FAMILY ENVIRONMENT, DEVIANT BEHAVIOR, AND HELP-SEEKING PRACTICES OF FAMILIES WITH A MENTALLY ILL MEMBER

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ABSTRACT

A retrospective, descriptive study was conducted to investigate the association between family environment, deviant behavior, and help-seeking. Family environment, measured by the Moos' Family Environment Scale, was the independent variable. The dependent variable was patterns of help-seeking behavior including duration of time spent in phases of the help seeking process. These phases were: The Prodromal Phase, Self-evaluation, and Lay-evaluation. Deviant behavior was the moderating variable measured by change in behavior and intensity of the behavioral change over time. Deviance was defined by the family.

The families of ten first admission patients diagnosed as psychotic were asked to complete a 90 item true-false questionnaire measuring family environment, and participate in a structured interview conducted by this investigator. The purpose of the interview was to gather information about the process the family went through in seeking help for their mentally ill member. Family members also filled out a Likert-type scale designed to measure the type, amount, and intensity of the deviant behavior they observed.

The data were analyzed descriptively. The majority of the families' FES scores depict a pattern of low conflict, low organization and high moral-religious emphasis, however no single scale was a useful predictor of time spent in the help-seeking process. Irrespective of how long families took before seeking medical help for their family member, the majority spent over 50% of their total help-seeking time in the prodromal phase and for most of these families the deviant behavior was kept within the family system until the family brought the patient to the Hospital Emergency Service Department. Eight of the ten patients were involuntarily committed to hospital. There was a general reluctance on the part of the families to define their family members' deviant behavior as psychologically determined and attribution of deviance seemed to influence the help-seeking process.

The generalizability of the study results is limited by the small sample size and the descriptive nature of the inquiry and data analysis, however, it produced hypotheses that could be tested in future research.

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CHAPTER I

INTRODUCTION

The manifestations of mental illness are as varied as the spectrum of human behavior. These manifestations are expressed not only by behavioral disturbance and functional impairment in the identified individual, but also in the disruptive interactions with others in the environment, particularly the family. Persons who are by clinical standards grossly disturbed, severely impaired in their functioning, and even overtly psychotic, may remain in the community for long periods of time without being recognized as mentally ill.

Labeling deviant behavior of a mentally ill person by the family is often a complicated process, one that does not automatically result in hospitalization of the identified family member. Even when professional assistance is obtained, there may be a delay in securing treatment because of professional differences of opinion. Thus, the process of becoming identified as a mental patient is not a simple and direct result of mental illness and its concomitant manifestations. Mental illness is first, and foremost, a social phenomenon. Any discussion of mental illness must address the concept of deviance and its effect on the family and society in general.

The family is a social system — the system that provides the context for each member's development. It is the family that determines, among other things, the health attitudes and practices of its members (Hall, 1980). Therefore, the family is the primary environment where health and illness behavior is shaped and health utilization practices are learned.

Statement of the Problem

This study investigated the relationships among family environment, deviant behavior, and help-seeking. As used in this study, family environment is defined as the nature of the structure and the process within the family system. Deviance is that behavior which differs markedly from what is accepted as the norm within the family. Help-seeking is that family activity related to recognizing deviant behavior of a family member and securing hospitalization for that member.

Individuals with psychotic processes best exemplify the deviant behavior of mental illness. Schizophrenia is likely to produce the most obvious patterns of deviance: illogical thinking, thought disorder, social incompetence, and diminished reality testing. The unique combination of psychotic symptoms, which are unrecognizable to the individual because of loss of insight and reality testing, often prevent the person with schizophrenia from initiating treatment. The family then, most often assumes the responsibility for seeking help for a mentally ill member of this kind.

Dentler and Erickson (1959) suggested that all social systems prompt deviant behavior. The volume of deviance induced is directly correlated with the amount of concern expended to control it. Waxler (1975) applied this thinking to family systems and noted that:

> ...we would expect that the volume of deviance in the family is directly related to the family's concern with and capacity to sanction deviance. How much time and effort the family is willing to put into rewarding and punishing members to keep them in line will determine how much behavior they are willing to call "deviant." (p. 44)

Families with a schizophrenic member are highly concerned with the management of deviance. They have been described as "pseudomutual," "Folie en

famille," and "consensus-sensitive" (Wynne, 1964; Lidz, 1963; Reiss, 1971). These family interaction theorists agree that these families have enduring styles of focusing attention, thinking and relating to ensure this process. Deviance control is a family-wide concern and is a part of the greater pattern within which the identified individual exists — namely, his family environment.

Clinical experience shows that family members and professional staff have competing realities about the meaning of deviant behavior which affects their respective assumptions about the causes and treatments necessary to bring about change. These opposing realities may have their greatest impact at the time of the identified patient's first admission to a psychiatric treatment facility. Both the patient and family are confronted with the reality of psychiatric treatment. The family's involvement in treatment is essential, since in all likelihood the patient will return home at the time of discharge.

With proposed changes in third party reimbursement policies, it is also likely that inpatient psychiatric care will attempt to focus on short-term treatment goals and discharge patients home quickly. Again, the family is the system most often faced with the responsibility for carrying out further treatment plans or at least reinforcing the patient's need for continued outpatient care. Nursing's understanding of the environment from which the patient came and to which the patient will return allows the family's perspective to be integrated into the psychiatric nursing care plan. The nursing perspective emphasizes the patient's social network in planning therapeutic treatment strategies (Ellison, 1983). This perspective broadens the focus of care beyond psychiatric symptom amelioration to include strengthening the patient's role within his family system. Understanding the interaction between family dynamics and the decision to seek psychiatric treatment for a member is the first step in developing a foundation on which to begin the rehabilitation process.

Review of the Literature

Guttman (1954) pointed out the need to define a universe of content before attempting to order data. The scope of this study includes family environment, deviant behavior, and help-seeking behavior. The family theories of schizophrenia provide the most detailed analysis of deviance within a family system. Their value in this study is not related to their definition of psychopathology, but rather their descriptions of dynamic and interactional patterns within families with a deviant member.

Family Interaction and Mental Illness

The research on the relationship between mental illness and the family has largely focused on schizophrenia. These family theories of psychopathology have been used with varying degrees of success to explain the extent to which the family contributes to or maintains the disturbed state of the deviant person. These theories based their premise on the symptomatology of the parents, the specific types of interactions between parent and child, or the idea of a disorganized family system. Again, schizophrenia is not the focus of this study; however, these theories do provide classic descriptions of family interaction patterns and deviance which are helpful in understanding family environment and family decision making processes.

While many investigators have contributed to these theoretical frameworks, the research groups led by Gregory Bateson, Theodore Lidz, and Lyman Wynne have had a major influence on the shape and direction of current theories relating family processes and schizophrenia. The work of these three groups has been almost solely responsible for generating the now existing body of re-

search on family theories of schizophrenia (Dell, 1983). Other clinical theorists (Bowen, 1978; Schaffer, 1964, and Whitaker, 1978) have described family interactional bases of schizophrenia, but have generated almost no research in support of their hypotheses.

A brief review of the theories of Bateson, Lidz, and Wynne will describe their respective findings on family interaction patterns. Each theory has evolved over the years and become more comprehensive, such that the three theories now appear more similar than did their original versions.

The general theory of the Bateson group is the concept of the "double bind" (Bateson, 1960a) which is defined as a special type of learning context from which the growing child cannot escape. Double binding sequences ensnare both victim and victimizer in the same net. Jackson (1965) pointed out..."There is no possible response to a double bind except an equally or more paradoxical message, so if neither can escape the relationship, it can be expected to go on until it matters little how it got started" (p. 5).

The hypotheses about schizophrenia derived from the "double bind" theory views communication as equivalent to human behavior rather than one aspect of it. There is a special focus on the equilibrium of the family state, that is, on the ways the family members maintain stability in their communication with each other by developing rules governing who says what to whom in what contexts (Bateson, 1960b). Haley (1963) defined the family as a self-corrective social system in which behavior is governed, regulated, and patterned by internal processes in which family members set limitations on each others' behavior. As in all families, members of schizophrenic families govern each other's behavior by imposing sanctions and other correctives when their rules and prohibitions are violated. The difference in these families, according to Haley, lies in the collective denial that anyone is setting the rules. The double bind theory is

not so much a theory as it is a language (Bateson, 1979). It is a specific way of viewing or categorizing the world that focuses on pattern of interaction rather than on single events, discrete elements, or individuals (Dell, 1983).

The emphasis on language and communication is relatively recent for the Lidz group. In their earlier thinking, this group emphasized the blurring of age and generation boundaries. Parents behave inappropriately for their sex and age with respect to each other and their child. The child, therefore, learns inappropriate behavior. More recently, Lidz (1972) has emphasized the role of language and categories as a means of conceptualizing experiences. Lidz believes that schizophrenic families foster the existence of inappropriately defined categories in an attempt to make sense of one's experiences.

Lidz's group identifies two deviant types of marital relationships in the families of schizophrenic patients. In the first pattern, called "marital schism":

> there is a state of severe chronic disequilibrium and discord...(and) recurrent threats of separation. Communication consists primarily of coercive efforts and defiance. There is little or no sharing of problems or satisfactions...(there is) chronic 'undercutting' of the worth of one parent to the children by the other. Absence of any positive satisfaction from the marital relationship is striking...mutual distrust is the rule (Lidz et al, 1957, p. 224).

In the second pattern, called "marital skew," the couples achieve a state of relative equilibrium in which the continuation of the marriage is not constantly threatened. However, "...family life is distorted by a skew in the marital relationship... (which is) the rather serious psychopathology of one marital partner..." (Lidz et al., 1957, p. 246). Both of these types of marital relationships lack "role reciprocity" which Lidz identifies as one of the requisites for a successful marriage. This lack of role reciprocity is associated with differences in role-appropriate behaviors for the different age-sex groups within the family. Thus, differences between the generations are not observed, the normal parental coali-

tion is not maintained, and the children become involved in the parental conflicts, with each parent competing for the child's support. These types of interpersonal relationships are viewed as abnormal family environments in which it is difficult for children to learn and behave in ways appropriate to their age and gender. Lidz also points out a tendency for these families to be isolated from their social and cultural environments, further reducing opportunities for reality testing. (Lidz, 1963).

Wynne et al. (1958) describe schizophrenic families as characterized by "pseudomutuality," a brittle persistence in maintaining the concept that everyone in the family shares the same expectations. The family is set into a rigid mold that does not yield to the vagaries of time and circumstances — even when old expectations and roles may become obsolescent or invalid. Wynne and Singer's (1964) later theory is closely related to social psychological theory in that the focus of attention is on the concept of identity which links the person and his culture. In their formulation of schizophrenia, there is special attention given to the impairment of ego functions and its associated thought disorders. Communication and interactions are disjointed and fragmented, with irrational shifts in the focus of attention. The pressures to maintain this facade and deny or avoid recognition of the basic meaninglessness of the relationship forces the child to conform to the family system. The imposition of sanctions isolates him from other sources of socialization. The thought disorder of schizophrenia is presumed to be of these disordered interaction patterns (Ryckoff, Day, Julian & Wynne, 1959, Singer & Wynne, 1963, Wynne et al., 1958).

Wynne and his group looked at the quality and structure of role relationships rather than the content of these relationships. They emphasized the family system as a whole, rather than dyads or triads. Their objective was to develop an interpretation of schizophrenia "that takes into account the social organization

of the family as a whole" (Wynne et al., 1958, p. 205). The general hypothesis underlying their work is:

> ...the fragmentation of experiences, the identity diffusion, the disturbed modes of perception and communication... are to a significant extent derived, by a process of internalization, from characteristics of the family's social organization.... Also internalized are the ways of thinking and of deriving meaning, the points of anxiety, and the irrationality, confusion, and ambiguities that are expressed in the shared mechanisms of the family's social organization (Wynne et al., 1958, p. 215).

Wynne and Singer (1964) have identified four main features that differentiate schizophrenic families from other families. First, the "transactional thought disorders" evident in communications that are fragmented, blurred, poorly integrated and disjunctive. Second, the erratic style of relating with inappropriate kinds of distance and closeness. Here the maintenance of proper distance includes distance from people, ideas, and objects. These modes of handling meaning and the styles of relating serve as defenses against the third feature, namely, underlying feelings of pervasive meaninglessness, pointlessness and emptiness. Finally, the overall structure of the schizophrenic family is characterized by shared maneuvers that serve to deny or reinterpret the reality of anxiety-provoking feelings.

The implications of these theories are not restricted to schizophrenic families, but serve as a model for understanding various forms of deviant behavior and their relationship to families. Concepts like the double bind, fragmentation, marital skewing, and pseudo-mutuality become the foundation for understanding the different social-environmental characteristics of families, particularly families with a mentally ill member. They alert the health care provider to important phenomena in family life and other interpersonal relationships that will have major impact on the family's ability to seek help and engage in treatment plans.

Evaluation of Family Interaction Research

In evaluating efforts to test family theories of mental illness, Dell (1983) identified the following factors that make research in this area formidable. Dell maintains that most of the research that has sought to investigate the theories of mental illness and the family are an admixture of family theory and individual theory, a combination of etiological explanations and transactional explanations. The research has mixed two epistomologies. One is based on force, quantity and characteristics; the other, on pattern, relationship, and differences. Under the epistomology of pattern, the psychotic process that causes an individual to be diagnosed schizophrenic is considered inseparable from the patterns in which it is embedded. The behavior and communciation of the rest of the family are also part of the pattern. Inasmuch as the pattern is a whole, no single part can be dualistically understood as causing another part of the pattern. The behavior of family members which together constitute the various aspects of the pattern are not linearly causal of one another. They are coevolutionary.

The transactional approach contends that causality must be understood in terms of complex feedback models and sets of interdependent forces. In this approach communication deviance is not a characteristic of individual family members that can be equated with traits such as thought disorders. Rather it is an emergent property of interaction. Wynne & Singer (1963, p. 194), state that "...the degree of disturbance in family interactions is greater and qualitatively different from that found in the contributions of any individual member." Due to the epistemological perspective of pattern, the transactional hypothesis may not be testable. Coevolutionary processes simply cannot be constructed

to be causal. In addition, the wholism of the pattern cannot be examined by the traditional experimental method of holding all factors constant except the variable be investigated. To do so changes the very pattern one is trying to investigate (Dell, 1983).

Family Environment

There is general agreement that the family environment is crucial in shaping the developing child, yet relatively few attempts have been made to systematically assess the social climate of the family. Most systematic measures describing families deal with structural aspects of the family unit; very few measure family functioning, or the family life style as a whole.

Lewis and Beavers et al (1976) provided a descriptive analysis of dysfunctional, mid-range, and healthy families who were divided into adequate and optimal groups. They used the concepts of "centripetal" and "centrifugal" to describe their families: "In centripetal families, the family itself holds greater promise for the fulfillment of crucial relationship needs than does the outside world. The world outside the family boundaries is perceived only dimly and appears frightening and threatening" (Beavers, 1977, p. 44). Sources of gratification are viewed by the "centrifugal" families as existing essentially outside, not inside the family. In the former family type, separation is difficult if not impossible; in the latter, children are expelled and premature separation is the rule (Beavers, 1977, p. 44-46).

Pless and Salterwhite (1973), developed a semi-structured interview to assess the overall adequacy of family functioning. They identified five dimensions of family functioning: communication, togetherness, closeness, decision-making, and child orientation. Pless & Salterwhite readily acknowledge that their concept of family functioning is vague and poorly defined, and they empha-

size that the semi-structured interview is proposed for use as an "index" rather than a scale or test (p. 614-616).

Deykin's (1972) assessment model for families with delinquent boys identified six major areas of family-life functioning: decision-making, marital interaction, childrearing, emotional gratification, perception and response to crisis, and perception and response to community. Deykin found that family-functioning scores were significantly related both to the type of anti-social behaviors and to the degree of behavior change after treatment. He maintained that family environment may determine both the specific characteristics of a delinquency problem and the results that can be achieved by initiating treatment for the problem.

Kantor & Lehr (1975) provided a descriptive analysis of open, closed, and random family systems; however, no empirical validation of this model has been published. Olson, Russell and Sprenkle (1979) have clustered a number of concepts into a circumplex model of marital and family systems. The dimensions of cohesion and adaptability are used to identify 16 types of marital and family systems. This circumplex model provided a conceptual linkage to the typologies of Kantor and Lehr (1975), and Wertheim (1975). Olson et al., (1979) have developed a self-report scale called Family Adaptability, Cohesion Evaluation Scale (FACES) so that the model can be tested empirically. The FACES model proposes that a balanced level of cohesion and adaptability is the most functional for family development.

Moos & Moos (1976) developed a Family Environmental Scale, FES, which assesses the social-environmental characteristics, or "personalities," of all types of families. Moos maintains that family environment cannot be described adequately using only two major dimensions. The FES focuses on the measurement

and description of three dimensions: the interpersonal relationships among family members, the directions of personal growth emphasized within the family, and the basic organizational structure of the family. Ten subscales are used to assess these three dimensions. They are: cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization and control.

The FES has been used in over 100 research projects. Five studies identified differences between perceived family environments of normal and distressed families. The most consistent findings are that distressed families have less cohesion and expressiveness and more conflict (Lange 1978; Scoresby & Christensen, 1976); are less oriented toward independence, achievement, and religious activities (White, 1978; Young et al., 1979); and are less concerned with intellectual and recreational pursuits (Janes & Hesselbrock, 1976; Lange 1978).

Deviance and Help-Seeking Behavior

One of the common prognostic indicators for psychiatric illness is symptom duration. Psychotic episodes, which cause the most obvious patterns of deviance, are no exception. There is a 30% chance that an individual hospitalized with psychotic symptoms will experience a second episode marked by the same symptoms as the first (Strauss, 1981, p. 64.). For many patients rehospitalization occurs more than once and for some, it becomes a way of life. These repeated admissions further disrupt family patterns. However, they may provide opportunities for professional involvement that assist the family to find ways to maintain their member within the family setting. To effect these changes, it is imperative that care providers understand the unique social-environmental characteristics of these families and the mechanisms employed to seek care. The contemporary

mode of intermittant short-term hospital treatment has reduced the possibility of long-term institutionalization, thus placing greater burden of care on the family and community. Although the hospital is no longer a respite option for the family, methods for helping families cope with a mentally ill member have been meager.

Competing conceptions of reality are nowhere more evident than in the area of mental illness, where laymen and mental health professionals hold views that proceed from different assumptions and end with different implications for action. Public opinion studies (Clausen, 1972, Douvan, et al., 1979) demonstrate that the public does not apply the term mental illness to case descriptions that psychiatrists would describe as evidencing severe mental illness. These studies suggest that society regards a much wider range of behavior as normal than the mental health professionals.

In contrast to psychiatric professionals' definition of deviance, the lay public does not have an organized framework for explaining unusual behavior. In general, behavior which is unfamiliar, incongruent and unexpected in a person's normal style, will not be readily labeled as deviant. Even stressful or threatening stimuli will tend to be misperceived or perceived with difficulty or delay (Clausen & Yarrow, 1955; Schwartz, 1957; Blackwell, 1966; Bentinck, 1967; Kulka, Veroff & Douvan, 1979).

Psychological explanations of deviant behavior are rarely invoked by the family during the early stages of mental illness. The most frequent explanations tend to be those attributing the behavior to character weakness (Schwartz, 1957), physical ailments, or situational factors (Blackwell, 1966; Kulka, 1979). Only 24% of the predominantly middle-class wives in Yarrow's et al (1955) study felt something was seriously wrong when their husbands first displayed abberant behavior. Similarly, in an interview conducted three weeks after a member's

first hospitalization, 18% of Lewis & Zeicher's (1960) sample of 109 families at three state hospitals denied the patien'ts mental illness. Mayo, Havelock, & Simpson (1971) reported that ten non-psychotic men in a mental hospital and their wives tended to accept a physical explanation for the husbands' illnesses. This general disbelief in psychological determinants for the patient's state was at variance with the staff's view of the nature of the illness.

Clausen (1959), using a focused interview technique with the spouses of 23 schizophrenic patients, demonstrated that symptomatic behavior directed against the spouse was more likely to be interpreted as deviant. This finding was replicated by Safilios-Rothschild (1968).

Yarrow et al. (1955) described the following phases a wife went through in defining her husband's behavior as deviant. These included the shifting interpretation of behavior, the occasional outright denial, and the stable conclusion, once a threshold for tolerance had been reached, that the problem was a psychiatric one. The family's naivete about psychiatric symptoms, the fluctuating course of the deviant behavior, and the presence of lesser forms of similar symptoms in "normal" persons acted against swift recognition of mental illness by family members.

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 much like Lederer's (1952) description of the reaction of patients to physical illness. He noted three definite stages of response. The first, the transition period from health to illness characterized by an awareness of symptoms, anxiety over their presence, denial or minimization, and some residual anger or passivity. When symptoms persisted, the patient was encouraged to accept the "sick role." This marked the second stage. In the third stage, the patient was encouraged to return to the functioning adult role.

Lederer's analysis was drawn primarily from the patient's changing perspective.

Alonzo (1980) identified six phases of social and care-seeking behavior surrounding the acute physical illness episode. The period between initial awareness of a health status deviation and arrival at a hospital bed could be divided into six analytic care-seeking phases: Warning or Prodromal Phase, Self-Evaluation Phase, Lay-Evaluation Phase, Medical-Evaluation Phase, Hospital Travel Phase, and Hospital Evaluation Phase. The actual phases used by the identified patient or his family and the duration of time in each phase vary and represent the sociobehavioral processes leading to the actual arrival for medical care.

Much of the research on deviance and help-seeking behavior is limited in significant ways. Many of these studies were conducted 10 to 20 years ago, and based their findings on small samples. Nevertheless, in reviewing this body of research, general patterns identified how families with a deviant member acted when confronted with ambiguous or stressful stimuli. Generally, they engaged in a delayed process of redefining the behavior secondary to psychological conditions. This may account for the lack of studies examining the help-seeking behavior in obtaining psychological care. The onset of symptoms, the nature of the behavior, and the family's social-environmental characteristics are likely to affect the process of seeking help for the family's mentally ill member.

Conceptual Framework

The conceptual framework for this study is presented in Figure 1. The model specifies the variables of interest and depicts their relationship. The study was designed to demonstrate that the process of help-seeking may be influenced by the family's social-environmental characteristics and the deviant behavior exhibited by the identified family member. Deviance was defined from the family's perspective, and included both a change in behavior and the intensity of the behavioral changes over time. The help-seeking process consisted of five, non-sequential phases which have differing elements of time. The time element was defined as the period from when a change in behavior was first recognized and labeled deviant by the family up to and including hospitalization of the mentally ill member. The five phases were: prodromal, self-evaluation, lay-evaluation, medical-evaluation, and hospitalization.

Definition of Variables

Family Environment	-The social-environmental characteristics of a family containing three domains of: a relationship dimension, a personal growth dimension, and a system maintenance dimension. The relationship dimension is measured by conflict; the personal growth dimension is measured by the family's moral-religious emphasis; and the system maintenance dimension is measured by organization.*
Conflict	-The amount of openly expressed anger, agression, and conflict among family members.*
Moral-Religious Emphasis	-The degree of emphasis on ethical and religious issues and values held by the family.*

*Taken from Moo's FES manual (1981)

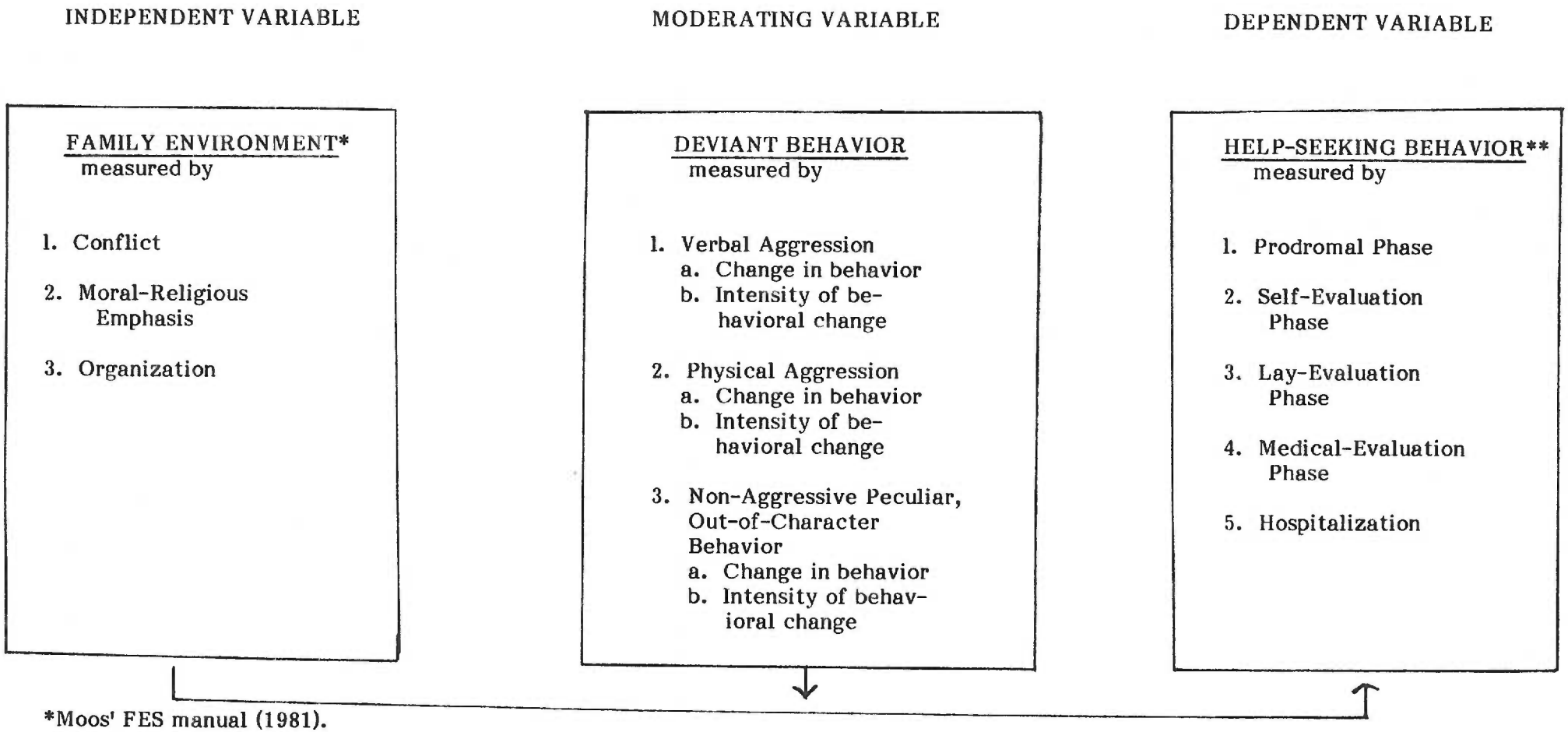
Organization	-The degree of importance of clear organization and structure in planning family activities and responsibilities.*
Deviant Behavior	-Behavior differing markedly from what is accepted as the norm within the family. The amount of deviance was the change in behavior, and the intensity of that change over time.
Help-Seeking Behavior Measured by Time	-The period between initial awareness of deviant behavior and admission to a hospital. Help-seeking behavior was divided into five phases: Prodromal Phase, Self-Evaluation Phase, Lay-Evaluation Phase, Medical Evaluation Phase, and Hospitalization.**
Prodromal Phase	-The period between initial awareness of deviant behavior and the onset of more acute symptoms; in retrospect, the deviant behavior foretold the impending episode.**+
Self-Evaluation Phase	-The period between acute symptom onset and the seeking of advice from lay or medical others; during this phase, the deviant behavior is a family phenomenon.**+
Lay-Evaluation Phase	-The period between seeking lay advice and the decision to seek medical evaluation; in this phase the deviant behavior became a social phenomenon with lay other's awareness.**+
Medical-Evaluation Phase	-The period between the decision to seek medical evaluation and the decision to go to the hospital.**
Hospitalization Phase	-The period between the decision to go to a hospital and the actual hospitalization.**

*Taken from Moos' FES manual (1981).

**Labels and definitions taken from Alonzo (1980), Acute Illness Behavior.

+Definitions were expanded to relfect the relationship of deviant behavior to psychological help-seeking behavior.

Figure 1: Conceptual Framework of Study



*Moos' FES manual (1981).

**Alonzo, A. (1980)

Purpose of the Study

This study investigated the help seeking patterns of families with a mentally ill member and the relationship among the amount and type of deviance and patterns of family environment as they effected the process of help-seeking.

Research Questions

Within a hospitalized population of first admission patients diagnosed as psychotic, this study aimed to answer the following questions:

1. Are there identifiable patterns of family environment?

2. Are there identifiable patterns of deviant behavior?

3. Are there identifiable patterns of help-seeking behavior?

4. Are there identifiable patterns among family environment and help-seeking behavior?

5. Are there identifiable patterns among deviant behavior and help-seeking behavior?

CHAPTER II

METHODOLOGY

Research Design

The research design was retrospective and descriptive, and permitted the exploration of the association between family environment, deviant behavior, and help-seeking behavior. Family environment, measured by the Moos FES, was the independent variable. The dependent variable was patterns of help-seeking behavior including duration of time spent in phases of the help-seeking process. Deviant behavior was the moderating variable measured by change in behavior and intensity of the behavioral change over time as measured by the family.

Setting

The study was conducted at a large teaching hospital on the East Coast. The institution's psychiatric service had three in-patient units. Family involvement was required for all patients. The service admitted all categories of psychiatric disorders except acute drug and alcohol abuse. DSM III criteria were used in formulating diagnoses.

Subjects

Subjects consisted of the families of first admission patients between the ages of 18-65 diagnosed as psychotic using DSM III criteria. The following DSM III diagnostic categories are included in this study: schizophrenia, paranoia,

acute and atypical paranoid disorder, schizophreniform disorder, brief reactive psychosis, schizoaffective disorder, atypical psychosis, bipolar disorder with psychotic features and major depression with psychotic features. Family was defined as all immediate relatives involved in the patient's treatment program. At least one family member was required for inclusion in the study. All subjects had to be able to read and write English. Data were collected between May and December 1984.

Data Collection Instruments and Methods

Data were collected using the following instruments:
1. The Moos FES Form R. 2. A focused interview. 3. A likert-type scale measuring deviant behavior. Each instrument is described in the following section.

Moos FES Form R

The FES form R (Appendix A) is a family social-environmental scale that significantly discriminates among families, is sensitive to parent child differences in the way in which families are perceived, is related to family size, ethnic minority composition, and family disturbance and incongruence. Each family member completes a ninety-item questionnaire. The individual items are grouped into ten subscales with nine true-false questions per subscale. Each true answer is worth one point, resulting in a range score from zero to nine. The family members' scores are converted to standard scores and a family profile is generated which can be compared with the population norms established for the scale. Also, the perceptions of any subsystem of the family can be

compared and contrasted to the perceptions of any other subsystem of the family.

Normative data for the FES form R were collected for 1125 normal and 500 distressed families (Moos, 1981). Subscale means and standard deviations for normal and distressed families make it possible for investigators to compare their subjects to either group. Reliability, as measured by Cronbach's Alpha, is in an acceptable range for all subscales, varying from .61 to .78. Test-retest reliability for the 10 subscales was calculated for 47 family members in 9 families who took the FES twice during an 8-week interval. The reliabilitiy coefficient varied from .68 for Indepencence to .86 for Cohesion. Test-retest stability was estimated for 4-month and 12-month intervals; these coefficients ranged from .52 to .91.

Another important aspect of measuring the characteristics of families is the stability of the resulting profile. The FES profiles are quite stable over time intervals of as long as a year. Profile stability correlations were obtained for 35 families tested 4 months apart and for 85 families tested 12 months apart. The mean 4-month profile stability was .78; the mean 12-month profile stability was .71.

Moos also studied three aspects of differences in perceptions of family environments: gender differences; parent-child differences, and the overall disagreement among family members. In terms of gender differences, there were few, if any, overall differences in perceptions of family social environment. However, there may be important differences among members of any one family. There were differences in parent and adolescent children's views of their family. The findings were consistent with findings in other settings indicating that people (such as parents) who have more authority and responsibility in an environment tend to view the environment more positively than people (such as children)

who have less authority and responsibility.

For the purposes of this study, conflict, moral-religious emphasis and organization were used to measure family environment. These subscales assessed the three underlying dimensions of Relationship, Personal Growth and System Maintenance. The internal consistency (Cronbach's Alpha) for each of the three subscales is adequate, varying from .75 for Conflict, .76 for Organization and .78 for Moral-Religious emphasis. The intercorrelational scores indicate that the subscales measure distinct though somewhat related aspects of family social environments. (See Table 1). The selection of the three subscales from Moos' nine subscales was based on the need to limit the number of scales because of the anticipated small study sample. The specific scales chosen were based on research using the Moos FES which demonstrated high conflictual and low organizational patterns in disturbed families. The investigator added the moral-religious scale for its potential value in detecting competing values of the family in using non-medical (non-scientific) health care resources, thus potentially prolonging the help-seeking process.

Table 1

Moos Subscale Intercorrelations*

Subscales	Conflict	Moral-Religious Emphasis	Organization
Conflict	(-)	-.10	-.33
Moral-Religious Emphasis	-.07	(-)	.27
Organization	-.33	.27	(-)

*Adapted from Moos (FES) 1981

The Focused Interview

A focused interview (Appendix B), developed by the researcher, was conducted with the subjects (families of all first admission patients diagnosed psychotic) to gather information about the family's help-seeking behavior and their response to the deviant behavior of the mentally ill member. The five phases used to describe the time element in the process of help-seeking were adopted from Alonzo's (1980) model of acute illness behavior. The period between initial awareness of deviant behavior and admission to a hospital was divided as follows: Prodromal Phase, Self-Evaluation Phase, Lay-Evaluation Phase, Medical-Evaluation Phase, and Hospitalization. The primary issue raised in distinguishing phases was the variability of the help-seeking process both in the duration of help-seeking and in the substantive differences in the family environments. These help-seeing phases were not considered unilinear or predetermined; the possibility existed that some phases may be skipped. Differences in Total Time indicated that different phases affected Total Time and individual durations within each phase. The phases were a manifestation of the different strategy utilized by families with different family environments.

Likert-Type Scale Measuring Deviant Behavior

A Likert-type scale (Appendix C) measuring deviant behavior was given to the family members. The families were asked to jointly fill out one set of questions about the deviant behavior of their hospitalized family member. The questionnaire was designed by the researcher to measure the specific type, amount, and intensity of the deviant behavior the family observed. The areas covered

verbal offensiveness, physical aggression, and peculiar, out-of-character (non-aggressive) behavior. The family was also asked to rate the degree of disruptiveness the deviant behavior had on the family, and the amount of family resources (emotional and physical energy, time) spent dealing with the deviant behavior. The scale's face validity was achieved through consultation with psychiatric clinicians working with the researcher. Statistical measures of validity and reliability were not possible at this stage of development of the scale.

Methods of Procedure

As part of the routine admission procedure, family members were seen by a psychiatric social worker (M.S.W.) on the day of admission. For those after-hour admissions, this family interview took place the following working day. At the conclusion of this initial admission interview, the Social Work staff agreed to introduce to this researcher those families meeting criteria for inclusion into this study.

Following introductions, this researcher identified herself as a graduate student in nursing from the Oregon Health Science University, explained the nature of the proposed study as described in the consent form and invited the family to participate. Families interested in becoming subjects were given the consent form to read and sign. Questions regarding the study were answered at that time. Appointments were scheduled within 2-3 days for those family members who were involved in the patient's treatment.

The data collection process began with the focused interview. Notes were taken and only first names were used. Following this, the family members were

asked to jointly answer the questions on the likert-type scale of deviant behavior. If and when disagreement among family members occured, the family was encouraged to discuss their differences and try to come to some agreement. When mutual consensus was not possible, the mean of their scores became the family score.

After the completion of the deviant scale each individual member, over the age of 10 was asked to complete the Moos FES. The researcher was present during the entire data collection process.

Protection of Human Subjects

This study met the criteria for Human Subjects approval. Confidentiality was maintained by using a coding system. Family names were not used. Only this researcher had access to the coding sheet. All data were kept in a locked file.

In an effort to address any difficulties that may have been caused by the process and/or subject matter of the study, the researcher remained with the family to answer questions or concerns. The offer to meet again and go over the findings was also extended to all families.

Methods of Analysis

This study investigated families with a psychotic member interfacing with the mental health care system for the first time. The proposed research was an hypothesis generating study designed to examine the patterns of family environment, deviant behavior and help-seeking behavior. The sample size was purpose-

fully small. The data were therefore analysed descriptively. The scores from the three measures: Moos FES, time and phases of help-seeking and deviant scores of the total population were examined using descriptive patterning profiles. Relationships between the three variables were studied. Within group differences were then compared with the remaining variables.

CHAPTER THREE

RESULTS

This study was designed to investigate the process whereby families seek psychiatric care for a mentally ill member and to distinguish patterns of family environment and deviant behavior of the mentally ill member which may effect the process of help-seeking. Data were collected on an inpatient psychiatric unit of a large teaching hospital. A total of ten families who volunteered to participate in the study met the following criteria for inclusion:

1) The mentally ill family member was undergoing his/her first psychiatric admission and was diagnosed 'psychotic';

2) At least one family member was involved in the patient's treatment; and

3) All participants in the study could read and write English.

Demographic Data of Identified Patient

Demographic data describing the mentally ill family member are listed in Table 2. The age range and gender distribution of this sample approximates that found in the yearly statistics for admissions to the psychiatric unit where the study was conducted. (NPEU Yearly Census Report, 1982, 1983). The modal age range was 10-19 with 50 percent of the patients under the age of 30. Sixty percent of the sample studied were single, separated or divorced. Over half of the patients were Caucasian; the remaining were black. There were twice as many females as males. The oldes member in the study was a 58 year old married male.

Table 2

Demographic Variables of the Mentally Ill Members (n = 10)

Variable	
Age	n
10-19	4
20-29	1
30-39	3
40-49	1
50-59	1
Marital Status	n
Single	4
Married	4
Separated/divorced	2
Race	
Caucasian	6
Black	4
Gender	
Male	3
Female	7

Hospitalization variables are listed in Table 3. All patients were diagnosed psychotic, a requirement for inclusion in the study. Approximately two-thirds of the mentally ill members were diagnosed with affective illnesses; the remaining one-third with thought disorders. Of the three patients diagnosed schizophreniform, one was an 18 year old black pregnant single mother of one. The other two patients were male: a new father, age 28, and an 18 year old white adolescent, living with his divorced mother and younger brother. The remaining seven patients all had an affective component to their psychosis. The two oldest patients in the

study, both white, had major depressions with psychotic features. One was a 58 year old married school teacher preparing for early retirement; the other was a 47 year old recently divorced paraplegic mother of four.

In general, families in this sample were influential in the decision to seek help for their mentally ill member. In spite of objections from the mentally ill member, eight of the study families requested hospitalization for their family member. Only two patients initiated the help-seeking process themselves. Of these two, one was the 58 year old teacher who had been symptomatic for over three months; the other was a 13 year old black girl acutely psychotic for five days. Of the eight patients brought to treatment by their families, all were disturbed enough to require involuntary admission.

The emergency service proved to be the most accessible entry point with eight patients referred to the inpatient unit from this service. These eight patients comprised the entire group of involuntary admissions. Of the remaining two patients, one was referred by his outpatient therapist at the patient's request; the other was admitted as a result of her mother contacting the treatment unit directly.

Table 3

Hospitalization Variables of the Mentally Ill Members (n = 10)

Variable	
Diagnosis	n
Brief Reactive Psychosis	2
Schizophrenifrom	3
Organic Affective	1
Major Depression - Psychotic	2
Bipolar Manic - Psychotic	1
Atypical Psychosis	1
Admission Status	
Voluntary	2
Involuntary	8
Help-Seeking Initiater	
Patient	2
Parent	4
Spouse	3
Son/Daughter	1
Route of Entry	
Emergency Service	8
Outpatient Therapist	1
Direct Referral-mother	1

Demographic Data of Families

Personal socio-cultural characteristics of the ten families varied considerably. These are listed in Table 4. Six families were white and four were black. All four black families were practicing Baptists. The six Caucasian families were Catholic, five of which were practicing. The families in this study were representative of the large ethnic groups in the surrounding community (e.g. Italian, Irish, Polish, and blacks). The one ethnic group not represented in this sample, but prominent in the community, was the Jewish sector.

Eight of the ten families had no family history of psychiatric illness. Of the two remaining families, the mother of a 17 year old white female diagnosed bipolar manic, had been treated for a brief psychotic episode ten years earlier. In the other family, the half-brother of a black 28 year old male had been hospitalized for psychiatric problems following his military duty.

Five of the ten families were single-parent households, and five were two-parent same household families. Two of the five single-parent households were 'three-generational' in which the patient was a single black mother living with her children, her siblings, and her own single mother. The remaining eight families lived in two-generational family units.

The head of the household for eight of the families, two of which were women, was employed. The two families with unemployed heads of household were single mothers, one black and one white. Using Hollingshead's two-factor index of social position to describe occupational roles of the eight employed families, two were business managers/professionals; three were clerical/sales/technical; and three were skilled factory workers.

Table 4

Personal-Social Characteristics of the Families (n = 10)

Characteristic	n
Race	
Caucasian	6
Black	4
Religion	
Protestant- Baptist	4
Catholic	6
Family Psychiatric History	
Negative	8
Positive	2
Family Constellation	
Parents	
Single parent household	5
Two parent same household	5
Generations	
Three-Generational households	2
Two-generational units	8
Employment	
Head of household employed	8
Head of household unemployed	2
Occupation of employed	
Managers, owners, professionals	2
Clerical, sales/technicians	3
skilled laborers	3

The relationship of the patient to the family members initiating treatment was divergent in this sample (see Table 5). One patient was an unemployed 47 year old single mother brought to the emergency service by her adolescent/young adult children. In three families, the parents and siblings of adolescent patients initiated treatment. The two black single mothers of the three-generational families had the involvement of their children, their siblings and their mother.

For the remaining four patients (two males, two females), the spouse was the initiator of treatment. In this sample, the results indicate that no single family member is more or less likely to initiate requests for care of a mentally ill family member. Essentially all family members had the capacity to recognize deviant behavior and mobilize the family unit into seeking help.

Table 5

Family Members Initiating Treatment

Member(s)	n
Children	1
Parents and Siblings	3
Children and Parents	2
Spouse	3
Self	1

Research Questions

The remaining data will be discussed according to the research questions of the study.

Question 1: Are There Identifiable Patterns of Family Environment?

The Moos Family Environment Scale was given to the family of the identified patient. Scores were obtained for three subscales: Conflict, Moral-Religious Emphasis, and Organization, and are presented in Table 6. The subscale means and standard deviations of this sample and those of Moos' normal and disturbed

families are compared in Table 6. As the data indicate, the study families could be characterized as less conflicted, highly religious, and poorly organized. This pattern is unlike either of Moos' family groups. The study families' scores on Conflict approached Moos' normal families', but they scored higher on Moral-Religious Emphasis and lower on Organization than either Moos' normal or disturbed families. Interestingly, the study families had less conflict and were more religious than Moos' normal families, yet they were less organized than Moos' disturbed families. Of interest is the range of scores on the conflict and organization subscales for this sample. Scores on the conflict subscales ranged from .5 to 7 (possible range = 0 to 9). Seventy percent of the families scored two standard deviations or more above or below the mean. The organization scores ranged from 3 to 7 (possible range = 0 to 9). Only two scored one standard deviation or more above or below the mean. In spite of the wide range of scores, the standard deviations of the study sample are not unlike those obtained by Moos.

Table 6

Comparison of Moos' Normal and Disturbed Families with the Study Families

	Moos' Normal Families (n - 1125)		Moos' Disturbed Families (n = 500)		Study Families (n = 10)	
Subscales	Mean	SD	Mean	SD	Mean	SD
Conflict	3.31	1.85	4.28	1.93	3.0	1.7
Moral-Religious Emphasis	4.72	1.98	4.45	1.87	5.5	1.8
Organization	5.41	1.83	5.06	1.91	4.7	1.3

For analysis of the following data, the means and standard deviations of the families in this study were compared with the means and standard deviations of Moos' normal families. Seventy percent of the families in this study scored below the mean (3.31) on conflict. Within this group, four scored 1 or less. The three most highly conflicted families scored equal to or more than two standard deviations above the mean. Thus, in this sample, the families were either extremely conflicted or nearly conflict free, but, as a whole, they remained less conflicted than Moos' normal families. The study subjects' FES scores for these subscales are listed in Table 7.

Table 7

Family Environment Scores (n=10)

	Low	High
Conflict	7	3
Moral-Religious Emphasis	3	7
Organization	7	3

A comparison of those seven families in the low conflict group are depicted in Table 8. For those seven families who scored low on conflicts, moral-religious emphasis and organization were negatively related. No pattern appeared for the three high conflict families, in part because of too few subjects. See Table 8 for a comparison of Family Environment conflict scores with the remaining subscales.

Table 8

Comparison of Family Conflict (n=10)

Low Conflict Families (n=7)		Moral-Religious Emphasis	
		Low	High
Organization	Low	1	3
	High	3	0

High Conflict Families (n=3)		Moral-Religious Emphasis	
		Low	High
Organization	Low	2	1
	High	0	0

Question 2: Are There Identifiable Patterns of Deviant Behavior?

A Likert-type scale, designed by the investigator, was used to measure deviance. See Appendix C for the Deviance Scale. Families were asked to agree upon the score which best described the type and intensity of the behavioral changes that caused them to seek help for their family member. The types of behavior measured by the scale included: verbal-offensiveness, physical aggression, and bizarre, non-aggressive, peculiar, out of character behavior. The raw scores are listed in Appendix F.

The means and standard deviations for the three scales of deviant behavior was as follows: Verbal Offensiveness (M-13 SD-9), Physical Aggression (M-6.5 SD=6), and Bizarre Behavior (M=23 SD=5.5). The scores from the ten families were divided into a high and low group. The scale midpoint was used to divide the group ($\leq$14 was low and >14 was high). All the patients were bizarre in their behavior, some were verbally offensive and only one patient was physically aggressive. Table 9 depicts the deviant behavior scores of the study sample.

Table 9 Comparison of Deviant Behavior (n=10)

Scale	Low	High
Verbal Offensiveness	4	6
Physical Aggression	9	1
Bizarre Behavior	0	10

A comparison of verbal offensiveness and the three Family Environment scores characterizes a pattern of high verbal offensiveness, high moral-religious emphasis and low conflict. Sixty percent of the patients scored high on verbal offensiveness. Of this group, five scored high on moral-religious emphasis and low on conflict. There was no apparent pattern for organization. Table 10 depicts a comparison of verbal agression and the Family Environment scores.

Table 10

Comparison of Verbal Aggression and Family Environment Scores (n=10)

High Verbal Offensiveness (n=6)

Religious Emphasis	Conflict: Low	Conflict: High
Low	0	1
High	5	0

Low Verbal Offensiveness (n=4)

Religious Emphasis	Conflict: Low	Conflict: high
Low	1	1
High	1	1

Question 3: Are There Identifiable Patterns of Help-Seeking Behavior?

The help-seeking process was divided into five phases. Alonzo's (1980) model of acute illness behavior was adapted to measure the different phases families went through from initial awareness of deviant behavior to hospitalization of a family member. The five phases were:

1. Prodromal Phase
2. Self Evaluation Phase
3. Lay Evaluation Phase
4. Medical Evaluation Phase
5. Hospitalization Phase

Definitions of these phases are listed on page 17.

This study focused on the process of help-seeking. In analyzing the data the question of how to interpret the medical and hospital phase became an issue. Outpatient treatment and hospitalization both constitute appropriate psychological help-seeking behavior. Therefore, the decision was made to eliminate phases 4 and 5, and define the help-seeking process as consisting of phases 1 through 3: Prodromal, Self-Evaluation, and Lay-Evaluation. Total help-seeking time was measured from the initial awareness of deviant behavior to seeking psychological help for the family member.

There was considerable difference between families in total time spent in the help-seeking process. Figure 2 depicts a comparison of time for the ten families. In this profile of each family, the figure demonstrates time spent in the three phases of help-seeking (HS) relative to total HS time.

In Table 11, families were divided into those with a total HS time of greater than 4 weeks and those with a HS time of two weeks or less. The percentage of total time spent in the three phases is also given. Of particular interest is that four of five families with a shorter HS time took less than one week. One pattern that is readily identifiable from this data is a prolonged prodromal phase. Irrespective of total help-seeking time, the majority of the families (80%) spent greater than 50% of their total help-seeking time in the prodromal phase. Conversely, the self-evaluation phase was consistently less than 50% of the total help-seeking time for both the short and long groups.

Figure 2

TOTAL TIME (WEEKS) AND PHASES OF HELP-SEEKING (n=10)

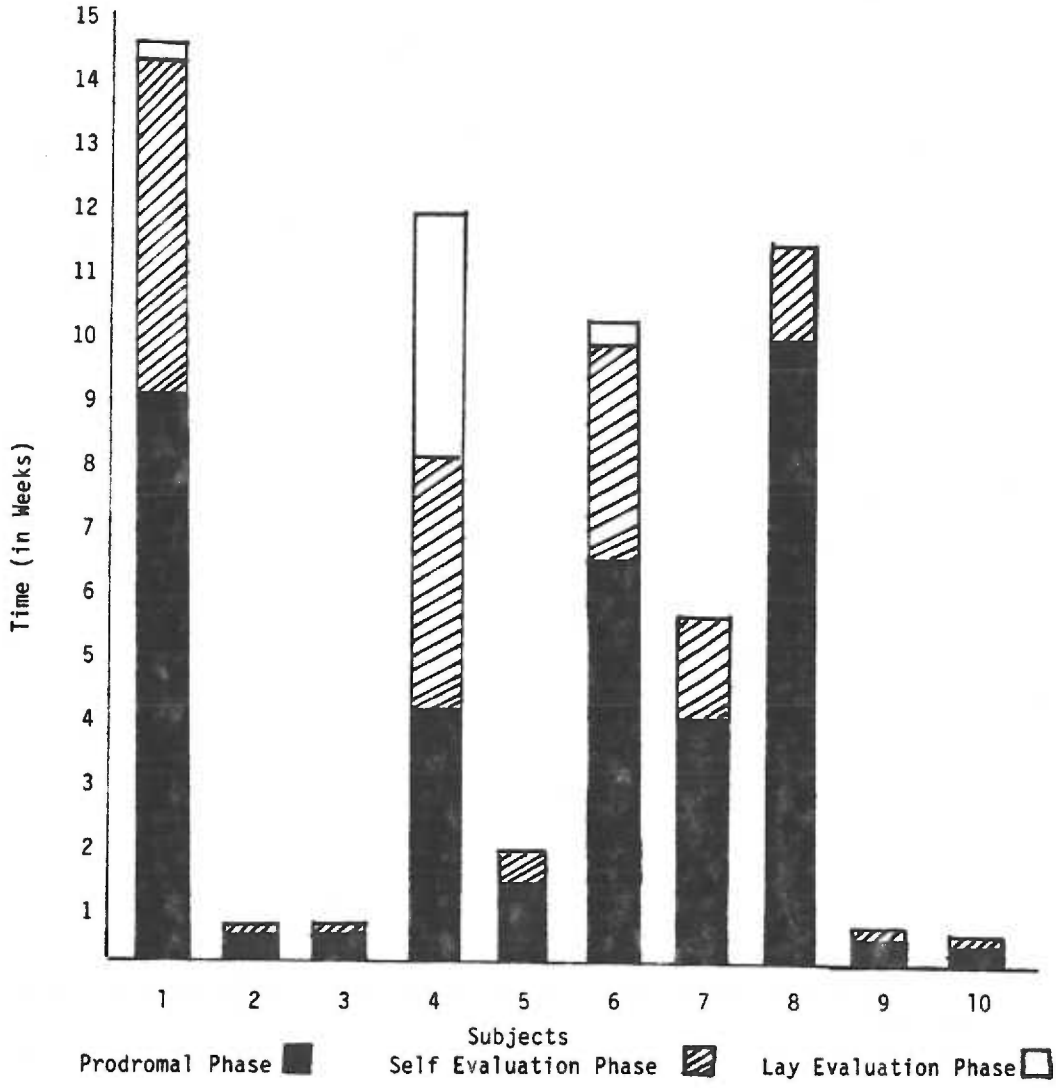


Table 11

Total Time in Days and Phases of Help-Seeking (n=10)

Short/Long Total HS. (S=< 2 wks L= > 4 wks)	% Total Time in HS Phases			Total Time (Wks.)
Family	Prodromal	Self-Eval.	Lay-Eval.	
1 L	60%	39%	1%	> 14
2 S	83	17	0	< 1
3 S	83	17	0	< 1
4 L	31	31	38	> 13
5 S	71	29	0	2
6 L	58	39	3	> 10
7 L	70	30	0	> 5
8 L	89	11	0	> 12
9 S	60	40	0	< 1
10 S	50	50	0	< 1
S=5 L=5				
M= Mean Days				
SD= Standard Deviation	M 26 SD 26	M 13 SD 14	M 6 SD 11	M 43 SD 41

Table 12 depicts those families with a lengthy and a shortened total help-seeking time relative to the prodromal and self-evaluation phases of the help-seeking process. For that group of families taking more than four weeks to seek help, four of the five had a prolonged prodromal phase and a shortened self-evaluation phase. The five families with a shortened help-seeking time all experienced a prolonged prodromal phase, and a very brief self evaluation phase. The Lay-evaluation phase was absent in this group. One family spent 50% of their total HS time in the prodromal phase and 50% in the self-evaluation phase. The total HS time for this family was less than one week.

Table 12

Comparison of Help-Seeking Phases with Total HS Time (n=10)

	Long HS Time (n=5) Self-Eval. Phase		Short HS Time (n=5) Self-Eval. Phase	
Prodromal Phase	Short	Long	Short	Long
Short	1	0	0	0
Long	4	0	4	0

*One family spent 50% of total HS time in prodromal and 50% in self-evaluation phase.

The second pattern that emerged from the data was the absence of a lay evaluation phase for the majority of the ten study families. Seventy percent of the families did not experience a lay evaluation phase. Those families who did seek advice or help outside the family system (30%) all had a prolonged help-seeking time. This may represent a third pattern, but remains unclear because of too few subjects.

Question 4: Are There Identifiable Patterns Between Family Environment and Help-Seeking Behavior?

Family organization may influence the help-seeking process. For the ten families there appeared to be a trend. Less organized families took a shorter time to seek help than the more organized families. Table 13 is a comparison of organization and total help-seeking time.

Table 13

Comparison of Organization and Help-Seeking Time (n=10)

Organization	Help-Seeking Time: Short	Help-Seeking Time: Long
Low	4	2
High	1	3

A comparison of moral-religious emphasis and conflict with total help-seeking time yielded no apparent pattern for the group with a short HS time ($\leq$ 2 wks). There was a definite pattern for those families with a long HS time (> 4 wks). These families were either highly conflicted, non-religiously oriented or the reverse, that is, nearly conflict free, religiously oriented families. Considering the sample size, one could only hazard a guess as to how conflict and religious orientation influence the use of medical health care systems. High conflict may have immobilized families. Religious orientation may serve to increase tolerance for deviant behavior or provide alternative care giving settings or strategies. Table 14 depicts this pattern.

Table 14

Comparison of Family Environment and Help-Seeking Time (n=10)

	Short HS Time (n=5)		Long HS Time (n=5)	
	Moral-Religious Emphasis		Moral-Religious Emphasis	
Conflict	Low	High	Low	High
Low	2	2	0	3
High	0	1	2	0

Question 5: Are There Identifiable Patterns Between Deviant Behavior and Help-Seeking?

Although all ten families defined their mentally ill members' behavior as very bizarre, this did not seem to influence the time element in the help-seeking process. A comparison of verbal offensiveness and help-seeking time revealed no pattern. The tool used may not be sensitive enough to discriminate adequately.

An incidental finding that seems noteworthy was the reluctance of the ten study families to define their family members' deviant behavior as psychological. Three families attributed the deviant behavior to a character trait, e.g. "He's always been like that... It just got worse." Three families attributed the cause to situational factors such as the stress of starting school, a new job or financial worries. Three families believed the deviant behavior was the result of a physical ailment. Attribution of deviance seemed to influence the help-seeking process. Table 15 depicts this.

Table 15

Attributions of Deviance and Time in Help-Seeking Process (n=10)

	Help-Seeking Time	
Attribution	Short	Long
Characterilogical	1	3
Situational	1	2
Physical	3	0

Those families who believed the deviant behavior was the result of a physical ailment had help-seeking time of less than two weeks. When the explanation of deviance was characterological, the help-seeking time was prolonged, twelve weeks or more. Of the three families who gave situational causes for the deviant behavior, one had help-seeking times of less than one week, two had help-seeking times of six and eleven weeks.

Summary

In summary, the patients in this study were newly diagnosed as having a psychotic disorder and were experiencing their first psychiatric hospitalization. The majority were young women under the age of 40 who were brought to the hospital by family members and admitted through the Emergency Service on an involuntary status. The majority of the families were without family psychiatric histories. They lived in two-generational family units with the head of household employed. Families in this study either sought psychological help quickly (less than one week) after defining their family member's behavior as deviant or they tolerated the deviant behavior for a substantial period of time (4 to 14 weeks) before seeking medical help.

Family environment scores from Moos' FES depict a pattern of low conflict, low organization and high moral-religious emphasis for the majority of the families studied. As the data indicated, no single scale from the Moos FES was a useful predictor of time spent in the help-seeking process. This was also true for the deviant subscales. Nine out of the ten patients were non-aggressive, and all ten patients scored high on bizarre behavior. Irrespective of how long families took before seeking psychological help for their mentally ill member, the majority spent over 50% of their total help-seeking time in the prodromal phase. For

most of these families the deviant behavior was tolerated within the family system until the family brought the patient to a Hospital Emergency Service Department. The patient's symptoms were severe enough to require involuntary admission for 80% of the study sample.

CHAPTER IV

DISCUSSION

The focus of this study was to understand the decision making and help-seeking processes whereby families obtained mental health care for a severely disturbed family member. The underlying premise guiding the organization of this study was the belief that mental illness is first and foremost a social phenomenon, and that the family is the social system where health and illness behaviors are shaped and health utilization practices learned and carried out. The manifestations of mental illness are as varied as the spectrum of human behavior and are expressed not only by the behavioral disturbance in the identified individual, but also in the disruptive interactions with others in the environment, particularly the family. Therefore any discussion of the help-seeking process of families with a mentally ill member must address the structure and process within the family system, namely, family environment and the families' concept of deviance.

Independent Variable

There is general agreement that family environment is crucial to understanding the family's decision making processes, yet few attempts have been made to systematically assess the social climate of the family. There is a paucity of instruments that measure family functioning or the family life style as a whole. Moos' Family Environment Scale, FES, is one such instrument designed to assess the social-environmental characteristics, or "personalities" of all types of families. The FES focuses on the measurement and description of three dimensions: the

interpersonal relationships among family members, the direction of personal growth emphasized within the family, and the basic organizatonal structure of the family. The following three subscales were chosen to measure these three dimensions: conflict, moral-religious emphasis and organization. In this study, the FES was used to define the family "personality" which in turn was hoped would help elucidate the decision making and help-seeking processes of families seeking care for a mentally ill member. For the most part this proved not to be the case. Families with similar "personality styles" took from four days to three months to seek help for their mentally ill family member. Although the sample size was small, one of the FES subscales, organization, seemed to demonstrate a trend. Less organized families took a shorter time to seek help than the more organized families.

Family "personality" was not useful in predicting how families explained the deviant behavior of a member. For example, the four families who attributed their family member's deviant behavior to characterological factors varied considerably in their moral-religious emphasis and the degree of organization and conflict within the family unit.

One supposition underlying the choice of the FES was that low conflict and high organization might be facilitating factors in the mental health help-seeking process. Likewise, it was thought that religious emphasis may give rise to competing, less medically focused health care utilization practices. The majority of the families scored low on conflict and high on moral-religious emphasis. There were too few study subjects with both low conflict and high organizational scores to substantiate the idea that these elements of family style facilitate mental health help-seeking practices. Of the seven families with low conflict scores, six also scored high on moral-religious emphasis. The help-seeking time for this group varied considerably. The premise that religious emphasis may provide

competing non-medical help-seeking options remains unfounded. Perhaps low conflict and high religious emphasis offset each other, rendering the FES less effective in predicting help-seeking behavior.

Regardless, the hypothesis that family "personality style" directly influences mental health help-seeking behavior may in itself be too elementary. When attempting to understand what happens in the face of mental illness, particularly the first time families are confronted with extreme deviant behavior of a family member, the notion of family 'traits' may be less helpful than measuring change or 'state' factors within the family unit. While the FES has been used to identify personality styles or traits of disturbed and normal families, the Family Adaptability and Cohesion Evaluation Scale, (FACES), may have been the preferred instrument to measure state factors influencing families faced with the aberrant behavior of a mentally ill member. This scale was developed on a circumplex model that emphasizes optimum balance in which there is enough that is familiar to ensure economical and efficient use of what is new. The theoretical view of the family system shifts from morphostatis (stability) to morphogenesis (change) (Olson, Sprenkle, Russell, 1979). An instrument, such as the FACES, that measures a family system's ability to change its power structure, role relationships, and relationship rules in response to situational stress may prove more beneficial in understanding family decision making and mental health help-seeking practices.

Dependent Variable

Analysis of family systems, irrespective of frame of reference, is but one aspect of understanding the changes and decision making processes in the face of mental illness. Mental health help-seeking behavior must be examined as well. Alonzo's (1980) Acute Illness Model was used to determine the family's style and route in seeking mental health care for a member. Alonzo identified

six phases of care-seeking behavior surrounding the acute physical illness episode that seemed applicable to an acute mental illness episode. Psychotic behavior, one of the more extreme forms of deviance in mental illness, produces unequivical mental health status changes similar to acute physical illness.

The notion that the help-seeking process is the same for physical and mental illness may be somewhat simplistic. The idea of a generic or common help-seeking pathway negates the social implications of mental illness, and was clearly not borne out in the study. For example, Alonzo found that the lay evaluation phase was highly significant in the care-seeking process of acute physical illness behavior. He found two dimensions of the lay evaluation process to be helpful. The first was termed "an assurance of the need for medical care" and the second dimension covered the manner in which the individual/family used lay others as resources (Alonzo, 1980, p. 520). The majority of the study families were without a lay evaluation phase. Perhaps stigma prevented these families from seeking consensual validation or assistance in mobilizing or persuing outside resources.

The deviant behavior was tolerated within the family system until resource exhaustion occurred. This is consistant with the family burden concept (Goldman, 1982) and gives rise to still another hypothesis in understanding the help-seeking process. Speculation about resource choice might be anonymity and/or the high degree of technical competence for a wide spectrum of problems. Additionally, use of the Emergency Services allows the family to secure health care at the moment of least resistance on the part of the mentally ill family member.

In addition to the absence of a lay evaluation phase, and irrespective of the total help-seeking time, the majority of the families (80%) spent the majority of their time in the prodromal phase. That is, these families spent most of their total help-seeking time aware of an existing problem in their family member but unable to take decisive action that would remedy the situation. Anecdotal

comments indicated that families could not act until they had conceptualized or characterized the behavior as necessitating health care. The concept of attribution is helpful in understanding mental health help-seeking practices.

In contrast to rather sophisticated medical health care models, these families did not have an organized framework for psychological explanations of deviant behavior. This is not surprising since individuals are given little training, media exposure or socialization in how to identify or deal with deviant behavior resulting from mental illness. Educational efforts in the arena of physical problems are much more apparent, one example being television advertisements and community training programs on cardio-pulmonary resuscitation. Signs and symptoms of mental illness are rarely pathognomonic of specific mental disorders and are frequently exaggerations of "normal" behavior making it difficult for families to rely on a conceptual framework for understanding or seeking help for a mentally ill member. It is little wonder then that the deviant behavior of mental illness generates anomic roles for families. The most frequent attributions of deviant behavior tend to be character weakness, situational factors or physical ailments. In this study, physical attributions of deviance were positively related to help-seeking. Perhaps such attributions legitimize help-seeking endeavors and provide an acceptable, well-established framework within which to act.

Moderating Variable

The moderating variable in this study was deviant behavior. Deviance was defined from the family's perspective, that is behavior differing markedly from what was accepted within the family system. A Likert-type scale, designed by the investigator, was used to measure verbal offensiveness, physical aggression and bizarre behavior. The most noteworthy finding was that ninety percent of

the families denied physical aggressiveness on the part of their family member, and all ten families reported the deviant behavior of their member to be extremely bizarre. The high bizarre scores may indicate that this term captured the ideas or descriptions that the families had made for the behavior they witnessed. Another obvious explanation was the limitations of the deviant scale. The tool lacked the ability to descriminate adequately what exactly the family defined as deviant and the degree of severity of the observed behavior. Although the term bizarre seemed to be qualitively accurate, it was less useful in predicting help-seeking practices. However, the term bizarre may also seem less stigmatizing than admitting tolerance of physical or verbal offensiveness from a family member. Physical aggression and verbal offensiveness may, on the other hand, be more likely considered socially tolerated behavior subject to the ups and downs of everyday life. Regardless, this study supported the mental health literature that indicates the prediction of physical aggression in the mentally ill population continues to be over estimated by professionals and the lay public alike (Monahan, 1984).

Demographic Variables

Although not a direct focus of inquiry, one interesting finding was the varying association between demographic variables and the help-seeking process. For example, a positive family psychiatric history did not seem to influence the help-seeking process. The ethnicity of the study families varied and was representative of the large ethnic groups in the surrounding communities with the exception of the Jewish sector. Four of the ten families were black, three of these four families had the shortest help-seeking times in the study (less than two weeks). A consistent finding in the three black families was the existence of a medical

condition under treatment in the mentally ill family member. While none of the attributions of deviance were directly related to the specific medical condition, all three black families did employ a physical explanation for the deviant behavior of their family member.

Implications for Nursing

Irrespective of the families' explanation of the problem, this study confirms the importance of the family as the primary vehicle for securing mental health care for a deviant family member. This is consistent with clinical observations that acutely psychotic individuals lack the insight necessary to identify the need for mental health care. Nine out of the ten families brought their family member to hospital for treatment. None of the study families were involved with schools or the legal system regarding the deviant behavior of their family member and eight of the ten patients denied the need for care and exhibited symptomology severe enough to necessitate involuntary commitment.

The families' understanding of the deviant behavior of their mentally ill member was categorized into three attributions: characterilogical, situational and physical. The study results indicated these attributions effected the help-seeking process. Physical attributions were associated with shorter HS times; characterilogical, with longer HS times. Through understanding the attributions of the family, nursing can tailor its psycho-educational interventions to the family's perspective of the deviant behavior. Nursing has always tried to merge the values of the health delivery system with the needs of the patient in a way that facilitates the individual's recovery to his/her highest level of functioning. Similarly, understanding the family's perception of what has caused the deviant behavior allows the nurse to incorporate the family as a partner in assuming the appropriate and necessary role in subsequent help-seeking and health maintenance of their

family member. In this era of cost containment, prospective payment plans and severely restricted treatment options, the family is likely to be a major health care treatment resource.

Before we can understand the association between deviance and help-seeking, we must understand how and what the famiy identifies as aberrant behavior. For those families dealing with the disruptions of a mentally ill member for the first time, the nurse can play a key role in establishing a treatment foundation that the family will utilize in subsequent illness episodes. Teaching the family how to define what they see and experience can clearly impact future help-seeking practices. Helping to instill confidence by joining the family in a mutually accepted frame of reference, and validating the family's assessment process should serve to shorten the prodromal phase of the help-seeking process.

Given that a third of those individuals suffering from a psychotic illness will experience repeated episodes, and many will become chronic mental patients, a major focus of nursing interventions should be directed towards supporting the family system so that the family unit continues to be responsible for its family member. The nurse must help the family avoid resource exhaustion. This can be accomplished by incorporating the family in the psycho-educational treatment plan facilitating a partnership in the care of the mentally ill individual.

Limitations of the Study

The generalizability of the study results are limited by the small sample size (N-10), which restricted the data analysis to descriptive procedures. Another limitation was the retrospective nature of the inquiry. Families were asked to recall events and identify phases of their help-seeking behavior over time. For some families this involved a four month period of time; others, less than a

week. The sample was collected form a private sector teaching hospital which in all probability skewed the data, as did the study design limiting the type of patients to those experiencing their first psychotic episode with no previous psychiatric hospitalizations. Help-seeking practices of families with a character disordered individual or a depressed member may be quite different. Repeated illness episodes may result in different help-seeking practices.

The instrument chosen to measure family environment was both reliable and valid. However, an instrument designed to measure change (state factors within the family environment) may have proven more useful in understanding the decision making processes of families experiencing the disruptions of a mentally ill family member for the first time. The deviant scale, developed by the investigator, may have had face validity but lacked the necessary sensitivity to descriminate bizarre, out-of-character behavior and predict one type of experience which may have precipitated or prolonged help-seeking.

Future Research

In spite of the small sample size, the study provided some initial insights into the help-seeking behavior aimed at securing mental health care. Although families did not use lay others to validate their concerns about the deviant behavior of a member, they nonetheless seemed unable to seek care until they had arrived at an attribution for the deviance they observed and selected a health care setting for evaluation.

Future research might expand the original study by enlarging the diagnostic categories and sample size. This would allow for comparison of help-seeking patterns for different illness groups such as depression or personality disorders. Another comparison might include private sector clients and their family members

with the pubic sector clients. These additional variables would expand the theoretical base of the study to include more health belief variables.

Since first admission subjects limit the research design to retrospective data collection, a prospective method might be employed to follow these identified families over time. This would more precisely document family help-seeking practices for subsequent illness exacerbations and note any changes in family 'personality' over time with a chronically mentally ill member.

With little relation between deviance and help-seeking behavior noted, a factor searching design might provide more descriptive data from which to design a mental health help-seeking model. As research on health belief models has shown, help-seeking behavior is influenced by multiple variables. As noted in this study the additional variables of attribution and stigma further complicate the interactiona between patient, family and mental health care delivery system.

BIBLIOGRAPHY

ALONZO, A. (1980). Acute illness behavior: a conceptual exploration and specification. Soc. Sci. and Med., 14, 515-526.

BATESON, G. (1960a). Minimal requirements for a theory of schizophrenia. Archives of General Psychiatry, 2, 477-491.

BATESON, G. (1960b). The group dynamics of schizophrenia. In L. Appleby (Ed.), Chronic Schizophrenia, Glencoe, Ill.: Free Press.

BATESON, G. (1979). Mind and Nature: A Necessary Unit. New York: Dutton.

BEAVERS, W. (1977). Psychotherapy and Growth: A Family Systems Perspective. New York: Brunner/Mazel.

BENTINCK, C. (1967). Opinions about mental illness held by patients and relatives. Family Process, 6, 193-207.

BLACKWELL, B. (1967). Upper middle class adult expectations about entering the sick role for physical and psychiatric dysfunctions. Jr. of Health & Social Behavior, 8, 83-95.

BOWEN, M. (1978). Schizophrenia as a multi-generational phenomenon. In: Beyond the Double Bind. ed. M.M. Berger. New York: Brunner/Mazel.

CLAUSEN, J.A. (1972). The sociology of mental disorder. pp. 169-88. In Freeman, Levine, and Reeder (Ed.), Handbook of Medical Sociology, Englewood Cliffs, N.J.: Prentice-Hall.

CLAUSEN, J. (1959). "The marital relationship antecedent to hospitalization of a spouse for mental illness." Presented at the Annual Meeting of the American Sociological Association, Chicago, Ill.

CLAUSEN, J.; & YARROW, M.R. eds. (1955). The impact of mental illness on the family. Journal of Social Issues, 11, 4-18

DELL, P.F. (1983). Researching the family theories of schizophrenia. In Bagarozzic, Jurick, and Jackson (Ed.), Mental and Family Therapy New Perspectives in Theory, Research and Practice, New York: Human Science Press.

DENTLER, R.A., & ERICKSON, K. (1959). The functions of deviance in groups. Soc. Problems, 7, 98-107.

DEYKIN, E. (1972). Life functioning in families of delinquent boys: An assessment model. Social Service Review, 46, 90-102.

ELLISON, E. (1983). Social Networks & the Mental Health Caregiving System: Implications for Psychiatric Nursing Practice. Journal of Psychiatric Nursing, 21 #2, 18-24.

GOLDMAN, H. (1982). Mental illness and family burden: a public health perspective. Hospital and Community Psychiatry, July, 557-560.

GUTTMAN, L. (1954). A new approach to factor analysis: the radex. In P.F. Lazarsfeld (Ed.), Mathematical Thinking in the Social Science, Glencoe, Ill.: Free Press.

HALEY, J. (1963). Strategies of Psychotherapy. New York: Grune & Stratton.

HALL, J. and HOUGAN, S. (1980). Reorganization Report of the Department of Parent-Child Nursing and the Family-Centered Child Nursing Graduate Major. University of Oregon Health Science Center School of Nursing. December.

JACKSON, D.D. (1965). The study of the family. Family Process 4: 1-20

JANES, C. and HESSELBROCK, U. (1976). Perceived family environment and school adjustment of children of schizophrenics. Paper presented at the Amer. Psychol. Assoc. Convent., Washington, D.C.

KANTON, D. and LEHR, W. (1975). Inside the Family. San Francisco: Jossey-Bass.

KULKA, R.A.; VEROFF, J.; & DOUVAN, E. (1979). Social class and the use of professional help for personal problems: 1957-1976. Jr. of Health & Soc. Behavior 20, 2-17.

LANGE, M. (1978). Some characteristics of the validity of Dutch translations of the FES and WES. Dept. of Clin. Psychol., Catholic Univ., Nijmegen, The Netherlands.

LEDERER, H. (1952). How the sick view their world. Journal of Social Issues, 8, 4-15.

LEWIS, J., BEAVERS, W., GOSSETT, J. and PHILLIPS, U. (1976). No Single Thread: Psychological Health in Family Systems. New York: Brunner/Mazel.

LEWIS, V.; & ZEICHNER, A. (1960). Impact of admission to a mental hospital on the patient's family. Mental Hygiene, 44, 503-509.

LIDZ, T. (1972). Egocentric cognitive regression and a theory of schizophrenia. Proceedings of the Fifth World Congress on Psychiatry, Amsterdam: Excerpta Media.

LIDZ, T. (1963). The Family of Human Adaptation. New York: Internatl. Univ. Press.

LIDZ, T.; CORNELISON, A.; FLECK, S.; and TERRY, D. (1957). The intrafamilial environment of schizophrenic patients: II. Marital schism and marital skew. Amer. J. Psychiat, 114,241-248.

MAYO, C.; HAVELOCK, R.; & SIMPSON, D. (1971). Attitudes towards mental illness among psychiatric patients and their wives. Journal of Clinical Psychology 27, 128-132.

MOOS, R. and MOOS, B. (1981). Family Environment Scale Manual. Palo Alto, CA: Consulting Psychologist Press, Inc.

MOOS, R. and MOOS, B. (1976). A typology of family social environments. Fam. Process, 15, 357-371.

OLSON, D.H.; SPRENKLE, D.H.; RUSSELL, C.S. 1979. Circumplex model of marital & family systems. Family Process, 18, 3-28.

PLESS, I.B. & SATTERWHITE, B. (1973). A measure of family functioning and its applciation. Soc. Sci. Med., 7, 613-621.

REISS, R. (1971). Varieties of consensual experience. I. A theory for relating family interaction to individual thinking. Fam. Process, 10, 1-27.

RYCKOFF, I., DAY, J., and HIRSCH, S. (1958). Pseudo-mutuality in the family relations of schizophrenics. Psychiat., 21, 205-220.

SAFILIOS-ROTHSCHILD, C. (1968). Deviance and mental illness in the Greek family. Family Process, 7, 100-117.

SCHAFFER, H.R. (1964). The too-cohesive family: a form of group pathology. Internatl. J. of Soc. Psychiat., 10, 266-275.

SCHWARTZ, C. (1957). Perspectives on deviance: Wives' definitions of their husbands' mental illness. Psychiatry, 20, 275-291.

SCORESBY, A. and CHRISTENSEN, B. (1976). Differences in interaction and environmental conditions of clinic and non-clinic families: implications for counselors. J. Marr. and Fam. Couns., 2, 63-71.

SINGER, M.; & WYNNE, L. (1963). Differentiating characteristics of the parents of childhood schizophrenics, childhood neurotics and young adult schizophrenics. American Journal of Psychiatry, 120, 234-243.

STRAUSS, J.S. and CARPENTER, W.T. (1981). Schizophrenia. New York, Plenum Med. Book Co.

SWIGAR, M. (1982, 1983). [Neuropsychiatric Evaluation Unit Annual Report]. Unpublished raw data.

WAXLER, N.E. (1975). The normality of deviance: An alternate explanation of schizophrenia in the family. Schizophrenia Bulletin, 14, 275-291.

WERTHEIM, E. (1975). The science and typology of family systems. II. Further theoretical and practical considerations. Fam. Process., 14, 285-308.

WHITAKER, C. (1978). Co-therapy of chronic schizophrenia. In M.M. Berger (Ed.), Beyond the Double Bind, New York: Brunner/Mazel.

WHITE, D. (1978). Schizophrenics' perception of family relationships. Dissertation Abstracts International, 39, 1451A. (St. Louis University).

WYNNE, K. and SINGER, M. (1964). Thinking disorders and family transactions. Paper presented at the Amer. Psychiat. Assoc.

WYNNE, L.C., & SINGER, M.D. (1963). Thought disorder and family relations of schizophrenia. Archives of General Psychiatry, 9, 191-198.

WYNNE, L.: RYCKOFF, I.; DAY: JULIAN; & HIRSCH, S. (1958). Pseudo-mutuality in the family relations of schizophrenics. Psychiatry, 21, 205-220.

YARROW, M.; SCHWARTZ, C.: MURPHY,H.; & DEASY, L. (1955). The psychological meaning of mental illness in the family. Journal of Social Issues, 11, 12-24.

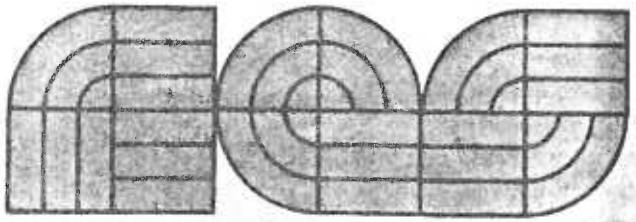
YOUNG, R., GAYNOR, J., GOULD, E. and STUART, M. (1979). The Family Environment Scale in a psychiatric inpatient sample. Dept. Psychiat. Univ. Calif., San Francisco, Calif.

68. In our family each person has different ideas about what is right and wrong.
69. Each person's duties are clearly defined in our family.
70. We can do whatever we want to in our family.
71. We really get along well with each other.
72. We are usually careful about what we say to each other.
73. Family members often try to one-up or out-do each other.
74. It's hard to be by yourself without hurting someone's feelings in our household.
75. "Work before play" is the rule in our family.
76. Watching T.V. is more important than reading in our family.
77. Family members go out a lot.
78. The Bible is a very important book in our home.
79. Money is not handled very carefully in our family.
80. Rules are pretty inflexible in our household.
81. There is plenty of time and attention for everyone in our family.
82. There are a lot of spontaneous discussions in our family.
83. In our family, we believe you don't ever get anywhere by raising your voice.
84. We are not really encouraged to speak up for ourselves in our family.
85. Family members are often compared with others as to how well they are doing at work or school.
86. Family members really like music, art and literature.
87. Our main form of entertainment is watching T.V. or listening to the radio.
88. Family members believe that if you sin you will be punished.
89. Dishes are usually done immediately after eating.
90. You can't get away with much in our family.

FAMILY ENVIRONMENT SCALE

FORM R

RUDOLF H. MOOS



INSTRUCTIONS

There are 90 statements in this booklet. They are statements about families. You are to decide which of these statements are true of your family and which are false. Make all your marks on the separate answer sheets. If you think the statement is *True* or mostly *True* of your family, make an X in the box labeled T (true). If you think the statement is *False* or mostly *False* of your family, make an X in the box labeled F (false).

You may feel that some of the statements are true for some family members and false for others. Mark T if the statement is *true* for most members. Mark F if the statement is *false* for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, we would like to know what your family seems like to *you*. So *do not* try to figure out how other members see your family, but *do* give us your general impression of your family for each statement.

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1. Family members really help and support one another.
2. Family members often keep their feelings to themselves.
3. We fight a lot in our family.
4. We don't do things on our own very often in our family.
5. We feel it is important to be the best at whatever you do.
6. We often talk about political and social problems.
7. We spend most weekends and evenings at home.
8. Family members attend church, synagogue, or Sunday School fairly often.
9. Activities in our family are pretty carefully planned.
10. Family members are rarely ordered around.
11. We often seem to be killing time at home.
12. We say anything we want to around home.
13. Family members rarely become openly angry.
14. In our family, we are strongly encouraged to be independent.
15. Getting ahead in life is very important in our family.
16. We rarely go to lectures, plays or concerts.
17. Friends often come over for dinner or to visit.
18. We don't say prayers in our family.
19. We are generally very neat and orderly.
20. There are very few rules to follow in our family.
21. We put a lot of energy into what we do at home.
22. It's hard to "blow off steam" at home without upsetting somebody.
23. Family members sometimes get so angry they throw things.
24. We think things out for ourselves in our family.
25. How much money a person makes is not very important to us.
26. Learning about new and different things is very important in our family.
27. Noboby in our family is active in sports, Little League, bowling, etc.
28. We often talk about the religious meaning of Christmas, Passover, or other holidays.
29. It's often hard to find things when you need them in our household.
30. There is one family member who makes most of the decisions.
31. There is a feeling of togetherness in our family.
32. We tell each other about our personal problems.
33. Family members hardly ever lose their tempers.
34. We come and go as we want to in our family.
35. We believe in competition and "may the best man win."
36. We are not that interested in cultural activities.
37. We often go to movies, sports events, camping, etc.
38. We don't believe in heaven or hell.
39. Being on time is very important in our family.
40. There are set ways of doing things at home.
41. We rarely volunteer when something has to be done at home.
42. If we feel like doing something on the spur of the moment we often just pick up and go.
43. Family members often criticize each other.
44. There is very little privacy in our family.
45. We always strive to do things just a little better the next time.
46. We rarely have intellectual discussions.
47. Everyone in our family has a hobby or two.
48. Family members have strict ideas about what is right and wrong.
49. People change their minds often in our family.
50. There is a strong emphasis on following rules in our family.
51. Family members really back each other up.
52. Someone usually gets upset if you complain in our family.
53. Family members sometimes hit each other.
54. Family members almost always rely on themselves when a problem comes up.
55. Family members rarely worry about job promotions, school grades, etc.
56. Someone in our family plays a musical instrument.
57. Family members are not very involved in recreational activities outside work or school.
58. We believe there are some things you just have to take on faith.
59. Family members make sure their rooms are neat.
60. Everyone has an equal say in family decisions.
61. There is very little group spirit in our family.
62. Money and paying bills is openly talked about in our family.
63. If there's a disagreement in our family, we try hard to smooth things over and keep the peace.
64. Family members strongly encourage each other to stand up for their rights.
65. In our family, we don't try that hard to succeed.
66. Family members often go to the library.
67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).

APPENDIX B

QUESTIONS IN FOCUSED INTERVIEW

1. What were the first changes you noticed in (Patient's Name) ?
2. Who noticed these changes first? Was it a member of the family, a relative, someone outside the family, or the patient him/herself?
3. Describe specifically what were the changes in _____ behavior that you first noticed.
4. When did you first notice these changes? Please try and be as specific as you can.
5. When did your family as a whole agree with the person who first noticed the changes in _____ behavior?
6. What was your understanding of _____ behavior? In your own words, what did you think was happening?
7. When did this change in behavior become the prevailing mode of behavior?
8. Whom did you first talk with about _____ behavior? Was that person a close friend, another member of the family, someone outside the family such as a priest or minister or a family doctor?
9. When was that?
10. (If not already mentioned) How did you decide to consult a doctor? What or Who caused you to do that?
11. When did you decide to bring _____ to the hospital?
12. What was the set of circumstances that made you decide to hospitalize _____ now versus earlier or later?

APPENDIX C

LIKERT SCALE FOR DEVIANT BEHAVIOR

1. HAS YOUR FAMILY MEMBER BEEN VERBALLY OFFENSIVE OR VERBALLY THREATENING TO YOU OR OTHERS?

   NO___ YES___ (If yes, please answer the remaining questions on this page)

2. HOW DIFFERENT WAS THIS BEHAVIOR (VERBAL OFFENSIVENESS) FROM HIS/HER USUAL BEHAVIOR?

1	2	3	4	5	6	7
not very different		slightly different		very different		drastically different

3. HOW OFTEN WAS YOUR FAMILY MEMBER VERBALLY OFFENSIVE OR VERBALLY THREATENING TO YOU OR OTHERS?

1	2	3	4	5	6	7
rarely		some of the time		most of the time		all of the time

4. HOW DISRUPTIVE WAS THIS BEHAVIOR TO YOU AND YOUR FAMILY?

1	2	3	4	5	6	7
minimally disruptive		somewhat disruptive		very disruptive		totally disruptive

5. HOW MUCH OF THE FAMILY RESOURCES (EMOTIONAL & PHYSICAL ENERGY & TIME) WERE USED TO DEAL WITH THE BEHAVIOR?

1	2	3	4	5	6	7
very few resources		some of our resources		most of our resources		all of our resources

GO TO THE NEXT PAGE

1. HAS YOUR FAMILY MEMBER BEEN PHYSICALLY AGRESSIVE (HIT AT YOU, THROWN OR BROKEN THINGS) TO YOU OR OTHERS?

NO___ YES___ (If yes, please answer the remaining questions on this page)

2. HOW DIFFERENT WAS THIS BEHAVIOR (PHYSICAL AGRESSIVENESS) FROM HIS/HER USUAL BEHAVIOR?

1	2	3	4	5	6	7
not very different		slightly different		very different		drastically different

3. HOW OFTEN WAS YOUR FAMILY MEMBER PHYSICALLY AGRESSIVE WITH YOU OR OTHERS?

1	2	3	4	5	6	7
rarely		some of the time		most of the time		all of the time

4. HOW DISRUPTIVE WAS THIS BEHAVIOR TO YOU AND YOUR FAMILY?

1	2	3	4	5	6	7
minimally disruptive		somewhat disruptive		very disruptive		totally disruptive

5. HOW MUCH OF THE FAMILY RESOURCES (EMOTIONAL & PHYSICAL ENERGY & TIME) WERE USED TO DEAL WITH THE BEHAVIOR?

1	2	3	4	5	6	7
very few resources		some of our resources		most of our resources		all of our resources

GO TO THE NEXT PAGE

1. HAS YOUR FAMILY MEMBER BEEN EXHIBITING STRANGE, OUT OF CHARACTER, PECULIAR BEHAVIOR?
NO___ YES___ (If yes, please state what that behavior was, and answer the remaining questions)

_____

_____

2. HOW DIFFERENT WAS THIS BEHAVIOR FROM HIS/HER USUAL BEHAVIOR?

1	2	3	4	5	6	7
not very different		slightly different		very different		drastically different

3. HOW OFTEN WAS YOUR FAMILY MEMBER ENGAGING IN THIS STRANGE, OUT OF CHARACTER, PECULIAR BEHAVIOR?

1	2	3	4	5	6	7
rarely		some of the time		most of the time		all of the time

4. HOW DISRUPTIVE WAS THIS BEHAVIOR TO YOU AND YOUR FAMILY?

1	2	3	4	5	6	7
minimally disruptive		somewhat disruptive		very disruptive		totally disruptive

5. HOW MUCH OF THE FAMILY RESOURCES (EMOTIONAL & PHYSICAL ENERGY & TIME) WERE USED TO DEAL WITH THE BEHAVIOR?

1	2	3	4	5	6	7
very few resources		some of our resources		most of our resources		all of our resources

GO TO THE NEXT PAGE

1. DID YOUR FAMILY MEMBER ENGAGE IN OTHER TYPES OF BEHAVIOR NOT LISTED HERE THAT CAUSED YOU TO BE CONCERNED AND SEEK HELP?

NO___ YES___ (If yes, please state what that behavior was, and answer the remaining questions)

_____

_____

2. HOW DIFFERENT WAS THIS BEHAVIOR FROM HIS/HER USUAL BEHAVIOR?

1	2	3	4	5	6	7
not very different		slightly different		very different		drastically different

3. HOW OFTEN WAS YOUR FAMILY MEMBER ENGAGING IN THIS BEHAVIOR?

1	2	3	4	5	6	7
rarely		some of the time		most of the time		all of the time

4. HOW DISRUPTIVE WAS THIS BEHAVIOR TO YOU AND YOUR FAMILY?

1	2	3	4	5	6	7
minimally disruptive		somewhat disruptive		very disruptive		totally disruptive

5. HOW MUCH OF THE FAMILY RESOURCES (EMOTIONAL & PHYSICAL ENERGY & TIME) WERE USED TO DEAL WITH THE BEHAVIOR?

1	2	3	4	5	6	7
very few resources		some of our resources		most of our resources		all of our resources

THANK YOU VERY MUCH

APPENDIX D

DEMOGRAPHIC DATA COLLECTION SHEET

Patient data

Code Number _____

Age _____

Gender _____

Diagnosis _____

Ethnic Origin _____

Past Psychiatric History _____

Religion_____

Family data

Family Constellation _____

Children _____

Parents _____

Other Relatives Living in Home _____

Income _____

Past Psychiatric History in Family _____

_____

Raw Scores

MOOS FES

Moral-Religion _____

Conflict _____

Organization _____

Family Incongruency _____

Help-Seeking Phases

Warning Phase: present absent time spent_____

Self-evaluation: present absent time spent_____

Lay-evaluation: present absent time spent_____

Medical: present absent time spent_____

TOTAL TIME _____

Deviant Scores

Verbal Offensiveness _____

Physical Aggression _____

Peculiar, out-of character Behavior _____

Other _____

TOTAL SCORE _____

APPENDIX E

Moos' FES Raw Scores for Study Families

Family	Conflict (M=3.31)* (Md=2.5)	Moral-Religious Emphasis (M=4.72)* (Md=6.1)	Organization (M=5.41)* (Md=4)
1	7	3.5	4
2	6.2	6.2	3.8
3	1	6.6	5.3
4	1	8	7
5	3	5	3.6
6	2	7	6
7	2	6	6
8	7	2.3	3
9	.5	6.5	4
10	1	4	4

*Means are from Moos' Normal Families

APPENDIX F

Study Families' Scores on Deviant Behavior Scale

Family	Verbal Offensiveness	Physical Aggression	Bizarre Behavior
1	17	0	25
2	13	0	25
3	16	0	24
4	21	0	28
5	19	0	25
6	25	0	27
7	0	21	26
8	0	0	21
9	16	0	24
10	0	0	19

*Total points per scale = 28

APPENDIX G

The Oregon Health Sciences University School of Nursing

Title: Family Environment and Help-Seeking Behavior in Families with a Mentally Ill Member.

By: Nora Goicoechea R.N., B.S.N.

Dear Family Members,

My name is Nora Goicoechea. I am a graduate student in Psychiatric Mental Health Nursing at the Oregon Health Sciences University. I am conducting a study, under the supervision of JoAnne Horsely, R.N., Ph.D., to better understand the decision-making process that family members go through when seeking care for an emotionally ill member. I hope to broaden my understanding of how family systems influence the way in which psychiatric care is obtained for your family member.

If you agree to participate in this study, you will be asked to complete a questionnaire about your family. This will take approximately 20 minutes. Additionally, I will interview you as a family to determine what behavior you observed in your family member that led you to seek professional help. This interview will last approximately 30 minutes. Participation in this study may not benefit you directly, but will assist me in better understanding the needs of families with an emotionally ill member, and will benefit future families.

You are free to decline participation in this study, and the care of your family member will not be affected by either your refusal or acceptance to participate. You may withdraw from the study at any time after you have agreed to participate and the care of your family member will not be affected. All information will be strictly confidential and will not be shared with others. Your name will not be used, and only I will have access to the coded data collection forms. If you are interested in the results of this study please let me know and I will forward a copy to you. Katey Tamm, Clinical Director of Psychiatric Nursing is also available to you if you have additional questions or concerns. She can be reached at (203) 785-2128.

Thank you.

Nora Goicoechea
(203) 785-2158

"I understand what will be required of me and I agree to participate in this study as described above."

Date:_____ Signature:_____