Living With the Mentally Ill: Factors Affecting Household Complaints

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Abstract

Data provided by case managers in community support programs are used to analyze the problems of families providing shelter to mentally ill relatives. Factors affecting complaints in 345 family households are contrasted with factors leading to complaints in a subsample of 622 other residential alternatives. Behavioral problems are the best predictors of complaints from all households regardless of type, but some causal factors identified are unique to family residences, notably failure to perform household chores and infrequently socializing with friends. Active and passive rule violations, encompassing both do's and don'ts, are more important than clinical history and social background in understanding complaints.

Studies of mental illness in the family now span about 30 years. During this time the system of care has changed from one with a predominantly institutional emphasis to another that is more pluralistic and features an array of community alternatives to long-term hospitalization. As the system has changed, so the focus of research has shifted from the family as an etiologic factor in patient distress to the patient's problems as a stress on the family unit (Kreisman and Joy 1974). Studies conducted in the 1950's and 1960's often focused on etiologic hypotheses concerning patterns of social interaction and communication within the family (Eaton 1980, pp. 78–88). By the 1970's, clinicians writing from a family systems perspective began to suggest that the designation of a particular person as the "patient" in the family had significance beyond the individual's symptomatology, and that the pres-

ence of an "identified patient" could be functional for the entire family unit (Minuchin 1974; Palazzoli et al. 1978).

However, with the reduction in hospital censuses in the 1970's and 1980's, and the discharge of thousands of patients to family households and other nearby community residences, researchers also became aware of the acute and long-term burdens being borne by families who chose to remain involved with mentally ill relatives, and especially by those who accepted chronic patients in the family household. Families with mentally ill relatives in residence complained of a variety of specific behaviors that were disruptive to daily family living such as wandering away (sometimes to places hundreds of miles from the family home), dressing bizarrely, and being disorderly. Burden was experienced subjectively, as worry and preoccupation, but was also manifest in terms of tangible costs in time allocated and money spent. Reflecting such concerns, researchers began to ask questions about the family as a reactor to mental illness. Sometimes referred to as "family burden" studies, this research tradition highlights the problem mental illness poses for family members, both as individuals and as a social unit (Grad and Sainsbury 1963; Hoenig and Hamilton 1969; Thompson and Doll 1982; Noh and Turner 1984; Tessler et al. 1987).

One of the difficulties in evaluating research in this area is that there is little consistency across studies in the way major constructs are defined and operationalized. To cite

one point of inconsistency, "burden" is sometimes defined by the consequences of living with a mentally ill person for parents, but other times it refers to the coping responses of spouses, and still other times to the reactions of children. Coping difficulties are discussed without specific attention being given to the family role in question, but structured differences probably exist in a family member's response that depend on his or her relationship to the person with mental illness. Expectations for mothers may differ from those of fathers, daughters from sons, and wives from husbands. In addition to gender differences, coping behavior may vary by family role. Spouses, for example, have the option of dissolving the marital relationship and, thereby, legally ending their obligation. Siblings can sometimes escape the negative consequences by leaving the household and moving far away (Gubman and Tessler 1987).

Another problem is the tendency of prior research to equate household burden with kinship to the mentally ill person. Yet, functions located within the family domicile also occur among unrelated adults (e.g., roommates or roomers who share space or tasks). Psychopathology has specific consequences for these social relationships, as well as consequences specific to the kinship bond. Distinctions among coresidence, shared function, and kinship have become blurred in the literature (Bender 1967). Measures of objective and subjective family burden combine being "noisy at night," "needing help with everything," and "embarrassment or shame" (Herz et al. 1976, p. 798). While the last response is probably more characteristic of kin, the others might be equally true of roommates

or staff responsible for the care and supervision of clients in a group home. The result is that the burden unique to the family relation is confounded with other nonfamilial factors. In this sense, the term "family burden" is somewhat of a misnomer.

The present article reports new data about factors associated with household complaints in familial and nonfamilial settings. Such complaints are, of course, a general phenomenon, but in a population of households with mentally ill persons they have special significance. When complaints reach the point where they are communicated to case workers, and thus take on a more formal status, we interpret them as signs of "burden," at least for research purposes.

Looked at theoretically, complaints qua burden are informal antecedents to official labeling processes. Emerson and Messinger (1977) have outlined these informal processes and suggest that problems between individuals may be "progressively elaborated, analyzed and specified as to type and cause" (p. 122), and in the absence of a satisfactory interpersonal remedy brought for resolution to a third party. When third parties get involved, whether as a last resort or earlier in the process, the ante is increased because official labeling of conduct becomes more likely. For these reasons, studies of complaint processes are of additional theoretical interest. The research question, then, is: What factors give rise to such complaints? And how, if at all, is the causal process conditioned by the presence of kinship to the mentally ill person?

Our working hypotheses are threefold: First, that within families it makes a significant difference who

the identified patient is. Accordingly, the sample is differentiated as to whether the mentally ill relative is a child, a spouse, or another family member. Second, that in any household, complaints arise in response to behavioral problems that violate strongly held expectations. We call these the "don'ts" of household living, and evaluate their effects net of patients' clinical status and social characteristics. The possible significance of behavioral problems for family burden is indicated by a number of prior studies (Grad and Sainsbury 1963; Hoenig and Hamilton 1969; Hatfield 1978; Thompson and Doll 1982).

The third hypothesis is that, in addition to behavioral problems signifying the active violation of social rules, household complaints also arise out of passive rule violations. This occurs when the mentally ill person fails to do what is expected of him or her, whether it be household chores or some other task of daily living. We think of these as the "do's" of household living, which derive their significance more from expected behavior that is omitted than from inappropriate actions committed. While labeling theory implicitly encompasses active as well as passive rule-breaking behaviors, much more attention has been given to the commission side of the ledger than to the omission side (Scheff 1984). In part, the current article seeks to redress this imbalance.

To summarize, all three hypotheses can be expressed in the following model:

Household complaints = F (Position in the family, Active rule breaking, Passive rule breaking)

where variations in clinical status and sociodemographic

characteristics are statistically controlled.

We note one assumption underlying the model's specification—namely, that acts either engaged in or omitted causally precede household complaints. This specification may be open to question, since it can be argued that patients' knowledge of complaints about themselves may motivate them to test the tolerance of family rules. While it seems plausible that to some extent this goes on, we believe the causal direction to be one in which complaints more often occur in response to patient behaviors than as a cause of them. While the true relationship is probably reciprocal, it is the latter assumption that is reflected in the current model.

Methods

The data for this analysis come from a subsample of 432 individuals with chronic mental disorders who at the time of data collection in 1980 were living in family households. Data descriptive of these individuals, and complaints about their household behavior, were provided by 248 case managers in 18 different community support programs sponsored by the National Institute of Mental Health. For comparison, we also examine trends among 622 persons in the original study who, while not living in family households, were living in other group settings. Further details about the larger study are contained in Tessler and Goldman (1982).

"Household complaints," the dependent variable in this analysis, is measured on a 4-point scale, with "0" indicating no complaints were received from the household during the last month and "3" indicating frequent and serious complaints. Six

different categories of independent variables are used to explain variation in household complaints. One category, "sociodemographic characteristics," captures the client's age, sex, education, and present employment. A second category, "clinical status," includes total time spent in hospitals for psychiatric illness, current diagnosis, episodes of hospitalization spanning 5 years, and evidence that the client was not taking prescribed medications at the time of the study. Since we expected structured differences in the response of family members depending on their relationship to the person with mental illness, we also included as independent measures whether the client was living with parents or spouse.

There are two categories of variables that capture passive violations of prescriptive rules: "household living skills" and "social activities." The relevant items for household living skills were "maintains personal hygiene," "maintains diet," "performs household chores," and "manages finances." For each of these ratings, higher scores indicate greater difficulty during the preceding month. The types of social activities included were "recreational activity outside the home," "having a daytime activity schedule," "socializing with friends," and "recreational activity at home." Higher scores indicate that the client engaged in the activity more frequently.

Specific behavioral problems reported by case managers constitute the final group of variables. This group includes the more active rule violations, i.e., the "don'ts" that we hypothesize underlie many household complaints. The specific behaviors

under study were "incontinent, wandered/loitered, inappropriate sexual behavior, temper tantrums, trouble with the law, destroyed/stole property, abused alcohol, abused drugs, suicidal threats, bizarre behavior, and used matches, cigarettes, or fire hazardously." As with the ratings of household living skills, these data encompass the previous month, and higher scores indicate more severe problems.

A potential problem in using these data is that independent measures, as well as the key dependent measure, are all based on case managers' ratings (Grusky et al. 1985; McCarrick et al. 1985). The troubling question is whether such ratings can be accepted as objective descriptions of household behavior and resulting complaints, or whether the information available to case managers was somehow too biased to be of value for this purpose. While this issue cannot be resolved fully, the case managers did vary their assessments of clients depending on available information, and their ratings were internally and logically consistent. Finally, these ratings were not related to the case manager's familiarity with the client.

Results and Discussion

Characteristics of the Subsample. The characteristics of the total sample of 1,471 Community Support Program (CSP) clients, from which a subsample of those living with family was drawn, have been reported elsewhere (Tessler and Goldman 1982; Tessler et al. 1984). The number of clients living with family is 432, but due to missing data the number of cases actually ranges from 384 to 432. About 30 percent live with a spouse, 40.5 percent live with parents, and the

remainder live only with other family members.[1]

One noteworthy difference between the family subsample and the sample of clients living elsewhere in the community is the age of clients. Age ranges from 14 to 43 in the family sample and from 17 to 78 in the sample of other community residences. The median for the family subsample is 12 years younger than that of clients in other residences. This is a difference one might expect given that younger clients are more apt to live in the family home (Woy et al. 1981). Age differences may also explain why this subsample has accumulated a median of 3 months compared to the 3.5 years of total hospitalization for clients who do not live with their family members. Their age, coupled with the availability of a family domicile, may explain why fewer clients living at home have had hospitalizations of long duration (18 percent compared to 40 percent).

While there are differences in the makeup of the two groups, there is little if any difference in either the overall severity of behavioral problems or the need of clients for assistance with basic living skills. The grand mean of behavioral problems is almost the same for both groups (.24 and .23), and the

mean level of independence in performing basic living skills, such as managing funds or maintaining personal hygiene, is only slightly higher for clients living with family (a range of 1.30 to 1.61 for this subsample compared to values of 1.53 to 2.08 for clients who do not live with their kin). The subsample of clients living at home is therefore apparently distinguished more by its age and who the client is living with than by the degree of problems clients present for their caregivers.[2]

Explaining Complaints in Familial Households. Six categories of independent variables were examined, using hierarchical regression based on a total of 345 family households. In order of introduction into the equation, these consisted of sociodemographic characteristics, clinical status variables, type of relative the client lives with (parent or spouse), household living skills, social activities, and behavioral problems. The R^2 changes shown in column 3 of table 1 indicate the relative importance of each of these categories in predicting household complaints.

As indicated, behavioral problems explain more of the variance than any other category of variables,

about 22.7 percent after all other variables have been introduced. In fact, the explanatory power of behavioral problems is about the same as all other sets of factors combined. The second most significant category is household living skills, which accounts for half as much variance as behavioral problems, but still explains more than the combined effects of clients' sociodemographic characteristics, clinical status, social activities, and family composition.

The first column in table 1 shows the effect of specific variables within each of the categories noted above. Within behavioral problems, the significant predictors are temper tantrums and bizarre behavior. Compared to the other behavioral problems examined, these two appear to be the most difficult for family members to endure without formal complaint. Within household living skills, the sole significant effect is failure to perform household chores independently, which is shown to increase complaints. Within social activities, only failure to socialize with friends is significant. As expected, when this occurs, it increases complaints. None of the sociodemographic or clinical status variables are significant in the multivariate model. Nor does the identity of the coresiding family member, whether spouse or parent, have a significant effect on complaints.

Explaining Complaints in Non-familial Households. To put the results for familial households into comparative perspective, the same model was estimated for a subsample of 622 clients who were living with at least one other person, but not with family. This includes housemates in private, staffed or su-

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[1]There is overlap among these categories. Some of those clients living with parents also live with other family members. Similarly, a portion of those households made up of clients and their spouses include other relatives. It is not difficult to guess who these people are likely to be. Those living in a parental home may include the client's siblings, and the client may live with a spouse and children. In only one case was a client living with both a parent and a spouse.

[2]For this particular variable, clients living alone were excluded from the sample of those not living with family, since in single-person households there was no one other than the client to generate complaints. Among this sample, household complaints were no problem for 66.4 percent and a minor problem for 15.9 percent. For the family sample, household complaints were no problem for 59 percent, and a minor problem for 18 percent.

Table 1. Hierarchical regressions of household complaints

| Client characteristics | Household complaints (Dependent variable is a case manager rating) | | | | | |
| | Family households ($n = 345$) | | | Other households excluding clients living alone ($n = 622$) | | |
	β	(SE)	R^2 Change	β	(SE)	R^2 Change
Demographic characteristics			.064[1]			.113[1]
Male (dummy)	-.019	(.095)		-.056	(.055)	
Age in years	-.003	(.004)		-.005[3]	(.002)	
Education (highest grade attained)	.014	(.034)		-.019	(.019)	
Presently employed (dummy)	-.184	(.105)		-.038	(.065)	
Clinical status			.035[1]			.049[1]
Not taking prescribed medication (dummy)	.174	(.160)		.522[1]	(.141)	
Years hospitalized	.008	(.013)		-.010	(.005)	
6 months' hospitalization in past 5 years (dummy)	.162	(.117)		.013	(.060)	
Diagnosed schizophrenic	.057	(.094)		-.048	(.063)	
Coresiding family member			.003[1]			
Spouse (dummy)	-.090	(.110)				
Parent (dummy)	-.074	(.111)				
Household living skills			.127[1]			.080[1]
Fails to maintain personal hygiene	-.038	(.086)		.067	(.043)	
Fails to maintain diet	-.131	(.073)		.025	(.034)	
Does not perform household chores	.247[1]	(.063)		.060	(.035)	
Does not manage finances	-.090	(.059)		.035	(.030)	
Social activities			.008[1]			.035[1]
Socializes with friends	-.85[3]	(.043)		.018	(.022)	
Daytime activity schedule	.024	(.037)		-.065[2]	(.024)	
Recreation at home	-.044	(.048)		-.065[3]	(.028)	
Recreation away from home	.068	(.054)		.066[3]	(.031)	
Behavioral problems			.227[1]			.282[1]
Incontinent	-.126	(.168)		-.098	(.067)	
Wandered/loitered	.140	(.090)		.260[1]	(.051)	
Inappropriate sexual behavior	.103	(.090)		.137[3]	(.057)	
Temper tantrums	.514[1]	(.079)		.409[1]	(.042)	
Trouble with law	.031	(.128)		-.204[2]	(.072)	
Destroyed/stole property	-.125	(.120)		.207[1]	(.059)	
Abused alcohol	-.027	(.081)		.018	(.050)	
Abused drugs	.053	(.091)		.046	(.062)	
Suicidal threats and attempts	.055	(.068)		-.037	(.057)	
Bizarre behavior	.256[1]	(.075)		.210[1]	(.045)	
Used fire, matches, and cigarettes hazardously	.199	(.185)		.049	(.056)	
Intercepted	.047	(.383)		.691	(.206)	
R^2	.464[1]			.559[1]		

Note. – β = regression coefficients; SE = standard error; R^2 – explained variance.
[1] $p = <.001$.
[2] $p = <.01$.
[3] $p = <.05$.

pervised apartments, board and care homes, and the like. The results are shown in columns 4, 5, and 6 of table 1. Since for any given independent variable the unit of measurement is the same, comparisons can be made across samples from columns 1 to 4, and columns 3 to 6, although it should be remembered that the sample sizes differ.

The aggregate effects of clients' demographic characteristics and clinical history are of about the same order of magnitude in nonfamilial households as they are in those in which the client lives with a family member. Again, the greatest increment in explained variance occurs when behavioral problems are included in the equation. They produce a 28.2 percent increase after all other factors in the model have been introduced. This is more than the combined total variance explained by all other predictors, and explains more of the variance than was reported for familial households. On the other hand, household living skills make a smaller contribution to the explained variance here than in the analysis of family households. While socializing with friends is not statistically significant in this subsample, all other measured social activities are. Planned daytime activities and recreational activities at home decrease complaints, while recreational activities outside the home tend to increase complaints. Recreational activities in the community may provide occasions for disruptive behavior including unauthorized departures from the group.

Comparison of columns 1 and 4 shows that there are many more significant predictors of household complaints in the sample of nonfamilial households than are present in family households alone.[3] For example, not taking prescribed medication increases complaints for nonfamilial households, but has no effect within the family subsample. In the nonfamily households, but not in the familial households, inappropriate sexual behavior, wandering/loitering, trouble with the law, and destruction of property predict complaints.[4]

The fact that some of the behavioral problem variables that are significant for families (i.e., temper tantrums and bizarre behavior) are also significant for

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[3]One interpretation of the smaller number of predictors in the family subsample is that there was less variability in the factors affecting the dependent measure in this sample. A sign test indicates that there is a tendency, albeit not statistically significant, in this direction. Perhaps the difference is a substantive one. In large measure, other households consist of residential programs in which staff members are trained and required to report problems, and the case manager is often the most appropriate recipient of these complaints. Programmatic requirements for staff reporting of incidents, particularly those associated with disruptive or injurious conduct, may explain the greater number of predictors.

[4]The significance of certain problems (i.e., wandering/loitering, inappropriate sexual behavior, trouble with the law, destruction of property, and not taking medication) for nonfamily households may reflect their shared responsibility for risk management. In the case of trouble with the law, the effect is negative; that is, complaints are less likely to come from households to case managers about this issue. While this is not easily interpreted, household complaints may be less likely to occur when there is trouble with the law only because such complaints are more likely to come to case managers from the police, rather than from the household.

nonfamilial households suggests that some complaints arise from factors associated with common residence and shared domestic functions, and not from kinship, per se. On the other hand, families seem to differ in their response to omitted behaviors. Failure to perform household chores increases the likelihood and severity of complaints, whereas socializing with friends decreases complaints. Neither is significant in the nonfamily residences under study.

Do's and Don'ts: Further Analysis of Familial Households. On the basis of the preceding analyses, it can be inferred that two constructs, one proscriptive ("don't") and the other prescriptive ("do"), have the strongest direct effects on household complaints. In at least one case, the inference partly rests upon the significant effect of a single item. To examine the role of don'ts and do's in explaining complaints more closely, and take measurement error into consideration, we reexamined the model for family households using scales derived from a principal components analysis of the observed variables.[5]

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[5]A principal components analysis identifies the principal factors which predictors have in common. These factors are linear combinations of the observed variables, ordered according to the amount of sample variance they explain. This procedure has the advantage of aligning the predictors of household complaints more closely with our hypothesized constructs. That is, if some of the components reflect "do's" and "don'ts" as we expect, summary scales based on these components will provide more reliable measures of our constructs than do the individual items from which they are derived.

Three components were extracted and given a varimax rotation. The three summary measures were DOS2, which combined all of the household living skill variables; DISORG2, which captured behavioral problems associated with symptomatic conduct including wandering/loitering, temper tantrums, inappropriate sexual behavior, and bizarre behavior; and DANGER2, which combined suicide attempts and firesetting. Two of the three principal components have correlations > .40 with the observed variables and a correlation ≥ .20 or better with the dependent measure. DANGER2 has a correlation of .40

with the observed variables, but is not strongly correlated with the dependent variable. It was included nonetheless so that the model would be more fully specified.

The standardized reliabilities of the summary scales (P) were used to adjust correlations and standardized regression coefficients for measurement error.[6] Table 2 contains the ad-

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[6]See table 2. The reliability for DISORG2 was .707 and that for DOS2 was .796 The reliability of DANGER2, a two-item measure, was assigned a value of 1 0, since coefficients cannot be derived for scales with fewer than three items.

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justed correlations among the summary scales, and between the scales and the dependent measure of household complaints. The table also includes a number of predictors of household complaints in addition to the summary scales derived from the principal components analysis. Among these are the client's failure to take prescribed medication (NTMEDS), the severity of sexually inappropriate behavior (SEXUAL BEHAVIORS), the client's level of education (EDUC), and employment status (PSTEMP). Sexually inappropriate behavior was also incorporated in the disorganized behaviors scale, but the strength of the correla-

Table 2. Correlates of family household complaints adjusted for measurement error ($n = 316$)

	DOS2	DISORG2	DANGER2	NTMEDS	Sexual behavior	Education	PSTEMP
DOS2	1.0	.351	.062	.116	.190	-.370	-.231
DISORG2		1.0	.509	.142	.635	-.127	-.116
DANGER2			1.0	.024	.276	.017	-.023
NTMEDS				1.0	.140	.025	.066
Sexual behavior					1.0	-.074	-.070
Education						1.0	.026
PSTEMP							1.0
Household complaints	.406	.462	.119	.187	.320	-.148	-.158

Note.—DOS2 = all household living skill variables; DISORG2 = behavioral problems associated with symptomatic conduct including wandering/loitering, temper tantrums, inappropriate sexual behavior, and bizarre behavior; DANGER 2 = suicide attempts and firesetting; NTMEDS = failure to take prescribed medicine; Sexual behavior = severity of inappropriate behavior; Education = level of education attained; PSTEMP = employment status; R^2 = 3058; F = 19.3806 ($p < .001$); SE = .0475.

Table 3. Regression of family household complaints[1] ($n = 316$)

	DOS2	DISORG2	DANGER2	NTMEDS	Sexual behavior	Education	PSTEMP
β	.241	.381	-.105	.106	.041	-.006	-.064
sb	.056	.073	.056	.049	.062	.051	.049
t test	4.29[2]	5.20[2]	-1.87[3]	2.18[3]	.66	-.12	-1.3

Note.—DOS2 = all household living skill variables; DISORG2 = behavioral problems associated with symptomatic conduct including wandering/loitering, temper tantrums, inappropriate sexual behavior, and bizarre behavior; DANGER2 = suicide attempts and firesetting; NTMEDS = failure to take prescribed medicine; Sexual behavior = severity of inappropriate behavior; Education = level of education attained; PSTEMP = employment status; β = regression coefficients; sb = standard error of regression coefficient; R^2 = .3058; F = 19.3806 ($p < .001$); SE = .0475.

[1]Regression coefficients (β) are adjusted for the reliability of the summary scales.
[2]$p = <.001$.
[3]$p = <.05$.

tion between this variable and complaints (r = .35) suggests its inclusion as a distinct predictor. Table 3 also includes the standardized regression coefficient for each predictor regressed on complaints (β).

The β coefficients for the estimated model show that omitted behaviors violating normative prescriptions do underlie household complaints. However, while the summary scale (DOS2) is significant, it is not so strong a predictor as disorganized conduct, DISORG2 (β = .241 versus β = .381). The regression based on principal components therefore supports the earlier finding that "don'ts" have a stronger impact than "do's." It should be noted, however, that other indicators of "don'ts," namely DANGER and SEXUAL BEHAVIORS, are not statistically significant, suggesting that their effects were mediated by the disorganized conduct scale.

Interestingly, failure to take psychoactive medication is significant in the analysis using principal components (see table 3), whereas it was not significant when observed variables were used (see table 1). None of the sociodemographic variables are significant. Using principal components to adjust for measurement error has underscored what was inferred from the previous analysis. "Don'ts" are the strongest predictors of complaints, followed by "do's."[7]

[7]A similar analysis was performed using the sample of nonfamily households. Again, the best predictors are "don'ts" and "do's" in that order, although the specific items in the scales are not always the same.

Conclusions

Comparison of the impact of the mentally ill on others in familial and nonfamilial settings, and the resulting complaints of both kin and nonkin, are important to a fuller understanding of how the mentally ill affect and are affected by others in their environment. Prior studies have been limited by not differentiating kinship from coresidence (Bender 1967). As a result, it has not been clear how much of the "family burden" effect, widely reported in the literature, is due to shared living arrangements, per se.

In this article we have suggested that household complaints arise in response to perceived rule violations, which we refer to as the "do's" and "don'ts" of household living. By these colloquial terms, we seek to convey the idea that rules may be violated in active as well as passive ways, and that the relative importance of such infractions is an empirical matter. While we believe that useful insights come from viewing complaints in this manner, we also recognize the limitations of basing these analyses solely on data provided by case managers. Such data may be biased by the case manager's familiarity with the patient and household. In addition, not every behavior that is rule-violating is complained of, and not every complaint gets brought to a case manager's attention. Nonetheless, the present analysis is a significant beginning and will, it is hoped, stimulate further research in this area.

The results show that behavioral problems are the best predictor of household complaints. Representing active violations of social rules, or "commissions," they increase the probability of household complaints. Certain behaviors, such as temper

tantrums and bizarre behavior, tend to generate complaints regardless of the household setting in which they occur. Other variables are also involved, including some indicative of passive rule violations or "omissions."

In terms of the initial hypothesis, it is interesting that in the family subsample the type of family member (i.e., parent, spouse, or other family member) with whom the client lives did not make a significant difference in the multivariate analysis. This contrasts with findings of some earlier studies suggesting that parents had lower expectations than spouses for their ill relative (Freeman and Simmons 1958, 1959; Linn 1966). Finer distinctions may need to be made, possibly including the number of actual caregivers in the family, their gender, and ages.

While distinctions among family members were not detected, there were differences in factors explaining complaints from familial and other residential settings. Differences were more likely to emerge in factors representing omitted ("do's") rather than committed ("don'ts") actions. Notable among these differences were the greater significance within familial households given to whether the person performs household chores and socializes with friends, and the greater importance within households made up of nonrelatives given to adhering to a schedule of social and recreational activities. The results have several interpretations.

It may be that significantly different role relationships are involved. While parents may want their children to have friends, boarding home staff may have less of a stake in promoting friendships and more concern with minimizing

violence and disturbing behavior by structured social activities. Other factors also may be important—for example, the size of the household and the corresponding possibilities for intimacy and specialization of function. Friendships may be unrelated to household complaints in staffed group homes, because staff role expectations differ from those of family members or, alternatively, because group homes contain more age peers than family households, and thus provide a larger pool of potential friends. In a similar vein, the failure of mentally ill relatives to perform household chores while living at home may be much more problematic than avoidance of chores in a board and care home, where licensing regulations may require that housekeeping staff be available. It remains an open question whether observed differences are a function of kinship or some combination of domestic arrangements, programmatic requirements, and household size. One study suggests that when some of these factors are considered, behavioral differences between family and nonfamily households disappear (Moss and Davidson 1984).

While the interpretation of many of these differences is fraught with ambiguity, it is clear that "do's" as well as "don'ts" are significant triggers for complaints that come to the attention of case managers, and in this sense the second and third hypotheses are supported. Although the predominance of "don'ts" in the prediction of complaints may seem intuitively obvious, it should be noted that this has not heretofore been shown empirically, nor has the differential weighting of behavioral rule violations been linked to complaints.

From a practical standpoint, developing a clearer understanding

of household complaints and their correlates may usefully inform case manager activities in planning and monitoring programs for chronically mentally ill clients. Expectations of and contingencies faced by family and nonfamily households may differ in a variety of ways and influence satisfaction with program plans. Awareness of these differences can be used in mental health program planning to alleviate some portion of the perceived burden and enlist cooperation. For example, if family members want greater socialization because it will benefit the patient, and secondarily offer them respite, a companionship program or social club might be valuable program interventions. Similarly, in residences affiliated with mental health programs, clients' participation in social and recreational activities may help staff fulfill their programmatic obligations and reduce the potential for disruptive client behavior. Assistance to residential staff in providing activities might therefore improve staff performance and morale, as well as contribute to client functioning. Household satisfaction, the obverse of complaints, is of broad concern to all involved, and we need to understand how it is developed and maintained across a variety of caregiving alternatives.

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