
	Student	1	(3.3%)		
	Teacher	1	(3.3%)		
				30	(100%)

Table 2

Demographic Data of the Patients

Name	Classification	Subtotal		Total	
Sex	Male	16	(53.3%)		
	Female	14	(46.7%)		
				30	(100%)
Age	11-20	13	(43.3%)		
	21-30	10	(33.4%)		
	31-40	5	(16.6%)		
	Above 40	2	(6.7%)		
				30	(100%)
Marital status					
	Single	21	(70.0%)		
	Married	9	(30.0%)		
				30	(100%)
Education level					
	None	1	(3.3%)		
	Primary school	1	(3.3%)		
	Junior high	6	(20.0%)		
	Senior high	10	(33.3%)		
	Vocational school	5	(16.7%)		
	Junior college	5	(16.7%)		
	College	1	(3.3%)		
	Graduate school	1	(3.3%)		
				30	(100%)
Occupation					
	Bookkeeper	2	(6.7%)		
	Businessman	1	(3.3%)		
	Housewife	3	(10.0%)		
	Labor worker	2	(6.7%)		
	None	8	(26.7%)		
	Vocational nurse	1	(3.3%)		
	Salesman	1	(3.3%)		
	Soldier	2	(6.7%)		
	Student	10	(33.3%)		
				30	(100%)

Table 2 (Cont.)

Demographic data of the patients

Name	Classification	Subtotal		Total	
Diagnosis					
	Adjustment disorder	1	(3.3%)		
	Affective disorders	5	(16.7%)		
	Paranoid disorders	3	(10.0%)		
	Psychotic disorders	5	(16.7%)		
	Schizophrenic disorders	16	(53.3%)		
				30	(100%)
Number of hospitalizations					
	1	18	(60.0%)		
	2	8	(26.7%)		
	3	4	(13.3%)		
				30	(100%)
Time of being diagnosed					
	Within 6 weeks	19	(63.3%)		
	More than 6 weeks	11	(36.7%)		
				30	(100%)

Worry and Anxiety

The clinical indicators of worry and anxiety were revealed in subjective and objective data of the participants. All thirty subjects had signs and symptoms of worry and anxiety (see Table 3). In the subjective segment, the responses included a) expressing direct worry about the mentally ill and about the medical expenses, b) feeling perplexed about the present situation and about the care of the patients, c) having multiple complaints.

The families expressed direct worry about medical expenses, patient's safety, patient's future life, patient's progress during therapy, prognosis of the mental illness, the impact on other family members of the mental patient, and other people's attitudes toward the mental illness of the patient. Fourteen subjects were worried about the patients' medical expenses. Eight subjects were worried that the patient might commit suicide or homicide, and two subjects were worried about the patient's inability to care for himself/herself. Sixteen subjects' main concerns about their patients' future life included: Could the patient continue his/her school? Could he/she find a job after his/her hospital release? Could the patient make a living by himself/herself? When fourteen subjects said that they were worried about their patient's progress during therapy,

Table 3

Clinical Indicators of Worry and Anxiety

Code	Classification	Number of subject		Rank	Total
W1	Content of direct worry				
	Patient's future life	16	(53.3%)	1	
	Medical expenses	14	(46.7%)	2	
	Patient's progress	14	(46.7%)	2	
	Others' attitudes	13	(43.3%)	3	
	Patient's prognosis	12	(40.0%)	4	
	Impact of mental illness on others	12	(40.0%)	4	
	Patient's self-care	10	(33.3%)	5	
					30 (100%)
W2	Perplexed feelings				
	Causes of mental illness	13	(43.3%)	1	
	Care for the patient	13	(43.3%)	1	
	Getting along with the patient	6	(20.2%)	2	
	Patient's behavior	4	(13.3%)	3	
					20 (66.7%)
W3	Physiological responses				
	Sleep disturbance	15	(50.0%)	1	
	Loss of body weight	11	(36.7%)	2	
	Cannot concentrating	6	(20.0%)	3	
	Headache	4	(13.3%)	4	
	Loss of appetite	4	(13.3%)	4	
					21 (70.0%)
W4	Objective data				
	Keep on talking	7	(23.3%)	1	
	Nervous gestures	4	(13.3%)	2	
					9 (30.0%)
TW	Worry and anxiety syndrome	Total			30 (100%)

they would say "I have to come and visit the patient every day. Otherwise, I do not feel secure or comfortable." Twelve out of thirty subjects expressed their concerns about the patients' prognosis: What chance had the patient for recovery? To what degree could the patient recover?

The impact of a patient's illness on others ranged from trouble within the family to greater problems in the neighborhood. For example, one patient spread insecticide around the house, three patients bothered their children's study and work, and three patients broke neighbors' windows. Two subjects worried that the other family members at home might get sick. In total, twelve out of thirty subjects were worried about the impact of mental illness and the mentally ill patient on other people. Also, subjects were worried about the neighbors' attitudes toward the patient and his/her mental illness. Thirteen subjects worried that the patient might draw people's attention to their families.

Twenty families (66.7% of the sample) felt perplexed about the cause of mental illness, the patient's behavior, how to help the patient, and how to get along with the patient. Thirteen subjects pondered on why the mental illness occurred. Was it related to heredity, constitutional factors, environmental pressure, or something abstract and intangible such as the patient's spiritual

belief or supernatural phenomenon? Four subjects were confused about the patients' behavior, such as why the patient had a tremendous personality change and why the patient's behavior was so hard to understand even by his/her close family. In addition, thirteen subjects had questions related to how to deal with the patient's daily life, including how to help the patient to get along with others, how to tell the patient he/she was ill, and what the appropriate attitude of relatives was toward the patient. Could the family beat the patient when his/her behavior was completely unacceptable or should the family be very patient with the mentally ill person? Six subjects had questions about how to get along with the patients.

Twenty-one families (70.0% of the sample) complainted that they lost sleep, had headaches, lost body weight and appetites, and lacked the ability of concentration. Half of the subjects mentioned that their preoccupation with their patients resulted in sleep disturbance. The patient could neither sleep well nor could members of his/her family. Also six subjects expressed that they had a hard time concentrating. One subject said she was afraid of the situation.

The fidgety nonverbal behaviors of the subjects such as tapping their feet, twisting their fingers, looking around

the room without specific purpose, and non-stop talking during the interview expressed worry and anxiety. In sum, nine subjects (30.0% of the sample) were observed to have objective signs of worry and anxiety.

Depression and Grief

The clinical indicators of depression and grief were extracted from subjective and objective data of the participants. All thirty subjects exhibited signs and symptoms of grief and depression (see Table 4). In the subjective segment, the responses included: a) grief reactions, b) feelings of hopelessness, c) feelings of helplessness, d) feelings of guilt, and e) feelings of self-pity.

Four subjects used denial as a defense mechanism. These subjects said that their relatives were not mentally ill or that they could not believe their relatives had mental illness. They said mental illness was a totally different thing from what their relative had.

Table 4

Clinical Indicators of Depression and Grief

Code	Classification	No. of subject		Rank	Total
G1	Symptoms of grief				
	Felt helpless	18	(60.0%)	1	
	Guilty	12	(40.0%)	2	
	Self-pity	12	(40.0%)	2	
	Denial	4	(13.3%)	3	
	Felt hopeless	3	(10.0%)	4	
					26 (86.7%)
G2	Content of multiple complaints				
	Sad	11	(36.7%)	1	
	Tired	10	(33.3%)	2	
	Shameful	7	(23.3%)	3	
	Sorry	6	(20.0%)	4	
	Cried frequently	6	(20.2%)	4	
	Loss of interest in social life	5	(16.7%)	5	
	Tense	2	(6.7%)	6	
					23 (76.7%)
G3	Objective data				
	Frown	15	(50.0%)	1	
	Weep	13	(43.3%)	2	
	Sigh	12	(40.0%)	3	
	Tearful	10	(33.3%)	4	
	Sad looks	8	(26.7%)	5	
	Low voice	8	(26.7%)	5	
	Forced laughter	4	(13.3%)	6	
	Voice quiver	4	(13.3%)	6	
	Downcast eyes	2	(6.7%)	7	
					30 (100.0%)
TG	Grief and depression syndrome		Total		30 (100.0%)

The families felt helpless. One subject said, "I am so poor, what can I do for the patient?" A second subject said, "I do not have medical knowledge. How can I help the patient?" Another said, "I just have to be patient with the mentally ill person." In total, eighteen subjects felt helpless about their present situation.

The families expressed feelings of being in a hopeless situation. Two subjects sighed, "He is my only son...." Two subjects said, "I no longer have expectations of him/her."

Twelve families felt guilty. Eight subjects blamed themselves by saying that they should have paid more attention to the patient from the onset of the patient's symptoms. Three subjects expressed guilt for having scolded and beaten the patient when he/she was ill. One subject regretted having overprotected the patient, stating that the protection had made the patient overly dependent. Another subject said he felt guilty about having his mother do the family chores which were supposed to be done by the patient while still another said she should not push the patient too hard even though the patient was her only son. One mother felt that her son's illness resulted from her neglecting his early education.

Most families suffered from self-pity. Twelve subjects

mentioned that they had misfortune, that they could not blame others, or that they had bad luck. Collectively, twenty-six out of the thirty subjects (87.7%) had subjective symptoms of grief and depression.

Twenty-three families (76.7% of the sample) complainted about feeling shameful, or sorry, or tired, or sad, or tense, or frustrated. They indicated that they cried frequently and had lost interest in any social life.

In addition, nonverbal indicators found during the interview included frowns, sighs, weeping, low voice, sad looks, forced laughter, tearfulness, and downcast eyes. All thirty subjects had at least one of the aforementioned nonverbal behaviors, and ten subjects had two of these nonverbal behaviors.

Anger

The clinical indicators of anger were shown in subjective and objective data from the participants of this study. Twenty-two out of the thirty subjects (73.3%) had signs and symptoms of anger (see Table 5). In the subjective segment, the responses included a) complaints about the patient's behavior and about the extra burden of caring for the patient, and b) blaming others.

Table 5

Clinical Indicators of Anger

Code	Classification	No. of subjects		Rank	Total
A1	Content of anger				
	Patient's irrational behavior	5	(16.7%)	2	
	Extra burden	12	(40.4%)	1	
					13 (43.3%)
A2	Blame others				
	Blamed the other family members	7	(23.3%)	1	
	Scapegoat someone else	6	(20.0%)	2	
	Blame other's attitude	5	(16.7%)	3	
	Blamed the hospital	4	(13.3%)	4	
	Blame past experience with patient's treatment	1	(3.3%)	5	
					18 (60.0%)
A3	Objective data				
	Voice raised	2	(6.7%)	3	
	Agitated	5	(16.7%)	2	
	Kept on complaining	9	(30.3%)	1	
					13 (43.3%)
TA	Anger syndrome	Total			22 (73.3%)

Thirteen families (43.3% of the sample) had complaints about the patient's irrational and demanding behavior, and the physical, psychological, social, and financial burdens which had been placed on them. Subjects complained that the patient did not behave, was unreasonable, and was unpredictable. The extra burden which had been placed on the subject included visiting the patient every day, no matter how much work the subject had to do and how tired he/she was. The subject physically had to assume the chores which were supposed to be done by the patient while he/she psychologically was constantly worried about the patient. The family felt the social pressure which resulted from the stigma associated with the mental illness. The families complained that so much money had been spent for the patient's treatment.

Eighteen families (60.0% of the sample) blamed others. The subjects employed someone or something as a scapegoat; four complained of the service in the hospital; five complained about neighbor's negative attitudes toward mental illness; and seven complained that his/her family did not give him/her support. The subject would try to place responsibility on someone else for the present tragedy, such as one said that a policeman who had restrained the patient caused the irrational behavior; another blamed a school

teacher who had taught meditation to the patient. One subject thought school had put too much pressure on the patient. Another subject thought the patient's illness was mainly caused by the poor living situation; her husband did not select the right place to build the house. Four subjects complained about the poor services of the hospital. For example, visiting hours in the hospital were too strict; the nurse who worked on the floor was indifferent and not helpful; there was too much red tape in order to see the doctor; and a shortage of professional workers resulted in a poor quality of patient's care. Two subjects were angry about their families indulging in gambling instead of being concerned for the patient. One subject said her relatives did not agree with her treatment plan for the patient, nor did they support the idea that the patient should be hospitalized. Two females complained that their spouses did not give them any support. One subject complained that her children constantly quarrelled with each other. Another subject complained about past experiences with religious people who attempted to treat the patient with prayers/rituals which had cost the family a large amount of money and had not improved the patient's condition. Four subjects blamed their acquaintances for the negative attitudes which were associated with mental illness. One

subject complained that the patient's insurance did not cover psychiatric care.

Subjects' nonverbal behavior in showing their anger included raised voices during the interview, agitation, and constant complaints. Thirteen out of the thirty subjects (43.3%) exhibited objective signs of anger.

Strong Teachable Moment

In this category, twenty-five out of the thirty subjects (83.3%) revealed information-seeking behavior and awareness of the ineffectiveness of old coping patterns (see Table 6). Five subjects indicated that they had realized that praying and religious rituals did not benefit the patient's mental illness, but medical treatment was a better method for relief of problems related to mental illness. Two subjects expressed that instead of sending the patient to the hospital when he/she was in need of professional medical attention, the family kept the patient at home. Staying at home did not help the patient at all.

Table 6

Clinical Indicators of Teachable Moment

Classification	No. of subjects		Rank	Total
Ask questions about the mental illness	23	(76.7%)	1	
Read related books and pamphlets	5	(16.7%)	2	
Question the effect of religious ritual	5	(16.7%)	2	
Question past attitude towards the patient.	2	(6.7%)	3	
TT (Teachable moment)				25 (83.3%)

In addition, twenty-three out of the thirty subjects (76.7%) asked the researcher about mental illness: What was the prognosis and what were the proper methods/ways for caring for the patient? One subject asked the researcher whether there was any resource to which he could apply for financial aid. Only five subjects had read related books and pamphlets about caring for the patients.

High Probability of Achieving a Good Health Level

Twenty-eight subjects (73.7% of the sample) had asked for help from various resources, such as community based financial aid, medical personnel, including the internal medical doctors and professional mental health workers, and counselors in schools. Also, they had shared feelings and problems with families and friends (see Table 7).

Table 7

Clinical Indicators of High Probability of Achieving a Good Health Level

Resources for help-seeking	No.of subject	Rank	Total
Medical personnel	24 (80.0%)	1	
Family	14 (46.7%)	2	
Religion	8 (26.7%)	3	
Friend	7 (23.3%)	4	
Chinese Herb	5 (16.7%)	5	
Counselor	2 (6.7%)	6	
Community based financial aid	2 (6.7%)	6	
Meditation	1 (3.3%)	7	
TP (High probability of achieving a good health level)			28 (93.7%)

Statistical Analysis of the Data

The computer program SPSS was used for statistical analysis in this study. The significance level was set at .05. The relationships between each theme and each subcategory of the five themes and the relationships among each theme, each subcategory, and the demographic data of the interviewed subjects and their mentally ill relatives were analyzed by Pearson correlation coefficient, factor analysis, t-test, and one way analysis of variance.

The results of Pearson correlation coefficients indicated a positive correlation between a) worry syndrome (TW) and grief syndrome (TG), ($r(30) = .37$, $p = .02$);

b) worry syndrome (TW) and high probability of achieving a good health level (TP), (r(30)= .48, p< .01);

c) worry syndrome (TW) and subjective grief complaints (G2), (r(30)= .44, p< .01);

d) physiological responses of worry syndrome (W3) and subjective grief complaints (G2), (r(30)= .43, p< .01);

e) the objective signs of worry (W4) and objective depressive symptoms (G3), (r(30)= .31, p= .05);

f) grief syndrome (TG) and direct source of worry (W1), (r(30)= .32, p= .04);

g) grief syndrome (TG) and the families' physiological responses of worry syndrome (W3), (r(30)= .46, p< .01);

h) high probability of achieving a good health level (TP) and the families' physiological responses of worry syndrome (W3), (r(30)= .44, p< .01);

i) high probability of achieving a good health level (TP) and the objective signs of worry (W4), (r(30)= .46, p< .01);

j) high probability of achieving a good health level (TP) and number of members in the same household, (r(30)= .32, p= .04).

Also the results showed that there was negative correlation between a) the perplexed feeling about mental illness (W2) and subjective symptoms of grief (G1), (r(30)=

.33, p= .04);

b) the subjective grief complaints (G2) and behavior of blaming others (A2), (r(30)= -.32, p= .04);

c) the teachable moment (TT) and subjective symptoms of grief (G1), (r(30)= -.32, p= .04);

d) high probability of achieving a good health level (TP) and behavior of blaming others (A2), (r(30)= -.31, p= .05);

e) patient's age and the families' behavior of blaming others (A2), (r(30)= -.33, p= .04);

f) number of family members and the time the patient has been diagnosed as mentally ill (r(30)= -.50, p< .01).

In general, there was a positive correlation between worry syndrome and grief syndrome, worry syndrome and high probability of achieving a good health level, and high probability of achieving a good health level and number of members in the same household. A negative correlation was found between subjective symptoms of grief and perplexed feeling about mental illness, subjective symptoms of grief and behavior of blaming others, the teachable moment and subjective symptoms of grief, and high probability of achieving a good health level and behavior of blaming others (see Table 8).

Table 8

Positive (+) and Negative (-) Correlations Between Clinical Indicators of Each Theme and Demographic Data

	TG	G1	G2	G3	A2	TT	TP	TIME OF BEING DIAGNOSED
TW	+		+				+	
W1	+							
W2		-						
W3	+		+				+	
W4				+			+	
G1						-		
G2					-			
A2							-	
Patient's age					-			
Number of members in the household							+	-

Note. TG, G1, G2, G3, A2, TT, TP, TW, W1, W2, W3, and W4 represent grief syndrome, subjective grief reactions, grief complaints, objective grief signs, blaming others, teachable moment, high probability of achieving a good health level, worry syndrome, direct worry, perplexed feeling, physiological complaints of worry, and objective signs of worry respectively.

In order to provide a final summary concerning the relationships among the various responses expressed, the response scores were submitted to principal components analysis. Two such analyses were performed, once using theme subcategories scores and again using theme total scores. The analysis of theme subcategory scores resulted in five significant components, having eigenvalues of one or larger. Using the conventional rule of thumb that any factor loading of $\pm$ .40 or larger indicates significance for that loading, the following interpretations were made of the factors (see Table 9): Factor 1, Objective Suffering (cluster of objective signs of worry and grief); Factor 2, Blame (cluster of blaming others and objective signs of anger); Factor 3, Subjective Suffering (cluster of feeling perplexed about mental illness, subjective physiological complaints of worry, and subjective complaints of grief); Factor 4, Resentment versus Confusion (cluster of subjective symptoms of worry and anger, objective signs of grief, and feeling perplexed about mental illness); Factor 5, Grief versus Hope (cluster of grief syndrome and lack of teachable moment).

Analysis of the response total scores resulted in two significant factors (see Table 10). The factors were named as follows: Factor 1, Constructive Suffering versus Anger

(cluster of worry syndrome, grief syndrome, and high probability of achieving a good health level versus anger syndrome); Factor 2, Grief versus Hope (cluster of grief syndrome versus teachable moment).

Table 9

Principal Components Analysis of 12 Response Subcategory Scores

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Communality
W1	.14048	-.18978	.18638	.62478	.05795	.48419
W2	.30845	.05904	.50262	-.58536	-.24900	.75590
W3	.31221	.03442	.76204	.14692	.18239	.73477
W4	.88273	.00970	.08502	.09004	-.05729	.79792
G1	-.30980	.09196	.16199	.26148	.74268	.75062
G2	-.00686	-.22895	.78803	.15966	-.03772	.70037
G3	.46176	.04028	.04221	.41722	.50024	.64093
A1	.13646	.24625	.16758	.65414	-.12527	.55093
A2	-.07348	.84471	-.12637	-.17771	.05679	.76970
A3	-.08547	.88166	-.03942	.19370	.00381	.82372
TT	-.11575	.02204	.06063	.21033	-.80214	.70523
TP	.64190	-.30564	.26478	.07391	.01759	.58133
Eigen.	2.70129	1.92900	1.45670	1.17477	1.03387	8.29563
% Var.	22.5	16.1	12.1	9.8	8.6	69.1

Note. W1, W2, W3, W4, G1, G2, G3, A1, A2, A3, TT, and TP represent direct worry, perplexed feelings, physiological responses of worry, objective signs of worry, subjective grief reactions, grief complaints, objective signs of grief, subjective angry reactions, blame others, objective signs of grief, teachable moment and high probability of achieving a good health level respectively.

Table 10

Principal Components Analysis of Five Response Total Scores

	Factor 1	Factor 2	Communality
TW	.74849	.29490	.64720
TG	.40641	.72797	.69511
TA	-.43118	.30798	.28077
TT	.16574	-.76807	.61740
TP	.86665	-.04967	.75355
Eigenvalue	1.78468	1.20936	2.99404
% Variance	35.7	24.2	59.9

Note. TW, TG, TA, TT, and TP represent worry syndrome, grief syndrome, anger syndrome, teachable moment, and high probability of achieving a good health level respectively.

These results collectively lend support to the construct validity of the interview process. Dimensions emerged which make good psychological sense; for example, grief (denial, helplessness, hopelessness, self-pity, and guilt) versus hope (strong teachable moment), and constructive suffering versus anger.

The results of *t*-test showed that a) the male subjects had more direct worry than the female subjects ($t(28) = 2.05$, $p = .05$);

b) the male subjects had more anger syndrome than the female subjects ($t(28) = 2.49$, $p = .02$);

c) the male subjects had more angry complaints than the

female subjects. ($t(28) = 2.44$, $p = .02$);

d) the subjects who had more than one patient at home had more direct worry about the mental illness and the mentally ill person than those who had only one patient at home. ($t(28) = 2.86$, $p = .01$);

e) the subjects who had more than one patient at home had more objective depressive expressions during the interview than those who had only one patient at home ($t(28) = 2.6$, $p = .02$).

The results of one way analysis of variance revealed that a) patient's educational levels made a difference on the subject's objective signs of worry; relatives of the patient who had a primary level of education had more fidgety behavior than the families of the patients who had senior high, vocational school, and junior college education ($F(29, 30) = 2.57$, $p = .04$);

b) the families of the unmarried patients blamed other more than the families of the married patients. ($F(29, 30) = 4.52$, $p = .04$);

c) the families of the patients that were housewives had more fidgety behavior during the interview than the families of the patients that had no occupation. Also the families of the patients that worked as labor workers had more fidgety behavior during the interview than the families

of the patients without an occupation, or those patients who worked as soldiers and students ($F(29, 30) = 3.63$, $p < .01$);

d) the subjects who worked as teachers had more depressive complaints than those who worked as managers, soldiers, housewives, and labor workers ($F(29, 30) = 3.14$; $p = .02$);

Summary

Data from the thirty families of the mentally ill patients have been analyzed and presented. The demographic data of the families and their mentally ill patients were presented by frequency tables. The clinical indicators of the critical attributes which included worry, grief, anger, teachable moment, and high probability of achieving a good health level were identified.

Common to every response from the relatives towards the occurrence of mental illness on their family member were worry and grief. In every interview, the signs and symptoms of grief and worry were evident. The themes of anger, teachable moment, and high probability of achieving a good health level were found in the majority of the interview data. The result of data analysis showed that there was positive correlation between worry syndrome and grief syndrome, worry syndrome and high probability of achieving a good health level, and high probability of achieving a good

health level and number of members in the same household.

A negative correlation was found between subjective symptoms of grief and perplexed feeling about mental illness, subjective symptoms of grief and families' behavior of blaming others, subjective symptoms of grief and the teachable moment, and behavior of blaming others and high probability of achieving a good health level.

The results of factor analysis showed that the subjects' responses toward mental illness and its attendant behavior could be categorized as subjective and objective suffering, blame, resentment versus confusion, grief versus hope, and constructive suffering versus anger. Moreover, these results support the construct validity of the interview process.

An additional finding was that the male subjects were predominant in subjective signs of direct worry, anger syndrome, and angry complaints than the female subjects. The families who had more than one patient at home had more direct worry and more objective depressive expressions than those who had only one patient at home. Single patients' family blamed others more often than the families of the married patients.

CHAPTER 5

SUMMARY OF THE STUDY

Chapter five contains the summary of the study and a discussion of the findings. The conclusions drawn from the findings are presented. Recommendations for further study are included.

Summary

The research problem of the study was to examine the nature of experience of having a family member diagnosed as mentally ill. The concept of pre-crisis was selected as the framework. A descriptive qualitative research methodology and content analysis as proposed by Wilson (1985) were used. The research setting was a Provincial General Hospital in the northern part of Taiwan, Republic of China. A non-probability sampling was used to select the thirty participants in the sample and ten participants in the pilot study. The participants were adult relatives of the patients recently diagnosed as mentally ill. Those diagnosed with drug addiction, mental retardation, and alcoholism were excluded. Two instruments, a demographic data form and an interview guide, were used for data collection. Each subject participated in the interview and completed the demographic data form.

From data analysis the clinical indicators of the five

attributes of pre-crisis, including worry, grief, anger, strong teachable moment, and high probability of achieving a good health level, were identified. Findings indicated that adult relatives of the mentally ill patients exhibited patterns of responses to the occurrence of mental illness in their family members. More specifically, people in pre-crisis experienced worry, grief, and anger and possessed the strong teachable moment and a high probability of achieving a good health level. The results of factor analysis showed that five different traits were contained in the subjects' responses to the occurrence of mental illness in their family members. These traits were subjective and objective suffering, blame and anger, resentment versus confusion, grief versus hope, and constructive suffering versus anger.

Discussion of Findings

The data collected from the interviews were categorized to identify empirical indicators of pre-crisis. Participants' responses concerning their experience of having a family member diagnosed as mentally ill were reviewed from the interview data. Evidences of a pre-crisis state were relatively consistent throughout each interview. Participants responded candidly to the interview questions.

Common to every response toward the occurrence of

mental illness within families was the theme of worry and grief. In every interview the signs and symptoms of worry and grief were evident. The theme of anger, teachable moment, and high probability of achieving a good health level was present in 73.3%, 83.3%, and 93.7% of the participants respectively.

The themes of worry , grief, and anger were strongly supported by the literature. These three reactions to a stressful event of significant loss are common (Caplan, 1961; Werner-Beland, 1980a). Theoretically, any illness results in disequilibrium and a certain degree of loss to the sick person and his/her family. This phenomenon is more obvious in the case of mental illness because of the uncertainty of etiology and prognosis (Schooler, Levine & Severe, 1980), the attendant irrational behavior (Walsh, 1985), the attached label of stigma, and the feeling of guilt (Lin & Lin, 1981). According to Schoenberg, Carr, Peretz, and Kutscher (1970), following the loss there is a state of thinking, feeling, and activity that is the first consequence of the potential or actual loss. Therefore, worry is important because it stimulates individuals to make the necessary adjustment and adaptation. Grief work lightens the subsequent load of the impending loss. Anger is the natural consequence when an important life goal is

blocked.

The findings of this study revealed that each of the thirty subjects had at least one event to worry about, nine had two, eleven had three, six had four, and three had five. The empirical data indeed supported the finding that the occurrence of mental illness brought about worrisome problems for the families of the mentally ill. The major source of worry was the patient's future life (53.3%). Could the patient continue his/her work or school? Could the patient make a living by himself/herself? In a community attitudinal survey in 1963, Rin (1978) found that the majority of Chinese believes that mental illness is always somatogenic and is caused by the weakening of some important physiological functions. Chinese also tend to believe that psychosis is incurable and cases need to be isolated. Twelve years later, another community survey (Rin et al., 1977) revealed a strikingly similar tendency. People still tend to believe that the treatment of psychosis is difficult and expensive, that psychiatric patients are not trustworthy and should be isolated or avoided. Implicitly, the families in this study were worried about who was going to take care of the patient, how long and to what degree the families had to be responsible for the care of the patients, and most importantly what the future life

of the patient would be.

Another worry was medical expenses (46.7%) and the patient's progress (46.7%). How much would be needed for medical expenses? Could the family afford the long-term expenses? Would the patient improve during his/her stay in the hospital? Some families worried about other people's attitudes (43.3%). They felt that the patients might draw other people's attention to their families. Other families worried about the patient's prognosis (40.0%) and the impact of mental illness on others (40.0%). What chance had the patient for complete recovery? To what degree could the patient recover? What hardships to the family and the community would be caused by the patient? A relatively small proportion of the families worried about the patient's ability for self-care (33.3%). Families worried that the patients might commit suicide and homicide or that the patients did not take good care of themselves. The families who had more than one patient at home had more direct worry about the mental illness and the mentally ill person than those who had only one patient at home ($\underline{t}(28) = -2.86$, $\underline{p} < .01$).

These sources of worry were not unusual findings. Grad and Sainsbury, Kint, and Hatfield had similar finding in 1963, 1978, and 1979. Kint's (1978) study indicated that

the overwhelming problem for the schizophrenic patients' families had been finding effective treatment. The primary need for the families was specific suggestions for coping with patients' behavior. The second need was for extensive knowledge and understanding of the symptoms underlying the patients' behavior. Result of factor analysis in the present investigation revealed that the resentment-confusion continuum was one of the five response patterns. In other words, the subjects might respond to the occurrence of mental illness in their family members with grief, worry, and anger or with perplexed feelings about mental illness, including the nature and prognosis of mental illness and methods of caring for the patients.

Twenty out of thirty subjects (66.7%) in this study felt perplexed about mental illness and its attendant behaviors. The causes of the mental illness (43.3%) and methods of care for the patient (43.3%) were two major concerns for these families of mental patients. Families expressed concern about how to get along with the patient (20.2%) and why the patient's behavior was so hard to understand (13.3%). In total, eight subjects felt perplexed only once, eight subjects twice, and four subjects three times. The great concern for methods of dealing with the patients' behavior could be interpreted as meaning that

knowledge about mental illness is closely related to the families' ability to manage the patients' problems. And evidently, the families of the mentaly ill did not have adequate knowledge about the mental health/illness. They need advice about appropriate expectations, specific techniques for managing the patient's disturbed behavior, and the availability of community resources.

In the present study, nine subjects had one subjective symptom of grief, eleven subjects had two, and six subjects had three. The major response in this area of concern was a feeling of helplessness (60% of the sample). A feeling of guilt (40.0%) and a feeling of self-pity (40.0%) were second. Using denial as a defense mechanism (13.3%) was third. A feeling of hopelessness (10.0%) was expressed the least number of times. Consequently, more people had feelings of helplessness than those who had feelings of hopelessness. In some way this phenomenon had more positive meaning than the opposite ratio, because the psychiatric mental health professionals could do more efficient active work with those who were in need of help. Denial of the mental illness has existed a long time (Lewis & Zeichner, 1960; Mayo, Havelock, & Simpson, 1971; Yarrow, Clausen, & Robbins, 1955; Yarrow, Schwartz, Murphy, & Deasy, 1955), but the families' feelings of guilt and self-pity should not be

neglected. At least three studies (Potasznik & Nelson, 1984; Reiter & Plotkin, 1985; Reynold & Hoult, 1984) suggested that mental health professionals promote advocacy for mental patients and their families and also develop community support systems.

Concerning the anger syndrome, nine subjects had one complaint about either the patient's irrational behavior or the extra physical, psychological, social, and financial burden which had been placed on them. Two subjects in this study had both of these complaints. Moreover, fourteen subjects had blamed others once during the interview, three had twice, and one had three times. Collectively, twenty-two subjects (73.3% of the sample) had an anger syndrome, and eighteen subjects (60% of the sample) had blamed others. This phenomenon needs to be noticed by the mental health professionals in order to start primary prevention, or more specifically, to prevent further complications. On the one hand, anger may be an individual's projection of guilt onto others in order to diminish his/her guilty feeling (Werner-Beland, 1980a). On the other hand, even though anger is a frequently observed response to a misfortune or a loss, anger is not without consequence. Expression of anger gives rise to new problems. The angry individual may be conscious of the fact

that his/her feelings are misdirected. The awareness of the fact that feelings are being misplaced or misdirected can produce increased psychological discomfort in the individual since he/she realizes the appropriate object for the aggression is missing (Brenner, 1976). Furthermore, taking out the individual's anger on an unrelated object, especially an unrelated person who has done nothing to merit these feelings, may increase the individual's feelings of guilt and may also increase fear of retaliation. In addition, the individual may not know who or what the appropriate object is (Werner-Beland, 1980a). The mental health professionals have been trained to understand and to accept the expressions of anger of the patients and their families. However, families usually directed their anger against a scapegoat. Both the angry family members and those whom they blamed need support.

This study revealed that the major objects of blame were the family members in the same household (23.3% of the sample), followed by someone unrelated to the family (20.0%), attitude of the acquaintances (16.7%), service of the hospital (13.3%), and past experience with the patients' treatment (3.3%). These data implied that the patients' families had a high tendency to have further conflicts within the household. Blaming other family members may lead

to another problem for the family. In general, the relatives' anger needed to be directed in an appropriate way. Hatfield (1981) and Walsh (1985) suggested that the self-support group made up of members who had the same problems and similar plights would be very helpful in terms of sharing feelings and methods of problem management.

The strong teachable moment and high probability of achieving a good health level were inferred from the subjects' behavior such as information seeking, awareness of the ineffectiveness of habitual coping methods, and seeking help from various resources. Theoretically, attitude change involves cognitive, affective, and psychomotor domains. To know intellectually is usually the first step for changing, but intellectual awareness of the situation does not necessarily lead to a behavior change (Werner-Beland, 1980b). No significant correlation between teachable moment and high probability of achieving a good health level was found in this study ($r(30) = .09$, $p = .312$). However, to maintain relatives' teachable moment should be one of the mental health professionals' concerns. This is a time mental health professionals especially the nurse should be alert to effect change and to help the families of the mentally ill have continuous learning.

Twenty-three subjects (76.7% of the sample) asked the

researcher about mental illness during the interviews: What was the prognosis? What were the proper methods for caring for the patients? Combining these data and subjects' perplexed feelings about mental illness and its attendant behavior, lack of knowledge in mental health/illness in patients' relatives became more evident.

The empirical data indicated that the resources from which the subjects had gotten help included medical personnel (80% of the sample), family members (46.7%), religion (26.7%), friends (23.3%), Chinese herbs (16.7%), community based financial aids (6.7%), counselors (6.7%) and meditation (3.3%). The high percentage of information obtained from medical personnel has occurred because the subjects had their mentally ill relatives staying in the hospital during the study period. The families had more opportunity to have contact with medical personnel. However, the finding of this study revealed that family members and friends played an important role in offering help. Caplan and Killilea (1976) placed high value on the family as a support system. They observed its value in providing a stable belief system, information and practical wisdom, a haven for rest and recuperation, and such practical assistance as transportation, housekeeping, and child care. Relatives serve as active listeners, permitting

grieving, and offering support and love. Friends may be serving as family substitutes in this highly mobile geographic area. On the other hand, psychiatric mental health professionals have to be very careful because sharing problems with families and friends is usually limited to people who have the same plight or who are able to understand the suffering (Hatfield, 1979; Lin & Lin, 1981). Without those people whom the families can trust, relatives of the mentally ill would not reach out for help. Public education and awareness of mental health/illness still merit attention.

The findings of this study revealed that the grief syndrome was closely related to the worry syndrome when individuals faced a stressful event ($r(30) = .37$, $p = .02$). Furthermore, the worry syndrome was positively related to the subjective grief complaints ($r(30) = .44$, $p < .01$); subjective grief complaints was positively related to physiological responses of worry ($r(30) = .43$, $p < .01$); objective signs of worry was positively related to objective signs of grief ($r(30) = .31$, $p < .05$); the grief syndrome of worry was positively related to sources of worry ($r(30) = .32$, $p = .04$). The major source of worry was identified as worry concerning the patients' future life. Again, public education concerning mental health/illness is imperative in

development of community mental health program. Public education should provide practical realistic advice on how to deal with the illness, offer empathy and support to relatives of the mentally ill, and ensure that adequate treatment and rehabilitation services are available (Falloon, Liberman, Lillie, & Vaughn, 1981; Lamb & Oliphant, 1978).

The other important finding was the significant correlation between high probability of achieving a good health level and worry syndrome ($r(30) = .48$, $p < .01$). In other words, worry is not necessarily negative. Worry stimulates the individual to get help from various sources. Conversely, this researcher found that there was a negative correlation between the teachable moment and subjective symptoms of grief. Individuals who had more subjective symptoms of grief, such as feelings of helplessness, hopelessness, self-pity, and guilt, were not aware of the ineffectiveness of their habitual coping methods and not being able to seek the related information for problem management. Finally, the continuum of grief-hope was supported.

Another interesting finding was the negative correlation between blaming others and high probability of achieving a good health level. If the individual spent most

of his/her energy blaming others, the individual would not have sufficient energy to get help from available resources.

Furthermore, the finding revealed that Chinese culture influenced relatives' responses toward the occurrence of mental illness in their family members. The male subjects had more direct worry about the mental illness and had more anger syndromes than the female subjects. Chinese society traditionally is male centered. Males are supposed to bear more responsibility in decision making and to be assertive. In addition, the families of the unmarried patients had blamed others more than the families of the married patients. The meaning of this finding became more significant in light of Chinese families' attitudes toward the patients' marriage; the Chinese family would try to arrange a marriage for the patients in order to bring back the harmonic state of yin and yan or get rid of the potentially embarrassing and burdensome problem of keeping a patient at home. However, arranged marriage is no longer easy in the modern society. The families of the unmarried patients had at least one more frustration than the families of the married patients.

Finally, the factor analysis which has been used in this study extracted five traits underlying the nature of relatives' responses to the occurrence of mental illness on

their family members, namely subjective and objective suffering, blame and anger, resentment versus confusion, grief versus hope, and constructive suffering versus anger. These categories could serve as a basis for the mental health professionals when planning services for the mentally ill patients and their families in Chinese society. Public education about mental illness and promotion of advocacy for the relatives and the patients of the mentally ill are imperative. Also, family support groups deserve attention from the mental health professionals in terms of developing, organizing, and helping the self-support group for the families of the mentally ill.

The Chinese family usually has a high tolerance for keeping the mentally ill patient at home. This is rooted in family loyalty and a sense of obligation to take care of the sick or unfortune member (Lin, Tardiff, & Donetz, 1978). Development of self-support groups for the families of the mentally ill is more practical for the Chinese population in terms of money saving and effective care.

Conclusions and Implications

Mental illness is different from physical illness. People who are physically ill may suffer more than those who are mentally ill, but the families of the mentally ill definitely have more difficulty in managing the patient's

problems than the families of the physically ill. However, what kind of suffering the family goes through and what assistance they need have not gained enough attention from the mental health professionals. This study adds more meaning to primary prevention in terms of delineating specific facets of relatives' responses toward the occurrence of mental illness in their family members. These include subjective and objective suffering, blame and anger, resentment versus confusion, grief versus hope, and constructive suffering versus anger.

This study also indicates the importance of qualitative research in concept clarification. Based on the findings of this investigation, the concept of pre-crisis is defined as a state of thinking, feeling, and acting following the occurrence of a stressful event. The attributes include worry and anxiety, grief and depression, anger and frustration, strong teachable moment, and high probability of achieving a good health level.

In addition, the interview guide enabled the researcher to elicit information which directly focused on each participant's responses to the occurrence of mental illness in family members. With the information obtained from this study, several potentially useful findings have been extrapolated. There is now a clearer understanding and a

more accurate description of relatives' responses to the occurrence of mental illness in a family member. By extending the current knowledge about relatives' needs and their reactions to the mentally ill patients and the mental illness, the mental health professionals can come closer to developing a more tangible plan for serving these people, such as public education and awareness of the mental health/illness and the care of the mentally ill, promotion of advocacy of the relatives and the patients of the mentally ill, and organization of self-support groups made up of the patient's families.

The general information collected from this study has been used to define and clarify the concept of pre-crisis. This research constituted the first step toward theory building. With the information obtained from this study, the proposed hypotheses include: a) Education concerning mental illness, including a knowledge of the disease and practical information about its management, to the relatives of the mentally ill reduces families' degree of worry, grief, and anger. b) Self-support groups made up of the relatives of the mentally ill provide opportunities for sharing sufferings and methods of problem-solving with group members.

Recommendations for Further Study

A limitation of this study is that the findings cannot be generalized. These data cannot be generalized to other ethnic groups or even to the Chinese immigrants in other countries. From this limitation, important implications for further research can be derived. This study suggests that the following research questions merit attention: a) What is the response pattern toward the occurrence of mental illness on the family members in other ethnic groups? b) How does the response pattern in the Chinese population compare with other ethnic groups and with Chinese immigrants in other countries? c) What factors contribute to the present pattern? and d) Does this pattern influence the choice of hospital and community services?

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APPENDIX A

PROTECTION OF HUMAN SUBJECT

TEXAS WOMAN'S UNIVERSITY
Box 22939, TWU Station
RESEARCH AND GRANTS ADMINISTRATION
DENTON, TEXAS 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Chia-Ling Mao Chen Center: Denton

Address: P.O. Box 25317, TWU Station Date: 4/26/85

Denton, TX 76204

Dear Ms. Chen,

Your study entitled Pre-crisis in Mentally Ill Patients' Family

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

XX Other: Debriefing of participating families, either orally or in writing

____ No special provisions apply.

cc: Graduate School
Project Director
Director of School or ✓
Chairman of Department

Sincerely,

Chairman, Human Subjects Review Committee

at Denton

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR DISSERTATION

This prospectus proposed by: CHIA-LING MAO CHEN

_____ and entitled:

PRE-CRISIS IN FAMILIES OF THE MENTALLY ILL.

Has been read and approved by the members of (his/hers) Research Committee.

This research is (check one):

_____ Is exempt from Human Subjects Review Committee review because _____

_____

_____

XXX Requires Human Subjects Review Committee review because AUDIO-TAPE-RECORDER WILL BE USED IN THE INTERVIEW PROCESS.

_____

Research Committee:

Chairperson Margaret T. Beard 3/7/85

Member [signature] 3-7/85

Member [signature] 3/7/85

Member [signature] 3/7/85

Member [signature] 3/7/85

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Provincial Tao-Yuan General Hospital

GRANTS TO Chia-Ling Mao Chen

a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Relatives' reactions to the occurance of mental illness on their family members.

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: May 7, 1985

Signature of Agency Personnel

Chia-Ling Mao Chen
Signature of Student

Margaret W. Bond
Signature of Faculty Advisor

* Fill out & sign three copies to be distributed as follows: Original - Student: First Copy - Agency; Second copy - TWU College of Nursing.

TEXAS WOMAN'S UNIVERSITY
HUMAN SUBJECTS REVIEW COMMITTEE

CONSENT FORM B

Title of Project: _____

_____

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time. I further understand that no medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

_____ _____
Signature Date

_____ _____
Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____ _____
Signature Date

_____
Position

_____ _____
Witness Date

One copy of this form, signed and witnessed, must be given to each subject. A second copy must be retained by the investigator for filing with the Chairman of the Human Subjects Review Committee. A third copy may be made for the investigator's files.

CONSENT FORM C (*to be used in addition to Form A and B when voices or images are to be recorded*)

TEXAS WOMAN'S UNIVERSITY

We, the undersigned, do hereby consent to the recording of our voices and/or images by _____, acting on this date under the authority of the Texas Woman's University. We understand that the material recorded today may be made available for educational, informational, and/or research purposes; and we do hereby consent to such use.

We hereby release the Texas Woman's University and the undersigned part acting under the authority of Texas Woman's University from any and all claims arising out of such taking, recording, reproducing, publishing, transmitting, or exhibiting as is authorized by the Texas Woman's University.

SIGNATURES OF PARTICIPANTS*

_____
Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

***

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____ _____
Authorized representative of the Texas Woman's University — Date

*Guardian or nearest relative must sign if participant is minor.

ORAL PRESENTATION TO PARTICIPANTS

My name is Charlene Mao, and I am a doctoral student in Nursing at Texas Woman's university, Denton, Texas. The purpose of the study that I am conducting is to investigate relative's feelings about having someone in the family with a mental disorder.

If you agree to participate, I would like to interview you. The interview will last approximately 30 minutes and will be audiotaped so as not to lose any of the valuable information. After the information has been transcribed, the tapes will be erased. You will not be called by your full name on the tapes so there will be no way that anyone can identify you.

You can withdraw your consent at any time before, during, or after an interview without fear or penalty, that the care I or anyone else provides your relative/patient or his/her family will be affected. I understand there is no risk involved and no names will appear in the reporting of the study, and you have opportunity to ask any question that you may have. There may be no direct benefit from participating in the study, but the findings will help health care professionals to have a better understanding about patient's families and aid nurses in assisting other families with their emotionally ill relatives.

If you have any question, please do not hesitate to ask.

Thank you.

APPENDIX B

INTERVIEW GUIDE

Part I: Demographic Data Sheet

Demographic Data of the Patient.

1. Patient's Age _____
2. Sex. Male _____, Female _____
3. Education. None _____, Primary school _____,
   Junior high _____, Senior high _____,
   Vocational school _____,
   Junior college _____, College _____,
   Graduate school _____.
4. Occupation _____.
5. Marital status Single _____, Married _____,
   Seperated _____, Divorced _____,
   Widow _____.
6. Diagnosis _____.
7. Approximate date of diagnosis _____.

Demographic Data of the Interviewee.

1. Interviewee's age _____.
2. Sex. Male _____, Female _____.
3. Education None _____, Primary school _____,
   Junior high _____, Senior high _____,
   Vocational school _____,
   Junior college _____, College _____,
   Graduate school _____.
4. Occupation _____.
5. Marital status Single _____, Married _____,
   Seperated _____, Divorced _____,
   Widow _____.
6. Relationship with the patient
   Father _____, Mother _____,
   Husband _____, Wife _____,
   Son _____, Daughter _____,
   Others _____.(specify)
7. Number of members in the same household _____.
8. Do you live in the same household with the patient?
   Yes _____, No _____.

Part II: Interview Questions

1. How do you describe the patient's mental illness.
2. What does mental illness mean to your family?
3. What is the impact of patient's illness on the family?
4. How do you manage the problems which is caused by that (from question 3)?
5. What are the resources available to the family?
6. Is there any further information you would like to share with me? (or any question the interviewee may raise.)

APPENDIX C

RESULTS OF THE PILOT STUDY

Table C-1

Demographic Data of the Interviewed Subjects

1. Sex: 4 males and 6 females
2. Age: mean: 42.2 ± 15.38; Mode: 45-year-old
3. Educational level:

None: 1	Elementary: 4
Vocational school: 1	High school diploma: 2
College: 2	

4. Occupation:

Student: 2	Housewife: 3
Teacher: 1	Businessman: 1
Labor worker: 1	Retired: 1
None: 1	

5. Relationship with the patient:

Father: 1	Mother: 4
Husband: 3	Sister: 2

6. All of the interviewed subjects are living in the same household with the patients.

Table C-2

Demographic Data of the Patient

1. Sex: 4 males and 6 females
2. Age: Mean: 26.9 ± 17.32; Mode: 16-year-old
3. Educational level:

None: 1	Elementary school: 1
Junior high: 2	High School Diploma: 2
Vocational school: 2	Junior College: 1
College student: 1	

4. Occupation:

None: 5	Housewife: 2
Secretary: 1	Cashier: 2

5. Diagnosis:

Unknown: 1

Manic depressive psychosis: 1

Manic: 1

Schizophrenia: 3

Acute psychotic stage: 1

Personality disorder: 1

Depression: 2

Table C-3

Clinical Indicators of Worry and Anxiety Syndrome

Subjective data	Frequency	Total
1. expressed directly their worry about		13
a. personal business	1	
b. family	1	
c. financial problems	2	
d. personal ability in taking care of the patient and the whole family.	1	
e. other people's attitude	1	
f. patient	7	
a) safety	(2)	
b) future	(2)	
c) patient's present condition	(1)	
d) prognosis	(2)	
2. felt perplexed about present situation regarding		19
a. causes of mental illness	4	
b. patient's behavior	3	
c. how to help their relative (the patient)	6	
d. what is wrong with the patient	2	
e. how to get along with the patient	1	
3. made comparison of the patient with other patients		3
4. had complaints of		4
a. sleeplessness	2	
b. headache	1	
c. loss of body weight	1	
Objective data		2
1. kept talking throughout the interview.	1	
2. Pre-occupation with patient's problem.	1	

Table C-4

Clinical indicators of grief and depression syndrome

Subjective data	Frequency	Total
1. use of mental defense mechanism of denial by saying that		3
a. I cannot believe that patient has a mental illness	1	
b. mental illness will not be happen in my family again	1	
c. we were shocked about his/her illness	1	
2. feel helpless and hopeless by saying that		9
a. there is no happiness at all	1	
b. I can just let the patient do whatever he/she wants to do	1	
c. I will collapse if it lasts longer	1	
d. there is nobody to share the burden	1	
e. I am the only one who suffers at home	1	
f. It is hard to get help from the outside	1	
g. nobody is able to help	1	
h. I only hope... but how long will it take	1	
i. I try to get away from the stressful situation, but there is no place to stay.	1	
Objective data		9
1. looks sad	1	
2. frowns	1	
3. looks sad with tears in the eyes	2	
4. looks desperate	1	
5. weeps	1	
6. looks tired and sighs	1	
7. laughs bitterly	1	
8. bursts out crying	1	

Table C-5

Clinical Indicators of Anger and Hostility

Subjective data	Frequency	Total
1. express their anger directly by saying that "I am angry with the patient because ..."		13
a. patient's behavior is intolerable	1	
b. patient is not supposed to do things like...	1	
c. patient makes extra burden such as	11	
a) family pattern has changed	(1)	
b) I have to come and visit him/her	(4)	
c) I cannot rest	(1)	
d) no one is taking care of the housekeeping	(1)	
e) I feel the stress physically, psychologically, and financially	(1)	
f) patient insists on going home	(1)	
g) I have to take care of the patient	(1)	
h) another member of the family cannot sleep well	(1)	
Objective data		3
1. looks mad	1	
2. keeps distance from the researcher	2	

Table C-6

Clinical Indicators of Strong Teachable Moment

Subjective data	Total
1. awareness of the ineffective of old coping pattern	
a. doubting about personal coping in the past	2
2. seeking information about treatment of mental illness and caring for the patients.	2

Table C-7

Clinical Indicators of Probability of Achieving a Good Health Level

Subjective data	Total
1. seek help from various resources	5