

family response to the mental illness of a relative: a review of the literature*

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One of the few persistent statistics in the mental health literature is that 30 percent of patients released from mental hospitals return to the hospital during the 1st year following discharge. Over a longer period of time, the statistics are even bleaker. In New York State, for instance, more than 60 percent of all admissions to State hospitals are readmissions. For many patients rehospitalization occurs more than once and, indeed for some, becomes a way of life. It has been customary to refer to such a series of hospitalizations as the "career" of the mental patient.

The contemporary, widespread policy of short-term multiple hospitalizations has meant that the old pattern of chronic hospitalization—in which the long-hospitalized patient each year becomes further removed from the concern of his family—is virtually a thing of the past. Increasingly, the family is becoming involved in long-term interaction with and care for the "former" patient, whether the patient returns to the family home on discharge, moves to his own quarters, or is a resident of a sheltered communal environment. Yet the mental health community's concern with the family's response to this new pattern of involvement has been meager.

In the past, the study of the family in relation to the mental illness of a relative has generally focused on its possible role as an etiological factor in the origin or outcome of the disorder. Family models of psychopathology—based on the symptomatology of the parents, the specific types of interactions between parent and child, or the idea of a disorganized family

social system—have been used with varying degrees of success to explain the extent to which the family contributes to or maintains the state in which the disordered person finds himself.

The role of the family in the etiology of schizophrenia is still uncertain (Frank 1965 and Mosher and Gunderson 1973), but we know that family members who have a psychiatric disorder can and frequently do have profound effects on other family members. The ambiguous nature of psychiatric illness (at least in its early stages) and the consequent episodic eruptions of deviant behavior require an adjustment in the family that is in itself stressful—an adjustment that includes definition and help seeking and, in all but acute cases, the responsibility for the continuing care of the patient. Additionally, family roles must shift to accommodate the behavior or deficiencies of the sick member, and the strain of this accommodation is often chronic. Considering these obvious stresses, it is surprising that the same investigators who provided ample documentation of the career of the mental patient have so sadly neglected the reciprocal career of the patient's family.

Recently, however, investigators have changed their perspective to incorporate a view of the family as *reactor* to (rather than purely causal agent in) the mental illness of a member. This change is important for its own sake. For one thing, it permits the specification of the kind of adaptation that occurs when a functioning family interacts over time with a deviant member for whom it feels and is considered responsible. For another, it permits a fuller description of the system in which the patient operates, one to which he may return and which will, in all likelihood, be a critical factor in determining prognosis.

*Studies cited in this paper often use as respondents families of hospitalized patients without regard to diagnosis. Occasionally, investigators restrict themselves to a sample of families of schizophrenics; when this occurs, it is noted in the text.

There is still another equally beneficial consequence of research on the family as reactor (although the literature has rarely been used to this end), and that is that such research may help clarify issues of causality by isolating the part the family's reaction to deviance plays in the family's current interactional pattern. It has frequently been assumed in family research that 1) the family's behavior instigates the patient's behavior, 2) the family observed at the time of the research has remained unchanged through time, and 3) any inferences of the past that are based on observations in the present are valid if they "make sense" or if they meet the test of statistical significance for correlational analysis. Such a view has been legitimately questioned (Fontana 1966) and is clearly in need of correction. The inclusion in the description of the patient's family system of the family as responder, as well as stimulus, has immeasurably broadened its conception and has permitted an important first step to be taken toward the development of a true interactional approach.

The introduction of the family as a subject of study in the attempt to understand the response to mental illness occurred in the early 1950's when a theoretical interest in deviance and social control (Festinger et al. 1952, Parsons 1951, and Schachter 1951) and in social perception (Bruner and Tagiuri 1954) provided a conceptual framework for social scientists who had become concerned with the mentally disordered patient and his family (Parsons and Fox 1952 and Yarrow et al. 1955). Not too much later, the practical needs of hospital psychiatry to assess the effects of the then innovative programs of community care for mental patients turned the attentions of psychiatric researchers to the families of patients as agents of rehabilitation and bearers of burden (Brown, Carstairs, and Topping 1958).

The convergence of these two lines of interest, practical and theoretical, led Clausen and Yarrow (1955)¹ to undertake pioneering research that dealt specifically with the problems and attitudes of the

families of mental patients. They had little relevant research to guide them, as their legitimately sparse bibliography made amply clear. Even as late as 1959, 4 years after the appearance of their report, a review of the literature by Spiegel and Bell (1959) for the *American Handbook of Psychiatry* cited Clausen and Yarrow as the major source for the section of the paper dealing with the impact of mental illness on the family.

The findings of the Clausen and Yarrow investigation reflected the natural history of the wife's reaction to her husband's deviant behavior. In ordering the literature to be reviewed in this article, we, too, employ a loosely defined natural history approach, one that derives somewhat from the Clausen and Yarrow (1955) presentation, but has the changes and extensions necessary to allow for the incorporation of new materials and different points of view. In this way we shall cover the evolution by the family of the mental illness hypothesis and the family's consequent attitudes and behavior in response to the labeling and hospitalization of the relative. In the final section, we discuss the relationship of family attitudes, particularly tolerance of deviant behavior, to outcome after discharge.

The Family's Definition of the Problem

Research on nonpsychiatrically involved samples indicates that the public labels very few behaviors as indicating mental illness. There appears also to be a general consensus that the public's attitudes toward the mentally ill in affective, cognitive, and conative terms is largely negative (see Rabkin 1972 and the preceding article in this issue for a review of opinions of mental illness). Given a definition of mental illness narrower than that used by professionals, and a setting in which attitudes are largely negative, how do families explain and react to the behavior of a relative who later will be labeled "mentally ill"?

The family's attempt to understand the meaning of the behaviors they observe is thought to follow a predictable course that shows both acceptance and denial, certainty and uncertainty. It is not unlike Lederer's (1952) description of the reaction of patients to physical illness. He noted three definite, established stages of response. The first of these, the transition period from health to illness, was characterized by an awareness of symptoms, anxiety over their presence, denial or minimization of symptoms, and some residual

¹ Throughout much of this paper, frequent reference will be made to Clausen and Yarrow (1955), Schwartz (1956 and 1957), Yarrow, Clausen, and Robbins (1955), and Yarrow et al. (1955). These articles discuss various aspects of a single retrospective study, and most were published in the *Journal of Social Issues*, vol. 11(4), 1955, under the general editorship of John Clausen and Marian R. Yarrow. The sample in this study comprised the wives and families of 20 psychotics and 13 neurotics who were hospitalized for the first time for mental disorder. Unless otherwise stated, findings reported in this article are for the total group of 33.

anger or passivity. If symptoms persisted and the interruption of everyday routines continued, then diagnosis and therapy resulted and the patient was encouraged to accept the "sick role." This marked the second stage. In the third stage, the patient was concerned with convalescence and the return to the functioning adult role. For part of his formulation of this sequence, Lederer drew upon Barker's (1948) discussion of the physically disabled.

Lederer's analysis of the sick role was the product of his own observations, and dealt primarily with the patient's changing perceptions. Yarrow et al. (1955) described a very similar process governing the family's coming to terms with the symptoms of mental illness. The wives of 33 mental patients were interviewed a number of times, from soon after the husband's hospitalization until 6 months after his return home or until 1 year after hospitalization. The investigators described the phases the wife went through in defining her husband's behavior: The shifting interpretations, the occasional outright denial, and the stable conclusion, once a threshold for tolerance had been reached, that the problem was psychiatric or, at least, one that could not be dealt with by the family alone. The family's naivete about psychiatric symptoms, the deviant's fluctuating behavior, and the observed presence of lesser forms of the symptoms in "normal" people all acted as factors operating against a swift recognition of mental illness. Yarrow et al. (1955) concluded:

The findings on the perceptions of mental illness by the wives of patients are in line with the general findings in studies in perception. Behavior which is unfamiliar and incongruent and unlikely in terms of current expectations and needs will not be readily recognized, and stressful or threatening stimuli will tend to be misperceived or perceived with difficulty or delay. [p. 23]

Psychological vs. Nonpsychological View of Illness

Psychological explanations of deviant behavior were rarely invoked by the family during the early stages of mental illness (decompensation). 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 et al.'s (1955) study felt something was seriously wrong when their husbands 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 20 percent of the wives of psychotic patients still denied that their husbands were mentally ill.

Similarly, in an interview approximately 3 weeks after a family member's hospitalization, 18 percent of Lewis and Zeichner's (1960) sample of the families of 109 first admissions at three Connecticut State hospitals 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 patients' state was at variance with the staff's view of the nature of the illness.

Some attempts to identify the correlates of a psychological versus nonpsychological view of illness were made in the works of Hollingshead and Redlich (1958), Freeman (1961), and Linn (1966). In the first two studies, social class or education was the moderating variable; in the last, family relationship. In Hollingshead and Redlich's sample of New Haven residents, the families of the three lowest class patients (classes III, IV, and V) showed a marked tendency to rely on somatic theories, heredity, or the "evil eye" to explain the patient's aberrant behavior. Classes I and II, on the other hand, had more detailed information about their relative's illness and explained the deviance on the basis of nerve strain, fatigue, or overwork. In contrast to the findings of Hollingshead and Redlich, Freeman found that education (but not other indicators of social class) and age were factors in the attitudes of relatives of discharged patients in the Boston area. He studied the relationship between relatives' attitudes regarding the etiology of mental illness and the degree to which responsibility for their condition was imputed to patients. A psychogenic view was related to the feeling that the patient could recover and was not to blame for

his illness. On the whole, better educated and younger relatives had more positive attitudes toward the patient.

Linn (1966) interviewed either the wives or mothers of 34 recently hospitalized schizophrenic men and found that mothers more often than wives had a psychological explanation for their sons' illness; wives tended to believe their husbands' behavior was caused by physical and environmental factors. Linn reasoned that, since wives more than mothers were concerned with role performance, they were more likely to see the illness in terms of negligence in fulfilling role obligations, or as a result of environmental stress.

Effects of Distance or Closeness of Relationship to the Patient

The view that motivation and values could affect the perception of other people, so much a part of the zeitgeist of the 1950's, generated an interest in the psychological impediments to a mental illness explanation of deviant behavior. Generally, it was assumed that the closer the relationship to the deviant, the greater the perceived threat and anxiety resulting from a psychological definition of deviance, with the consequence that, all other things being equal, closeness would result in delay or outright denial.² Schwartz (1957) was the first to observe and report the occurrence of this phenomenon in her investigation of the family's response to the mental illness of a member. Shortly after, Rose's (1959) study of the families of hospitalized patients in Massachusetts and Mill's (1962) impressions of English families in a similar situation also supported the view that the closer the tie of the relative, the less ready the family to perceive mental illness.

Still further confirmation came from Sakamoto (1969), who concluded that, on the basis of his experiences as a family therapist in Japan, *distance* appears to facilitate a diagnosis of psychological dis-

turbance. He 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. Sakamoto did not believe that this relationship was culturally determined, and he found support for his conclusion in the observation of the same phenomenon in families of American patients (Wynne et al. 1958).

This line of research has not gone unchallenged, and the simple hypothesis that closeness is associated with delayed recognition has not stood the test of time. Both the type of symptom and aspects of the patient-family relationship have been shown to be related to the recognition of mental illness.

A focused interview technique was used by Clausen (1959) in interviews with the spouses of 23 schizophrenics (males and females). He concluded that when symptomatic behavior was directed against the spouse, it was more likely that a deviance framework would be used to interpret the behavior. Safilios-Rothschild (1968) replicated Clausen's study in Greece and confirmed his findings. In fact, Safilios-Rothschild disputed Schwartz's original hypothesis, because she found that spouses who were maritally satisfied, and therefore presumably close, did not arrive at a deviance explanation later than dissatisfied spouses. Both Clausen and Safilios-Rothschild observed that the definition of the behavior as deviant actually resulted in feelings of relief for the spouse, since the marriage was no longer perceived as threatened.

In another study, Sampson, Messinger, and Towne (1962) isolated two types of marital accommodations, which were so high in their tolerance of deviance that either the patient or the community was responsible for first labeling the behavior as deviance and then arranging for hospitalization. Yet neither of these accommodations could conventionally be called close, and in both cases it was the withdrawal from the deviant early in the marital relationship that permitted bizarre behavior either to go unnoticed or to be explained in normal terms. Sampson, Messinger, and Towne intensively interviewed 17 schizophrenic women and their husbands during and after the wife's first hospitalization and found that some marriages were characterized by mutual withdrawal, and others by the wife's continued intense relationship to her mother. In both situations it was not until the conventional accommodation was threatened

² Another interpretation of the delaying mechanism may be derived from Goffman's (1963) work on stigma. There, it is proposed that the more intimate the relationship between two people, the more complex the picture they have of one another. If this is true, then a psychiatric symptom in a family member would not be seen as the defining characteristic of that person but would be interpreted in the context of the total person. In that case, the importance of the symptom might not be as obvious to the family as to an outsider.

and new role behaviors required that the deviant behavior became troublesome and consequently noticed.

Perhaps the hypothesis that emotional closeness delays labeling has attracted more attention than other problems in family labeling because it was clearly stated and could be derived from a popular theoretical position (perceptual defense theory). As a consequence, research on this hypothesis has done more than demonstrate the existence of an imperfect relationship between closeness and delay. More complex interactions invoking such variables as quality of the relationship between patient and family and whether symptoms are directed against a family member have resulted in alterations in the original formulation.

Typologies Based on Family Response

Three articles in the literature deal with typologies or classifications of the family's response to the mental illness of a member. Since these typologies have not been tested on samples other than the original and do not appear to have generated further research, neither their utility nor their heuristic power has been demonstrated. It is possible that they have not been used because it is expected that they will suffer, as do most typologies, from a lack of generalizability to new samples, an incomplete description of the data, or the inability of researchers other than the originator to use them satisfactorily. In any event, the absence of any followup study of these systems of classification makes it difficult to ascertain their value or deficiencies.

Korkes' (1959) interview study of the parents of 100 schizophrenic children yielded four basic "ideal" types:

- *Dissociative-organic type*—Parents falling into this category disavowed responsibility for the child's condition and generally offered a biological explanation for it.
- *Affiliative type*—This type of family acknowledged its own interpersonal influences as etiological factors.
- *Dissociative-social type*—The parents disavowed any responsibility and offered an extrafamilial explanation for the disorder.
- *A residual category* comprised parents who were highly and continually uncertain about etiology and the role they themselves played in their child's illness.

Korkes' data supported her expectation that parents who accepted personal responsibility were more likely to

undergo profound changes in personal values, marital relationships, and child-rearing behavior. These parents perceived the patient as a human being who had comprehensible responses and who could be included in family life.

Two aspects of family response to deviance interact in an effort by Spitzer, Morgan, and Swanson (1971) to develop a typology for describing the family's role in the evolution of the psychiatric patient's career. The family's level of expected performance and its propensity to label the deviance in conjunction with the family's appraisal of deviance, its decision to seek psychiatric help, and its implementation of psychiatric care yielded eight family subtypes, which bear such engaging names as stoics, poltroons, happenchancers, and do-nothings. Although the substantive description of each subtype does not seem to be precisely derivable from the component variables in the system, the authors were able to classify 76 of the 79 families of first-admission patients in the above typology.

A concern with the sociocultural determinants of definitions of mental illness led Schwartz (1957) to order three commonly occurring definitions of deviance (characterological, somatic, and psychological) along four variables (partial-global extent, alterability, recent-remote occurrence, and situational-somatogenic-psychogenic cause). Eighty percent of her sample of wives of recently admitted patients gave psychological explanations ("not completely crazy" or "out of his mind") of their husbands' illness. A patient who was defined as "out of his mind" was thought to have a global, unalterable, and recently occurring illness. In contrast, being "not completely crazy" was alterable, of recent origin, and only partially disabling. None of these definitions could be differentiated by cause.

Whatever the value of these particular typologies, it is clear, in reviewing the research on family labeling, that families attempting to define the problem posed by psychologically deviant behavior acted as most people do when confronted with ambiguous or stressful stimuli. They generally engaged in a process of redefinition in which they were slow, first, to view their sick member as deviant, and second, to view him as a deviant because of psychological aberrations. As expected, education and social class, which are associated with greater psychological sophistication and therefore reduce ambiguity, were related to the type of explanation used. Intimacy or psychological closeness acted as an impediment to

labeling the behavior as deviant only if symptoms were not directed against a significant other. In certain cases, withdrawal, not intimacy, in an ostensibly close relationship explained the delay in defining the behavior appropriately. These findings have led to a revision of the original closeness-delay hypothesis.

It is puzzling that symptoms, the observable manifestation of mental illness, have not been more widely examined with regard to labeling. The manner of onset, the nature of symptomatic behavior, and the family's ability to tolerate those symptoms being displayed are likely to have some effect on the rapidity with which the definition of the problem occurs. For instance, when onset is gradual and symptoms are not too bizarre, as is frequently the case in the undifferentiated chronic schizophrenic, deviance may come to be expected of the individual, interpreted as "normal" for him, and perceived as neither especially different nor upsetting. Similarly, a high tolerance of deviance, resulting from the interaction of personal history and cultural expectations, may also serve to retard a psychological explanation of the deviant behavior.

The Family's Attitudes Toward Its Deviant Member

By the time hospitalization occurs, most families have come to believe that their deviant member is mentally ill. The possible consequences 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 of affectionate ties. Such positive affect would be a reaction similar to that frequently shown the physically ill. On the other hand, quite different responses may occur. When symptoms are unpredictable or bizarre, the family may become fearful. Anger may occur because of the patient's disruptiveness, or because of family resentment due to increased strain. In cases in which the appearance of mental illness arouses guilt, or when the illness is evaluated in moral terms, attitudes of shame and rejection might be expected. In reality, it is likely that a complex amalgam of all of these responses best represents the family's evaluation with variables such as length and number of hospitalizations, type of symptoms, prehospitalization family interaction, prognosis,

and sociocultural status, to cite a few, determining the intensity with which such attitudes are held. A neutral affective dimension of family attitudes appears unlikely, since hospitalization cannot help but be a significant event in the family's experience.

Despite the wide range of possible responses to deviance in the family, professional interest seems to have concentrated on the negative response 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 behavior. Such a limited focus is probably the result of two factors: 1) a generalization to the family of the negative opinions the general public holds (see Rabkin 1972) and 2) the commonly held assumption shared by many mental health professionals that mental illness is indeed shameful.

In his essays on stigma, Goffman (1963) has not only summarized and elaborated on the professional consensus about the public's reaction to deviance but has provided some insights into the mitigating role that intimacy can play in that reaction. As a rule, when interaction is minimal and affective regard is low, the stigmatized person is assigned a nonhuman quality. The assignment of this quality to the deviant permits the environment to discriminate against him and encourages those who interact with him to behave as if the stigma were the essence of the person. The inevitable outcome of this process is generally believed to be rejection of the deviant.

However, the more intimate the relationship between the stigmatized and the other, the less the stigma defines the person; thus, closeness permits one to see qualities other than the flaw. But to be associated 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.

Goffman presents a persuasive and tenable case for the occurrence of stigma and rejection in response to mental illness, but research on this point, as we shall see, is far from conclusive. People who have had close contact with mental patients do not appear to be as prejudiced against them as those who have not, but there is little evidence that they accept the fate of the stigmatized person for themselves. At the same time,

when rejection does occur, it is not clear that its antecedents are to be found mainly in the family's sense of its own stigmatization.

Yet even within the limitations that a stigma-social rejection framework imposes, certain gaps in research interest are apparent. The literature on the family's affective response to the patient is unquestionably scant and simplistic, and research on the beliefs that families of the mentally ill have about patients generally, and their patient in particular, is virtually nonexistent. A study such as that carried out by Nunnally (1961) on the structural coherence of the affective and cognitive components of the public's attitudes toward the mentally ill has yet to be done with the family as its subject.

Social rejection studies that reflect the anticipated or actual behavioral outcome of interaction with a deviant are, as expected, more numerous. They are technically more sophisticated, but they are not especially complex in their conceptualization of the possible antecedents of rejection.

The Family's Affective Response

The family's affective response is generally assessed either through direct questioning or by the use of a semistructured interview that maximizes the probability of the occurrence of affective responses. Occasionally, affect is inferred from behavioral measures, 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.

One of the earliest studies (Yarrow, Clausen, and Robbins 1955) that examined family attitudes was done in the context of Lewin's (1948) social psychological theory of minority-group belonging. Families in that sample behaved as if they were minority-group members and characteristically showed feelings of underprivilege, marginality, extreme sensitivity, and self-hatred. Fear of the patient was reported by Waters and Northover (1965), who interviewed the wives of long-term schizophrenic patients 2 to 5 years after discharge. Wives were often found to be frightened of their husbands and experienced long periods of tension in the home. Schwartz (1956) and Clausen (1959) reported a considerable amount of anger and resentment on the part of husbands and wives toward their mentally disordered spouses prior to hospitalization.

Some studies have gone beyond the descriptive level. Hollingshead and Redlich (1958) examined social-class differences in the family response to mental illness and found that, whereas resentment and fear were prevalent reactions in lower-class families, shame and guilt were more pronounced in the upper classes. A more intensive interview of a schizophrenic subsample ($n = 25$) in that study (Myers and Roberts 1959), however, indicated that shame at having an "insane person" in the family was a common reaction in class V, the lowest social class. As a result of this shame and a general reluctance to involve themselves with authorities, class V patients were most often hospitalized by people outside the family. In contrast, class III families sought a physician's help, once decompensation occurred, and seemed to be more concerned with the patient's recovery than with feelings of shame and futility.

The general trend, however, despite the expectations of social scientists or the anticipations of common sense, is for families to report little fear, shame, anger, or guilt. For example, about 50 percent of Lewis and Zeichner's sample (1960) 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 study (1959), relatively little stigma and shame was evident in the feelings of family members.

The most positive response to the mentally ill occurred in a sample of Cape Coloured families in South Africa. The families of a group of chronic schizophrenics who had never been hospitalized appeared to have great warmth and love for the sick person (Gillis and Keet 1965). Even those families in the comparison group who had hospitalized a relative continued to express great sympathy for him and maintained regular contact with him.

Theoretically, feelings of shame and stigma should be particularly aroused in situations in which a public display of deviance makes the label obvious to on-lookers, when, as Goffman would say, the "discredit" is clearly observable. When unusual behavior is not evident, then it is less likely that shame would 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 (1963b) study, one might deduce that symptoms are neither bizarre nor easily noticeable. In that case, little shame would be expected. This relation-

ship was somewhat confirmed in a 2-year study of home care for schizophrenic patients by Pasamanick, Scarpetti, and Dinitz (1967). The main study group comprised potential patients who were returned to the home at the point when admission to the hospital was sought. Potential patients were given drugs or placebo, visited regularly by a nurse, and seen occasionally by a psychiatrist. The same treatment was given a second group of "ambulatory schizophrenics" (cases referred to the study by clinics or physicians in the area) who were living at home and had never sought admission to the State hospital. In both the main group and the ambulatory group, a comparison of family response at intake and 6 months later revealed that an already low level of shame and fear (approximately 15 percent) lessened even more over time for both the drug and placebo groups. At the 6-month interview, drug condition made no difference in family reports for the ambulatory group. For the main group, however, only 2 percent of the families in the drug sample reported being ashamed or afraid, whereas 7 percent of the families in the placebo sample were ashamed, and 13 percent were afraid at the 6-month interview. Since patient behavior was in part related to experimental condition, and since shame and fear decreased after contact with the hospital, it appears that when shame and fear do occur, they are as likely to be the consequences of unrestrained behavior as of the formal labeling of the patient.

Secrecy, Concealment, and Withdrawal

The relationship of secrecy, concealment, and withdrawal from friends to feelings of shame and the perception of stigma seems obvious, and Yarrow, Clausen, and Robbins (1955) and Goffman (1963) have been concerned with this problem. Goffman, whose formulations are similar to Lewin's (1948), distinguished between the discredited person who is obviously marked, and the discreditable person whose stigma is not so noticeable. For the discreditable person and his close associates, concealment is possible, and the problem for them becomes one of information management if secrecy is desired. How, then, do families deal with the question of information sharing about the sick person?

No studies have examined the issue of noticeability of symptoms, and the ease with which they can be defined as signs of psychological aberration, and related these variables to secrecy. Thus the test of the connection

between secrecy and discredibility has not yet been made. There are indications, however, that at least for some families efforts at concealment do occur.

One-third of the wives in Yarrow, Clausen, and Robbins' (1955) study 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. Members of the husband's family, who shared the "taint," were almost always told, particularly if they were living close by, and sometimes blamed. The remaining third of the wives could be described as communicating extensively and as expressing fewest fears of dire social consequences. While two-thirds of the sample had deliberately concealed the information about their husbands' illness to a greater or lesser degree, everyone had told at least one person outside the family, usually a personal friend.

Rose's (1959) sample did not report such seclusive behavior. He interviewed the principal or next-of-kin visitor of a sample of 100 currently hospitalized patients in a Veterans' Administration hospital in Massachusetts. The median hospital stay for the patients was 9 years. The majority of the relatives spoken with claimed that they felt no stigma and that they had discussed the illness with other people. Freeman and Simmons (1961) reported the results of a 5-item index of stigma developed for use in their long-term study of the families of recently discharged mental patients. The items dealt primarily with the respondent's behavior with regard to secrecy and social withdrawal. Only 10 percent of the sample indicated agreement with two or more of the items, and only 12 percent agreed with the most popular stigma item, "not telling fellow workers about the patient." Six percent reported avoiding friends. Agreement with at least one of the stigma items was positively related to severity of symptoms (a finding similar to that of Pasamanick, Scarpetti, and Dinitz 1967), social class, and a perception that "others" were unfriendly to them.

Unlike the subjects in Yarrow, Clausen, and Robbins' study, very few of the people in Rose's and Freeman and Simmons' samples reported avoiding friends. This contradiction may be due to the different types of respondents sampled. Yarrow, Clausen, and Robbins' sample comprised the wives of first-admission patients. Rose's sample included the relatives of long-term

patients, and Freeman and Simmons' sample was mixed in terms of number of hospitalizations. It is likely that experience with mental illness plays a role in the eventual reaction of the family to the patient. If this is so, a person faced with the first hospitalization of a relative may feel shame and anger and try to conceal the hospitalization but still not reject the patient, whereas those people whose relatives have been hospitalized a number of times, or for prolonged periods, may have accommodated themselves to the situation and no longer keenly feel and report shame. Lengthy or multiple hospitalizations may make impossible any attempts at concealment and may erode much of the willingness of the family to tolerate once again the patient's disruptive presence. So few studies have reported an analysis of data on number or length or hospitalizations that the process of accommodation to recurrent or prolonged disturbance in family life is virtually uncharted.

Social class was related to the openness with which the patient's illness was discussed by Hollingshead and Redlich (1958). There was a marked tendency for most relatives in all classes to be secretive about the mental illness. The ostensible reasons for secretiveness, however, differed in each class. Class I showed the least overt concern. Classes II and III worried about how public knowledge would affect the family's chances of getting ahead. Class IV reported the classic shame associated with stigma, and class V was secretive because of a wish to prevent snooping and interference with the family. Similar results were found by Myers and Bean (1968) in their 10-year followup of part of the Hollingshead and Redlich sample.

On the whole, the pattern of results with behavioral indicators of stigma (reports of concealment) confirms that found in attitudinal studies of affect. Shame, fear, and anger are present in some cases but do not appear to occupy as central a position as might be expected. Although it is difficult to draw any clear conclusions about the response of family members from these studies, it would be unwarranted nevertheless to underestimate the presence of negative affect, even when data to the contrary are reported. As in other areas of attitude measurement on sensitive issues, negative affect is generally underreported, and the absence of any controls for social desirability or acquiescence makes it almost impossible to judge the extent to which the respondents' statements truly reflect their evaluations. It

is possible, of course, that further research, using better measurement devices and exploring interactions rather than main effects, will result in a sharper and more accurate picture of the family's feelings about a patient member. It seems equally important, however, to expand the conceptual and theoretical notions that have determined the variables chosen for research if a fuller, more complex picture is to emerge.

While contemporary usage generally regards the affective dimension as the major defining dimension for attitudes, this does not mean that nonevaluative beliefs or behavioral predispositions are unimportant. A conceptualization of attitudes, which involves affective, cognitive, and behavioral components, allows one to speak meaningfully of the psychological structure of an attitude, to investigate the relationship among these components, to assess and predict the effect of change in one on the other, and to relate these data to behavior.

Much of the research on attitudes, particularly in the mental health field, attempts to measure action tendencies and is ultimately concerned with the prediction of overt behavior. This task is certainly a most difficult one, requiring as it does knowledge of the actor's feelings, beliefs, and postulated action tendencies along with knowledge of the situational and cultural demands impinging on him. Situations of any complexity are likely to render a number of attitude systems relevant at the same time, and attempts at predicting outcome from a single variable are likely to meet with failure. To give just one example, a family may be thought to provide a proper setting for the rehabilitation of a patient because its members express affection and warmth toward the patient and want him home. Yet the family members' conviction of their inability to care for him or their fear of his bizarre behavior may become obvious in stringent attempts to monitor his activities upon his return; this situation in turn may effectively sabotage the patient's attempts at rehabilitation.

Studies of Social Rejection

Studies of the behavioral component of attitudes toward the mentally ill can most easily be grouped under the heading of social rejection, since they measure a projected tendency to accept or reject a person or class of people.

Much of the research on this subject has drawn heavily on work done in the social psychology of ethnic prejudice and, in fact, the principal measuring tool used in studies of rejection of the mentally ill (the social distance scale) was developed by Bogardus (1925) to ascertain the degree of intimacy permitted by one group of people to another. The social distance scale consists of a number of ordered statements that vary the degree of intimacy of social interaction. The respondent is asked to indicate for each item whether he will accept a particular type of interaction with a *hypothetical* person; for example, whether he would permit a mentally ill person to work with him or to dine at his house or to marry his daughter. A person's attitude is inferred from the highest level of interaction he will accept with the target person.

The remaining studies in this section have focused on the family's attitude or actual behavior toward their hospitalized member and the willingness of the family to reactcept the patient into the home once discharge is a possibility.

Social Distance

To determine the avoidance reactions of the general public to former mental patients, Whatley (1959) administered an 8-item social distance scale to 2,001 persons in Louisiana. The items ranged from those involving "minimal ego involvement" (associating with a former mental patient) to those with "maximal ego involvement" (permitting a person who has been in psychiatric treatment to babysit with your child). The results generally indicated that the younger and more educated the respondent, the more likely he was to be willing to admit a former mental patient into a close relationship. Whatley also asked questions about whether the respondent had ever visited a mental hospital or, more crucial for our purposes, knew of any reported cases of mental illness in the family. Neither visiting a mental hospital nor having a mentally ill person in the family had any effect on attitudes toward the mentally ill—a seeming example of the relative's refusal to accept the fate of the stigmatized.

Bizon et al. (no date) studied a quota sample of Warsaw's residents and found that the closer the contact with the mentally ill, the greater was the expressed willingness to accompany former mental patients to the

theater, to invite them to a birthday party, and to befriend them on a lonely trip.

The results of Chin-Shong's study (1968) of attitudes toward the mentally ill in an extremely heterogeneous, urban American sample ($n = 151$) appear less than clear-cut. Using a social distance scale similar to Whatley's, Chin-Shong examined the effects of degree of closeness to a particular mental patient on social distance from mental patients generally. Analysis of the data showed that there was a significant decrease in attitudinal distance to the hypothetical patient if the respondent had a close tie with an actual mental patient. However, the results were not linear. There was more acceptance if the patient known was a close friend than if he was a family member. It appears that having a patient in the family was sufficiently threatening to mitigate some of the effects of intimacy. While the effects of family ties in this study were not strong, they were not absent as in Whatley's original study.

Chin-Shong's data further suggest that knowing many patients casually is less effective in decreasing rejection than being closely related to a patient. People with close ties to mental patients, unlike those without them, did not reject the hypothetical patient more when they perceived him to be dangerous; they also accepted him more when they judged their patient-relatives to have improved. Chin-Shong interpreted this finding as supporting Goffman's contention that intimacy forces an awareness of the other personal characteristics of the stigmatized person. Age and education continued to be correlated with attitudes toward mental patients in the expected direction.

The question of the impact of hospitalization and its consequences for labeling was the focus of Phillips' work (1963). Phillips, like Scheff (1963), believes that the 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. Phillips studied the relationship of the type of help source to the evaluation of five people described in Star's (1955) vignettes of psychiatric syndromes in a sample of 300 married white women living in a suburb in northeastern United States. The description of a psychiatrically symptomatic person and the help source were varied in a Greco-Latin-square design. After each vignette, the respondent was asked a series of social

distance questions. For each form of sickness described, the rejection score was less when no help source was mentioned and highest when the mental hospital was mentioned as the help source. This basic association was maintained within age groups, religious groups, and social-class groups. If the respondent had known either a family member or a friend who had actually sought help for emotional problems, however, the rejection scores changed. If a respondent's *relative* had sought help, then in the hypothetical cases, rejection was highest either *if no help was sought* or *if the help source was a hospital*, and rejection was lowest for those whose help source was a physician. Overall, respondents with family members who had been mentally ill were less rejecting than those who had a friend or knew no one with emotional problems.

Swanson and Spitzer (1970) wanted to test three hypotheses derived from Goffman's formulations. Specifically, they were interested in 1) how people who are mentally ill stigmatize others who are similarly afflicted, 2) how relatives of the mentally ill stigmatize the mentally ill, and 3) how the propensity of the patient and his family to stigmatize changes as the patient moves through the prepatient, inpatient, and postpatient phases. Six hundred and seventy patients and their families were interviewed at different points in the patients' career, using Whatley's social distance scale. The results on family attitudes indicated that the significant others were less rejecting 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 see this result as evidence of a general solution of the dilemma of the tainted person. Since the attitudes of the significant others were more accepting than those of the patients, they concluded that the family had embraced the patient's fate rather than the alternative of avoiding or terminating the existing relationship.

All in all, there is a slight trend for people who have had close contact with the mentally ill to be less rejecting in terms of the degree of social interaction they say they will accept. This conclusion can only be made very warily, however, since the paucity of studies on the topic limits the generalizability of the results.

Visiting

Visiting seemed, on the whole, to be an excellent indicator of the family's attachment to the patient. While abandonment was occasionally reported, it was generally related to chronicity (Rawnsley, Loudon, and Miles 1962, Rose 1959, and Sommer 1959), class (Myers and Bean 1968 and Myers and Roberts 1959), or age (Rose 1959).

The study that most completely described visiting behavior was carried out by Rawnsley, Loudon, and Miles (1962) in Wales. The records of 230 public and private patients were searched to determine whether the patients were visited, how often they were visited, and by whom. Although 67 percent of the patients in the study had spent more than 2 continuous years in the hospital, 72 percent of the total sample were visited at least once during the year. Twenty percent of the patients had absolutely no visible contact (visits, parcels, or letters) with anyone outside the hospital. For all age groups, visiting was inversely correlated with length of hospital stay. Visiting was more frequent for married patients than for single patients, but after 10 years of hospitalization, single men and married women were the two least visited groups.

The patient's "deculturation" as a result of prolonged hospitalization was the subject of Sommer's (1958 and 1959) studies of letter writing and visiting. Approximately 12 percent of the 1,600 patients in a mental hospital in Saskatchewan had been visited at least once during the 3-week study period, and 10 percent had either sent or received a letter during a later 2-week period. When these patients were compared to a random sample of the hospital's patient population, it was found that contact was related to sex and length of stay in the hospital. Women sent and received more letters, and they were visited more often. Patients who had been hospitalized longer had fewer visitors and less letter-writing contact. Interestingly enough, distance between hospital and home residence was not related to visiting behavior.

An informal analysis of interviews with 100 patients' relatives revealed that younger patients and those with fewer years of hospitalization had more family contact (Rose 1959). This finding is similar to those of Rawnsley

et al. and Sommer. The principal visitor was more likely to be the mother (a reflection of the fact that most of the sample of patients were unmarried), but when wives were the principal visitors, patients were visited less often than when parents were the principal visitors.

In contrast to Rose's study, Yarrow, Clausen, and Robbins (1955) found that wives and children of patients visited regularly, but that parents and in-laws, who would visit in the early weeks of hospitalization, were unlikely to return after one or two visits. The patient's mother was sometimes an exception to this pattern. Schwartz (1956), reporting on the same data, lists four reasons for the drop in visiting. All have an underlying anxiety dimension and deal mainly with the unpredictability of the patient's behavior and his failure to perform role functions.

It appears in one study that when the patient is visited, he is visited often, but when he is not visited, he is completely abandoned. Evans, Bullard, and Solomon (1961) found that 20 percent of their sample had not been visited at all during the previous year. However, 75 percent of those who were visited were seen at least once a month—a considerable degree of contact, especially since all of these patients had been hospitalized for at least 5 years, and 50 percent of the family sample was pessimistic about outcome for their patient-relatives.

Gillis and Keet (1965) interviewed a sample of 16 hospitalized and 16 nonhospitalized chronic schizophrenics and their relatives. Both samples consisted of South African Cape Coloureds, fairly well matched in demographic characteristics. The average duration of illness in both groups was 8 years. When the patients were hospitalized, the relatives were not uninterested in their welfare, and expressed concern by visiting and bringing gifts; they simply did not want the patient home. By placing the patient in the hospital, they had absolved themselves of all responsibility for the patient's condition and now saw the doctor as the main figure in the care of the patient.

A relationship between social class and visiting patterns was observed by Myers and Roberts (1959) and Myers and Bean (1968), whose studies indicated that less visiting, gift giving, and correspondence occurred in class V than in any other class.

The Gillis and Keet study is particularly interesting because it sets into juxtaposition two measures of social rejection, namely, visiting and reaccepting the patient. Under most circumstances, visiting is less likely than reaccepting the patient to be burdensome and/or disorganizing to the family even when the hospital is a considerable distance from the home. One person may be delegated or take on the responsibility of providing support for the patient and acting as the intermediary with the hospital, thus relieving the other members of the family of the need to concern themselves with the patient. (This may account for the dropping away of most of the family reported in Yarrow, Clausen, and Robbins 1955 and Schwartz 1956.) Not visiting can consequently be considered the strongest measure of rejection. While visiting and rejection of the patient's presence in the household seemed to be strongly related in some studies (Alivisatos and Lyketsos 1964 and Myers and Bean 1968), they were apparently independent in others (Gillis and Keet 1965 and Rose 1959). The relationship between visiting and the propensity to accept the patient on discharge would appear to yield a useful index of attachment to or rejection of the patient.

Accepting the Discharged Patient

Cumming and Cumming (1957) have recounted an instance in which a woman who had openly complained of being subjected to "sex rays" for many years was shunned by her sister only after she had been hospitalized briefly. The sister, unwilling to take the patient home, where she had been living continuously until her hospitalization, declared that now that her sister was sick there was no telling what she might do. The Cummings commented somewhat ironically, "Mental illness, it seems, is a condition which afflicts people who must go to a mental institution, but up until they go almost anything they do is fairly normal" (p. 101). While this may be something of an exaggeration, there is evidence that expectations about cure and homecoming are more pessimistic among family members than among the public at large.

In one of the rare studies comparing *beliefs* about mental patients in relatives and nonrelatives, Swingle (1965) asked guests at an "open house" at a Veterans'

Administration hospital to judge how many mental patients out of a hundred behaved in certain specified ways. He found that relatives expected approximately 50 percent of all mental patients to be incapable of returning home after treatment. Nonrelatives (guests with no relatives or acquaintances in the hospital) expected fewer patients (40 percent) to be unable to return home. Swingle also reported trends for relatives to believe that more patients would always remain patients and to perceive fewer patients as being able to conduct themselves properly in town on a 1-day pass. However, relatives and nonrelatives did not differ in their perception of the friendliness or violence of mental patients.

Pessimism about recovery has its behavioral counterparts in studies dealing expressly with family response to a patient-relative's discharge. Rose (1959) observed that whereas most families were verbally agreeable to the idea of discharge, they became resistant once the likelihood of discharge was a reality. Reluctance to take the patient home increased with the number of years the patient had spent in the hospital (see, also, Rawsley, Loudon, and Miles 1962).

Hollingshead and Redlich (1958) noticed a similar reluctance to have the patient return in some of the families they studied and offered a social-class explanation for this behavior. Since classes IV and V (the two lowest social classes) tended least often to have a psychological explanation for the deviant behavior they were exposed to, the authors had assumed that more deviance was generally tolerated in these two classes. On closer examination, however, they discovered that many patients in class V were not discharged because nobody wanted to take them home. This last finding was confirmed and elaborated on by Myers and Bean (1968), who interviewed 387 of the 1,563 relatives of patients who were originally in Hollingshead and Redlich's sample. They found that, with each successive hospitalization, more lower-class families cut ties with the patient. The harsh reaction to the label of mental illness, as well as the alleviation of a sense of burden in the families, operated to reduce contact with the patient and interest in him. As a result, discharges in the lower classes decreased more over time than in middle and upper classes.

Perhaps the harshest judgment of patients recorded was made by the families of 300 chronic schizophrenics hospitalized in Greece. Alivisatos and Lyketsos (1964)

had hypothesized that in a traditional society in which the moral obligations of the family were still strong and there were few special agencies to treat the mentally ill, patients or former patients would be readily reaccepted into the family. Instead, the investigators found that many families ceased to consider the ill person as a family member and felt no obligation for his care at all. Families who originally had been, on the whole, quick to hospitalize (70 percent sought help within a year after they suspected a problem) were slow to accept the patient home again (88 percent of the total sample wanted the patient to remain in the hospital). In almost 50 percent of the sample, the family required total cure as a condition for the patient's return.

Another form of social rejection, the desire to separate from the patient and, more important, an actual separation or divorce from the patient, is a measure of the response to patients by people who have an acquired, terminable relationship to them. Rogler and Hollingshead (1965) did a multiple-interview study of 20 married lower-class Puerto Rican couples in which at least one of the spouses was schizophrenic; they compared the couples' responses with those of 20 neighboring couples with no known history of psychiatric disorder. When asked whether they would marry the same person, a different person, or not marry at all if they had the decision to make today, fewer of the spouses of schizophrenics said they would marry the same person than spouses of normals.

When divorce rates for patients are compared to rates in the general public, they are generally higher. Adler (1955) reported an increased divorce rate for her patient population, and former patients in an English sample had a divorce and separation rate three times the national average (Brown et al. 1966). Seven of the 11 married chronic schizophrenic patients who had been selected for special treatment by Evans, Bullard, and Solomon (1961) had been divorced or separated.

Not all studies indicated such bleak rejection on the part of the family. Some studies reported more favorable attitudes to discharge, and it appeared that the patient's return was welcome. Evans, Bullard, and Solomon interviewed the families of chronic hospitalized schizophrenics who were in a special program preparatory to discharge. Almost 50 percent of the families favored the release of patients who had been hospitalized for 5 years or more. Most of these families had a hopeful but realistic view of the patient's future behavior.

Freeman and Simmons (1963) found that 95 percent of their informants and other family members wanted the patient to live in the household. Similar figures were reported by Brown et al. (1966) in their study of 251 English families who were seen 5 years after the discharge of a schizophrenic relative. Seventy-five percent of the families welcomed the patient home, 15 percent accepted him, and only 12 percent wished him to live elsewhere. These findings are interesting in view of the fact that during the 6 months prior to the interview severe or moderate distress was reported by 30 percent of the families of first-admission patients and 59 percent of the families of multiple-admission patients. In an earlier study by some members of the same group, Wing et al. (1964) reported that of the 99 relatives of English male patients, 40 percent indicated that they would welcome the patient home, 25 percent said they would accept him, 21 percent were doubtful about how they felt, and 13 percent were actively opposed to the patients' return. No family, however, refused to take the patient back when he was discharged. The willingness of English families to care for their mentally disordered relatives and to delay sending them to the hospital is further supported by Mills (1962). Most recently, in an American study, Barrett, Kuriansky, and Gurland (1972) found that 60 percent of the 85 families interviewed 4 weeks after patients were discharged expressed pleasure at the sudden return of a patient due to an unexpected hospital strike in New York State.

The question of who is willing to receive mental patients, and why, is a complicated one. Both acceptance and rejection have been reported in the literature. Overall impressions seem to differ, depending on the values and experiences of the observer. Lidz, Hotchkiss, and Greenblatt (1957), on the basis of their collective clinical experience, have spoken of stigma and withdrawal from the patient, starting at the time of hospitalization. Lemkau (1968), on the other hand, cited the "well-known clinical experience that families often resist the hospitalization of persons and that they often remove family members from the hospital against medical advice, facts not easily made consonant with a rejecting attitude toward mental patients" (p. 353).

Certainly, the absence of systematic empirical studies that take into account such reality factors as economic and social pressures on the family, optimism about outcome, the role the patient plays in the household,

and life-cycle variables permits just this sort of individual speculation based on personal experience.

While social rejection in the general population derives logically from a consideration of stigma, the relationship is not so clear-cut in the families of patients where rejection may be more closely attuned to the practical realities of life. In Grad and Sainsbury's (1963b) study, for instance, 81 percent of the rejecting and negative relatives had reality problems, whereas only 62 percent of the "accepting" group were rated as having such problems. In any case, when the family ceases to interact with the patient because it believes that the patient's condition is irreversible (Cumming and Cumming 1965)—a not untenable notion in view of current recidivism rates—or when discharge plans are met with theoretical approval but actual reluctance, then one must introduce the issue of the cost to the family of maintaining ties with the mentally disordered.

Elaine Cumming (1968) has forcefully brought our attention to the fact that we pay only lip service to the patient's own community, the family and friends who must live with him when he returns after hospitalization. In the United States, she argues, we have ignored the aggravation placed on the community by our present zeal for sending patients home. British psychiatric researchers, on the other hand, have been more concerned with the family, and indeed were the first to raise the issue of family burden in their research. The picture that has emerged from their studies is that of a family willing to receive the mentally ill member back into the home, at least after the initial hospitalizations, but nonetheless hard pressed by the strain and demands of living with a former patient. The entire family is shouldering a burden because one of its members is mentally ill. With the increasing shift in hospital policy toward early release of the patient and home care, the degree to which the family is able or desires to take on and live with this burden is an extremely important consideration.

The first study in this area was done in England in the early 1960's (Grad and Sainsbury 1963a and 1963b). The authors were interested in seeing whether the trend toward caring for the patient in the community really resulted in additional burdens for the family. Families of patients referred to two different types of hospitals were interviewed at 1 month and at 2 years after referral. One

hospital had a traditional policy of removing the patient from the community; the other stressed community care. The interviewing was done by a psychiatric social worker, who estimated the burden on the family by rating the effect the patient had on the family's income, social activities, and domestic and school routines, as well as the strain the patient put on other family members, and the problems he caused with neighbors. Grad and Sainsbury's hypothesis, that the burden would be greater when the hospital had a community-care approach, was confirmed. However, the authors believed their hypothesis was borne out not because of the greater attention required by the patient in the community-care program, but because burden was significantly lightened in families in the traditional hospital condition due to the regular visits to the home by the social work staff.

Somewhat later, Hoenig and Hamilton (1969) also studied family burden in two English communities where home care was the preferred method of treatment. The sample comprised 179 families who had lived continuously with a former patient for the 4 years prior to being interviewed. The investigators differentiated between *objective* and *subjective* burden by asking the family a single question on perceived burden and comparing that to a social worker's rating of the family's objective burden. Fifty-six percent of the families were rated as operating under an objective burden, with the parental home seemingly less burdened than the conjugal home. Fourteen percent of the families reported severe subjective burden, 40 percent reported moderate burden, and 46 percent reported no burden at all. None of the families who were rated as having no objective burden reported any subjective burden. If the patient was older, was from a conjugal home, and was rated as sicker or had spent more time in the hospital during the study period, then more subjective burden was experienced. The authors concluded that there was a great deal of *subjective tolerance* in view of the high objective burden.

While 90 percent of the families in this study were rated as sympathetic to the patient, 56 percent experienced great relief when inpatient admission was resorted to. Sixty-three percent of the latter group had complained of at least "some" burden. Overall, the families reported a remarkably high degree of satisfaction with the hospital and the treatment of the patient there. It

was not reported whether this was truly satisfaction, a rationalization of their decision to hospitalize, or an acquiescent or socially desirable response.

One of the British studies uncovered very little objective burden in the families of schizophrenic patients (Mandelbrote and Folkard 1961). Only 4 of 171 families were judged to be suffering any distress due to burdens imposed by the patient. Brown et al. (1966) questioned this underreporting of burden and referred to the high percentage of unemployed men (40 percent) in the sample as cause for skepticism of the findings. However, the unusually high proportion of first admissions (59 percent) in the sample may account for the low rate of observed burden.

The reduction of burden and the sense of relief that was experienced by some families as a result of hospitalization of the patient (Grad and Sainsbury 1963b, Hoenig and Hamilton 1969, and Myers and Bean 1968) may be reason enough to explain their rejecting behavior. Kelman (1964), in discussing the implications of labeling and hospitalization for the families of brain-damaged children, states that lower-class deviance, while recognized, is not assigned the same priority of familial concern and resources as other more pressing problems. In this context, hospitalization and abandonment may be viewed as the removal of one more draining problem (see Myers and Bean 1968 and Myers and Roberts 1959 on this point). As demonstrated by Barrett, Kuriansky, and Gurland (1972), when the patient contributed to the household rather than taxed its limited resources, there was significantly greater likelihood that the patient would remain out of the hospital. In such cases, the imputation of "felt" stigma as a cause for rejection of patients in high-problem groups may hardly be relevant to the issues determining behavior in these families.

The Effects of Attitudes on Outcome

Since the results of interactions between individuals are often highly influenced by the relevant attitudes of each individual, it has been generally assumed that the impact of those attitudes would strongly affect the experiences and posthospital adjustment of the patient. Indirect support for this assumption is available from studies showing that successful outcome was associated with the family settings to which

patients returned (Carstairs 1959, Davis, Freeman, and Simmons 1957, Freeman and Simmons 1963, Michaux et al. 1969, and Wing et al. 1964). It is not unlikely that differing attitudes and expectations held by parents, spouses, or siblings are at least partially responsible for such findings.

Studies in which family attitudes appear as independent variables that influence community adjustment have generally concerned themselves with 1) positive or negative attitudes toward the patient, 2) attitudes about mental illness and mental hospitals, and 3) attitudes regarding tolerance of deviance.

Usually, investigators have assessed relatives' attitudes through an intensive, generally semistructured, interview or series of interviews. Measurement techniques have varied considerably in sophistication. Both direct and indirect measures have been used; and response categories have ranged from a "yes...no" to a Likert format. In some cases, overall ratings were made by trained interviewers. The most commonly used indicators of outcome have been community stay versus rehospitalization, and community adjustment as shown by ratings of symptomatology and role performance.

Outcome and Family Attitudes Toward the Patient

A direct test of the hypothesis that the positive or negative attitudes of a relative were related to outcome was conducted by Kelley (1964) while working with the Psychiatric Evaluation Project of the Veterans' Administration in Massachusetts. Family acceptance, whether the patient was wanted at home, the degree of understanding of the patient, and attitudes toward the hospital and toward deviant behavior were not found to be significantly related to patient outcome as measured by exacerbation of symptoms in a group of 65 discharged schizophrenics. A replication of the study (reported by Kelley in the same article) confirmed these findings.

Significant results, however, were reported by Carstairs (1959), who found that success in remaining in the community was associated with greater welcome, the presence of a "key person" (a woman willing to involve herself with the patient), positive attitudes, and a perception that the patient was not dangerous. Similarly Barrett, Kuriansky, and Gurland (1972) reported a

significant relationship of family attitude to outcome. If the caretaker family recalled that its initial reaction to the patient's return was "very pleased," the patient tended to remain out of the hospital. Fifty-seven percent of the relatives of patients who did not require rehospitalization were initially "very pleased" at the patient's release; but only 7 percent of the relatives of those who were rehospitalized responded in this way. If the attitude of the family was negative, neutral, or simply "pleased," patients tended to return to the hospital. In the same interview, when families were asked how they felt about the patient's discharge after the patient had been home awhile, this same relationship was present to an even greater degree. Standard of living was also significantly related to community stay; patients with poorer care showed a greater tendency to remain out of the hospital.

While on the surface it appears reasonable to assume that family acceptance of the patient indicates a beneficial atmosphere for the former patient and would be positively correlated to outcome, the matter is not so simple. Brown, Carstairs, and Topping (1958) found that former patients living with mothers or wives had higher readmission rates than those living with siblings, distant kin, or in lodgings. They concluded that it was not always wise to send a schizophrenic back to close parental or marital homes even if the ties were affectionate. In an attempt to explicate this finding, Brown et al. (1962) interviewed 128 recently discharged patients and their female relatives and maintained contact with them and the patient throughout the 1st year after discharge. Utilizing the notion of an optimal level of emotional arousal, the authors hypothesized that a mental patient's behavior would deteriorate if he returned to a home where there was strongly expressed emotion of any sort. They further reasoned that in those families in which emotions ran high, rehospitalization could be avoided if family contact was minimal. Emotionality was measured by rating the interaction of the patient and his key relative on content of speech, tone of voice, and gestures. Their main hypothesis was confirmed. Patients had deteriorated in 75 percent of the "emotional" homes and only 33 percent of the "nonemotional" homes. Extent of family contact was important, however, only for those moderately or severely disturbed at discharge. When past history, home situation, and condition at discharge were taken into

account, the relationship between emotionality and deterioration was weakened, although not wholly destroyed.

To extend and refine this relationship, Brown, Birley, and Wing (1972) interviewed 101 schizophrenic patients and their families both before and after discharge. As in the previous study, the interaction of patient and relative in a joint interview was rated. An emotional expression score was derived, using the number of comments denoting criticism, hostility, dissatisfaction, warmth, and emotional overinvolvement. Again a significant association between high expressed emotion and relapse was found. The most significant component of this score was number of critical comments. Warmth could not be used in the overall index because it showed a curvilinear relationship with relapse. Patients in homes showing moderate warmth had the lowest relapse rate. Low-warmth relatives tended to be critical, and high-warmth relatives were overinvolved. The data indicated that it was the emotional expression, not previous work or behavior impairment, that was associated with relapse. Symptoms were also related to relapse, but independently of emotion.

This line of research is as important for its general theoretical and methodological implications as for its substantive findings. It clearly points to the need to examine more complex relationships in an interaction framework. It is not enough to relate family attitudes to outcome. Patient attitudes, their consequences for family attitudes, and patient behavior are equally important, and have too often been ignored. In the few studies attending to both patient and family attitudes, they were rarely analyzed in conjunction with one another. Yet the interaction between these sets of attitudes, their fit with one another and with various behaviors, will have to become the focus of new research if we believe the forces that influence relapse are embedded within a social matrix context. The use of an interactionist strategy would not only be consonant with the ecological approach used by many within the field of psychology today but would inevitably lead to the much-needed use of increasingly sophisticated methodological techniques.

Outcome and Family Attitudes Toward Mental Illness and Hospitals

Among early studies relating attitudes about mental illness or mental hospitals to outcome was one by Davis,

Freeman, and Simmons (1957), who found that patients with high performance levels were most likely to have relatives with an environmental view of mental illness, favorable attitudes to mental hospitals, and the belief that mental illness does not basically change a person. In a long-term study conducted by two of these authors, Freeman and Simmons (1963), similar attitudes were again measured. Relatives of successful patients tended to see them as normal, as somewhat blameless, and as having positive attitudes toward the hospital. The more educated the respondent, the less the likelihood of blaming the patient. Opinions about the etiology of mental illness were unrelated to any measure of rehabilitation, but the authors felt this to be a function of poor scale construction. They did find that the family's perception of management problems and the patient's symptomatic behavior were associated with return to the hospital (see, also, Myers and Bean 1968).

Lorei (1964) administered the Opinions About Mental Illness (OMI) scale (Cohen and Struening 1962) to the relatives of 104 released patients and correlated these scores with success or failure in remaining in the community for 9 months. Only three of the five OMI factors related significantly to outcome. Low scores on Authoritarianism and Restrictiveness and a high score on Benevolence were associated with the patient's remaining in the community. Scores on Interpersonal Etiology and Mental Hygiene Ideology were unrelated to community stay: these findings are in line with those previously noted (Davis, Freeman, and Simmons 1957). The family's perception of the patients as not unlike normals and not responsible for their condition was related to success in the community but not to recidivism.

In another study, Bentinck (1967) used the OMI to gather data from 50 male schizophrenics and their relatives and 50 male medical patients and their families 9 months after discharge from the hospital. Families of mental patients differed from families of medical patients only in that the latter endorsed items of Mental Health Ideology more than the former. Contact with a mental patient appeared to be associated with less acceptance of the medical model of mental illness. Although Bentinck simply compared the four groups and did not relate scores to outcome, her study indicated a potential source of conflict for the mental patient both in the hospital and after his return. The relatives of mental patients, who generally came from the same

social background as blue-collar hospital workers, were found to have attitudes more like those of the blue-collar hospital personnel than those of mental health professionals. They were generally more pessimistic about treatment outcome, more restrictive, and more authoritarian than mental health professionals. Thus, in both the hospital and home setting patients must deal with people who have ideologies unlike their professional therapists'.

Outcome and Family Tolerance of Deviance

Since the behavior demonstrated by a former patient is occasionally disruptive and may be considered deviant by the family, a prominent subject for investigation has been the relatives' attitudes regarding deviant behavior. For instance, Deykin (1961) interviewed either the patient or the family in a followup of 13 chronic cases and judged the patient's community adjustment by examining personal appearance, psychiatric and social functioning, and quality of interpersonal relationships. Although the families in her sample were receiving intensive casework help, which may have influenced both tolerance and outcome, she concluded that family and community tolerance for the ex-mental patient was one of the central factors relating to successful discharge, even for those patients who showed poor community adjustment. Deykin hypothesized that the family's deep love for the patient and guilt about his illness were responsible for the low recidivism rate.

Generally, however, it has been hypothesized that tolerance of deviant behavior as shown by low expectations regarding work and social participation is a key factor affecting outcome. Lower-class patients and/or those returning to parental homes (each considered to be returning to settings with lower expectations regarding performance) were expected to have fewer relapses, or at least fewer rehospitalizations. An early study by Freeman and Simmons (1958 and 1959) provided support for these derivations. Poorly performing patients who managed to remain in the community tended to be lower class, they had other males in the family to take over their roles, and they were living in parental rather than conjugal homes. Similarly, mothers were found to be more tolerant of deviant behavior in studies by Brown, Carstairs, and Topping (1958), Brown et al. (1966), and Linn (1966). On the other hand, Michaux et

al. (1969) reported a greater relapse rate for those returning to parental homes, and the relationship of social class and expectations to performance did not hold up for acute female mental patients returning to conjugal homes (Lefton et al. 1962). Posthospital performance in the latter study was best predicted by illness rather than class or expectations. The authors speculated that Freeman and Simmons' results may be true only for chronic male patients.

To obtain longitudinal data and to refine and extend their ideas, Freeman and Simmons (1963) conducted their classic year-long study of the posthospital experience of 649 men and women. In this study, the culmination of earlier investigations with the Massachusetts-based Community Health Project, Freeman and Simmons interviewed a key relative twice after the patient returned home. The informant (usually spouse or mother) was seen at about 6 weeks and 1 year after discharge. The interview tapped relatives' expectations regarding work, social participation and symptomatology, and the perceived performance in these areas. With respect to tolerance of deviance, they found, somewhat surprisingly, that relatives' expectations regarding work and social participation were high. In fact, former patients were expected to perform as anyone else did. There was little change in expectations throughout the posthospital year. Tolerance of deviance was directly related to performance—the higher the expectation, the higher the performance—but unrelated to successful community tenure. Unlike the results of Freeman and Simmons' earlier study, and in partial confirmation of Lefton et al. (1962), social class was unrelated to either expectations or successful community tenure. Social class was, however, related to performance.

Tolerance of deviance, defined as the extent to which a family will keep a symptomatic former patient at home, was the subject of two reports by Angrist et al. (1961 and 1968). Drawing heavily on Freeman and Simmons' conceptual and methodological model, they focused their attention on the posthospital experience of women only. In their 1961 article they described the results of a followup study of a sample of 264 women consecutively discharged from Columbus Psychiatric Institute in Ohio. This hospital is a short-term intensive therapy facility, where 90 percent of all admissions are voluntary and 75 percent are first admissions. Thus, the patient sample was from a higher socioeconomic class

and had fewer psychotics and multiple-admission patients than is usual in samples drawn from State hospital populations. A significant other, generally a husband, was interviewed 6 months after discharge by a social worker who used a structured interview. Low tolerance of deviance was significantly related to higher social class and to good posthospital performance, even when severity of illness was controlled.

The final, more extensive analyses of these same data and data from a control sample of the former patients' female neighbors and their significant others were reported in Angrist et al. (1968). A smaller sample of schizophrenics was also interviewed at 1 year after discharge, and comparisons between and within the research groups were then made. The major hypothesis that tolerance of deviance (symptom tolerance) and role expectations would predict rehospitalization was not confirmed. Similarly, social class did not have a marked relationship to rehospitalization. As in Freeman and Simmons' study (1963), tolerance of deviance and expectations were related to performance, with high-level performers having significant others low in tolerance and high in role expectations. Social class played no part in the posthospital performance of married women, at least directly. It did influence performance indirectly via class-related role expectations. The most significant predictor of failure and rehospitalization in this study was the reappearance of symptoms.

Relatives of normals and former patients differed on tolerance of deviance on only three items. When relatives of patients having organic problems were removed (these relatives were a special group low in expectations and high in tolerance), there were no differences between relatives of normals and the relatives of former patients except, obviously, in their perception of psychological difficulties.

A recent study by Michaux et al. (1969) also examined the family's expectations of the patient and the patient's social role performance, although the investigators did not specifically focus on tolerance of deviance. Monthly interviews were conducted with patients and, in most cases, a selected family member. Among other measures, information on the level of satisfaction with the patient's free time activities, the family's satisfaction with the patient's performance, and the occurrence of symptoms was collected. The patient's poor social role performance and the families' dissatisfaction, derived from their high but unmet expectations

for the patient, were significant but not powerful predictors of rehospitalization. These findings were at variance with those of Freeman and Simmons (1963) and Angrist et al. (1968). In common with the above studies, an increase in general psychopathology was noted by the family prior to hospitalization.

In summary, we find conflicting results regarding the influence of positive familial attitudes on outcome. Emotional expressiveness and differential attitudes about mental illness were significantly related to outcome. Tolerance of deviance, whether defined by low expectations for work and social participation or the extent to which families will keep a symptomatic patient at home, has been only slightly related to relapse. Returning to a family low in tolerance of deviance was likely to result in higher role performance, but it did not prevent rehospitalization. Similarly, returning to a family displaying understanding and noncritical attitudes may increase the chances for success but does not reduce rehospitalization rates when the strains become too great. Mills (1962) noted that even though families were willing to care for their symptomatic relatives, once the stress of living with the sick member became too great, the hospital was more often seen as attractive and as a place for cure. If cure did not take place, a deterioration of the relationship between patient and family ensued. This process has also been discussed by Pitt (1969), who saw the patient using up the "reservoir of good will" held by the family.

On the whole, we are confronted with a scarcity of significant results relating family attitudinal variables to successful outcome. The only finding that appears and reappears consistently in the literature is that failure in the community and subsequent return to the hospital is accompanied by the reappearance of symptoms (Angrist et al. 1968, Brown et al. 1972, Freeman 1961, Freeman and Simmons 1963, Michaux et al. 1969, and Pasamanick et al. 1967).

Conclusions

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 deviant behavior, attempts at explanation, and the response to the deviant. While these studies have been enlightening and heuristic, they have suffered from the shortcomings frequently found in the initial exploration of a complex phenom-

enon. With a few exceptions, much of this research has been impressionistic in nature, inconsistent, descriptive rather than explanatory, limited in scope and techniques, and has failed to incorporate the type of controls that would permit clear conclusions to be drawn. Further difficulties in interpretation have resulted from the use of small samples and the lack of rigorous sampling procedures.

The affective components of the attitude toward the deviant and the sense of burden that the family feels have still been inadequately treated. Also relatively untouched are the family's beliefs about their patient-relative. Some studies have inferred the family's cognitions of the patient from responses to items about a hypothetically mentally ill person, but items directly examining family members' beliefs about their own deviant family member have rarely been included as part of the research design. Finally, the interactions of the various aspects of attitude (affective, conative, and cognitive) and their relationships to behavior still remain a subject for systematic study.

Contradictory data abound on almost every subject that has been discussed in this paper. It is entirely possible that these contradictions reflect true differences in the real world. Yet scant effort has been made to explain the differences or to resolve them. Perhaps this is due to a scatter-shot approach by researchers who, with a few exceptions, have failed to follow through on promising leads in their own data. The lack of sustained interest has left us with fundamental pieces of information missing, and the promise in the early and thoughtful work reported by Clausen and Yarrow has hardly been actualized; this is unfortunate in light of the current emphasis on early detection and treatment of mental illness and the increasing trend toward shorter hospital stay and more extensive home care.

Research on the relationship of family attitudes to outcome has more often been conceptually sophisticated and programmatic. Yet here again results are inconsistent, which may be because few studies have focused on complex interrelated variables. For example, little effort has been directed at the measurement and analysis of patient and family variables in conjunction with one another. In addition, investigators have mainly studied families containing a sick member and have failed to establish any comparative baselines of attitudes for families with a member exhibiting a different type of deviance or for families without any sick member at all.

The perennial question of directionality is also a problem. Much of the research has viewed the patient in the role of reactor to the attitudes and behavior of the family. Researchers have assumed that family attitudes to deviance strongly influence the behavior of the former patient, particularly with regard to community tenure. Such a unilateral perspective has led them to neglect research aimed at distinguishing the extent to which attitudes of relatives are a function of the condition of the patients with whom they reside. Both Freeman and Simmons (1963) and Angrist et al. (1968) initiated their research with the hypothesis that family attitudes determine patient functioning. They concluded, however, that tolerance and expectations *reflect* patient functioning.

Evidence to support this conclusion is found in a dissertation that examined the effect of multiple hospitalizations on the role the patient plays within the family (Dunigan 1970). This study of the 66 husbands of patient-wives with varying numbers of hospitalizations indicated that there is a critical point at which expectations and tolerances change. Husbands seemed able to cope with one or two hospitalizations and to make temporary role adaptations to the deviant behavior of the wife-mother. With three or more hospitalizations, however, husbands withdrew from the wife, lowered their role expectations, and made other more permanent arrangements for the continued functioning of the household. These events in turn served to strain marital ties and to isolate the wife within the family setting. Dunigan concluded that families eventually exhaust their resources to expand and contract in ways that keep the wife-mother a contributing member of the family system.

This research is a promising move toward an interactional model of patient-family relationships. It would be furthered still more by the use of nonretrospective longitudinal research that would follow the family and patient through the various phases of their reciprocal role in the mental patient's career.

It is interesting to note that most investigators have concentrated on women's perceptions and expectations as they relate to male patients. While this is understandable, in terms of the supportive role that females in our society are expected to play regarding the sick, we are left with meager knowledge about the perceptions and expectations of males and the differential effect on the family of the illness of men or women. One study

that did present comparative data on this point (Rogler and Hollingshead 1965) reported striking differences in the response of the family and the effects on it of having a wife or a husband as the ill member. When husbands were ill, the wife frequently added his work role to her own nurturant one and the family was maintained as a functioning unit. Illness on the part of the wife had a pervasive and destructive influence on the family organization, since the husbands were unable or unwilling to take on parts of the female role. Although this study was done in a traditional society (Puerto Rico) in which male and female roles are very clearly elaborated, it does alert us to the various modes of adaptation to a stressful situation that may occur in our society as a result of sex-role and life-cycle differences.

A final important issue pertains to the type of attitudes measured. As noted before, the appearance of symptoms preceded rehospitalization in numerous cases. At the same time, work and social participation were only weakly related to rehospitalization. It may be that family expectations regarding work, social participation, and patient behavior in these areas are not important correlates of relapse, even though they concern aspects of instrumental performance that are considered important indicators of recovery and integration within our social system. In the only study that defined tolerance of deviance in terms of symptoms, Angrist et al. (1968) asked their informants to judge symptoms for which they would return the patient to the hospital. A tolerance-of-deviance score was derived from these responses, but this score was not a strong predictor of rehospitalization. However, it is difficult to know whether family members were responding according to their perception of the severity of the symptoms or were reacting in terms of personal discomfort. An approach that emphasizes the family's personal reactions to the particular symptom the patient is exhibiting, the tolerance of the patient for his own symptoms, and the meaning the symptoms have to both the patient and the family may prove to be more fruitful.

We are dealing here with an extremely complex set of interacting variables, and it seems likely that the important information is to be found in the interactions rather than in one or another main effect. The literature we have examined tends to be inconsistent, since specified variables may have different effects, depending on their interrelationships with other variables. What appears to be required is truly multivariate research.

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Acknowledgment

The preparation of this article was supported in part by National Institute of Mental Health Grant 1 RO 1 MH 21574-01. The authors would like to thank the staff of the Community Research Program for their contributions to the paper, particularly Ms. Carol Weiss, who assisted in the initial bibliographic search. They would also like to express their gratitude to Professor Richard Christie and Dr. Harold Markus for their very valuable comments about the organization and content of the paper.

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