TABLE OF CONTENTS

Abstract

Acknowledgements

I. Introduction 1

II. Method 3
- General concepts 4
- Operationalization 9
- Sample 10
- Data Collection 12

III. Data Analysis 16

IV. Implications 18

Bibliography

Appendix 1

FAMILY ACCEPTANCE AND ITS AFFECT ON THE COMMUNITY ADJUSTMENT OF THE SCHIZOPHRENIC PATIENT

by

Dianne Lafrenz
Ellen Landsman
Paul McClure
Glenn Reynolds

ABSTRACT

Submitted in partial fulfillment
of the requirement for
the degree of

MASTER OF SOCIAL WORK

Michigan State University
School of Social Work
East Lansing, Michigan

1968

ABSTRACT

It was the intent of the authors to investigate the necessity of family or family-like support in the successful community adjustment of the schizophrenic young adult. The three areas around which this was done included the family's attitude toward the agency contacts with both family and patient, the family's attitude toward the patient's re-socialization, and the family's attitude toward the patient's hospitalization. The significance of the family's attitude toward agency contacts and the greater significance of the family's attitude toward re-socialization indicate the necessity for more extensive involvement of the family by the treatment agency in the agency's efforts to assist the patient in making a successful community adjustment.

The third area of study, the family's attitude surrounding the patient's hospitalization, was not found to be significant and indicates the need for a more extensive study.

The authors would like to express their appreciation to Mrs. Lenore Kroman, director, and the staff of the Lansing Consultation Center for allowing us free access to their agency facilities and records. Also a special thanks to Mr. Kime for the time and effort he spent with us. Without them, this project would have been impossible.

INTRODUCTION

The current trend in the field of mental health is to treat the individual in the community, thereby keeping him as useful a community member as possible. In Michigan, the state hospitals are attempting to send back into the community as many of their patients as will be able to function there for at least some period of time. Regional consultation centers have been set up to keep these discharged patients, be they moderately mentally retarded or hallucinating schizophrenics, in their homes, with their families and on jobs. The staff of the Lansing Consultation Center, the agency in which this study took place, consider themselves successful if they are able to keep their patients functioning well enough so that neighborhood attention (because of bizarre behavior, unkempt personal habits, neglect of children or home, or other maladaptive behavior) does not demand the patient's rehospitalization. This study will look at one aspect of the problem of community maintenance--the patient's family as it facilitates the patient's adjustment.

According to Lutz's Family System Theory, the family has certain tasks relating to its family members. One of the most important tasks is that of emotional support. The family of the schizophrenic has that same task. The authors of this study contend that the interpersonal

family relations of the schizophrenic have a major impact on how successful the patient will be in sustained community living and adjustment. Those families whose emotional input is adequate, on the basis of their goals for the patient and acceptance of his limitations and symptoms, will produce a patient who will remain out of the hospital and in the community longer and will function at a higher adjustment level.

The major hypothesis to be tested in this study states that family support and acceptance will significantly affect the patient's ability to satisfactorily adjust to community living. This can be further broken down into three sub-hypotheses as follows: 1) The family's attitude toward patient and family contact with the helping agency will affect the patient's ability to adjust in the home and community; 2) The family's attitude toward the re-socilazation of the patient upon hospital release will significantly affect the patient's home and community adjustment; 3) The family's attitude surrounding the patient's hospitalization will affect his adjustment after release.

It is felt that the first set of attitudes is the major factor in patient adjustment to community living. The second and third sets are considered to be ~~significantly~~ important, although not to the degree of the first.

METHOD

In order to test the previously stated hypotheses, a sample was selected from the Lansing Consultation Center's schizophrenic patient population (criteria for selection will be discussed at a later point). Three broad areas were defined as playing significant roles in the patient's community-family adjustment. The first area covered the family's attitude toward all patient-family contacts with the agency. This included their attitude toward the contacts the patient had with the agency as well as their own contacts or in some cases, lack of contacts. It also included the family's attitude toward the patient' overt symptoms. It was felt that this particular area is related to the kinds of attitudes the family has toward the agency in general. Those families who accept the agency and see it as a helping place are more likely to seek the agency's help when symptoms arise, or seem to be worsening. The second area included the family's attitude toward socialization. How did they view the patient and participation in activities that included others? It also included expectations the family held for the patient after his return from the hospital to the community. The third broad area covered the family's attitude surrounding the previous hospitalization of the patient. How did they feel at the time of hospitalization? What was their attitude toward the patient's release? How often did they visit?

What was their general attitude toward the illness before and during hospitalization?

These were the general concepts involved in the hypothesis. The actual operationalizing was done as follows:

Area one was broken down into three categories (each of which was then scaled). Category one was the family's attitude toward the patient's contacts with the consultation center. An accepting family was defined as one that encouraged patient-agency contacts, co-operated with the agency's suggestions and encouraged the patient's co-operation. A non-accepting family was one that hindered the patient's coming to the agency and tried to destroy or sabotage the help offered there. Category two dealt with the family's attitude toward their own contacts with the center. An accepting family saw their contacts as necessary, while a rejecting family refused all contacts. Category three involved the family's toleration of the patient's overt symptoms. Such symptoms aroused hostility in the rejecting family (who did nothing but react with hostility), while the accepting family tried to act on agency recommendations on how to handle them. These categories were weighted more heavily than the others because it was felt that they were more indicative of family support of change in the patient.

Area two was broken down into four categories.

The first required scaling of the family's attitude toward the patient as a participant in the family. The accepting family encouraged the active participation of the patient in family affairs while the rejecting family worked to keep him an inactive, possibly withdrawn member. The accepting family might encourage the patient to help with family chores, participate in family recreational activities and interact with other members. Non-accepting families encouraged isolation and minimal contact with other members. Category two scaled the family's attitude toward the patient's participation in outside social/community activities. The accepting family encouraged such participation while the non-accepting did not allow such participation on the part of the patient. Category three was concerned with the family's attitude toward employment for the patient. The accepting family was in favor of employment if it was in the interest of the patient and encouraged his efforts in that direction. They also might have aided him in his search for a job that was within his ability to handle. The final category indicated the family's expectations for the patient upon release from the hospital. The accepting family expected the patient to get better, but also expected him to move at his own pace. The expectations at the other end of the scale were for the patient to get well immediately upon release (or to have been cured before

release) or for him to remain at his release level of functioning and never progress.

The third area was also broken down into three categories surrounding hospitalization. The first included the family's attitude toward the patient's hospitalization at the time of the hospitalization. The accepting family saw a need for it and had encouraged it. Hospitalization may have been at their own request. At the other end of the scale, the family tended to hinder the hospitalization process, submitting to it only in the face of some outside pressure. (The authors began with the premise that encouragement of hospitalization is a positive support for the patient as it provides help for him despite evidence of a generally non-accepting attitude. Case histories tended to support this premise.) Category two dealt with the family's attitude toward the patient's release from the hospital. The accepting family worked toward his release and encouraged him to do likewise. At the other end of the scale, they were against his release and might have set up blocks in planning for the release. Category three was concerned with the frequency of family visits during hospitalization. The accepting family was defined as one which visited the hospitalized patient often, or at least with some regularity (assuming that the distance between home and hospital was not prohibitive), while the rejecting family never visited during the course of hospitalization.

The final category scaled the family's attitude toward the patient's illness before and/or during the patient's hospitalization. The accepting family felt it would be of some benefit to the patient and viewed the patient as ill. They did not expect a miracle cure however. The non-accepting family usually did not view the patient as ill, and tended to see little reason for or value in hospitalization.*

As to the dependent variable, a patient's family and community adjustment was defined as successful if certain criterion were met in terms of roles and the performance of the tasks appropriate to those roles. Within the family, the patient needed to be participating as an active member. He needed to be more than an isolated individual who spent the entire day in his room or watching television. The housewife needed to be able to assume responsibility for some of the jobs around the house and be able to cooperate with those who were also assuming responsibilities. There also had to be an indication that she was performing well generally and notjust fulfilling specific roles while seeming to come apart overall. For example, those patients who were either employed or conscientiously seeking

*See Appendix 1 for details of scaling as shown in the instrument itself.

employment (in addition to performing adequately in the home) were judged a success. Those holding jobs needed to be stable in them (as opposed to those who were constantly job-hopping) and getting along relatively well with fellow employees and employers. Success in employment was not rated solely on the ability to obtain a job and perform some of the tasks appropriate to it. Return to school was also considered a measure of success in adjustment. The patient who constituted the strongest success was the patient who was able to do above average work and complete the course(s) enrolled in. A final measure of success was progress in therapy as judged by the individual's therapist.

Success and failure were measured on a very pragmatic basis. The patient who was having difficulty with his family, could not hold a job, exhibited much bizarre behavior, appeared very withdrawn and isolated, or finally was returned to the hospital could not be termed a success. If he seemed to be functioning without a great deal of difficulty and seemed to be making an effort to perform, he was termed a success regardless of the necessity of agency support. It was felt that it was appropriate for the patient and/or his family to look to the agency for understanding and guidance, and would be a sign of strength rather than failure. No actual score was recorded for success or failure. If the patient indicated more areas

of adjustment strength than failure and stabilization or consistent progress (rather than regression) was indicated, he was recorded as a success. If he showed little progress beyond hospital release level, regression or was having a great deal of difficulty in most areas of functioning, he was recored as a failure. Success was judged on an individual basis rather than on a general group scale because of the diversities of adjustment levels at the time of hospital release and agency/therapist expectations for each patient.

The sample for this study was drawn from the schizophrenic population seen at the Lansing Consultation Center and its branch in Jackson, Michigan. This agency serves all discharged and convalescent status patients from state hospitals and training schools who live in the Lansing-Jackson area. Initial contact begins after hospital release and terminates at the decision of the patient or patient and therapist. In rare instances it is required of such a patient that he be in contact with the agency as a condition of his release from the hospital, but all patients in the sample were seen at the agency on a voluntary basis.

Selection for the sample was made of the basis of age, diagnosis and length of contact. The age range was twenty years to thirty years of age AT THE TIME OF FIRST CONTACT with the Consultation Center. This increased the likelihood

of there being a family involved with the patient. It decreased the inclusion of patients with a long history of previous hospitalizations. The diagnostic label was limited to that of schizophrenic reaction. Personality disorders were not included. Severely retarded patients were also not included, although borderline and very moderately retarded patients were included as long as the major diagnosis was schizophrenic reaction. The sample was also limited to patients having had contact with the agency for at least four months, regardless of how extensive such contacts may have been. This allowed the patient's worker sufficient time to get to know the patient and evaluate and record the patient's progress.

The data was collected in two parts, which were the attitude ratings and the success-failure ratings. All the information needed for both was available in the patient's case record. There was the possibility of each rating being influenced by the other in that a rater might be more likely to score a patient successful if he knew that there had been much positive family involvement and vice-versa. It was felt that there was minimal biasing of scores for both parts as the material for the two areas (success-failure and acceptance) appeared in separate parts of the file. The acceptance rating score was derived from

the first half of each record by two researchers independently. In most instances there was very close agreement between the two independent scores for each item. In the case of differences in scores, the two raters came to an agreement on a score by discussion. Once the ratings were done, the file was given to a third rater who determined success or failure entirely on the basis of the other part of the record. All ratings and judgements were made on the basis of the material recorded in each case record.

DATA ANALYSIS

The four hypotheses concerning the effect of the family's acceptance of the schizophrenic patient on his adjustment to community living were translated into null hypotheses for purposes of testing. These are:

1. Family support and acceptance will not significantly affect the patient's ability to satisfactorily adjust to community living;
2. The family's attitude toward patient and family contact with the helping agency will not affect the patient's ability to adjust in the home and community;
3. The family's attitude toward the re-socialization of the patient upon hospital release will not significantly affect the patient's home and community adjustment;
4. The family's attitude surrounding the patient's hospitalization will not affect his adjustment after release.

The number of cases in the sample was 65. 37 were scored successful, while 28 were scored failures. The mean scores for the success groups for all hypotheses were higher than the mean scores for the failure groups. There was a difference of 3.30 for the major hypothesis (1 above) ($t=1.72$, $p<.05$); 1.89 for sub-hypothesis one ($t=1.76$, $p<.05$);

1.89 for sub-hypothesis two ($t=2.32$, $p<.05$). While the success group did score higher on sub-hypothesis three, the difference between the groups was only 0.21. The t-test showed three of the four to be significant at the $p<.05$ level. The major hypothesis and the first two sub-hypotheses were each found to be confirmed at this level, while the third, concerning attitudes surrounding the patient's hospitalization, was not confirmed.

Sub-hypothesis two, being so strongly significant ($t=2.32$, $p<.05$), may have been the major factor in confirmation of the total hypothesis. Sub-hypothesis One was weighted more heavily in scoring (see Appendix 1), which may or may not have had the effect of keeping One and Two as close as they were.

The tests indicate a negation of three of the four null hypotheses. The general hypothesis that family support does significantly affect the patient's ability to adjust satisfactorily to community living is thereby confirmed, as are the particular hypotheses that the family's positive attitudes toward contacts with the helping agency and even more significantly that positive attitudes toward the patient's re-socialization will facilitate the patient's successful readjustment outside the hospital.

Table 1

Group Mean Scores by Attitude Areas

Area	Success Group n= 37	Failure Group n=28	Differences
Attitude toward agency contact	12.78	10.99	1.79*
Attitude toward socialization	9.03	7.82	1.89*
Attitude toward hospitalization	9.81	9.60	0.21
Total of all [illegible]	31.62	28.32	3.30*

* These differences were significant at $p < .05$

The test results did not, however, permit us to reject the fourth null hypothesis. There was no significant difference between the family's attitudes surrounding the patient's hospitalization and the patient's adjustment after release. This particular hypothesis was more difficult to test than the other three. There was more missing data here. For those with no score for a particular category, the mean score was assigned for that category. While the information for categories A, C, and D was generally available, it was more difficult to find and often had to be implied. An accurate measurement was more difficult to obtain on this part than on any of the others.

IMPLICATIONS

The results of this study indicate that agency contact with both patient and family plays an important part in aiding the schizophrenic patient to maintain a successful community adjustment. It indicates further that the family's attitude toward the patient's participation in community and family affairs is also a very important factor. The significance of this attitude holds an added implication for the treatment agency. While individual patient focus is important, an added emphasis on a broader, family-centered focus may be beneficial. Such an emphasis could be used by the agency to aid the family in developing the support and encouragement seen here to be important to the patient's successful recovery and post-hospital adjustment.

Further research might delve into three areas suggested by the test results. The difficulty in reaching any significant conclusion about the family's attitude toward the patient's hospitalization might be explored further. A more objective study might be done by gathering the data directly from the hospital records where it is possible to review all dates of visits, correspondence with patient and hospital staff and reports of all other family contacts.

A breakdown and analysis of the individual items and sub-areas of the rating scale might be helpful, to see

where the actual differences occur. This was not done here only for reasons of limited time.

A third area for more extensive research lies in the formation of research and control groups composed of families where special work would be done in teaching them how to give support and encouragement to their schizophrenic members. If family support and acceptance is indeed the key to the patient's successful adjustment, in what ways can the family be helped to provide that support most effectively? An assumption underlying this is that the family can be so helped and that these attitudes are not non-communicable. That, also, would need to be proven.

BIBLIOGRAPHY

Greenblatt, Milton, Maida A. Soloman, Anne Evans, George Brooks, eds., DRUG AND SOCIAL THERAPY IN CHRONIC SCHIZOPHRENIA, C. C. Thomas, Springfield, Illinois, 1965.

Jackson, Don D., ed., THE ETIOLOGY OF SCHIZOPHRENIA, Basic Books, New York, 1960.

Lidz, Theodore, Stephen Fleck, Alice R. Cornelison, SCHIZOPHRENIA AND THE FAMILY, International Universities Press, New York, 1965.

Lutz, Werner A., THE FAMILY AS A SYSTEM, Great Lakes Regional Institute, Detroit, Michigan, 1966.

APPENDIX 1

ATTITUDE RATING SCALE

I. Attitude toward agency contacts

A. Attitude toward patient's contacts
   a) attitude toward contacts with agency per se
      1. Hindered his coming
      3. Allowed to come
      5. Encouraged his coming
   b) attitude toward help given at agency
      1. Tried to destroy worker's help
      3. Indifferent
      5. Cooperated with worker's suggestions

B. Attitude toward own (family) contacts with agency
   1. Refused to come (refused all contacts)
   2. Reluctant
   3. Came, but felt there was nothing there for them.
   4. Saw some possible help
   5. Saw as necessary

C. Toleration of patient's symptoms (as related to agency's views on handling)
   1. Aroused hostility
   2. Ignored
   3. Accepted but did nothing
   4. Called agency (primarily to complain)
   5. Tried to act on agency recommendations

II. Attitude toward socialization

A. Family's attitude toward patient's participation as family member
   1. Kept out of
   2. Allowed participation
   3. Encouraged participation

B. Family's attitude toward patient's participation in outside social activities
   1. Not allowed to participate
   2. Allowed
   3. Encouraged to participate

C. Attitude toward employment
   1. Against
   2. Accepted
   3. Encouraged

D. Family's expectations for patient upon hospital release
   1. Expected patient to never get well or to get well immediately
   2. Expected patient to get well
   3. Expected patient to get well, but will allow patient to go at own pace

III. Attitude surrounding hospitalization
  A. Attitude toward patient's hospitalization at time of hospitalization
    1. Hindered
    2. Allowed
    3. Encouraged (may have requested)
  B. Attitude toward release
    1. Against
    2. Indifference or acceptance, but did nothing in anticipation
    3. Worked for patient's release
  C. Frequency of visits during hospitalization
    1. Never
    2. Seldom
    3. Often
  D. Attitude toward illness before or during hospitalization
    1. Denied illness
    2. Expected complete cure
    3. Felt it would help somewhat

All statements about the agency are at the point nearest to, but after four months after inital contact.

Point range: 12-44

STATE OF MICHIGAN

GEORGE ROMNEY, Governor

DEPARTMENT OF MENTAL HEALTH

WILLIAM H. ANDERSON, M.D., Director

REGIONAL CONSULTATION CENTER-LANSING
1203 West Oakland Avenue
Lansing, Michigan 48915
Area 517 373-1700

May 16, 1968

I hereby grant permission to Ellen Landsman, Paul McClure, Glenn Reynolds, and Duanne Lafrenz to use agency records for a group research project in partial fulfillment of the requirements for a M.S.W. at Michigan State University, School of Social Work.

Lenore J. Kroman, ACSW
Executive Director