The social, social-psychological and psychiatric correlates of outcome: The relationships between psychiatric history, life events, 'social support', 'powerful emotion' and cognitive appraisals among routinely-discharged patients of an acute, short-stay admission ward of a psychiatric hospital.

by

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THESIS DECLARATION.

I declare that the work reported in this thesis is my own, having been completed within the normal terms of supervision (by Dr. B.T. Jones) in the Faculty of Social Science in the University of Glasgow, Scotland.

David Michie Morrison.

D.M. Morrison, 1992.

ABSTRACT.

Recent reviews of the research literature whose concern is the association between 'life events', health and 'social support' have found the evidence to be strongest for mental health (e.g., Ganster and Victor, 1988). Several studies of the relationship between various forms of social support and mental health have revealed evidence for two kinds of effect. These are, (a) the 'buffering effect', whereby social support in its many forms buffers the impact of stressful life events on the experience of psychological distress, and, (b) the 'main effect', whereby forms of support, irrespective of the experience of stressful life conditions, engender an experience of levels of psychological well-being that are the antithesis of distress and demoralization.

Research whose concern has been the influence of social, social-psychological and psychiatric factors on the 'community adjustment' of psychiatric patients discharged from psychiatric hospitals following short periods of stay has found the most consistently significant factor, after 'previous psychiatric history', to be a 'social' one. Recent reviews of these factors (e.g., Avison and Speechley, 1987; Rushton, 1990) call attention to the need to monitor and examine the *processes* - rather than the *structural* components - by which patients, recently discharged from hospital, 'revolve back through the doors' of the wards of those hospitals within six months to two years of discharge.

The current investigation was designed to marry these two highly-related research domains: i.e., research into the factors that associate with successful 'community adjustment' was considered most fruitfully advanced through its integration with research concerned with the relationships between life events, social support and mental health. Good reasons for this 'integration' are summarized in the first chapter.

Using a 'life events' model, with special emphasis on the global construct 'social support', the thesis of the current investigation - an exploratory one given the considered uniqueness of the enterprise - can be summarized thus: "What forms of stress and/or social support combine to precipitate or to postpone the return to the hospital ward of the routinely-discharged psychiatric patient?".

The subjects of the investigation were all patients on the short-term assessment ward of the psychiatric hospital who were about to be routinely discharged from record, who had no evidence of organic brain damage, and who were willing to participate. Using a longitudinal, repeated-measures design, 52 patients were interviewed on the ward immediately prior to their respective discharge and then once again six months thence. Each patient was interviewed using reliable and valid formal questionnaires as part of a semi-structured interview that assessed the various factors in the hypothesized 'model' of the 'revolving door' process. These factors were: a) each patient's experience of life events prior to current hospital stay, b) 'social support', conceptualized as six distinct components: i) close and ii) general attachment ('social integration') availability; iii)

perceived interpersonal support; iv) actual received support; v) pleasurable social contact; vi) satisfaction with close and general attachments; c) psychiatric history prior to current hospital stay; d) experience of the 'powerful emotions' (Brewin et al., 1989) shame and guilt in respect of the patient status, and e) each patient's 'cognitive appraisals' of their patient status - the degree of self-blame, consensus and isolation from others.

Two of the 52 patients seen at discharge later died during their tenure in the community (committing suicide). A further twelve patients were lost to follow-up giving a follow-up rate of 76% (38 patients). These patients were seen either back on the hospital ward (the 'readmitted' patients) or in their respective homes in their respective communities in and around the city in which the study took place (the 'non-readmitted' patients).

Two formal 'outcome' criteria were employed: (a) readmission to the hospital ward (thus there was a group of 'readmitted' and 'non-readmitted' patients at 6-months follow-up); and, (b) the change in level of severity of 'psychological distress' following discharge (thus there was a group whose level of severity of symptoms of distress (i) remained the same after discharge, (ii) improved, and, (iii) deteriorated).

With respect to the outcome criterion 'readmission to hospital', it was found that the two groups of patients - readmitted (N=6) and non-readmitted (N=32) - were barely distinguishable in their experience of each of the 'revolving-door' outcome indicators. Rather, all patients, for the most part, were characterized by (a) markedly high levels of severity of psychological distress <u>both</u> at discharge and at follow-up; (b) markedly high numbers of severely distressing life events before admission and after current discharge; (c) markedly low levels of all components of 'social support'; (d) lengthy previous contact with the psychiatric hospital; and, (e) a marked feeling of isolation from other people regarding the problems they face.

Patients who returned to hospital could be distinguished from the *patients still living at home* at the six-month follow-up period in the following ways: (i) their experience of adverse life events showed less improvement during the 6-month period after discharge compared with the non-readmitted group; (ii) their experience of symptoms of psychological distress had undergone significant deterioration compared with the more stable, though chronically severe experience among non-readmitted patients; (iii) only two of the six patients who returned to hospital had any form of close attachment **person** in their lives - whether *partner* or *figure* - compared with 27 of the 32 patients who did not return within 6 months; (iv) none of the six readmited patients were satisfied with this condition, preferring, instead, to be closely or more securely attached with someone in a secure, lasting relationship.

With respect to the outcome criterion, 'change in level of severity of psychological distress following discharge', it was concluded that excessively *low* levels of 'social support' availability and receipt and, concomitantly, *high* levels of life adversity and severity of psychological distress is almost certainly *characteristic* of the sample as a whole. Significant differences among groups were found, such that:

1) <u>deteriorated</u> patients could be distinguished from those patients whose symptoms stayed the same or got better on the distress symptoms or attitudes: (a) paranoid thinking, (b) psychotic thinking, (c) self-

condemnatory thinking, (d) suicidal wishes, (e) difficulty making decisions and (f) finding work an effort;

2) 'Improved' patients were observed to have undergone the most significant experienced fall in the level of stressfulness of the life events with which they met during the six-month period following discharge;

3) Symptomatically 'Worse' patients had a significantly lower (a) 'sense of belonging' and (b) likelihood of making a positive comparison when comparing themselves with others (undergoing a significant drop in this form of support provision following discharge), compared with the 'Improved' and 'Same' groups;

4) 'Deteriorated' patients had significantly less pleasurable social contact with their families following discharge compared with the other two groups;

5) This group of patients also experienced a significant drop in the availability of 'social integration' after discharge, compared with 'improved' patients whose level of satisfaction with this form of support after discharge significantly rose;

6) Finally, the 'deteriorated' patients were significantly more ashamed about feelings, thoughts; and about being in a psychiatric hospital, compared with the 'improved' group of patients.

The findings are discussed with special emphasis on (a) identifying significant predictors of likely outcome, and (b) the practical implications for treatment and care, either in the hospital or in the communities.

To identify (i) which factors in the model best *predict*, in a longitudinal analysis, subsequent outcome of change in level of severity of psychological distress, and (ii) which factors in the model best *correlate*, in a cross-sectional analysis, with this outcome, appropriate stepwise multiple regression analyses were carried out. In the longitudinal regression analysis, the most significant contributor to the variance in subsequent distress was *prior* level of distress, measured at discharge. The next best predictors of distress were life events prior to admission, the availability of 'general attachment' support, and the perceived interpersonal support provisions, 'sense of belonging' and 'tangible support'. These findings are discussed with special emphasis on the importance of the existence of basic, 'network' support, where the variable 'general attachments availability' (or 'social integration') was found to play an important 'suppressant' or 'mediating' role.

In the cross-sectional analysis the most significant contributor to variance in the outcome was the perceived interpersonal support provision, 'perceived likelihood of a positive comparison when comparing one's self with others'. This variable was the only one to satisfy the strict minimum tolerance criteria for stepwise entry into the multiple regression analysis. The variable accounted for 41% of the variance in subsequent distress controlling for all other variables in the equation. This finding is discussed with particular emphasis on the work of Festinger (1954), Bowlby (1973, 1980, 1982) and latterly of Sarason et al., (1991) on the impact of *self-perceptions* on ability to cope with life adversity.

The variable 'life events' continued to play a significant role in the cross-sectional analysis together with the 'perceived' support components, 'pleasurable social contact with friends and family', 'perceived sense of belonging' and the actual, received support component, 'actual emotional support'. This last variable was found to make a moderately large and significant contribution to the variance in subsequent distress (around 10%), although its Pearson correlation with psychological distress was marginal (r= -.097). The variable was found to have a 'suppressant' or 'mediating' role, largely similar to that of 'social integration' support in the longitudinal analysis.

In the concluding chapter there is a general discussion which pulls together the various findings from each of the three 'waves' of analysis. This discussion draws upon the 'attachment theory' research of Bowlby (e.g., 1988) in accounting for the findings of each successive wave of analysis. In doing so, an examination is made of the likely cognitive determinants of patients' perceptions of being able or unable to cope with their severely adverse life circumstances - perceptions which, in turn, are likely to precipitate symptom relapse and/or return 'back through the doors' of the hospital ward; perceptions which are encompassed by the more traditional term 'institutionalization'.

An informal description and analysis of the non-structured information relating to patients' experiences of life events both prior to and during the six months after hospital discharge follows, which reveals support for previous findings (e.g., Brown et al., 1988; and Oatley and Perring, 1991). Thus, patients whose symptoms of distress significantly deteriorated a) were less likely than those patients who 'improved' to have experienced any kind of 'fresh start', and, b) were more likely to have experienced continuation of their already chronically distressing life conditions, with no improvement of any kind.

Considerable attention is given to the paper by Brewin, MacCarthy and Furnham (1989) in drawing together in a meaningful way the various findings relating to patients' experiences of shame and guilt about their patient status and to their cognitive appraisals thereof.

Finally, some attention is given to the perceived difficulties associated with the design of a study such as this. Each criticism is countered in a reasoned way with suggestions put forward for possible improvements. Further research concerned with the central thesis of this investigation is considered best advanced by incorporating measures of patients' own constructs of *themselves* - of their patient status, their problems (their causes, impact and likely solution), and of *others* - how they view 'normal' people in their communities, their family and friends, their selves in relation to these informal carers; and their selves in relation to *formal* helping agents such as consultants, doctors, nurses, occupational therapists and psychologists. Such research will likely provide fruitful insight into support-eliciting and support-seeking processes.

Further, given the importance of *shameful* experiences in relation to their patient status, suggestions are made about the efficacy of incorporating more reliable and valid measures of such experiences in any intended research enterprise.

CHAPTER ONE:

RESEARCHING THE CORRELATES OF ROUTINE PSYCHIATRIC DISCHARGE: A FOCUS ON THE SOCIAL SUPPORT OF THE DISCHARGED PSYCHIATRIC PATIENT.

Chapter summary.

Chapter One: Researching the correlates of routine psychiatric discharge: a focus on the social support of the discharged psychiatric patient.

SUMMARY.

What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?

Throughout the course of this chapter reference will be made to this central, underlying question of the research project, a question it is considered best addressed by incorporating measures of what is known as the 'social support' of each patient. Information from both empirical and theoretical sources will be recruited in support of this proposition. The chapter divides into three main sections: (a) identification of what the problem is and why it is a problem; (b) historical coverage of the problem; and, finally, (c) a review of new attempts at answering the problem.

The first section identifies the problem: patient readmission to hospital for acute, crisis-intervention when such readmission could be prevented or the problems giving rise to the need for readmission dealt with much sooner. Patients are, instead, discharged back to the "interpersonally distressing" environments from whence admitted - their problems only dealt with in terms of "psychopathology" (Hoult, 1986). It is not clearly understood what the 'underlying interpersonal stresses' are that precipitate or postpone such readmission. There is **also** lack of agreement, it will be seen, about: 1) The types of information to include within the definition of the term 'adjustment'; 2) how best to conceptualize the characteristics considered representative of any definition of this term; and, 3) how best to measure these characteristics.

The second section begins with a brief historical background to the problem. Four separate research focuses on this problem are identified and the central focus of this research study defined: the correlates of psychiatric outcome in patients routinely discharged from the acute-assessment ward of a psychiatric hospital.

Evidence from empirical studies of brief-hospitalization is presented whose main conclusion is that brief periods offer no discernible disadvantage to patients relative to standard hospital care. However, these studies have received criticism for their limitations in design and execution. Moving from a discussion of these methodological flaws, one of the central problems in this research domain is next identified: the selection of criteria that best represent the outcomes for those patients routinely discharged from hospital. There is no universal agreement about what constitutes 'successful outcome'. As a consequence, many different criteria have been used - often global, imprecise and non-standardized across research enterprises. Refinement of the definition of the term 'adjustment' has been attempted and various criteria identified (Avison and Speechley, 1987). The criterion community tenure is described in detail to illustrate the difficulties imposed on any investigation by imprecise conceptualization and measurement. Ideal outcome criteria are then suggested to provide possible guidelines for those researching the central question of this study.

Evidence from empirical studies of the correlates of psychiatric outcome are reviewed. Five components of the discharge process are identified as most predictive of readmission: clinical and psychiatric history, previous employment history, symptoms of distress on discharge and at follow-up, and the 'social' functioning of

each patient. Two difficulties are identified: the first is the conceptualization of the variables considered 'good to know'; the second, how best to measure such variables once identified and clearly defined.

The third section - New attempts at answering the problem - begins with a description of one particular attempt to provide a different, broader perspective to the problem: 'quality of life' studies. Criticism of these studies is reviewed before introducing the term 'social support': a research concept with an established literature which, it is argued, offers a framework within which knowledge on patient outcome can be better organized and understood. A brief historical background to the concept is introduced before presenting evidence from empirical studies of the linkage between support and mental health. This is followed by a section that provides good reasons for the use of this concept in a study of this kind. In the course of this address, it is made clear that the decision to incorporate measures of concepts of 'social support': 1) is both theoretically- as well as empirically-grounded; 2) allows the generation and testing of specific hypotheses about the patient's life back in the community; and, 3) satisfies almost all of the eleven ideal outcome criteria proposed by the NIMH task force (NIMH, 1986).

1. THE PROBLEM.

1.1. THE PROBLEM: PATIENT RETURN TO PSYCHIATRIC HOSPITAL FOR CRISIS INTERVENTION.

Following periods of acute and, for many, near suicidal disturbance patients are admitted to their local psychiatric hospital or to the psychiatric ward of their local general hospital and receive there traditional forms of in-patient care. In Glasgow's North-West End the local psychiatric hospital is Gartnavel Royal. On routine discharge from hospital, after what will have been a brief period in the short-term assessment ward of the psychiatric hospital, each patient is expected to return to their homes from where admitted in and around the city. In Scotland, most will return home (around 80%); a smaller number - around 6% - are referred to other wards within the hospital complex; some are placed in local authority hostels (around 5%); and a proportion will die, some 8-9% (Scottish Health Statistics, 1990).

After discharge back to their homes in local communities in and around the city some patients will receive appropriate forms of 'aftercare', more often termed 'continuing care' (Lavender and Holloway, 1988). That is, patients receive continued treatment in the community after discharge. This care might simply represent a fortnightly appointment with the GP for a depot injection of appropriate psychotropic medication (in the case of the schizophrenic patient). Others may be directed toward continued contact with the hospital by referral to another ward or to other facilities within the hospital complex. For example, patients can be referred to the hospital's Occupational Therapy department for guidance on the acquisition of self-care habits, this forming part of an organized day-care programme of treatment.

However, most will return home - to the minor and sometimes major hassles and conflicts, and to the lonesome or interpersonally-stressing households which in their own way helped bring about the recent need for specialist help.

Thus, as patients are routinely discharged from the hospital's short-term assessment ward following treatment, so the ward's professional staff - nurses, doctors, consultants and occupational therapists - routinely expect to see many of these people back on the ward within one to one and a half years of discharge, often much sooner (e.g., Goering, Wasylenki, Lancee & Freeman, 1984, and in correspondence with one of the ward's consultant psychiatrists). Estimated base rates of readmission at 6 months are between 30 to 40% and 65 to 75% within 3 to 5 years, reported from reviews of follow-up studies of discharged psychiatric patients (Anthony, Buell, Showatt and Althoff, 1972; Anthony, Cohen and Vitalo, 1978).

This somewhat **circular process** of symptom presentation, hospital admission, assessment and treatment, followed by discharge home, only to be followed, in turn, by eventual re-admission to the hospital has been referred to as the "revolving door" syndrome (Bachrach, 1986, among others). That is, most patients will be 'back through the doors' of the hospital's short-stay ward within an indeterminate yet imminent period of time, sometimes within weeks; for others within months, certainly within a 1 to 2 year period.

This, then, is the **problem**.

1.2 WHY IT IS A PROBLEM.

For the patient it is a **problem** for the simple reasons outlined by Hoult (1986). He wrote that, "the underlying interpersonal stresses which have precipitated the symptoms and signs are **ignored**, or are **not dealt with**, and so they persist to **precipitate further episodes**, which are again**dealt with only in terms of psychopathology**" (Hoult, 1986).

He continues, "To the staff working in a hospital, a patient's admission is the beginning of a treatment episode, but for the patient and his family, it is the culmination of weeks or even months of increasing suffering **which often could have been relieved much earlier, if help had been available.** Instead, they may be forced to wait, as their distress intensifies, until the patient's symptoms and behaviour are of such severity that admission to hospital, sometimes even compulsorily, becomes the only option. Hospital admission gives the relatives temporary relief, and alleviates the patient's symptoms and more disturbed behaviour, but before long he returns home; in the case of the patient with schizophrenia, either his apathy or his unpredictability may then again cause concern to his relatives, who have to wait for the next relapse." (Hoult, 1986, p.137).

The **research** problem can be summarized as follows:

1. Patients are often discharged without having had their needs adequately met;

2. Once discharged, the former patient will return to the interpersonally-distressing environments from where they were admitted for the period of hospital-based crisis-intervention;

3. It is not clearly understood what are the 'underlying interpersonal stresses' and other characteristics which precipitate the symptoms and signs which in turn render hospital readmission more likely.

The question that seeks to address this problem is an apparently simple one, and it is this:

What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?

That is, the problem is about why people are re-admitted to hospital when such readmission could be prevented. It would be in many groups' interest to prevent or preempt as far as possible this readmission. For the patient in particular it would mean preempting or relieving much sooner the experience of the intense suffering and distress of which Hoult (1986) writes. Throughout the course of this chapter it will be seen that the problem is a problem because of the lack of agreement in this area about:

1. the **types** of 'underlying interpersonal stresses' (and stresses in general) experienced by the patient following discharge on which to focus interest: i.e., about what the term 'community adjustment' should incorporate in its definition - "its meaning. . . " (Avison and Speechley, 1987);
2. how to **conceptualize** the stresses, interpersonal stresses and other characteristics considered part determinants of the process by which former hospital patients adapt to their lives back home, where terms are either non-standardized across research enterprises or global and imprecise; and,
3. following from (1), how to **measure** these characteristics (". . and so its measurement" - Avison and Speechley, 1987).

2. COVERAGE OF THE PROBLEM.

2.1. HISTORICAL BACKGROUND TO THE PROBLEM.

This is a question which has been examined and increasingly refined since its introduction during the mid- to late-60s when the policy of what is known as the deinstitutionalization of long-term psychiatric patients had become well established (e.g., Bachrach, 1980; Friedman, 1985). A historical review of the antecedents of this movement - political, fiscal, humanitarian, and psychopharmacological - is provided by Friedman (1985) and Ramon (1988). The policy of deinsitutionalization has been defined by Bachrach (1976) as the contraction of institutional settings, with the concurrent development of community-based services for people who would otherwise have used the hospital. The locale of treatment shifted from the hospital to the community where it was thought more appropriate treatment and continuing care for long-term chronic psychiatric patients could be provided.

The policy has proceeded, fuelled in several ways. Firstly, upon the premise that such continued institutional-based care is in fact detrimental to the patient's mental health and well-being (e.g., Goffman, 1961; Scull, 1977). Secondly, through the development of effective psychotropic medication (e.g., Bassuk and Gerson, 1978; Bellak, 1964). Thirdly, as facilitated by a favourable economic climate in the 1960s when the process first drew enthusiasm (e.g., Williams, Bellis, and Wellington, 1980). Fourthly, as a response to political and economic-based pressure on health authorities to make more efficient and cost-effective use of resources coupled with evidence which demonstrated that community-based services was a cheaper option (e.g., Mills and Cummins, 1982). Fifthly, in response to the gradual shift toward treating acute psychiatric patients in district general hospitals where there is little or no scope for expansion of the number of psychiatric patient beds made available (Bachrach, 1980).

The components of the process of deinstitutionalization have been described by Thornicroft and Bebbington (1989). Further to Bachrach's (1976; 1986) definition, there have been three other distinctions made in the literature. The first, described by Thornicroft and Bebbington (1989), is that between asylum as an institution and asylum as a function, where the provision of a place of haven or safety is not necessarily related to the size of the institution that provides these functions (Goldman et al., 1983c; Rosenblatt, 1984; Wasow, 1986; Wing and Furlong, 1986; Wing, 1990). Secondly, the concept 'community care' requires further explanation. It implies both care **in** the community and care **by** the community. Goldman et al. (1983c) suggest that it may merely imply a change in the locus of care or in the methods and financing of care delivery. The third component of the process is identified by Brown (1975) and is most closely linked with the orienting question of this chapter. This component is the prevention of inappropriate mental hospital admissions when **alternative** (community-based) forms of preventative care could be (and in some places are) made available (Brown, 1975).

In describing this movement away from hospital to community-based forms of care, Ramon (1988) writes that, "by the end of the 1970s care in the community had become a reality for many long-term clients even if they continued to use an inpatient unit for brief periods." In this informative review of community care in Britain, Ramon (1988) proceeds to outline the main forms this service took, a service which, remaining today in much the same form, includes,

" 1. GP consultation and prescription of medication, including major tranquilizers;
2. outpatient clinic appointments;
3. home visits by community psychiatric nurses in some areas;
4. day care facilities - i.e. day hospital, day centre;
5. group homes and hostels;
6. a few therapeutic communities (e.g. the Richmond Fellowship);
7. brief periods of hospitalization."

2.2. FOUR DIFFERENT RESEARCH FOCUSES ON THE PROBLEM.

It is critical at this juncture to make a clear statement of this study's frame of reference since, as might be inferred from the historical background, the general area of concern ranges very widely. The shift in treatment philosophy from 'general-respite' psychiatric care provided in large public mental hospitals more to 'acute care' facility-provision in psychiatric units of district general hospitals and in community-based clinics and health centres has generated a high volume of research that has examined **the correlates of adaptation of the discharged patient to life back in the community**. The research is most easily conceptualized by dividing it into four discrete categories:

(a) research that has assessed the impact on post-hospital adjustment of 'standard' in-patient treatment modalities;

(b) research that has examined the effectiveness of community-based alternatives to hospital treatment;

(c) research on the post-hospital adjustment of patients receiving treatment provided by the community-based health and support services;

(d) research whose central concern is to identify the correlates (social, social-psychological or psychiatric in nature) of adjustment in those patients discharged back into the community (Avison and Speechley, 1987).

What each of these approaches share, is a common attempt to identify, describe and locate specific features of the events and circumstances which obtain in the life of the discharged person which contribute to outcome, 'community adjustment'. Where each of these approaches differ is in their **focus** on a particular **treatment modality** to which the discharged person is subject, the effects of which - in combination with additional non-treatment influences in the community - are examined for their impact on the patient's level of community adjustment. For example, in those studies examining the relative influence on adjustment for patients participating in a community-based program of treatment compared with traditional forms of hospital-based care the specific modality is the community-based program (e.g. Beiser et al., 1985). Controlled trials have been initiated of,

(a) alternatives to hospital admission (for example, so-called 'case-management' programs, Wasylenki et al., 1985);

(b) alternatives to standard hospital care (Brown et al., 1966), and,

(c) modifications of this standard hospital-based care (e.g., Herz et al., 1975, and Caffey et al., 1971).

The current investigation falls into the fourth category outlined by Avison and Spechley (1987). That is, it is the interest of this research to investigate the nature of the process of adjustment in patients routinely discharged from a Scottish psychiatric hospital (Glasgow's Gartnavel Royal) following brief periods of traditional hospital care.

This component of deinstitutionalization, variously termed "sub-institutionalization: providing community aftercare to shorten hospitalization" (Friedman, 1985) or "brief hospitalization" (eg. Braun et al., 1981; Hirsch et al., 1979; Kirschner, 1982), has attracted very little research. It is distinct from the more widely-understood definition of deinstitutionalization as the discharge of long-stay chronic psychiatric patients from hospital wards - an area which, as already referred to, has been extensively researched (though not until after the policy of closure of many hundreds of mental hospitals in states across the US was well under way, Bachrach, 1986). Rather, sub-institutionalization is a component of deinstitutionalization, best viewed as the prevention of inappropriate long-stay residence in mental hospitals through the re-directing back home of referrals following assessment in the short-term assessment wards of hospitals. Back home, they are maintained and supported usually by family members and close friends (when needed), with the weekly or fortnightly prescription or injection from the GP together with the sometimes fortnightly or monthly check-up, either with the CPN or with the consultant they were seen by in hospital.

Length of stay as an issue of concern came about through increasingly relevant external pressures for economic justification of the expensive in-patient, crisis-intervention treatment modality, together with "clinical and research misgivings about possible adverse effects of hospitalization" (Kirshner, 1982). Whilst this index of clinical performance can hardly be regarded as independent of a number of patient- and treatment-related variables, nonetheless, as Kirshner (1982) continues, "psychiatrists now face increasing pressures to conform to even briefer and in many ways arbitrary norms for length-of-stay of their patients."

This study is designed in an attempt to recognize what characteristics of patients and of their lives back home are most strongly associated with whether or not that person **remains** at home after discharge from the psychiatric hospital's acute-assessment ward. The amount of time spent in hospital can be considered to be one of the characteristics likely to influence patients' tenure in the community after discharge. Too lengthy a stay might induce an "adverse effect" (Kirshner, 1982). Too short a stay might not give the patient time enough to recover from the recent acute crisis or might allow the patient's episode of distress to be "dealt with only in terms of psychopathology" (Hoult, 1986).

2.3. EVIDENCE FROM EMPIRICAL STUDIES OF 'BRIEF HOSPITALIZATION'.

The few studies that have examined what happens to the patient discharged from brief periods of hospital-based care have demonstrated its effectiveness in alleviating patient symptoms and in promoting social functioning when compared with the traditional forms of longer-term hospitalization (Lieberman & Strauss, 1986). In their review of outcome studies of deinsitutionalization of psychiatric patients, Braun, Kochansky and Shapiro (1981) state that, "experimental alternatives to hospital care have led to psychiatric outcomes not different from and occasionally superior to those of patients in control groups." Their conclusion was best supported for both alternatives to admission - 'non-institutionalization' - and for modifications of conventional hospitalization - brief hospitalization.

In his critical review of the length-of-stay of psychiatric patients on hospital wards Kirshner (1982) combines the results of studies of day-treatment and community-based treatment with those of different lengths of standard hospitalization. He suggests that only one reasonable conclusion follows, namely, "The shortest feasible in-hospital stay is best for the patient and the most cost-effective." However, he does caution that, (a) extended in-patient hospitalization is unnecessary *given adequate alternative resources* - current author's italics; (b) though the briefer length-of-stay gives rise to more cost-effective outcomes, "we should accept extended hospital stays in selected cases, such as unresponsive patients with major acute illness or schizophrenics with good premorbid histories"; and, (c) variation in the length-of-stay of any individual patient is both inherent in the nature of the treatment and desirable for individual treatment (Kirshner, 1982).

In not one of the studies examining modifications of traditional hospitalization was there any difference in outcomes, between those receiving brief hospitalization compared with those patients who received varying periods of standard, long-term hospitalization (Caffey, Galbreacht, Klett, 1971; Glick, Hargreaves, Drues & Showstack, 1976; Glick, Hargreaves, Drues & Showstack, 1977; Hargreaves, Glick, Drues & Showstack 1977; Herz, Endicott & Spitzer, 1975; Herz, Endicott & Spitzer, 1977). For example, Braun, Kochansky and Shapiro (1981) summarize the findings of Caffey et al. (1971) thus: "brief-stay patients showed as much sustained improvement as those who stayed longer. Both groups given intensified aftercare manifested less pathology at 12 months. There were no differences between groups in readmission rates or community adjustment." Mattes, Rosen & Klein (1977) in attempting to identify particular diagnostic groupings of patients likely to derive greater, accountable benefit from longer periods in hospital found no discernible differences.

To summarize: numerous studies of what has become known as 'brief-hospitalization' have been carried out (eg. Herz, Endicott, and Spitzer 1977; Hirsch S, Platt S, Knights A, and Weyman A, 1979) whose findings have tended to support the claim that a general policy of brief hospitalization offers ***no discernible disadvantage*** to psychiatric patients.

The briefer, hospital-based care, then, is seen to promote the stabilizing of some of the patient's more florid psychiatric symptoms. This provides the patient with a more stable platform from which to focus on and thereby attempt to modify current functional deficits relating to the environment in which s/he lives (which constitutes rehabilitation). An additional focus of an investigation of community adjustment should be the short-term assessment ward, one which has attracted some research previously. For example, in an exploratory study by Lieberman and Strauss (1986) an attempt was made to "identify clinically-important variables and processes (during the brief period of stay) not considered in other investigations of short-term hospitalization." Their findings suggest that subtle change and a growing self-awareness does take place among patients, where improvements were made,

(a) in their ability to make cognitive connections and to think with perspective;

(b) in their sense of affiliation and affection toward others; and,

(c) in their perceptions of themselves as effective, respectable people.

Whilst this component of the hospital-community 'revolving-door' process is recognized as playing a potentially critical role, limitations on time and resources will prevent any current examination of what role this might be. However, in any discussion of the changes which will surely take place across patients routinely discharged from the 'brief-hospitalization' period considerable importance will be accorded those "inner changes and processes of brief hospitalization (which) may be an important **beginning** to this phase. ." of post-hospital, transitional adjustment (Lieberman and Strauss, 1986). Thus, there is a recognition of the importance of the in-patient treatment on subsequent adjustment - both in itself and as a context within which information collected from the community can be better interpreted.

Despite these findings from studies of brief hospitalization a number of limitations in their applicability and generalizability were identified. Braun et al. (1981) criticize the majority of studies of modification of standard hospital treatment for having, "serious limitations in design and execution". Particular limitations were identified with respect to randomization and the selection of controls where matching on variables such as education, socioeconomic status, premorbid adjustment, and aftercare service-uptake was poor. Other methodological flaws included non-blind ratings of outcomes and omission of baseline data on chronicity of illness.

It is not the concern in this chapter to illustrate in any detail the methodological problems raised (see Braun et al., 1981). The main concern, rather, is the issue of **criteria** used to assess outome in studies both of de-and sub-institutionalization (which has also been described by Lavender and Holloway (1988) as 'continuing care'). This is an issue raised and described previously both by Lieberman & Strauss (1986) and by Avison & Speechley (1987) in their review of the social, social-psychological, and psychiatric correlates of outcome for the discharged psychiatric patient. It will become clear that the methodological difficulties are most intimately tied to the issue toward which emphasis will now shift: that of the conceptualization of outcome criteria in psychiatric research.

2.4. OUTCOME CRITERIA IN RESEARCH ON PSYCHIATRIC OUTCOME.

Having identified the make-up of the sample of psychiatric patients - the adjustment of which to life back in the community is the main issue under address in this chapter - and the treatment modality to which they have been subject, it would be fruitful to consider next the kinds of information which **could** be recruited to help address the study's central, orienting question. That is, once a patient has been discharged from hospital *what sorts of features of that person's life back home might it be useful to identify and measure?* The obvious answer would be to examine those features which have been identified in the literature, that is, the correlates and predictors of 'successful community adjustment' (for instance, 'increased length of stay in the community following discharge', a term more often labelled 'community tenure'). These will, indeed, be presented in due course. However, in seeking to provide answers to this question there is a fundamental difficulty that must be addressed.

The difficulty is a simple one and it is this. There is no universal agreement in this field (Rushton, 1990) about what constitutes 'successful outcome' - "the meaning and the measurement of adjustment" (Avison and Speechley, 1987). As a consequence, many different indicators of outcome have been used, measured using non-standardized measuring instruments that provide "imprecise measures of predictor and outcome variables" (Avison and Speechley, 1987; p.16).

Elsewhere in mental health research the standardization of assessment instruments for case identification, instruments which are linked to clearly stated disgnostic criteria (see Goldberg and Huxley, 1980), developed gradually in response to the problems of unreliability in psychiatric diagnosis and the concurrent anomalies in reported rates of prevalence of forms of mental disorder originally highlighted by Kramer and Zubin in 1969 in the US (Klerman, 1986). The use of the structured interview and other standardized diagnostic instruments also gave renewed impetus to an epidemiology of mental disorders in the classic medical model away from the conceptualization of mental health as a continuum from normality through psychoses (Weissmann and Klerman, 1978). In so doing, this helped expand the opportunities for carrying out large-scale community surveys of mental disorders such as the Epidemiologic Catchment Area (ECA) project (Barrett and Rose, 1986). Provided that each survey employs similar diagnostic systems, for example based on the DSM-III (The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association), and identifies their cases using case-finding instuments appropriate to whichever system adopted, for example the Diagnostic Interview Schedule (DIS) of Robins et al. (1981), then fairly reliable comparisons across studies of patient populations can be made.

From comparatively broad measures of psychiatric outcome which focussed upon the patient's post-hospital adjustment in terms of clinical and other illness-oriented characteristics, there has been a gradual refining of the concept to attempt to embrace the much wider forms of influence in the patient's daily 'community' experience. This refinement is still in its infancy precisely because of the disagreement about what constitutes adjustment, its meaning and so its measurement (Avison and Speechley, 1987).

Various criteria have been used, the most common of which, as cited by Avison & Speechley are:

1. re-admission during a specified follow-up period;
2. the community tenure of each patient following hospitalization;
3. symptom-level at time of interview;
4. measures of the patient's core role performance, as indicated by various employment indices; and,
5. measures of social adjustment.

An example will now be used to illustrate some of the difficulties and confusion that surround one particular type of outcome measure - community tenure.

2.4.1. A CRITERION OF OUTCOME: COMMUNITY TENURE.

The term 'community tenure' has been employed as a measure of outcome success in several investigations of the community adjustment of the discharged chronically mentally ill (e.g. Bene-Kociemba et al., 1979; Byers, Cohen and Harshbarger, 1978; Drake and Wallach, 1979; Sands, 1984). It has been most frequently employed to refer to the amount of time the former in-patient spends in the community following discharge. Usually this has been measured as the number of days the patient spends in the community - i.e. out of the psychiatric hospital - from the date of discharge until readmission. Or, should there be more than one readmission, it is defined as the total number of days in the community within a designated follow-up period, usually between six months and two years of discharge. In that the patient will be unable to 'adjust' to a non-institutional way of life should he or she remain resident in a psychiatric hospital then the selection of this outcome measure seems defensible, if a little obvious. That is, in order for 'community adjustment' to occur the psychiatrically-disturbed person must be living in the community, and the longer the patient stays in that community - so the thinking goes - the more likely he or she will adjust. This is stated as such by Bene-Kociemba et al. (1979) who identify increased community tenure as a goal of the aftercare service precisely because "it is a prerequisite of community adjustment".

The measure - employed on its own - is a fairly crude though frequently employed form of dependent variable. In view of the observation made more than 30 years ago that "living in the community is not synonymous with a patient having recovered" (Clausen and Yarrow, 1955) the measure does not yield much in the way of explanation. In other words, that a former psychiatric patient should remain in a given community for an ever increasing length of time following discharge is no guarantee that that patient has 'adjusted' in other less crude ways to living outside the hospital. Neither does it inform us of the processes by which the patient manages to remain in the community where s/he is without the more dependable and accessible forms of in-patient care once available.

Of these criteria employed since the late 60s, the vast majority of studies have measured outcome by hospitalization experience, community tenure, or employment, measures identified in an earlier review (Anthony et al., 1972) as those most frequently employed to assess outcome. In other words, Avison & Speechley (1987) lament the little advance that has been made over the past decade in developing newer, additional indicators of psychiatric outcome: an outcome following discharge that is most frequently termed **community adjustment**. As will be seen, studies which have employed these outcome measures in association with either, (a) badly conceptualized and measured indicators of social and psychiatric functioning, or, (b) global and imprecise indicators of social and psychiatric functioning, have little extended our understanding of the processes by which tenure is lengthened and maintained, or re-admission brought about.

2.4.2. IDEAL OUTCOME CRITERIA FOR SELECTING THE BEST MEASURES.

Some advances in the conceptualization of indicators of community adjustment have been made. The former, more rigid, constructs - e.g., length of stay in the community; number of times readmitted within 6 months or 1 year - represent more easily acquired **stuctural** properties of what is quite clearly an ongoing **process** of adjustment and adaptation. Any study that seeks to address itself to the question of why it is that a routinely discharged psychiatric patient returns back through the doors of the hospital ward within a relatively short period of time (and if not, whether such a patient could therefore be described as having ‘adjusted' to being back home) must provide a clear operational definition of the term ‘successful adjustment'. If it does not do so, the internal validity of any such study cannot but be “compromised by shortcomings in design" (Braun et al., 1981).

To address this issue a National Institute of Mental Health (NIMH - U.S.) task force was convened to develop some tools for assisting with the selection of outcome measures in psychiatric research, one of which is a set of 11 ideal outcome criteria (NIMH, 1986). As reported by Green and Gracely (1987), these criteria proposed by the task force can be regarded as a particularly welcome heuristic, helping to introduce some form of standardization to the process of outcome measure selection.

Where there is no consensus about outcome criteria across studies, appropriate comparison of results is hindered: the indicators or factors hailed as an advance in one study may prove to be of no or limited predictive value in another whose criterion is represented by some other form of human experience. For example, in her study of the influence of environmental factors on the community adjustment of the mentally ill, Sommers (1988) conceptualized adjustment in terms of the patient's personal and social functioning. “Personal functioning relates to the individual's feelings about self and self-directed behaviours. Social functioning concerns the individual's interaction with the community and his/her ability to perform socially expected roles." She incorporated a measure of each. She found that the longer patients remained in the hospital the more likely they were to return to **low-expectation** sheltered accommodations. Whilst these settings were highly associated with increased community tenure, "the dilemma is that they were also associated with low scores on the (Sommers') community adjustment measures." Had this study defined and measured 'community adjustment' to mean merely the structural indicators "readmission" and "community tenure" - increased length of stay in the community as a criterion for successful adjustment - it would have appeared to have provided evidence for 'adjustment' in those patients still living in the community, who were not readmitted. However, in expanding and enriching the definition of the criterion 'adjustment' - to incorporate aspects of patients' psychological and social functioning - the meaning of the evidence that demonstrates a link between 'adjustment' and 'community tenure' ('number of days in the community after discharge') becomes qualified. That is, like Clausen and Yarrow (1955), Sommers (1988) reveals that increased tenure in the community is "not synonymous with a patient having recovered": that is, the former patient still felt negatively about him or herself, interacted little with the community and demonstrated little ability to perform socially-expected roles. In short, where there is no consensus about the definition of outcome criteria across studies then comparison of findings becomes less reliable and valid.

The eleven criteria proposed by the NIMH task force (NIMH, 1986) for selecting the best outcome measures are as follows:

1. An outcome measure (or set of measures) should be relevant and appropriate to the client group(s) whose treatment is being studied; that is, the most frequently observed symptoms, problems, goals, or other domains of change for the group(s) should be addressed by the measure(s). . .

2. Measure(s) should involve simple methodology and procedures that can be implemented uniformly by a majority of service facilities, using accessible and well-defined training materials and instructions.

3. The scores from a measure should,to the greatest extent possible, have clear and objective referents ("meanings") that are consistent across clients, to ensure interpretability of individual and group scores and score <u>changes</u>. . .

4. Assuming equal feasibility of obtaining information from various respondents, the measure(s) should <u>reflect the perspectives of all relevant participants</u> in the treatment process. .

5. Measures that provide information regarding the means or processes by which treatments may produce positive effects are preferred to those that do not. . .

6. The measure(s) used should meet minimal criteria of psychometric adequacy, including : a. reliability. .; b. validity. .; c. demonstrated sensitivity to treatment-related change; d. freedom from respondent bias, and nonreactivity (insensitivity) to extraneous situational factors that may exist (including physical setting, client expectations, staff behaviour, accountability pressures, etc.). . .

7. The measurement materials and implementation procedures should be relatively inexpensive, not exceeding 0.5% of a mental health facility's operating budget.

8. A measure's content and the presentation of its results should be understandable and "sensible" to a wide

audience, including patients, public servants, and the general public as well as to mental health professionals. . .

9. A measure's scores should be capable of quick, easy feedback to various audiences, and readily interpretable without extensive statistical skill. . .

10. Measures that are useful in clinical service functions (diagnosis, treatment, planning, case review) are preferred to help facilitate acceptance and implementation of the outcome measurement effort.

11. The measure(s) used should be compatible with a wide range of theories of psychopathology and the goals and procedures of various treatment approaches (Ciarlo et al., 1981, pp. 51-53).

The criteria, as reported by Green and Gracely (1987), were assigned different priorities by the task force. The highest priority was accorded Group Relevancy and Psychometric Adequacy. Objectivity of Referents and Wide Understandability received a high priority. Low Cost and Clinical Usefulness recieved a moderately high priority. A moderate priority was given to Rapidity of Feedback and Theory Compatibility. Procedural Simplicity and Process Identification received the lowest priority, with no priority at all accorded Variety of Respondents.

Reference will be made to this NIMH tool when required in the remaining of this introductory chapter. Suffice to say this tool provides essential guidelines, otherwise absent, for both developing and selecting materials for use in any intending study and for defining the criterion, adjustment.

2.5. CORRELATES OF PSYCHIATRIC OUTCOME: EVIDENCE FROM EMPIRICAL INVESTIGATION.

The question to which emphasis will now turn is one raised much earlier in this chapter, namely **which** characteristics of patients' lives outside the hospital most strongly correlate with each outcome criterion adumbrated by Avison and Speechley (1987). Throughout this examination of relevant findings it would be helpful to keep in mind the methodological misgivings, particularly those concerning the reliability and validity of actual measuring instruments generally developed specifically for any given study. A summary will now be given of some of the more widely agreed-upon findings from this review of the social, social-psychological, and psychiatric correlates of discharge-community adjustment outcome.

With respect to readmission to hospital, by far the most solid predictors were measures of what has variously been referred to as 'social resources', 'social stability', or 'social competence'. Serban and Gidynski (1974) found that chronic schizophrenic patients who were socially incompetent were more likely than their acute incompetent counterparts to be readmitted. However, those with acute schizophrenia and moderately socially competent had the highest readmission rates. The more socially active the patient - involved in leisure activities and/or with family and relatives - the less likely they were to be readmitted (e.g. Franklin et al., 1975; Klein et al., 1978; Miller and Willer, 1976; Willer and Bibgin, 1976). The greater interpersonal conflicts within the home the more often those patients were admitted (Caton, 1982; Franklin et al., 1975, amongst others). This result essentially reflects the significant findings of Vaughn and Leff (1976; 1980) and of

Vaughn, Leff, Jones et al., (1984) who made a telling contribution to an understanding of the ways in which family interaction, specifically attitudes of over-protection, -caring, and -criticism toward the mentally disturbed schizophrenic family member, help to determine the likely outcome of this member during post-hospital adjustment. Those patients subject to significantly more intense family involvement - through the family's tendency toward expressing hostile emotion and emotional overinvolvement ('expressed emotion', or EE)- were more likely to relapse and so require subsequent periods of asylum in hospital.

In a review article charting recent developments in the 'expressed emotion' concept and schizophrenia, Kavanagh (1992) identifies a narrowing of the concept to mean, "negative or intrusive attitudes that relatives express about the patient." Reviewing outcome studies of schizophrenia that have examined the predictive effect of EE, he notes that support for this effect is more consistent in studies that have employed as a criterion of relapse exacerbation of symptoms than in others that employed psychiatric hospital admission (citing Dulz and Hand, 1986; McCreadie and Phillips, 1988; Parker, Johnston and Hayward, 1988). With exacerbation of symptoms as the relapse criterion, Kavanagh's (1992) review of 26 outcome studies found a median relapse rate over 9-12 months of 21% among low-EE subjects compared with 48% among high-EE subjects. Only two studies identified a significant predictive effect of EE on hospital readmission, that by Cazullo, Bertrando and Bressi (1988) and another, recently submitted study, by Vaughan, McConaghy and Doyle (1992). He concludes that this 'interpersonal' variable, expressed emotion, is as valuable clinically as medication.

Thus, there emerges from the published literature a clear association between the "social" variables and,

1. return to hospital (e.g. Cazullo et al., 1988; Fontana and Dowds, 1975; Zigler and Phillips, 1961) or,
2. tenure in the community (Turner and Gartrell, 1978) or,
3. the experience of symptoms of varying degrees of severity at follow-up (Sartorius et al., 1978) or,
4. return to gainful employment (Strauss and Carpenter, 1977).

The second conclusive finding is that identified by Anthony, Buell and Sharratt (1972) in an earlier review and must surely be regarded as something of a 'given' in this body of research: namely, the strongest predictor of subsequent readmission to hospital is previous hospital admissions. That is, the more often the patient has had recourse to asylum in the hospital as a means of coping with his/her psychological distress the more likely it is that s/he will return there. This finding is one deserving of greater attention. Specifically, it requires that greater attention be paid to the role this apparent 'revolving-door' process plays in the development of dependency and chronicity. Whilst it is not the intention at this current stage of the thesis to pay this greater attention, Goldberg and Huxley (1980) examine in some detail some of the influences on why and how any given vulnerable ('at-risk') person experiencing symptoms of mental distress might be '<u>filtered</u>' through various levels of the healthcare process. Goldberg and Huxley (1980) present evidence that there are three filters through which people must pass before presenting eventually to psychiatry, within which there is a strong likelihood their problem will remain (Goldberg and Huxley, 1980).

Finally, there is some strong evidence for a relationship between previous and subsequent employment history (e.g. Bland, Parker and Orn, 1976; Buell and Anthony, 1973; Lorei and Gurel, 1973). Much less agreement is evident among research studies about the impact of several demographic indicators, such as age, sex, race, education, social class on outcome - be this community tenure, core role performance, or any of the others listed earlier. Some studies conclude these variables do have some predictive value (e.g. Bland et al., 1976; Byers et al., 1978; Lorei and Gurel, 1973); others do not (Caton, 1982; Di Scipio and Sommer, 1973; Klein et al., 1978; Munley et al., 1978, among others). And whilst the claim is made that psychiatric variables can be useful as predictors of both subsequent symptomatology and readmission rates, few studies have addressed this (only Clum, 1978, who observed an association between symptoms at time 1 and time 2 follow-up, controlling for several social and psychiatric variables).

2.5.1. ISSUES ARISING FROM THIS RESEARCH.

From the review of findings from studies investigating factors associated with any patient's subsequent 'adjustment' or 'adaptation' following periods in psychiatric hospital, it can be concluded that it would be useful to incorporate a measure of,

1. previous clinical and psychiatric history;
2. social demography;
3. previous employment history;
4. symptom presence on discharge and at any intended follow-up; and,
5. the 'social' functioning of the patient.

This is not to propose the omission of any of the other indicators, merely an appreciation of the greater predictive value of these ones already listed. It would be appropriate, not to say prospectively more informative, to attend to those characteristics clearly identified and recognized as playing a somewhat significant role in the 'revolving-door' process of adaptation or institutionalization.

However, although the first three of these indicators can be acquired with no great difficulty - available from hospital medical records and, in the case of symptoms of distress, in the form of standardized research instruments - the lattermost, measures of 'social functioning', pose greater problems since they are not as clearly defined nor easily measured.

There are at least two reasons, and perhaps more, why this should be so. The first difficulty is one of **conceptualization**. Zigler and Phillips (1960; 61; 62) and Turner and Gartrell (1978) label this intervening variable, "social competence", each with a separate understanding of the term. Buell and Anthony (1973), Byers et al. (1978), Munley and Hyer (1978) and Lorei and Gurel (1973) vaguely term this variable, "social resources" or "social competence". Fontana and Dowds (1975) came up with the term "social stability" to index the combined impact on post-hospital adjustment of age, marital status, occupational level, age at first hospitalization, number of years at current job and number of months in current living situation.

Within the published literature, there appears to have been little attempt to agree upon **a standard or standard conceptualizations** of the intervening 'social' variable. Where conceptualizations differ so **measures of these predictor variables will fail to correspond**: the second of the reasons why measurement of this indicator poses such problems to those researching the topic. When there is disagreement about the definition of similarly-labelled constructs (such as 'social competence') any measures taken will yield findings that are likely to be confusing. The interpretations made of such findings will be unlikely to meet with wide agreement since similarly-labelled constructs will refer to different kinds of experience. That is, the generalisability and consistency of such findings will be minimal. Thus, with less precise, non-standardized definitions and measures of these 'social' influences on adjustment there will be greater variability, in what is measured, and less reliability from study to study, in the statements and generalizations made.

From this review of the literature, then, two firm conclusions can be drawn. First, there has been little advance made over the past decade in developing newer, additional indicators of psychiatric outcome. The vast majority of studies have measured outcome by hospitalization experience, community tenure, or employment, measures identified in an <u>earlier</u> review (Anthony et al., 1972) as those most frequently employed to assess outcome. This is a complaint voiced most strongly by Avison and Speechley (1987) who claim that, "In general. . studies fail to advance our understanding of the process of adjustment. . . In many respects, these studies, conducted over the last 10 years, largely confirm the relationships uncovered more than two decades ago. . with attendant theoretical and methodological shortcomings. ." (p. 16).

In his literature review of British studies of community-based versus hospital-based care for acutely mentally ill people, Rushton (1990) makes two points in support of the conclusions drawn here. He asserts quite convincingly that, "*Harder measures such as the number of days out of hospital or type of accommodation are easier to obtain but do not go to the heart of what we need to know.*" He also acknowledges the difficulties that go hand in hand with devising and developing measures capable of representing such a "value-laden notion as the life satisfaction of someone living with a remitting illness in a community context." This statement brings into sharp focus the **second** of the conclusions, for without clear specification of the conceptualization of what any 'social' indicator might be, the validity and subsequent reliability of any measure taken will be jeopardized. Any such measure obtained will be ambiguous since the construct being measured is unclearly defined; since ambiguous, any statements based on such measures will be less reliable and valid.

It is at the stage of selecting the characteristics or features that are to be regarded as best representing the patient's 'community experience' that the greatest caution must be exercised. Any characteristic that might be considered to *contribute* to the patient's "adjustment in the community" can be used to form the basis of the ultimate definition of this construct, "adjustment". On the other hand, one would have to be incredibly naive to believe that ***all*** possible contributory causes and features of the patient's experience could be identified and included in the definition and assessment.

Rather, what a team of researchers must try to achieve is a measure of the most ***salient*** features of the patient's post-hospital experience in order that a valid and reliable representation can be carried away (either embodied on paper, or in the mind of the researcher / healthcare worker or within a computer) for a wider net of individuals to further examine, discuss and for it to be subsequently acted upon. ***Capturing the salient features and representing them for use elsewhere is the key concept here*** - it is (in its wider and proper sense) a problem of measurement.

There is, unfortunately, a major difficulty when a representation of any domain is attempted. Representation causes, as a side effect of its valuable short-hand function, a net information ***loss***: it can never hope to be a complete picture of patients, the healthcare resources available or used and the 'community' scenario that is carried away and discussed for action but some subset appropriation. It becomes crucially important, therefore, that the representation or measures that are ***selected***, ***collected*** and ***used*** are those which most closely 'fit' the particular scene and issue currently addressed, and that those measures that are irrelevant or might mislead are eschewed.

Different representations incorporate different information from the scene: perhaps less perhaps more, but certainly different. As a consequence, different representations (different ways of modelling) used in different projects will generate different project-outcomes. For example, those studies that have only used as an index of 'adjustment' a measure of 'community tenure' would **not** have been able to conclude (since they were not addressing, nor taking a measure of, ***other*** features of the process of adjustment) that though patients might be staying for increasingly lengthy periods in the community they could not be considered 'adjusted' as indicated by their scores on any number of other, less crude, and more embracing measures of community adjustment (Sommers 1988).

When the different representations (or ways of measuring) that could be used is large and when it is not clear what the most efficacious representations should be (such as in the "multiple cause" domain, Parkes 1982, of psychiatry) then the problem of getting the measurement 'right' becomes so much more important.

It is to those attempts at providing solutions to these issues that attention will now turn.

3. NEW ATTEMPTS AT ANSWERING THE PROBLEM.

3.1. QUALITY OF LIFE.

Dissatisfaction with the conceptualization of treatment outcome led Lehman (1983; Lehman, Possidente and Hawker, 1986), among others, to introduce the concept 'quality of life' into the literature arguing that it offered "a broader perspective for an understanding of patients' needs and the impact of services on their lives." These early studies (e.g., Lamb, 1979; Lehman, Ward and Linn, 1982; Lehman and Linn, 1984; Markson, 1985) - though based on a very general QoL model, asking unvalidated questions of, for example, leisure, health, social relations, and family - found that the explanatory power of the models were greatly enhanced (doubled in one) when subjective indicators were added to the 'personal characteristics' and 'objective' indicators of well-being.

The concept is best understood as being an ***organizing*** framework that was established in response to the demands for integrating the voluminous information on patient discharge that is relevant to the more efficient planning and evaluation of services for such patients. This voluminous information comprises patients' housing conditions, family environments, social networks, financial situations, safety, and practical coping skills.

Quality of life (QOL) has been examined much more systematically in the field of gerontology and in the assessments of the impact of general medical care on persons with chronic physical illnesses (eg. Larson, 1978; Najman and Levine, 1981). In the psychiatric domain the concept is now becoming increasingly recognised (e.g., Simpson, Hyde, and Faragher, 1989).

In recent years much progress has occured in the development of techniques for assessing QOL. One QOL model based on extensive national survey data (Campbell, Converse, and Rogers 1976) makes two central points, that:

1. ultimately, QOL is a subjective matter, reflected in a sense of global well-being; and that,
2. this experience depends on at least three types of variables:
    (a) personal characteristics such as age and sex;
    (b) objective QOL in various domains of life, such as relationship network and income level; and,
    (c) subjective QOL in these life domains, such as satisfaction with aftercare services and with income.

Objective indicators of 'successful' community adjustment tend to be more tangible, reflect accepted norms of function and life-style, and more directly address environmental conditions and behaviours that can be manipulated in service programmes. Their major disadvantage is that they indicate little of how patients **feel** about their lives and so exclude any patients' input to hospital and community service planning and evaluation: an imbalance redressed by the inclusion of subjective indicators. This complementarity suggests that both types of indicators should be used whenever feasible (Lehman, 1983).

These studies, however, have been criticized for their overemphasis on subjective indicators of global outcome, as well as for their difficulties in definition and measurement of terms (Simpson et al., 1989). On the other hand, there are statements that can be made in support of this series of QoL studies:

1. Firstly, no attempt was made by Lehman and his colleagues to 'reconstrue (completely) the field'. The studies, instead, explored "the utility of the concept, 'quality of life'", acknowledging the need for an organizing, "conceptual framework for integrating the voluminous information that is relevant to both the planning and evaluation of services for them" (chronic mental patients) (Lehman, 1983).

2. Secondly, the structured interviews designed for the studies confirmed the significance for adjustment of social and interpersonal characteristics of community life among patients where five of the eight 'life areas' reflected just these components: living situation, family, social relations, work and leisure activities.

3. Thirdly, disagreement is quite widespread about the utility and value of *subjective* assessment of psychological well-being or 'life quality', however defined. One group espouses the view that what people report of what they are feeling and what people report of why they act in given ways does not reflect what is 'in there' (Nisbett and Wilson, 1977). The other states that this does not matter (e.g., Bannister and Fransella, 1986;

Kelly, 1958b). Instead, what **does** matter is simply what an individual reports him or herself to be thinking or feeling since it is the **effects** of these subjective beliefs which impact behaviour and, perhaps most compellingly in the case of a psychiatric patient, his or her **perceived** ability to cope.

It should also be noted from the Lehman studies (1982; 1983; 1986) that of the seven objective QoL indicators regressed on their global well-being measures, besides utilization of medical care, **the most salient predictor was the frequency and intimacy of social relations**. (Coincidentally, the emergence of the medical care-use variable as a significant predictor of subsequent well-being supports the findings from the research investigating the impact of aftercare use on the community tenure of discharged psychiatric patients - e.g., McCrainie and Mizell, 1978; Solomon, Davis & Gordon, 1984. That is, a general finding has emerged that length of tenure in the community will be prolonged where patients continue to be in contact with formal, professional 'aftercare' services.)

Thus, to recapitulate, outcome measures as well as the factors studied in relation to these measures have been subject to extensive criticism over the past few years (eg. Rushton, 1990; Sommers, 1988; Thoits, 1986). Additional indicators have been advocated to supplement traditional ones in the hope of better assessing and broadening understanding of the <u>process of adjustment</u> (eg. Anthony et al., 1978) <u>particularly</u> those which are guided by **theory**, unlike "most of the research on adjustment." (Avison & Speechley, 1987).

3.2. SOCIAL SUPPORT: AN INTRODUCTION.

One such attempt to explore a conceptually-distinct outcome, as well as those factors associated with outcome - adjustment and well-being, was the introduction to the research arena from gerontology of the concept quality of life by Lehman et al. (1983; 1986). Another, potentially more fruitful attempt at cross-fertilization has been suggested both by Avison and Speechley (1987) and Paykel (1985) in his review of the current state of findings regarding the role of recent life events and social support in the stress process in clinical psychiatric disorder. Each suggests the introduction of measures of what has become known as the "social support" of the discharged psychiatric patient in an attempt to advance our understanding of psychiatric outcome. That is, each suggests that by referring to the involvements people have with one another that are of supportive value in enabling them to maintain general and manageable levels of emotional and psychological well-being <u>a better understanding can be gained of why it is that some patients will return to hospital within an indeterminate period of time following discharge, whilst others will not</u> (and, concurrently, why it is that some patients can tolerate varying degrees of psychological distress whilst others cannot).

It is hypothesized by these researchers (among many others, most notably, Caplan, 1974, Cobb, 1976 and Cassell, 1976) that the stress and distress experienced by any person on their discharge from hospital is, in some central way, interpersonally-mediated. It does not occur in a vacuum, but instead involves the person in relation; in relation with some other person or persons, real or fantasized (e.g., Hoult, 1986; Laing, 1967; Sullivan, 1953). This stress-support process, in turn, is considered to play a large part in determining whether or not any given patient will be readmitted. Such readmission, it is argued, will be conditioned by the experience of critically severe degrees of psychological distress following discharge from a brief period in the short-term acute wards of the psychiatric hospital. This consideration was made much earlier in this chapter by Hoult (1986). He wrote that, “the underlying interpersonal stresses which have precipitated the symptoms and signs are ignored, or are not dealt with, and so they persist to precipitate further episodes, which are again dealt with only in terms of psychopathology" (Hoult, 1986).

The term ‘social support' might be regarded as a more precise, standardized definition of the ‘social variable' variously termed “social resources" (Byers et al., 1978), “social competence" (Munley and Hyer, 1978) or “social stability" (Fontana and Dowds, 1975) - variables that were clearly associated with outcome in the published research. It is toward an examination of this concept - borrowed from the literature on the effects of life-events on coping and subsequent illness - that attention will now turn. Throughout this examination careful attention will be paid to the relevance of this concept to the current research question: an examination of the stresses and supports of the routinely discharged psychiatric patient which help to precipitate or postpone eventual return to the hospital's short-stay ward In the course of this examination it will be seen that the concept itself:

1. is both theoretically- as well as empirically-grounded;

2. allows the generation and testing of specific hypotheses about the patient's life back in the community; and,

3. allows satisfaction of almost all of the eleven ideal outcome criteria proposed by the NIMH task force (NIMH, 1986).

3.2.1. SOCIAL SUPPORT - BRIEF HISTORICAL BACKGROUND.

Interest in the concept of ‘social support' has developed apace since a series of influential review papers in the mid-70s led first by social psychiatrist Gerald Caplan (Caplan, 1974). Along with Cobb (1976) and Cassel (1976), he drew attention to the nature and influence of informal support systems in the community, and to the roles that mental health workers could assume in fostering their development.

His clinical experience with methods of crisis intervention was instrumental in formulating his thoughts about the fundamental role of the individual's relationship network in responding to stressful life events and transitions. His position was that outcome of individual responses during crises (those ordinarily leading to admission for acute psychiatric treatment) was influenced “most importantly by the quality of emotional and task-oriented assistance provided by the social network within which that individual grapples with the event." (Caplan, 1974).

As early as 1959 there was an acknowledgement by Wing, Denham and Monro (1959) - followed by Brown, Monck, Carstairs & Wing (1962) and Wing, Monck, Brown & Carstairs (1964) - that more direct indices of symptomatology and ‘social adjustment' were required in order that an explanation might be advanced of patient morbidity following discharge. In their description of the social and clinical progress of a group of male schizophrenic patients discharged from several London mental hospitals several measures of patients' and relatives' attitudes were taken. Patients were asked a quite straightforward question about how “helpful and sympathetic" were their relatives. Relatives, in turn, were asked what they thought about the impending return home of the schizophrenic family member. The 'social component', then, though quite simply formulated, was nonetheless acknowledged as early as 1959.

3.2.2. SOCIAL SUPPORT - THE CONCEPT.

'Social support' has, however, been a notoriously globally-conceptualized construct (Barrera, 1986; Dakoff & Taylor, 1990; Gottlieb, 1983; Kessler et al., 1985; Reis, 1984; Winefield, 1987). Well-intentioned researchers are not lacking in good ideas about what matters for health and well-being. Rather, they have difficulties in articulating and measuring them. (This will be a central focus of one of the sections in the subsequent chapter of the thesis.)

What, then, is social support? Quoted by one of the foremost practitioners in the field (Henderson, 1988), Francis Bacon (1965) wrote that "this communicating of a man's self to his friends works two contrary effects; for it redoubleth joys, and cutteth griefs in halfs. For there is no man that imparteth his joys to his friends, but he joyeth the more; and no man that imparteth his griefs to his friends, but he grieveth the less." The poet, Gerard Manley Hopkins, wrote, "this seeing the sick endears them to us, us too it endears. My tongue had taught thee comfort, touch had quenched thy tears, thy tears that touched my heart, child, Felix, poor Felix Randal."

Definitions from the literary sphere apart, there is a great diversity of formal definitions of support which have been articulated (eg. Cobb, 1976; House, 1981; Kaplan, Cassel & Gore, 1977; Walker, MacBride & Vachon, 1977), one of which by Kahn & Antonucci (1980) defines it as, "interpersonal transactions that involve the expression of positive affect, the affirmation or endorsement of the person's beliefs or values, and/ or the provision of aid or assistance."

Fortunately, these attempts at more systematic and precise conceptualizations of the construct have struck a chord of agreement among researchers. Specifically, two distinct components of social and interpersonal functioning have been identified. The first, the structural component, embraces such characteristics as living arrangement, social activity, and social embeddedness (Barrera, 1986). The functional component describes what it is that interpersonal involvement can provide, such as the expression of positive affect or emotional reassurance; expression of agreement with a person's beliefs or feelings; provision of advice, guidance, or information; and, drawing from the theories of Erikson, Sullivan, and Rogers, Reis & Shaver (1988) posit the feelings of being understood, validated, and cared for.

3.2.3. SOCIAL SUPPORT - THEORIES OF THE SUPPORT-HEALTH LINKAGE.

This beneficial (some would say 'existentially-securing' - Thoits, 1985; or 'confirming' - Buber, 1957a) consequence of having and being involved in ongoing relationships with people has been attributed in the literature to two, not altogether different, processes. On the one hand, **the "stress-buffer" model** proposes that the effects of stress on health are attenuated in the presence of adequate interpersonal relations. Thus, the 'support' provided by others, buffers persons from the potentially pathogenic effects of stress (for example, Cohen & Wills, 1985). On the other hand, **the "main-effect" model** proposes that social attachments in general have a direct and positive role in psychological adjustment and health irrespective of whether persons experience stress (for example, Sarason, Pierce & Sarason, 1990).

The social support construct emerged from the larger body of research on the impact of life stress on health where it has become regarded as a major psychosocial resource, buffering or modifying the impact of stress and subsequent vulnerability (eg. Alloway & Bebbington, 1987). Thoits (1986), for instance, regards it as a coping facility.

The evidence from this research quite clearly suggests that not all people for whom stress and misfortune has become an ineluctable part of their lives go on to develop emotional disorder. In his review of coping, defences and stress, Haan (1982) presented evidence that stressful encounters sometimes have the effect of promoting or augmenting an already extant coping capacity. For these reasons, much activity within the field became focussed on the identification and explanation of variables, so-called **resistance** or **vulnerability** factors, that might address this differential responsiveness to the 'slings and arrows of outrageous fortune'. The label "social support" has been conferred on those intervening variables whose essential component is constructive human interaction, the function of which is "to sustain mental and physical health" (Rook, 1985). Brown (1989) asserts that "social support is a label for something which has many components". (This definition will be carefully examined in a section in the next chapter.)

3.3. CURRENT CONCERNS.

It is not the concern of the present chapter to enter upon a discussion of some consistent criticisms of the social support literature. These criticisms are examined by Barrera (1986). They pertain to the conceptualization of the construct, its measurement and so to the apparent lack of consistency in research findings. These issues will be dealt with more fully in the next chapter. Their examination is essential such that confusions might be ironed out - confusions about conceptualization, measurement, and research findings - and study guidelines proposed else the term "social support" shed its usefulness as a research concept (Barrera, 1986).

The remainder of this chapter will be devoted to two pressing concerns. The **first** will be to present and examine the evidence from empirical studies of the linkage between social support and health, evidence which Ganster and Victor (1988) conclude is "strongest for mental health". The **second** concern will be to put forward good reasons why research on 'social support' - rich in conceptualizations, measures and research findings (none of which has escaped criticism, yet each of which can provide ready arguments in defence) - provides an opportunity to advance an understanding of the mechanisms by which patients recently discharged from hospital come to adjust to living back home. Or whether, instead, they relapse and return to hospital. These are advances the lack of which has been so uniformly protested (Avison and Speechley, 1987; Rushton, 1990).

That is, it is hoped to make clear from the following examination both of the findings from empirical research and of the methodological and conceptual issues addressed that the original question - <u>What sources of</u>

stress and/or support help to precipitate or to postpone the routinely discharged psychiatric patient's eventual return to hospital after a brief period in the short-stay acute ward of the hospital? - is better addressed by incorporating measures of what is known as "social support". For this will provide a much clearer theoretically-grounded conceptual framework, incorporating measuring instruments of known reliability and validity. This will allow the generation and testing of specific hypotheses which might be expected to advance understanding of the **processes** by which structural and experiential features of patients' lives following discharge effect a change on outcome, the exacerbation of symptoms of psychological distress, symptoms ordinarily diminishing ability to cope.

3.4. SOCIAL SUPPORT AND MENTAL HEALTH - THE EVIDENCE.

3.4.1. COMMUNITY SAMPLES.

Hundreds of empirical studies have been carried out that have assesed the direct and indirect effects of social support on mental and physical health driven by the consistency of the finding of a relationship between the two (eg. Cohen & Syme, 1985; Leavy, 1983). Within the past 10 years over 500 studies of the concept have been published in psychology (Shumaker and Brownell, 1984). The vast majority of these investigations have been conducted in the community on student samples and on persons developing for the first reported time symptoms of psychiatric diorder (Alloway and Bebbington, 1987). Much less research has been devoted to examining social support among clinical populations.

It would be inappropriate to dismiss the findings of these studies merely because they were restricted to non-clinical populations. For instance, information about support mobilization among 'normals' might be incorporated by mental health professionals in their dealings with psychiatrically-disturbed persons living in the community, such that more effective use be made of available persons within that person's social network (for example, Kessler and McLeod, 1985). Thus, close attention will be paid to a selection of those studies of support among non-clinical samples.

In the conclusion to their review of the buffer theory of social support Alloway and Bebbington (1987) claim "it is likely that there is a direct association between social support and disorder." Their central conclusion, however, takes the form of a plea "for studies free of the reservations we have expressed." These reservations follow the now expected pattern consisting of calls for (a) more reliable and valid measures of social support, (b) clearer conceptualization within studies of the construct to be investigated, (c) the establishment at interview of psychiatric status, and (d) greater attention to be paid to the assessment of the **content** of any supportive interaction.

Their review of longitudinal studies of the buffer theory provides weak evidence for the existence of a clear-cut buffering effect, where social support modifies the deleterious effects of stress on psychiatric disorder or psychological well-being. All but one of the studies is criticized on methodological grounds (inappropriate use of statistics, failing to realize the potentialities of the panel design, failing to take measures of all relevant variables at each separate, time-lagged interview).

Two of the most widely publicized longitudinal studies investigating the **moderating influence** of social support on subsequent development of mild psychiatric disorder are those by Henderson, Byrne, and Duncan-Jones (1981) and by Brown, Andrews, Harris, Adler and Bridge (1986a). That these two have received (and merited) such close attention has everything to do with their superior design and execution, and it is toward an examination of the research findings that emphasis will now turn. It's careful to keep in mind that neither study involved clinical samples of formerly hospitalized patients - this kind of study is, as will be seen, surprisingly thin on the ground.

Henderson et al. (1981) carried out a longitudinal study of a subsample of men and women living in Canberra, Australia as part of a larger investigation of psychiatric disorder. Their assessment of social relationships, involving the development of their own reliably and validly tested measuring instruments, was particularly intensive. Those of most explanatory power were the measures termed Availability of Attachments and Social Integration together with the perceived Adequacy of these provisions. Their interaction with life events and psychiatric disturbance was analysed. They found that attachment measured at first interview multiplied the effect of subsequent life events on disorder assessed at the second interview, but only for Perceived Adequacy of these attachments, not their availability. This was regarded as failing to support the buffer theory, where it should be possible to demonstrate the effect with the relatively more objective assessment of Availability. In its absence, Henderson and his colleagues (1981) proposed an alternative account for their results whereby perceived adequacy was considered to be more a reflection of personality than of the actual state of relationships. Alloway and Bebbington (1987) suggest a further explanation. Availability of attachment at the first interview may not have been predictive, they suggest, because the critical variable was the **actual support mobilized** during specific crisis events in the person's life.

Crisis support refers to that assistance offered or available **specifically at the time of a crisis**, and not simply that available on a more general, day-to-day basis. Cohen and Wills (1985) claim that true social support is effected whenever the type of support received matches the specific demands of the stressor. With this in mind, it does appear reasonable to suggest, as Alloway and Bebbington (1987) do, that it may **not** be <u>routine social support</u> that is relevant to the buffer theory, but the <u>specific assistance</u> at the time of the crisis event. This 'specific assistance' may be words of reassurance or sympathy or advice. Or it may be the receptiveness, attentiveness, acceptance and understanding apparent in the presence and demeanour of the person present at the time of the specific crisis event.

In the other highly publicized longitudinal study, Brown et al. (1986) studied a mixed sample of single mothers and of working class mothers who were married or cohabiting. All women in the study had at least one child under 18 at home. Measures of social support, self-esteem, and psychiatric disturbance were made at the initial interview. At the second interview, the Present State Examination was once again administered. Life events during the 6 months prior to onset of disturbance, for the cases in the sample, and before interview, for the non-cases, were elicited. The actual crisis support given in response to life events was established at the second interview.

The research team found that among wives regardless of whether or not a confiding relationship existed at the first interview there was no associated lower risk of depression developing in the succeeding year. In contrast, single mothers were less likely to become depressed following the first interview if they were originally involved in socially supportive relations with a close confidant.

Their design was a superior one in many respects - as acknowledged by Alloway and Bebbington - yet it offered little ostensible encouragement for those advocates of the buffer theory of social support. However, despite the apparently high degree of control over error variables in their design, Brown et al. (1986) argue that measurement at the first interview of the support mobilized by the married women was a poor reflection of the actual crisis support received during the period of adversity in their lives.

If one is to employ these studies as benchmarks providing guidelines for any subsequent research then one may draw the following conclusions. Firstly, and this is an issue referred to with such frequency its import cannot be doubted, instruments for measuring support must be valid and reliable, measuring the specific conceptualization of ‘social support' for which it was devised and developed. Otherwise, claims made in support of a buffering or main effect of support on mental health on the basis of information obtained from such instruments must be met with qualified scepticism since open to artifactual influence.

Secondly, it would be instructive to incorporate measures of perceived support - that reflecting the individual's current generalized sense of being supported, whether real or otherwise, for this perception will, in whatever way, colour the perceived ability to cope with whatever life crises come his/her way. Thirdly, measures of the actual support received at the time of any crisis must be obtained else a spurious explanation of the role of support at these crisis points will likely emerge.

3.4.2. CLINICAL SAMPLES.

As will be seen, much of the direction in this area has been toward an examination more of structural properties of the patient's social life back in the community with attendant neglect of the functional provisions support affords within these structures - e.g. family, church, self-help groups: functions considered essential for a sense of “existential security" (Thoits, 1985). These structural properties differ from the functional provisions referred to earlier (e.g., Cobb, 1976; House, 1981; Kahn & Antonucci, 1980; Kaplan, 1977; Walker et al., 1977).

Research comparing the social support - conceived of as ‘social networks' - of psychiatric patients and normals has been widely reviewed by Mueller (1980), Leavy (1983), Paykel (1985) and Ganster and Victor (1988). Leavy (1983) concludes his comparison of clinical and non-clinical populations thus, “. . the studies clearly indicate a relationship between a lack of social support and serious psychological disorder. Particuarly in depression , a lack of emotional support in marriage is related to dysfunction under stress. A lack of emotional support and affirmation (what House might call appraisal support) seems to differentiate disabled from non-disabled discharged schizophrenics." (Leavy, 1983).

Froland et al. (1979) contrasted the size of the support system, its perceived supportiveness, the nature of the supportive relationships, the density of the support relationships and who the supportive others were among four separate groups of individuals. Thirty state hospital patients were compared with 30 individuals from the general population, 20 patients in day treatment, and 27 outpatients. This work was an attempt to advance a more detailed understanding of the studies undertaken by Kaplan, Cassel and Gore (1977), and Walker, MacBride, and Vachon (1977). These studies indicated that social support networkshave a strong bearing on whether one is recognized or defined as ill, has resources to deal with being ill or under stress, and can satisfactorily adjust to community life. Their findings were quite striking. Relative to the general population sample, the average profile of the social network of those in the treatment groups was as as follows:

smaller in size,
fewer ties with kin,
fewer members living far away (i.e. further than 400 miles),
fewer different sources of friends,
fewer long-term friends,
less interaction with family, friends, relatives,
fewer friends who know family members,
greater degree of change in terms of moves, deaths, etc.,
greater feelings of loss of help from relationships (Froland et al., 1979).

Further, state hospital patients scored significantly lower than either of the other three groups in psychological well-being and productivity. Unsurprisingly, given current knowledge of the social, social-psychological, and psychiatric correlates of psychiatric outcome, the state hospital patients also had poorer treatment histories with greater amounts of time spent in hospital - this illustrating the 'past behaviour driving the present' phenomenon.

Froland et al. (1979) conclude that a central feature of the social support of the hospital groups is the "mutuality of exchanges". Whilst family members and friends may appear to provide support to the chronic patient, this is only so long as reciprocity exists. Lack of reciprocity may cause feelings of burden. Thus, for the chronic patient, the sole remaining source of support often becomes the professional health worker.

The 'average profile' identified by Froland and his colleagues (1979) was mirrored in successive studies of mainly schizophrenic groups compared with the general population (for example, Clark and Cullen, 1974; Cohen and Sokolovsky, 1978; Garrison, 1978; Hammer, Makiersky-Bariou, and Gutwirth, 1978; Pattison et al., 1975; Tolsdorf, 1976). This led Leavy (1983) to the conclusion that compared with nonclinical populations, clinical populations (mainly schizophrenic groups) have social supports which differ in the following ways:

"(1) they are smaller support systems,
(2) which emphasise non-family ties, and,
(3) which, among the more disturbed, are more one-sided than reciprocal." (Leavy, 1983).

In his review, Paykel (1985) argues that too few studies have been attempted for any firm conclusions to be drawn. He contends that the literature on social support in patients is too variable, with encroachment into other areas such as demographic risk factors for psychiatric illness. In particular, “social support, as contrasted with other social factors, requires more explicit study in schizophrenia." He continues, “. . more studies are required of severe and bipolar depression, of other disorders and of the nature of any causal links" (between social support and the disorder).

Roy's (1978; 1981b; 1981c) series of studies comparing the support of depressed patients with gynaecology and orthopaedic controls generally confirmed the findings of the seminal work in this area by Brown et al. (1978) on depression in women in the community of Camberwell, London and in a remote Orkney community. Brown et al. (1978) identified four factors which rendered a woman in the community of Camberwell much more susceptible to clinical depression when that woman encountered any event in her life which represesnted a long-term threat. These ‘vulnerability factors' - not working outside the home, presence of at least 3 children under 14 in the home, no intimate confidant, and early loss of mother - did not act to the same extent in those women actually receiving treatment for clinical depression. Women with no intimate who experienced life stress were almost ten times more likely to manifest serious depression than those women facing similar types of stressor but who had someone in whom they could confide.

As adumbrated by Leavy (1983), this study acted as a catalyst in the research arena with five subsequent studies of depression in **both** men and women all demonstrating this effect, namely, that having a confidant made depressive experience much less likely, “although the confidant did not need to be of the opposite sex in some cases." Depression was especially marked among those women for whom emotional and instrumental support from their husbands was absent.

Surtees (1980), in what is one of the few studies to make use of a longitudinal research design, measured support and depressive symptoms among patients on admission to a psychiatric institution, and again following *improvement*. Like Brown et al., (1978) before him, and Henderson et al., (1981) soon to follow, he found a significant predictor of subsequent improvement in symptoms to be the presence of a close, reciprocal, confiding relationship, particularly for those patients who experienced high levels of continuing stress after the onset of symptoms.

At least among clinical populations, then, there is one consistently reported finding: **the absence of social supports is associated with increased psychological distress** (Brown et al., 1978, 1986; Brugha, 1991; House, 1981; Tolsdorf, 1976; Turner, 1979, 1981; among others). This distress, in the form of depression, is particularly highly associated with, (a) the absence of close, confiding relationships; (b) the perceptions of satisfaction with these relationships and with (c) several ‘vulnerability' factors but **only** when the experience is present of being under stress.

Though few studies of functional social support in clinical populations other than depressives have been undertaken, one of those investigated the social supports of formerly hospitalized schizophrenics (Turner, 1979). He demonstrated that ‘disabled' patients did not differ from ‘non-disabled' on a number of indices of assessment: they did not differ on the basis of their previous hospitalizations; on the type or amount of out-patient care; or on socio-demographic variables. Where they did differ was in their level of ***social support,*** with the disabled having far less. A low level of social support was defined in terms of, (i) having fewer confidants, (ii) being less satisfied with one's support interactions and (iii) experiencing a sense of stigma in the community.

Whilst there have been several *cross-sectional* studies of the structural properties of patients' social networks, very little *longitudinal* research has been initiated (Avison & Speechley, 1987; Gottlieb, 1983; Leavy, 1983). As these authors state, by adopting such an approach, an assessment and evaluation will be made of support sytem *changes* over time. Leavy (1983), for instance, writes:

“With longitudinal designs we learn how support interacts with the person to affect coping (and so adjustment) across time and circumstance."

No attempt will be made within this chapter to explore some of the issues which impact upon these research findings and which currently exercise the minds of those attempting to advance understanding of the construct, one so beset with “conceptual infelicities" (Brown and Bifulco, 1985). These will be covered in the next chapter. (Issues such as the potential contamination of support measures with disorder and imprecise conceptualization and so measurement - one issue somewhat touched upon in the previous exposition!).

Instead, emphasis will now shift to the second of the concerns stated previously. That is, why it is that this body of research provides an excellent opportunity to make some of the advances demanded by Avison and Speechley (1987) and Rushton (1990) in their respective reviews of the literature on psychiatric outcome. The advances to which they refer are in an understanding of the mechanisms by which the discharged patient comes to adapt or not to the social environment to which they have returned following brief periods of psychiatric treatment in hospital.

3.5. THE APPLICATION OF ‘SOCIAL SUPPORT' TO RESEARCH ON PSYCHIATRIC OUTCOME: GOOD REASONS.

The original question was framed thus:

What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?

The research on social support and mental health will be of value to any attempt to address this question for the following reasons:

3.5.1. THE EVIDENCE

It is clear from the review of studies examining the relationship between social support and various forms of psychological disturbance among clinical populations that support both buffers the deleterious effects of stress and provides a main effect for health and well-being (for example, Alloway and Bebbington, 1987;

Ganster and Victor, 1988; Leavy, 1983; Thoits, 1983). That is, particular forms of support-diminution have been associated with increased severity of disorder. This, of course, says nothing about whether or not that person eventually ends up back in hospital as a consequence, since no study of social support specifically framed the question in this way.

<u>However, this assumption, one of the most fundamental to be made, remains</u>. It is this: that those persons:

1. lacking in particular forms of support, and
2. who for whatever reason meet with adversity during their lives back home, and,
3. who then develop symptoms of psychological distress - such as anxiety, depression, heightened interpersonal sensitivity, paranoiac thoughts, hearing voices or seeing things which others cannot,

these persons, it is presumed, **will be more likely to present back to the hospital under these demoralizing conditions.**

Indeed this analysis is made by Hoult (1986): an analysis made at the beginning of this chapter in defining 'the problem'. He wrote:

> "To the staff working in a hospital, a patient's admission is the beginning of a treatment episode, but for the patient and his family, it is the culmination of weeks or even months of increasing suffering **which often could have been relieved much earlier, if help had been available.** Instead, they may be forced to wait, as their distress intensifies, until the patient's symptoms and behaviour are of such severity that admission to hospital, sometimes even compulsorily, becomes the only option. Hospital admission gives the relatives temporary relief, and alleviates the patient's symptoms and more disturbed behaviour, but before long he returns home; in the case of the patient with schizophrenia, either his apathy or his unpredictability may then again cause concern to his relatives, who have to wait for the next relapse." (Hoult, 1986, p.137).

Thus, the first good reason for borrowing from this body of research is the strength of the relationship that has been identified between social support and mental health, a relationship greatly relevant to an intended investigation of the <u>predictors</u> of patient return to hospital; return, itself, predicted by the increased severity of symptoms experienced. Symptoms of underlying psychological distress could, then, be a central criterion of 'outcome', where their role in bringing about likely hospital return is likely to be highly influential, measures of which can be taken. That is, 'adjustment' need not only be conceived of as whether or not the patient returns to hospital, but also as the severity of experience of psychological distress. This distress - it will be argued in the next chapter - *precipitates* likely readmission, particularly where its severity renders the individual less able to negotiate 'ordinary day-to-day living' (Lavender and Holloway, 1988).

3.5.2.. CONCEPTUALIZATION AND MEASUREMENT.

The earlier review of the correlates of adjustment among patients discharged from psychiatric hospitals consistently found a strong association between the (largely global and imprecise and/or unvalidated and unreliable) measures of "social resources", "social functioning", and, "social stability" and subsequent likelihood of readmission or increased community tenure. However, disagreemant amongst researchers over the conceptualization - and so measurement - of this 'social' component rendered quite misplaced clear generalization from one study to another.

Though earlier research on the term 'social support' appeared destined toward a similarly muddied impasse recent developments in conceptualization and measurement have done much to circumvent this. Whilst disagreement may yet be what unites some of those researching this linkage, this disagreement is more about **which** issues within the social support-health linkage should be addressed than any muddied impasse regarding the need for more refined conceptualization and measurement of the 'social support' construct.

Henderson (1984), interpreting the evidence on social support, points out that the generic hypothesis must be broken into several parts since the concept is "a rubric for many conceptually-distinct components." This echoes the words of Brown (1989) mentioned previously who asserts that "social support is a label for something which has many components." The crucial point is,

(a) that provided one makes it quite clear <u>what</u> it is one means by social support - i.e. one has a clear conceptualization of support; and,

(b) that provided demonstrably reliable and valid measures of this specific conceptualization are available or can be developed and tested for acceptable levels of reliability and validity,

then there can be a stronger guarantee that any statements made on this basis will themselves be possessed of demonstrably high degrees of reliability and validity . Certainly any statements made on this basis will have clear referents for a wide audience.

Additionally, since current measures of support assess process as well as structural features (so-called 'network' indices) of the individual's 'support system', by incorporating these measures in this research project a better understanding will conceivably be gained of the "process of adjustment", the lack of which was so forcefully lamented in the review article of Avison and Speechley (1987).

That is, it is important, critical even, that any intending investigation should seek to examine both:

(a) the structural properties of the patients' formal network of family, friends and neighbour support; **yet too,**

(b) the **processes** whereby the person's involvement in and through these structures forms part of a continued, dynamic process of negotiation with his/her social environment. This dynamic process will, itself, contribute in large part to recovery and adjustment on the one hand, and to symptom exacerbation and demoralization on the other. Incorporating social support measures of structure and function will help to address this area of neglect.

3.5.3. OUTCOME CRITERIA.

The series of studies by Lehman et al. (1983; 1986) represented a laudable attempt to provide a more conceptually-rich organizing framework for the study of the community adjustment of the routinely discharged chronic psychiatric patient by advancing the quality of life (QoL) model borrowed from the field of gerontology. These studies, however, lacked theoretical direction and suffered from the same liabilities in measurement and conceptualization as those reviewed by Anthony and Buell (1972), Braun et al. (1981) and Avison and Speechley (1987).

Its failings, then, can be regarded as falling short of those 11 ideal outcome criteria for selecting good measures proposed by the NIMH task force (NIMH, 1986) and presented by Green and Grace (1987). Specifically, these QoL studies fell short on the criterion assigned the highest priority, that, "the measure(s) used should meet minimal criteria of psychometric adequacy, including : a. reliability. .; b. validity...etc.", and a little less so on the 'Objectivity of referents' and 'Theory compatibility' criteria.

The body of research on social support and health goes much of the way toward mitigating these failings. Meeting all eleven criteria - excepting, perhaps, the fourth, that "assuming equal feasibility of obtaining information from various respondents, the measure(s) should reflect the perspectives of all relevant participants in the treatment process" - it scores most strongly on those criteria assigned the highest priority by the task force, namely:

1. An outcome measure (or set of measures) should be relevant and appropriate to the client group(s) whose treatment is being studied; that is, the most frequently observed symptoms, problems, goals, or other domains of change for the group(s) should be addressed by the measure(s); and,
2. The measure(s) used should meet minimal criteria of psychometric adequacy, including : a. reliability. .; b. validity. .; c. demonstrated sensitivity to treatment-related change; d. freedom from respondent bias, and nonreactivity (insensitivity) to extraneous situational factors that may exist (including physical setting, client expectations, staff behaviour, accountability pressures, etc.)

Further examination of the remaining eight criteria will confirm this statement: that the social support construct, incorporated into - indeed forming the backbone of - any intended investigation of psychiatric outcome allows the satisfaction of most, if not all of these 11 'ideal' outcome criteria.

3.5.4. SUGGESTIONS MADE BY THOSE RESEARCHING 'PSYCHIATRIC OUTCOME'.

As made clear many times throughout this introductory chapter, outcome measures as well as the factors studied in relation to these measures have been subject to extensive criticism over the past few years (eg. Rushton, 1990; Sommers, 1988; Thoits, 1986). Rushton (1990) writes, "Disturbingly few adequately designed and conducted trials of alternative care have been carried out, particularly in the UK. We need to capture the complex processes of interaction that are involved."

Additional indicators have been advocated to supplement traditional ones in the hope of better assessing and broadening understanding of the process of adjustment (eg. Anthony et al., 1978) particularly those which are guided by theory, unlike "most of the research on adjustment." (Avison & Speechley, 1987).

Again, it is being claimed that this intended investigation can more adequately address and explore some of these issues: an investigation of the multiple relationships between (what is known as) social support, life stress, personality, and psychological distress in the process of adjustment of short-stay patients to being back home following brief periods of hospital-based care.

It is for these reasons, in attempting to address the original, orienting question - What sources of stress and/ or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital? - that measures of the patient's experience of social support and life adversity should be incorporated alongside, thus supplementing, the more traditional indicators of outcome.

The strength of this type of approach to the examination of the 'community adjustment of the discharged psychiatric patient', will be in its ability to detect changes in each individual's level of social support, experience of life stresses, and change in cognitive and emotional distress over a 6 months follow-up period: changes which will help to explain why some patients will return to the hospital within the 6-month period of investigation whilst others will still be living at home.

This approach will now be examined in chapter two.

CHAPTER TWO:

CONCEPTUALIZATION AND MEASUREMENT OF THE COMPONENTS OF THE FRAMEWORK FOR UNDERSTANDING 'PSYCHIATRIC OUTCOME'.

CONTENTS:

CHAPTER SUMMARY.

The previous chapter served to identify and elucidate the main issues involved in investigating the research question:

What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?

The current chapter has two main functions. **Firstly,** it will identify the difficulties earmarked in the first chapter. Any intending investigation of the problem that does not address these difficulties will be of much poorer quality making any advance in understanding of the problem unlikely. These difficulties consist of the following:

(a) There is no universal agreement about what should be meant by the term ‘adjustment' when referring to patients living back in the community after discharge from hospital.

(b) There is a marked absence in the research domain of a theoretically-formulated, guiding framework within which information can best be organized and understood.

(c) Conceptualizations of the **social** attributes are either global and imprecise or non-standardized across research enterprises giving rise to the difficulty of generalizing findings.

(d) The measurement of attributes frequently does not meet minimal criteria of psychometric adequacy, including reliability and validity. Measures of many of the attributes have been obtained from study-specific instruments designed and developed to assess whatever it is a team of researchers regards as best representing the concept under focus. This difficulty is tied intimately to (c).

The **second** function of this chapter will be to outline and examine in detail the **ways** in which these difficulties will be handled. This will involve providing a clear description of:

(i) what is currently meant by the term ‘adjustment'. This conceptualization of the term, it will be argued, remains faithful to those articulated in previous research enterprises whose concern has been the emotional equilibrium of the discharged patient.

(ii) the research framework considered to best represent the problem-domain under focus;

(iii) the attributes identified and selected for study. That is, statements will be made about the clinical, psychiatric, demographic, social and personality characteristics regarded as best able to improve understanding of what happens to patients once discharged.

(iv) the measurement of these attributes. Details will be provided of measuring instruments. Particular attention will be paid to their psychometric properties and to the appropriateness of each for the current research.

In the course of this chapter each of these problems will be examined and evidence provided in support of the suggested solutions. Each problem will be examined with specific reference to the research question with which each is intimately associated: What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?

In this way, where each specific problem is examined with reference to a specific problem-domain - deinstitutionalization - specific solutions can be identified. It should be noted that those solutions advanced might not necessarily be regarded as the most appropriate in reference to a wider research-domain: no claims are made that the solutions offered are the 'best' **outright**. Rather, the solutions advanced to the problems identified in this research field are designed to provide the most effective means of assessing the specific problem under focus.

1. 'ADJUSTMENT': NO UNIVERSAL AGREEMENT.

1.1. TRADITIONAL INDICATORS OF ADJUSTMENT.

In chapter one a claim was made for the need to formulate more precise conceptualizations of what is meant by 'psychiatric outcome', a term referred to in this research domain as "successful community adjustment". One might validly claim that there is no universal agreement in this field about what constitutes 'successful outcome'. As a consequence, many different indices of outcome have been used, measured using non-standardized measuring instruments, in the hope that they will generate something of why it is that the particular definition of 'community adjustment' has been effected, or not, for any given patient.

From comparatively broad measures of psychiatric outcome which focussed upon the patient's post-hospital adjustment in terms of clinical and other illness-oriented characteristics, there has been a gradual refining of the concept to attempt to embrace the much wider forms of influence in the patient's daily 'community' experience. This refinement is still in its infancy precisely because of the disagreement about what constitutes adjustment, its meaning and so its measurement (Avison and Speechley, 1987).

Various criteria have been used, the most common of which, as cited by Avison & Speechley (1987) are:

1. re-admission during a specified follow-up period;
2. the community tenure of each patient following hospitalization;
3. symptom-level at time of interview;
4. measures of the patient's core role performance, as indicated by various employment indices; and,
5. measures of social adjustment.

These criteria are employed as the dependent variable in previous studies which have examined the question that is being addressed. Typically, each criterion is correlated with each of the attributes selected for measurement. These attributes are regarded as best representing the most salient determinants of that criterion measure. For example, 'length of tenure in the community' is typically correlated against social demographic attributes of the discharged person in order to identify significant, predictive associations. Thus, Sands (1984) in her analysis of the correlates of success and lack of success in deinstitutionalization found that two socio-demographic attributes, age and cohabitation, were the best predictors of success among former outpatients of a community mental health centre, with older people living with others having the longest tenures.

Alternatively, the dependent variable is regressed on a number of independent variables in multiple regression analysis. This technique enables control of the impact of the selected 'independents' on each other ruling out spurious associations between the criterion and its dependents. This method is particularly suitable for prospective analyses of the predictive relationship among a set of independent attributes and the chosen criterion since this controls for the effects of the initial levels of the independents on subsequent improvement or deterioration.

Referring in the previous chapter to the study by Sommers (1988) careful attention was paid to the advances made in the refinement of the independent variable attributes. There has been a movement away from the structural, more rigid and less informative attributes such as age, sex, race, education, previous number of hospital admissions and clinical history employed in seventies and early eighties research towards more clearly refined and conceptualized independent variable attributes. These attributes, since relatively more detailed and precise representations reflecting the perspectives of the persons about whom research questions are asked, more closely approximate the determinants of a process of recovery, maintenance or deterioration for each patient returning home following hospital admission.

In her study, Sommers (1988) found that patients returning to low expectation sheltered accommodations were more likely to stay there for longer periods after hospital discharge. However, former patients living in these settings were also more likely to score poorly on the measures of 'adjustment' developed by Sommers. That is, though ostensibly 'doing well' by staying out of hospital, the people in these accommodations felt badly about themselves, did not engage in health-directed behaviours, engaged very little with others in the community and were less able to fulfill socially-expected roles (Sommers, 1988). This example illustrates that though it is possible to retain the more crude, less informative criteria formerly regarded as best representations of 'adjustment' these criteria are, however, best supplemented by indicators of increasing sensitivity and specificity to patient needs and views (Lehman, 1983; 1986).

These index criteria continue to generate interest for the fundamental reason that when a 'patient' returns to hospital, that is when the patient's tenure in the community comes to an end, s/he is transferred from one locus of treatment and care to another. S/he moves back from the community to hospital. Being readmitted will have implications not only for the patient's health and care but will influence and in turn be influenced by the interests of those intimately involved in the management and delivery of healthcare: the professional carers who provide the service; the health board management teams who plan and coordinate the service; local and national health service policy makers who formulate the service. Put in another way, what matters in the research domain is whether the patient who returns home following discharge can be helped to stay there or whether that patient requires readmission. If the patient is unable to remain in the community s/he will go on to receive care and treatment from a different, geographically-based team of health professionals. That the criterion of readmission to hospital be incorporated in the current research project as a dependent variable is considered essential. The orienting question asks what sources of stress and support precipitate or postpone the patient's return to hospital.

This criterion does not however enable anything of descriptive or explanatory value to be said about the **components** of the process of recovery, maintenance or deterioration which result in continued, increased tenure in the community or readmission. Rather, the return of the patient to the hospital following indeterminate periods back home from hospital can be considered to be **the final step of a process** whereby 'things get so bad' the patient can no longer cope or, alternatively, improvement or stabilization to manageable levels takes place.

This process was described early in the previous chapter by Hoult (1986). He said, "To the staff working in a hospital, a patient's admission is the beginning of a treatment episode, but for the patient and his family, it is the culmination of weeks or even months of increasing suffering **which often could have been relieved much earlier, if help had been available.** Instead, they may be forced to wait, as their distress intensifies, until the patient's symptoms and behaviour are of such severity that admission to hospital, sometimes even compulsorily, becomes the only option."(p.137).

The view taken toward the incorporation of these traditional indicators of psychiatric outcome is similar to that of Avison and Speechley (1987). That is, measures such as readmission and tenure in the community are considered valuable but are representative of many interests other than the patient's and, as such, are only useful when supplemented by additional attributes that are more representative of the patients' recuperative, post-hospital experiences which are likely to impact their experience of psychological distress.

1.2. WHAT IT WOULD BE 'GOOD TO KNOW': FACTORS INDICATIVE OF 'ADJUSTMENT'.

Beyond the traditional indicators of outcome, what other types of information should be drawn upon and considered representative of 'adjustment'? There were seen to be two sources from which information could be drawn. From the review of the published literature on the correlates of psychiatric outcome in chapter one several good predictors of adjustment were identified. These were:

1. the patient's clinical history;
2. the patient's employment history;
3. the patient's clinical symptom profile;
4. the patient's 'social functioning'; and,
5. the social demography of the patient.

The evidence from the review of studies that have examined the relationship between social support and various forms of psychological distress among clinical populations suggests the salience for adjustment of the following predictors:

1. the 'social support' experience of each former hospital in-patient;
2. the stress which they confront in their day to day lives;
3. the patient's style of responding to stressful circumstances. That is, a measure of components of personality: 'powerful emotions' (Brewin, MacCarthy and Furnham, 1989) and attributions of blame and judgements of consensus. (These will be examined in due course).

1.3. READMISSION AND SYMPTOMS OF PSYCHOLOGICAL DISTRESS: DEPENDENT VARIABLES.

The evidence from these two separate domains of research can be seen to share a common focus when one considers the **nature** of the dependent variable to which each refers:

(a) Research on the correlates of psychiatric outcome has focussed on those indicators in a process whose dependent variable 'adjustment' is, in the main, patient readmission to hospital (or its complement, community tenure). The question is ordinarily addressed thus, "What are the factors which correlate with adjustment?".

(b) Interest in the concept of social support, on the other hand, has been generated from research on the aetiology of psychiatric disorders (Henderson, 1988). Research on the influences of social and cultural factors on the origin, development and maintenance of psychopathology has been dominated in the past decade by the role of stress and of factors which modify its influence (Kessler, Price and Wortman, 1985). Support is regarded as one of the central components in an interactive process directed toward the protection of the individual's good health and sense of well-being.

As indicated in the first chapter, this beneficial consequence ('existentially-securing' - Thoits, 1985) of having and being involved in ongoing relationships with people has been attributed in the literature to two not altogether different processes (the "**stress-buffer**" and the "**main-effect**" models - see chapter one, section 3.2.). The dependent variable in this domain of research is psychological distress or well-being - akin to readmission and community tenure in the former domain.

Returning to the orienting question, the precipitation or postponement of readmission is predicated on the presence of psychological distress to levels with which the former patient can no longer contend. Such distress precipitates the return to hospital whose central focus is the treatment of such acute episodes (Wing, 1990). This quite **axiomatic relation** between hospital readmission on the one hand and psychological distress - or psychiatric disorder - on the other has been obscured somewhat within the literature. Thus, distinctions have been made between outcome criteria such as readmission or community trenure and psychiatric symptomatology - and their separate impact assessed - when truly they reflect mutually interactive components in an ongoing process. In their review of the psychiatric correlates of outcome, Avison and Spechley (1987) conclude that psychiatric variables **are** good predictors of outcome, as good as "social, interpersonal and work skills" (Avison and Spechley, 1987).

One of the central concerns of the current research project will be to provide an assessment of the type and severity of psychological distress to which each patient is, by definition, subject. The assumption underlying this emphasis is a quite fundamental one, yet one which must be made where previously it has become obscured. In attempting to address this question - What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital? - there is a quite fundamental assumption:

Patients who develop symptoms of psychological distress (for reasons to be disclosed) will be more likely candidates for return to hospital when that distress becomes unbearable; when it becomes a crisis without apparent means of resolve.

This distress can take many forms but the evidence from the literature on the influence of stress and support on the aetiology of psychological disorders suggests a related assumption:

Those patients bereft of particular forms of support and who during their lives back home meet with adversity will become psychologically distressed. (The origin and development of this distress relative to these indices will be examined in due course.)

Should this distress be prolonged and without any apparent means of resolve (also for reasons to be discussed) these people will be more likely to present, eventually, for help. For many this help will consist of a period of asylum (with a small 'a' - described by Wing, 1990, as "a haven of needed refuge but also a harbour from which to set out again."). This asylum, in psychiatric hospital, will provide the means by which treatment can be effected in terms of 'crisis intervention'. This proposition has been made elsewhere by Hoult (1986). He wrote that the patient "may be forced to wait, as their distress intensifies, until the patient's symptoms and behaviour are of such severity that admission to hospital, sometimes even compulsorily, becomes the only option" (Hoult, 1986, p.137).

In order to provide a comprehensive account of the **components** of this process whose functioning brings about the emergence and either management or deterioration of symptoms of psychological distress it is essential that this issue of **what is meant by distress** be made quite clear. In the following discussion an attempt will be made to provide an account of:

(1) the current conceptualization of psychological distress;

(2) the reasoning behind this conceptualization;

(3) the linkage between the experience of psychological distress and readmission; and,

(4) the measuring instruments that will provide an index of psychological distress.

1.4. WHAT IS PSYCHOLOGICAL DISTRESS?

Within the course of this section the careful distinction will be made between the experience of psychological distress on the one hand, and the roots or causes of distress on the other. The experience of distress can be viewed as a dependent or 'outcome' variable whose 'roots' or 'causes' (or correlates) are the equation's independent variables.

It has been argued that this outcome has traditionally been conceptualized as readmission, or its complement, community tenure. This, in turn, is predicated on the experience of various forms of psychological distress which have grown intolerable. It will be argued within the course of this section and the next one on 'life events' that, "human misery, of which psychological distress forms a significant part, does not crop up, as it were, *within* individual people, but arises out of the interaction of people with each other and from the nature of the world we have created." (Smail, 1987, p.1). It is toward an examination of the nature of this psychological distress that emphasis will now shift. Throughout the course of this section clear reference will be made to the published work of Mirowsky and Ross (1989) and Berscheid (1983) which deals with this issue.

1.4.1. THE EXPERIENCE OF 'PSYCHOLOGICAL DISTRESS'.

The first argument to be made is that psychological distress consists primarily of a state of emotional disequilibrium. This disequilibrium will be maintained whenever sufficient, explanatory cause for the emotional arousal is either currently not available (that is, it is unavailable to consciousness - Smail, 1987) or is available but results in a continued sense of what Spence (1982) terms "dissatisfaction": a dissatisfaction with the "narrative truth" of one's experience. In this latter case, Spence (1982) defines "narrative truth" as the "criterion we use to decide when a certain experience has been captured to our satisfaction; it depends on closure, continuity and on the extent to which the fit of the pieces takes on an aesthetic finality. . .Once a given construction has acquired narrative truth, *it becomes just as real as any other kind of truth.*" (Spence, 1982). In other words, whenever emotional disequilibrium is experienced attempts are made to find reasons for and solutions to such disequilibrium. This emotional disequilibrium is defined by Mirowsky and Ross (1989) as "unpleasant subjective states which have emotional and physiological manifestations". That we 'tell' or 'convince ourselves' that the cause of the distress is one thing or another, irrespective of the real reasons (should they be identifiable), has telling impact on the management of this disequilibrium. The claim is, however, made that the person will attempt to attribute or 'capture' the meaning of this emotion: however appropriate or not this might be. Where the experience is "captured to our satisfaction" so equilibrium in the emotions is promoted. "We act and feel rationally according to the circumstances and indeed our interests. To say that we act rationally is not to say that we act necessarily correctly or sensibly, but simply that we have reasons for what we do which follow from our experience of the world and our bodily relation to it" (Smail, 1987, p.75).

Psychological distress, then, is conditional upon a state of emotional disequilibrium. There is "a disturbance of the emotions that affects thinking and action" (Lavender and Holloway, 1988). "These experiences," Lavender and Holloway (1988) continue, "have, within the medical tradition, been defined as symptoms, and certain patterns of symptoms have been identified to which particular diagnostic labels have been attached." It is not the intention of this chapter to concern itself too greatly with the rights and wrongs of labelling, that is, with the place of psychiatric diagnosis in the treatment of those suffering from symptoms of psychological malaise. (This malaise brought about not, it is argued, through any inherent 'weakness' or 'disease' within the person, but as an inevitable and reasoned response to the many conditions which obtain in the life of that person.)

A clear statement, therefore, is called for of the current conceptualization of psychological distress that will be observed and measured to form one of the central dependent variables in this research project. In doing so, it is considered essential that reference be made to the comparable process of diagnosis.

1.4.2. CLINICAL DIAGNOSIS IN PSYCHIATRY.

The New Collins English dictionary (1982) defines diagnosis as, "the identification of diseases from the examination of symptoms." The role of the psychiatrist is to detect the presence of an entity, determine its species and in doing so select an appropriate pharmacological substance against it. Mirowsky and Ross (1989) argue that such a conceptualization of psychological problems as discrete entities is "a legacy of nineteenth century epidemiology and microbiology, according to which a person is diseased or not" (p.27). They continue, "Psychiatry has come to equate categorical assessment with true science. The method of research and the form of ideas in nineteenth century epidemiology and microbiology are built into the official language of medicine, and if psychiatry is medicine, then it must use the official language. Instead of shaping the methods and language of psychiatry to suit its **dimensional and graded subject**, psychiatrists and psychiatric epidemiologists insist that there must be discrete entities hidden in the shades of psychological problems" (Mirowsky and Ross, 1989, p.29).

These authors introduce the term "reify" to illustrate that by referring to any abstraction as if it had a material existence one commits , "the fallacy of misplaced concreteness" (Srole and Fischer, 1980). Effectively, their argument is that the entities 'clinical depression' or 'schizophrenia' are not real in the way that the person who feels bad is real, or the person's feelings are real: "The shape of the pigeon hole is mistaken for the shape of reality" (Mirowsky and Ross, 1989). Whether this view is essentially right or wrong - or correct or incorrect - is a matter for continued debate. However, what this study will not concern itself with is the issue of diagnosis: whether or not any patient possesses the sufficient number of symptoms of sufficient severity which meet the cut-off criteria for a particular categorical disease-entity. This is not to side-step the issue altogether. Psychological distress is thought to be best conceived as a state or states of emotional disequilibrium, together with the thoughts about these states, which "arise out of the interaction of people with each other and from the nature of the world we have created" (Smail, 1987). There is no allusion to distress as so-called disease or 'mental illness'.

These, then, are some of the reasons for removing this investigation from a consideration of distress in terms of disease entities and so of the need to diagnose. There is considered to be no real need for the provision of diagnosis in this research project. Instead, the project tends toward the view that such labelling,

(1) "often obscures the nature of the difficulty. . ; and,

(2) . .has serious consequences on individuals' lives in terms of their own and others' expectations." (Lavender and Holloway, 1988).

Diagnosis can be viewed as a four-stage process (Mirowsky and Ross, 1989). **Assessment** of the amount of symptoms together with the duration of the difficulties and the depth of the functional impairment is the first stage. The second involves **splitting** this amount at some arbitrary cut-off point, "so that differences in degree are collapsed into two discrete categories: amounts that meet the criterion and amounts that do not" (Mirowsky and Ross, 1989). The third stage involves **adding up** such that every possible combination of met/ unmet on the three criteria are represented in a single overarching split. Finally, cases are **excluded** that are considered to meet other criteria external to the 'disease-entity' (such as recent separation or unemployment).

Were the central focus of this research the identification and examination of the causal factors in the development of psychiatric disease-entities then an appropriate and necessary stage of this process would have been the incorporation of a standardized interview, "which would yield something approaching a diagnosis according to internationally used criteria" (Henderson, 1988). Any other approach would have violated quite fundamental principles and standards within this research domain. However, this is not the current concern. Rather, it is the **nature** of the psychological distress which renders intolerable the continued existence of the former patient back in his/her community. Incorporating measures whose purpose is the identification and classification of psychiatric disorders in diagnostic terms precludes the means of being able to detect subtle changes in the psychological distress of the person **over time**. A categorical assessment which "splits the information (on emotional distress) into a crude yes or no distinction" does not allow for the assessment of these subtle and what is regarded as **crucial** changes in psychological distress over time. Some of these changes, it is argued, will "help to precipitate or postpone the patient's return to hospital." Within this context it is considered equally inappropriate not to use measuring instruments which assess the continuous change in symptoms along a **dimension** of psychological distress.

1.4.3. A DIMENSION OF PSYCHOLOGICAL DISTRESS.

In this way, our emphasis is aligned with those who:

(a) construe psychological distress along a dimension of well-being through excessive "demoralization and distress" (Dohrenwend, Bruce, Shrout, Egri, and Mendelson, 1980); and who,

(b) consider psychological problems in terms of their **type** and **severity**. "Each type of problem ranges from not at all severe to very severe on a continuum. People score at all points on the continuum. . .from very few symptoms to many symptoms. People get a severity score for each *type* of *psychological problem*" (Mirowsky and Ross, 1989).

1.5. THE EXPERIENCE OF PSYCHOLOGICAL DISTRESS: INDIVIDUAL UNIQUENESS.

It is considered quite essential that an assessment be made of the type and severity of each person's experience of psychological distress which represents in large part the patient's **own** views of their distressing symptoms. Whether people have access to the reasons or causes which underly their sense of "demoralization and distress" (Dohrenwend et al., 1980) is a matter for debate in which no clear conclusions can be drawn. However, what the person regards him/herself as suffering from - the symptoms of distress with which s/he is bedevilled and which connote deeper psychic disturbance - is the issue of concern at this juncture. This issue is a complex one and critical:

(i) where the likelihood of hospital readmission is considered contingent upon such distress; and,

(ii) where one of the central dependent variables in the research project will be each patient's experience of 'psychological distress'.

An individual's self-report of events can only necessarily draw upon what appears in consciousness (Berscheid, 1983; Laing, 1967). The cognitive-emotional theorist Mandler (1975) writes that, "Events and objects in consciousness can never be available to the observor without having been restructured, reinterpreted, and appropriately modified by structures (unconscious cognitive structures of which we are unaware) that are specific to the individual doing the reporting" (Mandler, 1975, p.51). He continues (quoted from Berscheid, 1983), "People's reports about their experiences, their behaviour, and their actions are very frequently, and may always be fictions or theories about those events" (Mandler, 1975). An outline of Mandler's (1975; 1983) theoretical framework for construing human emotion will be presented in due course. It should be noted that his statement reinforces that quoted earlier by Spence (1982) on the subject of 'narrative truth'. That is, people attempt to find acceptable, "satisfactory" reasons for the way they feel. The reasons they come up with might not be the 'right' or 'correct' ones, but these reasons will determine the nature of the emotional response thereof. Their reasons might also only seem sensible and plausible to themselves. It is their own reasoning, however, which determines their subsequent response. MacMillan summarises these arguments thus:

> "If we are hooked on the discovery of 'historical' truths and unearthing 'how things really were', this must feel like very slippery ground. But when we are dealing with the meaning of a person's life, and his or her past, we can only have **interpretations** that vie for credibility in accounting for the known events of a life, and in relation to other possible interpretations. We rarely have access to objective criteria or to an independent perspective, that can stand outside the push-and-pull tensions of beliefs, needs, and desires, and **within the interplay of which our own personal truths are mapped out**. As Paul Ricoeur (1985) says: 'It makes little difference whether (the stories we tell) are true or false, fiction as well as verifiable history provides us with an identity' " (MacMillan, 1989, p.25).

David Smail (1984; 1987) provides an account of the embodied nature of our experience of psychological distress which serves to examine, and suggests an explanation of, "the issue of concern at this juncture", namely, what the person regards him/herself as suffering from - the symptoms of distress with which s/he is bedevilled and which connote deeper psychic disturbance. It is worth quoting Smail (1987) at some length.

He writes:

> "We experience the world through our bodily engagement with it, and our conduct is for the most part (Miller, 1990, and Rowe, 1991, say "is always") the rational product of the physical structures of our bodies on the one hand and the social structures and exigencies of the world on the other. We can, it is true, pretend that the world is not as it is, and that our experience of it, especially when painful, is other than what we feel, and it may be that such pretence may become the norm, but in fact we cannot escape our suffering. However much we mystify our understanding and deceive ourselves about the meaning of our experience, there is in the last analysis absolutely no way in which we can avoid the consequences of being bodies within a world, and knowing (even if we cannot say) what it is like to be such. . . However ingeniously we may play with words, seek to create objectivities on the one hand or relativities and perspectives on the other, we all know what it is like to **feel** cold, just as we bleed if you prick us. The 'truth', such as it is, of our situation lies, then, not in the discovery of some absolute reality beyond ourselves, nor in the constructions of our infinite ability to dream alternative worlds, but in the experience of the inescapable relation between our bodies and the context which envelops them." (Smail, 1987, pp. 74-75).

Thus, no matter how hard we try to "capture to our satisfaction" the 'narrative truth' of the reasons for our current state of distress, where these reasons are **unsatisfactory** we cannot escape the feelings of distress which are an inevitable consequence of "being bodies within a world." For it is within our bodies that we first recognize - since emotionally aroused in some way - that things are not quite right. "My unhappiness," Smail (1987) continues, "seems to *stem* from *inside* myself because that is where I *feel* it." It follows that any felt and recognized 'symptom' of distress is symptomatic of just this "rational product of the physical structures of our bodies. . and the social structures and exigencies of the world" (Smail, 1987). Since the 'rational product' of this relation between body and context is **felt** as suffering of some kind - as symptoms of distress - so there must be conflict or what Mandler (1983) has termed "interruption": something is not quite right. The experience of being emotionally aroused alerts us to the possibility that conflict or interruption might be present. The persistence of the emotional arousal will lead to the experience of distress. These feelings will persist for the reasons remarked upon much earlier in this chapter. To recap, it is argued that emotional disequilibrium will be maintained whenever sufficient, explanatory cause for the emotional arousal is either currently not available (unavailable to consciousness - Smail, 1987) or available but results in a continued sense of what Spence (1982) terms "dissatisfaction": a dissatisfaction with the "narrative truth" of one's experience.

The **experience** of distress, then, is an "individual matter" (Smail, 1987). The real reasons, or **sources**, for this distress are not, however, necessarily "individual matters". They are a function of our bodily engagement with the world: a world over which individuals, no matter how ingenious they might be, ultimately do not have complete control. The reasons we provide or construct for our distress are, however, unique to the individual: they are "individual matters." The **reasons** we have are reasons found through a process of "cognitive evaluation" of the meaning of the emotional consequences of "external events or stressors" (Mandler, 1983). It would therefore make logical sense to derive measures of these two determinants of the person's distress experience, an experience that will render hospital readmission more likely when sustained. That is, it would be logical to obtain measures, (i) of each person's experience of symptoms of psychological distress, and, (ii) of each person's account of the conditions that surround this distress. This will be particularly appropriate when considering such distress to be the "rational product" (Smail, 1987) of our bodily engagement with the world. Smail (1987) continues,

> "Having for some years now watched, as attentively as I am able, people (including myself) struggling to feel and act differently from how they do feel and act, I am convinced that feeling and acting are far from being matters of will, but are, as it were, held in place by the situation in which people find themselves - unless, that is, the person is in some way impelled to act contrary to reason. This is not to say that people's conduct is determined by their environment, but rather that they conduct themselves the way they do for good reasons. Determinism fails when applied to human conduct not so much because it is wrong as because it is logically inappropriate when applied to conscious beings: there is no conceivable situation in which human beings could have full knowledge of their circumstances and yet still be completely determined by them, and for this reason determinism becomes of no further relevance to psychology. On the other hand, this does not mean that we are free to do what we like or to feel what we want or think we ought to feel. We act and feel rationally according to our circumstances, and indeed our interests. To say that we act rationally is not to say that we act necessarily correctly or sensibly, but simply that we have reasons for what we do which follow from our experience of the world and our bodily relation to it" (Smail, 1987, p.75).

Provided that a measure of each patient's experience of psychological distress can be obtained which reflects, at least, the 'contents of their consciousness' of this experience then, it is contended, it is possible to grow closer to a valid and meaningful appraisal of the nature and content of this subjective distress within the context of this study. This distress is considered to "precipitate" hospital return when it becomes intolerable, or to "postpone" this need whenever the distress is kept within tolerable levels (Hoult, 1986).

Within the confines of the research question it doesn't matter that patients do not have access to the 'real reasons' for their distress. What does matter, and this is a quite critical point, is that the person 'thinks' they feel in this way or that; that they consider themselves to be, for example, sad, anxious, depressed, overly active, lonely, conspicuous in groups of people, or evil and unworthy people. For it is the accumulation and persistence of these thoughts and feelings which, without any hope or means of their satisfactory resolve, will make a period back in hospital much more likely since leading to states of demoralization, despair and attempts at suicide.

1.5.1. SUBJECTIVITY AND STANDARDIZED ASSESSMENT TOOLS.

Such an assessment of distress does, however, depend on the 'good faith' (Mair, 1989) of the 'self-reporting' patient: a process of no less importance when assessment is being made with a standardized interview technique such as the Present State Examination (PSE) developed by Wing, Cooper, and Sartorius (1974). The Diagnostic Interview Schedule (DIS) developed by Robins, Helzer, Croughan, and Ratcliff (1981) is an example of another such standardized interview instrument. It was developed for the large Epidemiologic

Catchment Area studies in the U.S. (Reiger and Burke, 1988). Interviews of this kind are standardized in that "the questions asked and the observations on behaviour are not left to the idiosyncracies of the interviewer. Variability in this can be greatly reduced, **though not completely**, by trying to ensure that interviewers behave in the same way, wherever in the world the instrument is being used. Inevitably, some differences are likely and this source of variance has to be accepted and allowed for" (Henderson, 1988, p.24). What is missing from Henderson's (1988) summary of the nature of these 'standardized interviews' is an acknowledgement of the role of the person whose thoughts and feelings are being noted for diagnosis. This despite the fact that **"observer" ratings of symptoms** "made on the basis of behaviour, affect and speech observed during examination (with the PSE) **are**, on the whole, **less reliable than those of subjectively described symptoms**" (Wing et al., 1974).

With standardized interviews each patient is asked questions the responses to which dictate the type of score the examiner provides for him/her. These scores are then added up to see whether or not a specified cut-off point has been reached. If it has, then the person being rated is considered to have the symptom under examination. Symptoms are then classified according to rules for the combination of syndromes in order to produce a number of descriptive categories. Wing et al. (1974) continue: "One patient may be allocated up to six of these, each with an appropriate degree of certainty, although usually only two or three are used. A patient allocated six categories would have shown an extremely mixed clinical picture, different elements of which would allow designation as schizophrenic, manic, depressed, anxious, hysterical and obsessional. Usually one of these categories would be more 'certain' than the others."

Most relevent to the current argument concerning the nature of the patient's subjective distress and of the legitimacy of relying on what they say they are feeling, however, is Wing et al.'s (1974) final instruction on the use of the PSE. They caution that, "It should be emphasised that using the PSE schedule will not in itself guarantee useful results. The quality of the output of any system depends on the *quality of the input.*" (Wing et al. 1974). When one adds to this their observation of the greater reliability of subjective assessment of distress relative to objective assessment in their schedule then it should become quite clear that by listening and noting down what the patient considers to be the matter is a legitimate and essential activity. However, whether using a standardized interview schedule such as the PSE (Wing et al., 1974) or a self-report checklist such as the General Health Questionnaire (GHQ) developed by Goldberg (1972; 1978) there remains a reliance on what the person believes to be the matter with him/her. Standing alone, without the presence of an interviewing psychiatrist, psychologist or epidemiologist, the self-report checklist method of obtaining measures of the patient's distress provides conditions more germane in which the person responding may do so in bad faith (dishonestly) or haphazardly. It is **not** to say that with the presence of someone else, enabling the formation of a dialogue between the two people, that such 'checklist' measures would **not** provide useful information about the patient's experience of distress. **Nor** is it to say that the presence of someone else - such as with the PSE - necessarily rules out the possibility of dishonest or haphazard responding. Standardized assessment of the presence of symptoms of psychological distress does not preclude the role of the person being rated or diagnosed.

1.5.2. LEGITIMACY OF SELF-REPORTS OF PSYCHOLOGICAL DISTRESS.

There is no fullproof method of ensuring that the symptoms experienced by the patient and which have been elicited actually reflect an honest appraisal of the 'contents of consciousness'. One can only depend on the "good faith" (Mair, 1989) of the person responding to the questions asked of him/her. That is, one must depend on the person's honest appraisal of what that person thinks is wrong with him or her.

However, there are two methods, and perhaps more, by which the legitimacy of the patient's complaints can be verified, albeit in less than full-proof fashion:

1. Firstly, patients' reports of their current experience of psychological distress can be verified against the clinical notes taken in the course of the patient's initial interview by the admitting psychiatrist. Extensive notes on each patient's day-to-day experience on the ward and on their previous clinical history can be obtained from medical records and from the daily up-dated kardex notes kept on each patient as a means of continuous monitoring. These two types of information should be quite similar in content.

2. Secondly, the **consistency** of each patient's reporting of symptoms of psychological distress can be examined. This involves analyzing all instruments that measure psychological distress to identify those items that are, across measuring instruments, exactly the same. Thus, across 2 or 3 different measuring instruments there will be 3 or 4 items which measure exactly the same feeling or perception or cognition. In this way, whenever one of the group of 3 or 4 items all measuring the same experience is positively endorsed so all 4 items should be similarly endorsed **whenever that person is being consistent.** Whilst this method does not preclude the possibility of consistently responding in bad faith it is, however, regarded as a good means by which the legitimacy of patients' responding to questions can be examined. The assumption is that where patients are seen to be consistent in their responding this can be interpreted as evidence for the legitimacy of their reports of the contents of their consciousness of these matters. That is, patients who are consistent in their reporting of the type and severity of their experience of psychological distress are not considered to be consistently responding in bad faith/dishonestly. Although it might be possible that people could be consistently dishonest nevertheless it is considered unlikely.

However, where inconsistency is evidenced the conclusions to be suggested are quite different. Such inconsistency might reflect:

1. the complete disorganization of the thoughts and consciousness of the person being interviewed, such that they are unclear about how they feel from moment to moment;

2. the bad faith of the patient. That is, items are responded to in a haphazard way - 'throwaway' statements are made in relation to each item.

This possibility that patients will be inconsistent in their responding will remain. However, there is a simple method by which such inconsistent responding can be checked. Whenever an inconsistent pattern of responding seems likely during the course of a formal interview each patient can be questioned as to their reasons for doing so. In this way, the assessment of the psychological distress experience of each patient can be construed as a process of interaction between the interviewer and interviewed - a process, dialogue, or transaction which goes puzzlingly unacknowledged within the research domain. This assessment does not **guarantee** honesty or legitimacy, it merely makes it more likely.

1.6. A RECAP: PSYCHOLOGICAL DISTRESS AND READMISSION.

1. Psychological distress is born of a state of emotional disequilibrium. This disequilibrium takes many forms. When it goes unresolved this distress can have considerable consequences leading to acute discomfort and to forms of thought disorder. The prevalent forms of thought or cognitive disorder - i.e., forms of reflection upon the nature and meaning of this emotional experience - among a psychiatric population are described by Lavender and Holloway (1988). These include:

"(1) a strong feeling that people with whom you come in contact are against you and are plotting, sometimes with elaborate means to keep you under surveillance;

(2) a distressing experience, such as hearing arguing voices or seeing images that nobody else can see or hear;

(3) a strong belief in an idea or an explanation about events in your life that others neither believe nor understand;

(4) a feeling of great despair out of which it seems impossible to break;

(5) a feeling of the greatest optimism and belief in yourself that seems to others completely unjustified by your circumstances and that seems to be often followed by deep despair;

(6) a feeling of severe isolation from other human beings where any contact becomes a painful experience to be avoided.. .From a sufferer's point of view the experience is that of a disturbance of the emotions that affects both thinking and action." (Lavender and Holloway, 1988).

2. There is no concern with making a diagnosis. Instead, distress is construed as a continuum from states of well-being to complete demoralization. Each patient gets a **score** on a continuous variable rather than receives a categorical 'is' or 'isn't' on a diagnostic entity. This, (a) allows for the assessment of distress over time which enables examination of the **changes** in the distress experience; and, (b) is particularly suitable for studies which necessitate the use of the prospective longitudinal research design.

3. Assessment will focus on the patients' own views of what they consider to be the matter with them.

1.7. HOW IS THIS PSYCHOLOGICAL DISTRESS TO BE MEASURED?

It is not the concern of this research project to obtain measures of the positive components of subjective well-being. This obviates the use of measures of subjective well-being such as The General Well-Being Schedule

(Depuy, 1978), the Delighted-Terrible scale (Andrews and Withey, 1976), or Bradburn's (1969) Affect Balance scale (from Deiner, 1983). Neither is the interest in diagnosis. This rules out the use of standardized psychiatric interview methods designed to yield diagnosis such as the Present State Examination (PSE) of Wing et al. (1974) or The Diagnostic Interview Schedule (DIS) developed by Robins et al. (1981). The concern, instead, is with the continuous experience of psychological distress manifest in many types of symptoms to which all patients will, by definition, be subject. The instruments of choice in this context are those which provide index measures of symptoms which can be scored on a continuum from the complete absence of negative emotion to severe experience of "dread, anxiety, sadness, hopelessness, worthlessness, enervation, guilt, distraction. . interchangeable indications of demoralization and distress" (Dohrenwend et al., 1980).

1.7.1. MEASURES OF PSYCHOLOGICAL DISTRESS: DIMENSIONAL MEASURING INSTRUMENTS.

Within the U.K., the most widely-used instrument of this type in psychiatry is the General Health Questionnaire (GHQ) developed by Goldberg (1972; 1978) and described by Goldberg and Williams (1988). This scale was originally devised in a 120-item format, subsequently modified to provide four separate forms: the 60, 30, 28, and 12-item forms. It is a self-report questionnaire directed toward the detection of functional psychiatric disorders in the community and primary care settings. The scale has been extensively tested in various cultures and linguistic groups (Harding, 1976; Henderson et al, 1981; Hodiamont, 1986). It has been demonstrated to be superior to other screening instruments, such as the Hopkins Symptom Checklist (Derogatis et al., 1974) and the Langner Scale (Langner, 1962).

There are several measuring instruments for the detection of symptoms of psychological distress which are quite similar to the GHQ. Among instruments of the same general type are:

1. The Beck Depression Inventory (Beck, 1967);
2. The Zung Self-Rating Depression Scale (Zung, 1965);
3. The Delusions-Symptoms-Signs Inventory (Bedford and Foulds, 1978);
4. The Hopkins Symptom Checklist-90 (Derogatis, Lipman, and Covi, 1974).

1.7.2. ADVICE ON THE SELECTION OF MEASURING TOOLS - Henderson (1988).

Henderson (1988) offers advice on the selection and use of measuring instruments of psychological or psychiatric distress. He writes, "The choice of instrument should be made after consulting experienced researchers and clarifying the exact purpose of its use." This advice was followed. An experienced top-grade clinical psychologist was consulted on the feasibility and appropriateness of several of these types of instruments for use with the population of former psychiatric patients on whom our research question is focussed.

Henderson (1988) continues, "Often it is wise to use more than one instrument. This provides wide coverage of symptoms and levels of severity. It also reduces 'measurement error', which becomes important in recently developed statistical analyses, such as structural equation models. In these, it is assumed that all instruments for measuring, say, depression, carry a certain amount of error, and that the construct of depression is latent and cannot itself be directly observed or measured. If one has several measures of the construct, one is able to calculate a more accurate estimate of it." (Henderson, 1988). This led to the selection of three instruments that provide a measure of the experience of psychological distress. These will be described shortly. The decision to use three types of measuring instrument also reflects the concern with being able to identify whether or not people are being consistent in their responding. There will be identical questions across the three instruments. These items can then be grouped together and the consistency of individuals' responding within these groups tested in post-hoc fashion.

1.7.3. MEASUREMENT OF PSYCHOLOGICAL DISTRESS: THE INSTRUMENTS.

Within the course of this section, a careful attempt will be made to provide a description of three features of these measuring instruments. Firstly, each measure will be described in terms of its origin and development together with an account of the criticism it has drawn. Secondly, the constructs measured by each instrument will be described, together with details of their psychometric properties such as reliability and validity. Finally, a summary description will be provided of the reasons for the use of each instrument in this research project.

1. THE GENERAL HEALTH QUESTIONNAIRE - 30 (GHQ-30)

The General Health Questionnaire (GHQ; Goldberg, 1972, 1978) is a self-report questionnaire directed toward the detection of functional psychiatric disorders in the community and primary care settings. There are several versions of the GHQ developed by Goldberg (1972): the long form (140 item) version, and several shorter forms: the GHQ-60, GHQ-30, GHQ-28, GHQ-20, and the GHQ-12.

The 30-item was derived from the original 60-item version by excluding symptoms that were commonly present in subjects with entirely physical illness. It focusses more on psychological and psychosomatic symptoms rather than somatic symptoms (Huppert et al, 1989). The reliability and validity coefficients show a gradual fall with progressively shorter versions of the questionnaire, although even at a length of only 12 items they are still surprisingly high (Goldberg et al., 1972).

It has been demonstrated to be superior to other screening instruments such as the Hopkins Symptom Checklist (Derogatis et al., 1974) and the Langner Scale (Langner, 1962). The GHQ does, however, have several shortcomings. False positives, for example, may be generated through endorsement of some items by mentally healthy individuals who have a physical disorder. Long-standing symptoms can thereby be missed through the respondents' correctly recording no recent change.

1. Basic constructs measured by the GHQ-30.

Huppert and her colleagues (1989) carried out factor analyses of the GHQ-30 on the understanding that given the comprehensiveness of behaviours covered by the scale it would be possible to derive subscales each concerned with a particular type of symptom. It would follow that scores could subsequently be calculated for each individual on each of these subscales. Their results indicated an impressive degree of consistency of the factor structure, and the identification of five distinct factors. These factors were considered to correspond to: anxiety, feelings of incompetence, depression, difficulty in coping, and social dysfunction. In addition, a global rating of psychiatric disturbance and a global rating of chronicity of disturbance is produced.

2. Reasons for inclusion in the study.

The 30-item version of the GHQ focusses on the psychological and psychosocial symptoms of psychiatric disturbance. It covers symptom areas such as psychophysiological symptoms and minor affective disorder - like the SCL-90 - but also contains items dealing with role satisfaction and outwardly observable behaviour. The main difference between the GHQ-30 and, for example, the SCL-90 lies in their different response scales and scoring procedures: scores ranging from between 0 and 30 with the GHQ, and 0 - 360 with the SCL-90.

Though similar to the SCL-90, there are obvious differences between the two with respect to screening capacity and type of clinical information detected. It was for this reason a decision was taken to include the GHQ-30 as a measure of both global psychological distress and of the nature of this disturbance as measured on the five factors of disturbance identified by Huppert et al. (1989). The scoring format of the GHQ-30 is also amenable to the type of longitudinal analysis required by the current investigation. Baseline measures of distress can be compared with any changes identified at follow-up assessment. Finally, the GHQ-30 was originally tested and calibrated with British populations, unlike the SCL-90 - an American scale which has, nonetheless, been tested with British subjects and found to demonstrate high degrees of reliability and validity (Wilson et al., 1985).

2. THE SYMPTOM CHECKLIST-90 (SCL-90).

The Hopkins Symptom Checklist-90 (SCL-90) is a 90 item self-report clinical symptoms rating scale oriented toward the symptomatic behaviour of psychiatric outpatients. It is comprised of 90 items which reflect 9 primary symptom dimensions believed to underly the majority of symptom behaviours observed in this class of patient. Each item is rated on a 5-point scale of distress (0 to 4) from 'not at all' through 'a little bit', 'moderately', 'quite a bit', to 'extremely'. In addition to the scores derived on the 9 symptom dimensions, the scale also provides three global indices of pathology.

Although a 'new' scale, the SCL-90 may be accurately described as having evolved from the Hopkins Symptoms Checklist (HSCL). The HSCL is a self-report instrument which has been used in various forms for over a decade, with data available on thousands of patients (Derogatis et al., 1974). Several factor-analytic studies of the HSCL have been completed in which five clinically meaningful dimensions were isolated (encompassing the first 5 dimensions of the SCL-90). The SCL-90 incorporates these five together with the four additional dimensions of psychiatric disorder to provide a broader, more adequate representation of the outpatient symptom domain (Derogatis, Lipman and Covi, 1973).

1. Basic constructs measured by the SCL-90.

Of the 90 items that constitute the SCL-90, a small number fall outside the principal dimensional framework. These items refer primarily to disturbances in appetite and sleep. The majority of items go to make up nine dimensions that cover major psychiatric symptom behaviours.

The nine symptom dimensions measured by the SCL-90 and described by Derogatis et al. (1973) are:

1. **Somatization**: The items comprising this dimension reflect distress arising from perceptions of bodily dysfunction. Complaints focussed on cardiovascular, gastrointestinal, respiratory, and other systems with strong autonomic mediation are included. Headaches, backaches, and pain and discomfort localized in the gross musculature are also represented, as are other somatic equivalents of anxiety.

2. **Obsessive-Compulsive**: These items reflect behaviours that are closely identified with the clinical syndrome of this name. The focus of this measure is on thoughts, impulses and actions that are experienced as unremitting and irresistible by the individual but are of an ego-alien unwanted nature. Behaviours indicative of a more general cognitive difficulty (e.g., mind going blank, trouble remembering) also load on this dimension.

3. **Interpersonal Sensitivity**: The symptoms that are fundamental to this factor focus on feelings of personal inadequacy and inferiority, particularly in comparison with other individuals. Self-deprecation, feelings of uneasiness, and marked discomfort during interpersonal transactions are characteristic of persons with high levels of IS. Feelings of acute self-conciousness and negative expectancies regarding interpersonal communications are also typical sources of distress.

4. **Depression**: Symptoms of dysphoric affect and mood are represented, as are signs of withdrawal of interest in activities, lack of motivation and loss of vital energy. The dimension mirrors feelings of hopelessness and futility as well as other cognitive and somatic correlates of ‘depression', and several items are included concerning suicide ideation.

5. **Anxiety**: The anxiety dimension is comprised of a set of symptoms and behaviours associated clinically with high manifest anxiety. General indicators such as restlessness, nervousness and tension are represented, as are cognitive signs of anxiety. Symptoms reflecting free-floating anxiety and panic attacks are also included.

6. **Hostility**: The hostility dimension reflects thoughts, feelings or actions that are characteristic of the negative affect state of anger. The item selection is representative of all three modes of manifestation and reflects qualities such as aggression, irritability, rage, and resentment.

7. **Phobic anxiety**: This is defined as a persistent fear response to a specific person, place, object or situation which is characterized as being irrational and disproportionate to the stimulus and which leads to escape or avoidance behaviour. The items of the present dimension focus on the more pathognomic and disruptive manifestations of phobic behaviour.

8. **Paranoid ideation**: This is represented fundamentally as a disordered mode of thinking. The cardinal characteristics of projected thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy, and delusions are viewed as primary reflections of this disorder.

9. **Psychoticism**: This scale was developed in a fashion to represent the construct as a continuous dimension of human experience. Items indicative of a withdrawn, isolated, schizoid lifestyle were included, as were first-rank symptoms of schizophrenia, such as hallucinations or thought broadcasting. The psychoticism scale provides a graduated continuum from mild interpersonal alienation to dramatic evidence of psychosis.

The dimensional structure of the scale was factor analysed by Derogatis and Cleary (1977) to compare the hypothesized nine-dimensional clinical-rational structure with the dimensional structure developed empirically. They found excellent agreement for the dimensions of: Somatization, Hostility, Obsessive-Compulsive, and Depression. Interpersonal Sensitivity, Anxiety, Paranoid Ideation, and Phobic Anxiety were each observed to have very good agreement (Derogatis and Cleary, 1977). The final dimension - Psychoticism - when factor analysed revealed a somewhat less homogeneous pattern of agreement.

There are three additional measures derived from the SCL-90 (mentioned in the previous section), namely, the summary indices of distress: 1. The General Symptomatic Index (GSI); 2. The Positive Symptom Distress Level (PSDL); and, 3. The Positive Symptom Level (PSL).

2. Reasons for inclusion in the present study.

The nature of the current investigation required that a measure be derived of the degree of psychological upset in patients over a period of time. The SCL-90 was selected for inclusion for a number of reasons. There was a need to produce an index of psychogical well-being that would be sensitive to change across a period of time (in this instance, six months). Each patient's experience of psychological distress could then be monitored from a baseline assessment obtained just before discharge. Subsequent assessments could reveal the degree of change occuring over that period. The SCL-90 was considered most suitable for this purpose. The scale provides measures of the presence or absence of symptoms; scores these symptoms on a rating scale from ‘not at all', through ‘a little bit', ‘moderately', ‘quite a bit' to ‘extremely', and provides a global index of overall symptoms present together with their severity.

A third reason is its additional capacity to gauge the multidimensional nature of psychological disorder. Though conceptualizing emotional disorder as a continuum from levels of well-being to extreme distress, it is, nevertheless, acknowledged that particular symptoms cluster in noticeably consistent patterns: each of which can be expressed as a continuum of severity. Two of the most prevalent forms of symptomatic reaction to stress are anxiety and depression. By adopting this scale, identification and classification of symptoms is made possible. This will enable assessment and comparison of both level and type of distress precluding any diagnostic classification in the population under investigation: short-stay psychiatric patients discharged from the short-term assessment ward of a psychiatric hospital.

3. THE BECK DEPRESSION INVENTORY (BDI).

The revised Beck Depression Inventory (BDI) (Beck, Rush, Shaw and Emery, 1979) is a 21-item instrument designed to assess the severity of depression in adolescents and adults. Introduced at the Center for Cognitive Therapy (CCT) of the University of Pennsylvania Medical School in 1971, the revised BDI replaces the original BDI developed by Beck, Ward, Mendelson, Mock, and Erbaugh (1961).

During the last 26 years the BDI has become the instrument of choice in clinical psychology and psychiatry for assessing the intensity of depression in psychiatric patients (Piotrowski, Sherry, and Keller, 1985) and for detecting possible depression in normal populations (Steer, Beck, and Garrison, 1985). A number of comprehensive reviews about its psychometric properties have been conducted (for example, Beck and Beamesderfer, 1974; Boyle, 1985; Edwards et al., 1984; Lambert, Hatch, Kingston & Edwards, 1986; Moran and Lambert, 1983; Snaith and Taylor, 1985).

1. Basic constructs measured by the Inventory.

The original BDI was based upon clinical observations and descriptions of symptoms frequently given by depressed psychiatric patients as contrasted with those infrequently given by non-depressed psychiatric patients (Beck et al., 1961). The clinical observations and patient descriptions were sytematically consolidated into 21 symptoms and attitudes which could be rated on a 4-point scale ranging from 0 to 3 in terms of severity. The items were chosen to assess only the severity of depression, and were not selected to reflect any theory of depression.

The 21 symptoms and attitudes assessed by the original BDI are: 1. Mood; 2. Pessimism; 3. Sense of Failure; 4. Self-dissatisfaction; 5. Guilt; 6 Punishment; 7. Self-dislike; 8. Self-accusations; 9. Suicidal Ideas; 10. Crying; 11. Irritability; 12. Social Withdrawal; 13. Indecisiveness; 14. Body Image Change; 15. Work Difficulty; 16. Insomnia; 17. Fatiguability; 18. Loss of Appetite; 19. Weight Loss; 20. Somatic Preoccupation; and 21. Loss of Libido.

The original version was designed to be administered by trained examiners, and the items were read aloud to patients. Administration time is approximately 5 to 15 minutes. This will be the method adopted in this research project.

The instructions employed with the scale are crucial for determining whether or not the inventory is assessing "state" or "trait" depression. Sacco (1981) concluded that the BDI scores represented mood states for the day on which the scale was administered. In the original version, patients were asked to rate themselves "right now", whereas in the revised version patients are asked to describe themselves for the "past week, including today". The original version measured a present "state", while the revised version assesses a more persistent "trait". In the current investigation, patients will be asked to describe themselves for the past week, including the day of administration. In this way, it could be stated that a "trait" measure of depression will be recorded.

2. Reasons for inclusion in the present study.

Over two thirds of patients previously discharged from the ward under focus had a primary diagnosis of depression. In reviewing measures of psychiatric disturbance it was considered appropriate to include a single, additional measure of depression partly to derive a more detailed account of this kind of disturbed experience across a large number of the patients interviewed. (This decision was arrived at following several conversations with a Top Grade clinical psychologist colleague regarding the suitability of a number of measures of clinical depression. The decision, in turn, was influenced by various determinants such as the nature of the investigation, availability of personnel to administer the tests, ease of administration, population of patients under review, and clinical perspective on depression).

An additional reason for including the Beck Depression Inventory in the current investigation was that stated previously by Henderson (1988) in his review of measures of psychiatric symptomatology for use in research studies. That is, it is considered wise to use more than one instrument in surveys of this kind since more comprehensive coverage of both symptoms and the level of severity will be obtained. The BDI provides a means of more accurately measuring the construct of depression and correlating this against the two additional measures derived from the GHQ-30 (the 6-item Depression factor) and from the SCL-90 (the 13-item Depression dimension).

Finally, it was considered important to incorporate a measure of depression that considers the construct to be a predominantly cognitive one. That is, regardless of the precipitating factors in its onset, the construct 'depression' is considered to be a cognitively-mediated one. The BDI has been subject to several factor analyses of which the major dimension reported has been a cognitive self-evaluative one (Steer et al., 1986). Across the range of patients (with various formal diagnoses) it is predicted that variations in the number and severity of symptoms of thought disorder will be evidenced.

2. A RECAPITULATION: THE DETAILS WHICH IMPACT PSYCHOLOGICAL DISTRESS AND READMISSION.

Thus far, the discussion has focussed upon the need for more precise conceptualization and measurement of outcome. This outcome is patient readmission to hospital. Readmission, in turn, is considered dependent upon the experience of psychological distress. Any person who is psychologically distressed and who is unable to make a satisfactory attribution of its source and meaning will be more likely, it is believed, to return to hospital. That is, some patients might first attempt suicide and fortunately be unsuccessful. Others might simply be instructed by others to go to hospital, or go of their own volition. It is the experience of intolerable psychological distress which renders more likely a period of treatment in hospital.

Within this chapter there has, however, been little examination of the **details** within patients' lives which renders their experience distressing. That is, having identified and examined the instruments for measuring our conceptualization of ‘psychological distress' - one of the components of the framework of ‘community adjustment' - it is necessary to explore these details of patients' lives which come to bear upon this ‘adjustment'. In order to achieve this, it will be necessary to re-examine the rationale for the current conceptualization of psychological distress. This might make more comprehensible the **linkages** between these details and the experience of psychological distress.

The current view of emotional disequilibrium and of its causes and consequences - both physiological and psychological - reflects that of a number of recent theorists (e.g., Smith and Lazarus, 1990) and is most succinctly expressed by the cognitive-interactionist emotional theorist George Mandler (1964; 1975; 1983). From this presentation it will become clear that the experience of psychological distress can best be understood within the context of a model which takes into account those components earlier identified as being “important to know" when seeking answers to the research question. These components, identified from the review of the deinstitutionalization and social support literatures, play an integral role in the ongoing perception, monitoring and interpretation of arousal. They are:

1. the patient's **clinical/psychiatric history**;
2. the patient's **employment history**;
3. the patient's **clinical symptom profile**;
4. the patient's ‘**social functioning**' or ‘**social support**' experience;
5. the **social demography** of the patient;
6. the **stress** which they confront in their day to day lives;
7. the patient's characteristic **styles of responding to stressful circumstances**.

The influence of these components on distress - whether in isolation or in particular combinations - can be better understood when considered part of a framework. This framework can be thought of as the influential context within which an experience of psychological distress is brought into being: each component in the framework being a potential influence on the *way* in which arousal, following “interruption", is reflected upon and interpreted .

2.1 MANDLER'S THEORY OF EMOTION, STRESS, AND PSYCHOLOGICAL DISTRESS.

Mandler's is a constructivist approach (1982a,b,c), “about the representation of arousal and the evaluative processes that combine into a single emotional experience." Emotion is a function of two sets of events. Firstly, there is an ‘arousal factor' which depends upon activations of the autonomic nervous system which reach awareness. Evaluative cognitions that follow determine the quality of the emotion. This postulation derives, in part, from the experimental work of Schachter (1962; 1964). He demonstrated that physiological experience can be subject to multiple interpretations since it can often be ambiguous. As a consequence, the perception of emotion can be relatively indirect and labile (Fiske and Taylor, 1984; Jones, 1990).

Central to Mandler's (1983) argument about the interactive process between the awareness of autonomic arousal and its interpretation is, “the realisation that (this arousal) is triggered by the interruption and discrepancies among thoughts and actions" (p. 196). We become aroused and aware of a disruption of the continuity of our experience. This arousal will result whenever “an organized action or thought process" is interrupted. This **interruption** is to be viewed simply as, "**the disconfirmation of an expectancy or the non-completion of some initiated action**" (Mandler, 1983). The interruption will give rise to emotionality, that is, to a change in autonomic arousal activity which is then subject to that person's own specific interpretation. Should that interruption be the knock on the door of 'the man from the pools' then the emotion experienced would most likely be joy. This joy is a function of the person's interpretation of their feeling on seeing this man from the pools. This joy might subsequently turn to anxiety and anger should that person be at the receiving end of numerous ‘begging letters'.

2.1.1 A DISTRESS RESPONSE TO ‘INTERRUPTION'.

Mandler (1983) considers some of the reasons for the psychologically distressed response to an interruption. He introduces the concept of the **schema** to represent the structure of organized experience referred to earlier. Quoting Rumelhart and Ortany (1978) he says that we “identify our surroundings in terms of the congruity between the environmental evidence and our stored schemas." When our experience in the world does not confer with what is ‘stored' in our ‘schemas' then “the new and strange (will need) examination and adaptation before it can enter the realm of the known and the liked." (p. 198). When the “new and the strange" - born of “the disconfirmation of an expectancy and/or the non-completion of some initiated action" - undergo examination, and when that examination fails to generate the expectancy that adaptation will come about, then the experience of psychological distress is made more inevitable. The magnitude and severity of the psychological distress experienced will be contingent upon the usefulness of the available ways of coping with the “new and the strange." That is, the effective management of the new and the strange requires the presence and use of methods by which re-interpretation of the “interruptive quality" of these experiences can be made possible. Such re-interpretation would render them less threatening, since less interruptive and so less emotionally distressing.

The distress experienced is contingent, then, upon the interpretation of events that are new and strange such that they might, “enter the realm of the known and the liked." (1983, p. 198). That's to say, the experience of distress depends upon the recognition, in the first instance, of the experience of what is more often described as “stress". It is to an examination of the psychological definition of stress proposed by Mandler (1983) that emphasis will now turn. This will act, in turn, as an introduction to the current study's conceptualizations and measurement both of ‘stress' and of the attributes which moderate its influence.

At the outset of this account of Mandler's (1983) definition of stress and of its relationship to the onset and sustainment of psychological distress it is important to make quite clear that a thorough examination will presently be made of the current **issues** within this body of research. In the course of this examination the relevance of these issues to the aims of the current research enterprise will become clear.

2.1.2. A PSYCHOLOGICAL DEFINITION OF STRESS - IN RELATION TO HEALTH AND PSYCHOLOGICAL DISTRESS.

Mandler (1983) criticizes former definitions of stress which have met with wide agreement by those researching its effects on long term psychological functioning. These definitions regarded the causes of stressful subjective experience as residing in a class or classes of event with which the individual meets in the course of ‘ordinary living' (Lavender and Holloway, 1988). Some events, more than others, were considered to require lengthy mental and physical efforts on the part of the individual ‘meeting them' in order for adaptation to occur. The development and subsequent wide use of the Social Readjustment Rating Scale - SRRS (Holmes and Rahe, 1967), “kindled an interest in the role of recent stress on the onset of illness, a hypothesis which had hitherto lacked a method for its systematic study" (Henderson, 1988, p. 79).

The SRRS is a checklist in which classes of events - each weighted according to the degree of adaptation required - are read by subjects and endorsed should they apply. Subjects receive two separate scores. One represents the total number of events experienced over a period of time. The other score represents the ‘severity' of those events as judged by a team of independent raters. These judges rate each event for the degree of adjustment and coping necessary to deal with the target events. However, “as various commentators have noted, this does not tell how the individual who is being rated by such a scale can and does cope with the actual event. It is therefore misleading to consider the scales to be objectively reliable measures of life stress" (Mandler, 1983, p. 201). The availability of this ‘stressful events' measuring instrument led to a vast amount of research whose quality as described by Henderson (1988) is “mixed".

Mandler (1983), instead, provides a psychological definition of stress. He writes, “External stressors are effective to the extent that they have organismic consequences." Where emotional arousal is one of the most common reactions to events considered stressful, “these emotional responses **depend** on psychological interpretive mechanisms." There should be emphasis on the word ‘*considered*' here. Critical to an understanding of the events to be considered stressful within any individual's life, together with the **changes** or **interrup-**

tions which these entail, is "the degree to which the changes entailed by these events are discrepant with one's expectations. . the degree to which the new state of world is **subjectively perceived** as different from the 'normal' one" (Mandler, 1983, p. 199). That is, when one **considers**, when one "judges, looks at, bears in mind, thinks carefully about" (New Collins English Dictionary, 1982) those events in one's life which bring about change, is the changed world inhabited by that person different from 'normal'? But not merely different, for difference constitutes change. Rather, is this differentness **discrepant** with what one expects and is accustomed to? And, finally, is this differentness disruptive or does it promise disruption of an individual's activities (Dohrenwend and Dohrenwend, 1969; Holmes and Rahe, 1967; Thoits, 1983).

This position echoes that of a great many whose research interest lies in this domain. Brown (1989) charts the change in emphasis on what is considered important to an understanding of the stress-response-disorder triad since the introduction of the Holmes and Rahe schedule. This emphasis has moved in a direction away from a conception of life events as **disruptive of behaviour** toward one which considers life events as necessiting **change in thought and feeling.** This movement in emphasis is, "consistent with the emerging agreement that if life events are involved in the aetiology of psychiatric disorders it is because of their **meaning**" (Brown, 1989, p. 10). This reiterates the claim of Selye (1956) that, "the stressor effects depend not so much upon what we do or what happens to us but on the way we take it" (Selye, 1956, p. 370). The importance of an event is determined, in part, by the extent to which it matches or mismatches with the concerns of the individual (Fridja, 1986). Its importance lies in the degree of effort it requires for it to "enter the realm of the known and the liked" (Mandler, 1983): for it to be adapted to. These views cohere with Mandler's (1983) who emphasises that **change** will be interruptive when it disconfirms an expectancy or prevents the completion of some initiated action (Mandler, 1983): expectancies and actions unique to that individual.

It should be clear that for the experience of emotion to be adequately described and understood one must consider both the experience itself and that which brings this into being. This position is scrutinized by Brown (1989) who claims that,

"We are faced with the problem (then) of the **translation** of an event into an **internal representation**. And in doing this we need to bear in mind that for methodological reasons it is highly advantageous to place as much weight as possible on characteristics of the event itself." (Brown, 1989, p. 14). Within this framework of analysis and interpretation, "there can be little dispute about the critical role of **emotion** in such translation" (Brown, 1989, p. 15).

Brown's (1989) words make it possible to see the clear link between the research on external 'life events' and the psychological definition of stress proposed by Mandler (1975; 1982). According to Mandler (1983), the emotional quality associated with an external life event is the outcome of an interactive process between two 'internal events'. The first is the experience of autonomic arousal. The second is the 'cognitive evaluation' or interpretation we make of our experience under this condition. When the arousal experienced,

(a) confirms an expectation about the life events with which one meets; and,

(b) when the arousal does **not** involve disruption of the satisfactory quality of our experience, then there will be no "subjective perception" (p. 199) that one is 'stressed'. Under such conditions, the emotional arousal can be considered 'conducive', 'expected', or even 'enabling', in that it is perceived to be benign. It is 'to be expected'. There is no disconfirmation of an expectancy or belief, nor does it disrupt or engender the non-completion of an action. Therefore, there is no subjective appreciation of being unable to adapt to the events. The arousal is thus contained: equilibrium in the emotions is promoted. Where there is no subjective experience of objective life conditions as being stressful (that is, as maladaptive) there can be no distress since distress - in the conceptualization - is necessarily conditioned by the experience of being stressed: the anticipation of being unable to adapt to an interruption in one's life.

There is, then, an "effort after meaning" (Bartlett, 1932) in one's experience. The conclusions arrived at or reflections made on the basis of this effort will determine, in part, the nature of the reactions one makes to the 'events' in one's life - i.e., to the external life events which are experienced, the interpretation of which determines the *psychological* distress response. That is, these authors - Brown (1989), Mandler (1983), Selye (1956) and Smith & Lazarus (1990) - argue that for objective events to be 'stressful' (which could give rise to a secondary interpretation that one is 'psychologically distressed') these events must first be **interpreted** - consciously or not - as such by the individual: engendering the anticipation of being unable to adapt to them.

2.2. THE RELEVANCE OF THESE ISSUES TO THE CURRENT RESEARCH.

From this examination of the definitions made of 'stress' and of 'psychological distress' a number of points can be made which will have bearing upon the nature of the conceptual definitions to be made and the measurements to be taken in the current research project. The orienting question reads thus:

<u>What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital</u>?

In seeking to address this question, the need to be precise in the conceptualization of outcome was identified. Within this limited research question the central dependent variable measure of outcome is hospital readmission within the six month period. However, this <u>structural</u> index does not inform us of the <u>processes</u> which make the return to hospital necessary, even essential. Referring to the comment made by Hoult (1986) an additional indicator of outcome was identified: the experience of psychological distress, evidenced by the presence of symptoms of various qualities and of varying degrees of severity. A psychological definition of 'stress' was proposed, one which:

1) considers the experience of distress as best construed as a continuum or a spectrum from states of symptom-free well-being to despair and demoralization;

(2) considers the experience of distress to emerge as follows:

(a) an interruption or change brings about emotional arousal;

(b) cognitive evaluation of the interruption which engenders an expectation that adaptation will not occur can be described as the experience of being stressed;

(c) the experience of being stressed (anticipating non-adaptation to the new life event) will maintain the emotional arousal;

(d) such persistence of emotional arousal can be considered definitive of a state of 'psychological distress': where there is no apparent means of resolving the changed circumstances in one's life;

(e) A secondary interpretation might then occur - of the arousal - which is itself felt as suffering of some kind: as a state of disequilibrium, emerging in the voice of 'symptoms' of distress.

(f) These interpretations might then lead to related forms of distress when integrated with the unique standards and values of the now symptomatically distressed person bringing about, say, feelings of interpersonal sensitivity, inferiority, persecution, loss of agency and the like.

The experience of stress is predicated by the presence and awareness of autonomic arousal (that is, of being aroused). This arousal, in turn, is conditioned by "interruption" (Mandler, 1983). That is, "any event that involves a normal and expected outcome is capable of generating autonomic nervous system arousal <u>if and when the world changes in such a way that that outcome no longer occurs or is no longer possible</u>" (Mandler, 1983, p. 199).

With respect to the **stress** component of this framework, the experience of emotional arousal is evinced "whenever an organized action or thought process is interrupted." (Mandler, 1983). Conceptualizing these interruptions does not represent too great a difficulty. However, there has been much less agreement amongst those researching the domain of 'life stress and well-being' about the **type** of instrument that is best able to measure these interruptions. Attention will now turn to the types of instrument within this research domain.

2.3. WHAT IT WOULD BE GOOD TO KNOW: (ii) LIFE STRESS / ADVERSITY.

1. It would be good to obtain measures of the interruptions in patients' lives: of the **'life events'** that interrupt;
2. It would be good to know something of the <u>meaning</u> of these interruptions for the individual: their context and significance.

2.3.1. HOW TO OBTAIN MEASURES OF LIFE STRESS: INTERRUPTIONS.

Patients who are routinely discharged from psychiatric hospital who meet with experiences in their lives which lead them to feel stressed and then distressed will be more likely to be candidates for readmission whenever that stress and distress persists and is intolerable. This is the hypothesis. That a better understanding of the process of readmission be had, measures must be obtained of the psychological distress experience of any routinely discharged patient. This stage of the research framework has been outlined and examined in some detail. <u>What is being claimed now is this</u>: In order for a better understanding to be gained of psychological distress, measures must be obtained of the 'stressors' with which patients meet in their lives. In order that measurement of this kind be made possible - measures that are demonstrably reliable and valid - there are a number of questions which have to be addressed. These are listed by Henderson (1988), and include:

1. What is an event?
2. How are those events which are to be counted to be defined?
3. Should the rest of the individual's life situation, which determines the context of the event, be taken into account?
4. Can a reverse direction of causality be excluded, whereby the illness itself, or its prodromata, cause the life event?
5. What is the strength of any demonstrable contribution made by life-events to the onset of a specific disorder? (Henderson, 1988).

Some of these questions are of little or no relevance to the current research in that this is **not** an aetiological or epidemiological investigation. Instead, the aim is merely to address the question, "What correlates with success?". In this way, it is of no specific concern in this project whether, (4) a reverse direction of causality can be excluded. Nor is there interest in, (5) the contribution of life events to the **onset** of a specific disorder since patients will have advanced beyond a stage of 'onset' passing through, at most, three 'filters' in the healthcare process to psychiatry (Goldberg and Huxley, 1980).

2.3.2. METHODS OF INVESTIGATION.

There are currently two methods by which this type of information can be obtained each with its band of adherents and critics. The first, is the 'Inventory' or 'Checklist' method.

A. THE INVENTORY METHOD.

This method has its origins in the development of the Social Readjustment Rating Scale by Holmes and Rahe (1967). As described earlier, this measure originates from a conceptualization of the life events and illness process as one in which individuals must respond to the events with which they meet such that adjustment can be said to take place. An event is regarded as a stressor - that which evinces an experience of **being stressed**: a state of undesirable emotional arousal and of various cognitions about such arousal and the event.

The inventory method enables the researcher to obtain information about the stressor events: the type and quality as experienced by the respondent. It is the **quality** of the experience of the stressor that is thought to determine the distress response to the stressor. That is, its undesirability, time-clustering, magnitude and uncontrollability are considered important: features documented as critical to an understanding of the development of psychopathology (Thoits, 1983).

The SRRS (Holmes and Rahe, 1967) is an inventory that allows the measurement of any respondent's experience of 43 commonly experienced life events and was described elsewhere in this chapter. An underlying assumption of this scale and of others of the same type is that the greater the amount and degree of change brought about by stressor events the more susceptible one is to an experience of being psychologically distressed.

The scale was used in over one thousand publications within the first ten years of its existence (Holmes and Rahe, 1979). The simple checklist approach has been used in around 90% of all existing studies that incorporate a measure of the life events or life adversity with which people meet (Cohen and Wills, 1985) and "practically every study from the United States to date has used them" (Brown, 1989).

HOW EFFECTIVE IS THE INVENTORY METHOD?

Brown (1989) lists several reasons in support of his claim that the 'checklist dictionary' approach has proved to be "ineffective." These can be summarized thus:

1. The measures obtained from such instruments have had low reliability;
2. The measures have demonstrated poor accuracy when respondents are asked for their agreement about the same event;
3. The research findings are inconsistent. For example, Rabkin and Struening (1976) point out that life events have only accounted for around 9-10% of the variance in health outcomes.

Brown (1989) considers some of the reasons for these shortcomings. Firstly, most checklist studies use scores based on the overall weightings of the separate events. This removes the possibility of examining event variability. Secondly, it has been assumed that events summate in their impact. There is no empirical evidence for this claim. Thirdly, these qualifications have diverted attention from the crucial issue of the meaning of events for the person experiencing them. These points have already been raised elsewhere in this chapter.

Improvements have, however, been made to the original Holmes and Rahe Schedule (1967). One important innovation has been to ask individual respondents to rate the importance of particular events for them (e.g., Hurst, Jenkins and Rose, 1979; Uhlenhuth, Balter, Haberman, and Lipman, 1977; Sarason, Johnson and Seigel, 1978). Additional improvements have been made to the checklist method by Tennant and Andrews (1976) and Henderson, Byrne, and Duncan-Jones (1980). These two instruments will be examined and outlined within the course of a subsequent section on "The choice of measuring instrument". It will be seen that these instruments help to remedy some of the shortcomings identified by Brown (1989).

B. THE INTERVIEW METHOD: The Life Events and Difficulties Schedule (LEDS).

Partly based on earlier work with schizophrenic patients (Brown and Birley, 1968), the LEDS is an interview method from which an attempt is made to utilize "the notion of understanding to deal with the meaning" (p.21) of events which involve change in an activity, role, person, or idea. Henderson (1988), in summarizing this method says, "In this, the individual's experience of events and difficulties is first determined by interview, using a list of possible occurences. Events which could be due to the disorder or its prodromata are later excluded, so that only 'independent' events are considered." (p. 81). Standardization of questions is achieved in the sense that a large number of topics has to be discussed together with a number of suggested probes. Brown (1989) continues, "It is, however the interviewer's job to question until he or she is confident that enough information has been obtained to rate the various qualities of each event. For this, there are 28 rating scales. They deal with, (1) basic characteristics; (2) prior experience, plans, and preparation; (3) immediate reactions; and, (4) consequences and implications Most emphasis is placed on obtaining a full account of the situation at the time of the event." (p. 24).

Interviews may take from between 2 to 3 hours to administer. This information is then presented to a group of raters trained to assess the events according to documented procedures. These include definitions, examples, and guide-notes, (interviewers are expected to be conversant with a manual of several hundred pages length). Interviews are tape-recorded and final ratings of each event are made on various scales, but "only after listening to these later and making notes about **all** relevant statements." (Brown, 1989).

2.3.3. WHICH METHOD?

Of the two methods, the checklist/inventory approach has met with most criticism. This concerns the following:

(1) the inventory approach assumes that a particular event carries the same impact for everyone, irrespective of the circumstances and biography of the person (Henderson, 1988; Shrout, 1981).

(2) the inventory approach assumes that respondents will be reliable in their nomination of the same items in the list for the same event. They are **not** expected to forget its occurrence or change its category if they were asked to say what happened to them over the past 6 months, say, a few weeks after first providing such information. It has been demonstrated that people do change their choice of items for the exactly same experience or event in their lives (Neugebauer, 1981; Steele et al., 1980).

(3) weighted indices do not necessarily add to the conceptual clarity of life events on health. Appropriate weights do not necessarily mean that different people experience such weighted events in any kind of systematic emotional and psychological manner. There is wide variation among people. The weight assigned is unlikely to be valid across individuals (Brown, 1981; Henderson, 1988). Similar events do not necessarily have the same meaning for different people. Similar types of event in different circumstances do not necessarily have the same meaning for the <u>same</u> person.

(4) Some of the original life event inventories did not control for the possibility that systematic confounding might take place between the experience of illness and that of objective, happenings 'out there'. This criticism has been corrected somewhat in recent developments, referred to previously, of the life-event inventory approach (Henderson, 1981; Paykel, 1971; Tennant and Andrews, 1976).

This is not to say the LEDS approach of Brown and Harris (1978) is without its critics. For instance, compared with a self-report method taking each respondent from between 15 to 30 minutes to fill in, the LEDS is a phenomenally time-consuming instrument, taking between 2 to 3 hours to complete.

2.3.4. PRACTICAL CONSIDERATIONS.

A number of points should be borne in mind when considering which instrument to use for this particular research study:

1. The LEDS provides information which is of limited value unless complemented by measures of psychological disturbance, social support, demography and other attributes already mentioned.

2. One must bear in mind the logistical problems associated with spending such lengthy periods of time with people who - in this study - might not be **expected** to be able to remain comfortable nor to be able to concentrate throughout long periods of time.

3. One must be aware of the limited resources which are commanded. Unnecessarily lengthy interviews will be exhaustive of time, particularly where all interviews are to be conducted by the one person. On top of this, training for the LEDS lasts about two weeks. Training for the use of any inventory is not necessary.

It is with these methodological considerations in mind that careful attention was paid to the selection and use of measuring instruments for the present study. At this juncture in the discussion of some of the central issues within this domain of research it would be advisable to be reminded of the nature of the question in which our interest lies, namely, What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital? Any attempt to seek to find answers to this question must, it was argued from the review of the correlates of psychiatric outcome, incorporate measures of seven separate sources of information (reviewed in section 2.).

This is a considerable amount of information that could and should be obtained for any satisfactory answers to be provided to this orienting question. However, one must be cognizant of **the nature of the population** which one seeks to test. Very little mention is given in the literature to this issue, certainly where clinical populations are involved. The point to make is this. People who have had recourse for hospital treatment, who may be 'first-time' admissions, or, what is more likely, who are well-known to the psychiatric services as 'chronic' or 'continuing care' patients, will have been and will probably continue to be in sensitive and vulnerable convalescent states of being. This vulnerability and sensitivity will make it more difficult for them to be as attentive as one would want and perhaps expect with, say, a student sample. This will be most likely when the length of the interview is protracted. Their vulnerability and sensitivity will also, it is argued, make it less sensible to embroil them in lengthy and potentially stressful interviews. That is, for this given population, one must be acutely aware of one's ethical responsibilities toward the patients: patients whose difficulties one seeks to understand such that they might subsequently be better solved and resolved. In attempting to do so, one must be careful not to exacerbate their current difficulties. For these reasons, any reduction in the number of items of information is to be sought.

To put this another way, it is important that measures are **not** included which need not be taken; which have not been incorporated, “according to the purpose of the study and the resources available" (Henderson, 1988, p. 87). In seeking to address the research question it is considered essential that a measure be obtained of each of the attributes listed above. That a measure will be included of **all** components of this framework will have significant impact on the nature and form of the instruments with which one seeks to obtain this information. In seeking to obtain measures of each of these seven attributes there is an immediate response, made on practical grounds of:

1. who is going to collect the information?
2. how do they intend to collect it?
3. how long it will take to collect: (i) per se?; (ii) from each patient to be interviewed?

Obtaining measures of life stress by the interview or inventory method is one obvious and examined source. The medical records of each patient - to which this study seeks and anticipates access - is another. These records contain information both about the patients' clinical and referral history but also extensive notes that provide a **context** by which the patients' distress can be understood. A third source of information is the daily record of each patient's progress kept by the nursing staff (the Kardex information). These two hospital-based sources of information on the patient's experience of stress before coming into hospital can be viewed as complementing that which will be obtained by the formal measuring procedure.

These, then, are the reasons identified for the emphasis on the need for brevity in the measuring instruments:

1. the **manpower resources** which, in this project, amounts to the one research student;
2. the **constraints** on the use of **time** this implies for reasons already detailed;
3. the **nature of the difficulties** experienced by the subjects of this investigation: soon-to-be discharged patients from a short-term unit of a psychiatric hospital;
4. the quantity and quality of **information sought on all other indices** of 'community adjustment'.

2.3.5. THE OTHER COMPONENTS IN THE FRAMEWORK.

The fourth point requires further elucidation. In seeking to address the research question a central focus will be each patient's experience of the multidimensional concept, ‘social support'. That is, from the review of the published literature on the correlates of psychiatric outcome among those receiving brief forms of hospital treatment, a special focus was identified. This focus is the role of the “social" experience of the former patient on subsequent functioning and adjustment. The relatively greater emphasis on the role of this attribute on the post-hospital experience of the psychiatric patient requires, by definition, that **priority** be given these indices over others. Within the constraints imposed by the practical considerations outlined earlier, it becomes clear that decisions must be made that necessarily involve compromise.

A central focus of this investigation will be on the role of the various social components of patients' post-hospital experience in their management and understanding of psychological distress. It is hypothesized that psychological distress will best predict the major outcome criterion, hospital readmission. This focus will be examined and the measuring instruments for obtaining an index of these components will be detailed in the next section - "Social support - its conceptualization and measurement". However, this is not to underemphasize the importance of the role that is played by the patient's exposure to life stressors. Rather, it is simply to acknowledge the **precedence** that will be given measures of social support over life events in this particular research project. **It is for this reason that the decision was made to incorporate in this study measures of the life-stressor experience of each patient that will be obtained by the inventory method**.

An additional reason for choosing this type of method has been alluded to throughout this second chapter. This inquiry is not an epidemiological one: it is not a central concern "to throw light on disease aetiology" (Henderson, 1988) **nor** "to set out to consider the aetiological role of particular events. . vis-a-vis any onset of disorder." (Brown, 1989). Instead, there is a concern with the **moderating** influence of the life stressors with which patients meet and the social support experience of patients, (a) "after the onset of a particular disorder" (Henderson, 1984); and, (b) "who have already developed affective or neurotic symptoms (where the social support) has a therapeutic effect, shortening the episode and reducing symptoms" (Henderson, 1988).

The LEDS approach is considered most appropriate for those research inquiries whose concern is the aetiological role of the experience and meaning of 'life events' in the development of disorder termed psychological. However, the thesis of this research project is concerned with the role that that experience which can be termed **supportive from others** plays in the outcome of patients routinely discharged from a psychiatric hospital. Were this central focus to be, instead, on the role of the experience of 'life stress' on the outcome for a separate population then there can be little doubt of the appropriateness of the LEDS method.

2.4. CHOICE OF MEASURING INSTRUMENT: The List of Recent Experiences.

2.4.1. THE LIST OF RECENT EXPERIENCES (Henderson, Byrne, and Duncan-Jones, 1980).

The List if Recent Experiences (LRE) is a 73-item inventory that provides measures of the life stressors with which people meet in their lives. It is organized into 11 separate categories of event. These are:

(a) illness, injury, and accident (9 items); (b) bereavement (3 items); (c) pregnancy and childbirth (5 items); (d) changes in relationships (15 items); (e) separation (6 items); (f) changes in living conditions (5 items); (g) study and schooling (6 items); (h) work and employment situation (13 items); (i) financial situation (5 items); (j) legal difficulties (4 items); (k) disappointments (open-ended items); and, (l) continuous worry or stress (open-ended items).

The inventory is a modified version of a 67-item list developed by Tennant and Andrews (1976). This originates, in turn, from the checklist method of Holmes and Rahe (1967) and Paykel et al. (1971).

A system of scaling the events in the LRE has been developed. This system comprises:

(i) subjective estimates of the impact of experiences for each person.

(ii) weighted scores for each event (Henderson et al., 1981, p. 68-69).

(iii) a concise nine-page guide for interviewers is available. This is clear and easy to read. It provides notes on the dating, and the elicitation of duration, description, and subjective rating of events. It takes approximately one to two days reading to become fully acquainted with the use of the LRE.

2.4.2. ITS ADMINISTRATION..

The administration of the LRE to patients in the research study will be by interview. This has been done previously by Henderson et al. (1981) in their examination of the aetiological role of the social environment on the onset of minor psychiatric complaints. That is, the LRE will not be administered in a self-report format but will, instead, involve each item being read aloud to the respondent with subjective estimates of the impact of events obtained when applicable.

Additional, and some would consider essential (Brown, 1989), contextual information will be elicited. Thus, on the part of the interviewer administering the measuring instruments, there will be an attempt to follow the 2 broad principles adumbrated by Brown (1989) to which interviewers are encouraged to work toward:

> "**To show curiosity about everything they are told** and **to respond as much as possible to what is said as a story**. This involves, for example, looking out for possible links between answers, although they may be far apart in the interview. Or, to give another example, a certain hesitation in a reply should be followed by another question along much the same lines if there is any hint that the respondent has something extra to impart. But, curiosity will often need a focus, and so the interviewer, as already noted, is encouraged to react to what is said as if it were a story. The decision to stop asking questions is then not so much settled by coming to the end of a list of standard questions, but by the feeling that the material makes sense or hangs together." (Brown 1989, p. 24-25).

2.4.3. ADVANTAGES AND DISADVANTAGES OF USING THIS METHOD.

A. DISADVANTAGES.

The disadvantages of using the LRE are considered small in relation to the nature of this particular study. The checklist method has been criticised on grounds already mentioned (section 2.3.2.). In addition, there exist methodological difficulties. "There is no control over what the respondent will have in mind when rating the event" (Brown, 1989). Nor might there be control of the (possibility of the) occurence of bias: where "reports of the 'severity' of (an) event may be influenced by the fact that the respondent has . . already developed the illness" (Brown, 1989).

One of the acknowledged experts in this research domain, George Brown (1989) offers a "viable alternative" to the complete dependence on facts obtained by scientifically-sound research instruments:

> "As far as life events are concerned, a viable alternative is to continue to listen to what respondents have to tell us, but to use ourselves to filter this. In so doing, however, we have to go beyond the mere documenting of the world in an empirical sense to create a picture in terms of the meaning both of what has happened and of what might have been. A restatement of the *facts* about a birth (e.g., weight, age of mother, parity, and physical complications) is not enough. Their likely meaning to those involved must be considered, and this must be done by taking into account the wider social context. For example, in the case of a birth, factors that must be considered include the likely relevance of the mother's housing (is there overcrowding?), financial security (is it uncertain?), career plans (will it mean giving up going to college?) and even apparently minor matters (e.g., is a grandmother willing to babysit?). Concern with meaning ultimately reflects a commitment on the part of an investigator to explore the likely significance of an event for those involved in terms of their role identities or lives as a whole. Fortunately, since we all spend much of our time doing just this for ourselves, the human mind is a suitable instrument for this task." (Brown, 1989, p. 14).

In 'continu(ing) to listen', it is considered possible to circumvent one of the other difficulties often identified with the checklist-self-report method, that respondents may be too embarrassed to disclose certain experiences. It is hard to conceive of anyone having other than an "accepting style of listening" (Brown, 1989) which the LEDS method is considered to encourage. Anyone with a good understanding of human distress and misery would find it hard, and certainly existentially-incongruent, to be other than 'accepting' of people's experience, whether about events in the world 'out there' or about events inside their heads alone. This is not to say that one must be in agreement with what is said: only that what they say, provided they say it in what appears to be 'good faith' (Mair, 1989), is real for them and so must be listened to in order to be understood. This understanding then guides the approach taken toward the resolution of their distress and misery.

B. ADVANTAGES.

Firstly, in response to the criticism levelled against the inventory method, the LRE provides the following:

1. Accurate dating of events is possible.
2. Information about the impact of particular events is also possible - with 11 separate categories of events, each amenable to separate tabulation and statistical analysis.
3. Information about the **meaning** of each event is made possible through the use of the LRE in conjunction with the approach to the patient proposed by Brown (1989) - i.e., (a) to show curiosity about everything one is told and (b) to respond as much as possible to what is said as a story.

The LRE shares the advantages of other checklists in that it can be administered and responses obtained within a 20 to 30 minute period, depending on the amount and degree of the difficulties with which any respondent has met. It requires little training of the interviewer where extensive guide notes are provided (Henderson et al., 1981). There is no time-consuming rating session with skilled research staff afterwards. It is therefore cheap to use.

Finally, the use of the relatively brief LRE is considered appropriate where extensive interviews will be conducted with patients at 2 separate points in time. They will be interviewed just before they are discharged from hospital and then again 6 months later. Irrespective of the reasons outlined in support of our decision to forego the use of the LEDS method, it was considered quite infeasible to expect some patients to be able, let alone willing, to sit through an exhausting nine or so hours of interviewing about their experience and understandings of the things that happened to them during the previous 12 months (preceding admission) and subsequently (over the ensuing 6 months). For these reasons, then, it was considered most appropriate to obtain in this study a measure of the life stressors with which patients meet through the use of an inventory method - the List of Recent Experiences (Henderson, Byrne, and Duncan-Jones, 1980).

2.4.4. EVENTS AS STORY-LIKE NARRATIVE.

The second of Brown's (1989) principles reinforces and extends the view that, "people conduct themselves the way they do for good reasons . . We act and feel rationally according to our circumstances, and indeed our interests. To say that we act rationally is not to say that we act necessarily correctly or sensibly, but simply that we have reasons for what we do which follow from our experience of the world and our bodily relation to it." (Smail, 1987, p. 75). As such, "human beings will always search for an appropriate way to interpret the surroundings, a process that is automatic." (Mandler, 1983). This 'appropriate way' can be conceived of and understood as a story-like narrative (Crites, 1986). "Our sense of self is not something that we bring in to the world with us, which organizes our experience. It is **constructed** through our experiences, and the sense of an enduring self seems to depend phenomenologically on numerous remembered and related experiences" (MacMillan, 1989). This author continues, drawing on the ideas of Crites (1986):

> A storylike narrative, "establishes a particularly strong sense of personal continuity, because it can link an indefinite number of remembered episodes, from the **single** point of view of the one who recounts or merely recalls the story. This single point of view is the 'I' who speaks or recalls. Not that a sense of an enduring self requires an unbroken narrative thread. We all tolerate gaps and discontinuities, and there may be a disconcerting slippage from the 'I' who recalls and the self that is recalled, the self who is the principal character in the various episodes that are linked together." (MacMillan, 1989, p. 21).

Oliver Sacks (1986), in his book, 'The Man who Mistook his Wife for a Hat', continues along this theme of life experience as life stories, as a narrative unique to and for ourselves:

> "We have, each of us, a life-story, an inner narrative - whose continuity, whose sense, *is* our lives. It might be said that each of us constructs and lives a 'narrative' and that this 'narrative' is us, our identities. . . Each of us **is** a singular narrative, which is constructed, continually, unconsciously, by, through and in us - through our perceptions, our feelings, our thoughts, our actions; and, not least, our discourse, our spoken narrations. . . To be ourselves we must have ourselves - possess, if need be, repossess, our life stories" (Sacks, 1986).

This principle - to respond as much as possible to what is said as a story - will also, it's believed, permit the acquisition of contextual information about each life event in that the meaning of any experience will best be identified in a "more inclusive context of meaning" (Weber, 1964). That is, an assessment of meaning can include information not only of the immediate situation (say, the divorce of a woman from an alcoholic husband), but the wider context (say, she is a formerly devout Catholic with an overly domineering father and with 3 children to raise on her own without any regular form of income). The LRE provides the means by which information can be obtained about the nature of the event and its immediate context. However, additional information that would place such events in their wider context depends on the further probing by the interviewer. This is not thought to represent any great difficulty and every effort will be made to relate the event described to a wider context within the patient's experience.

3. THINGS IT WOULD BE GOOD TO KNOW: social demography and clinical/ psychiatric history.

Returning to a concern with "what it would be good to know" there remain four sources of information which require clarification. It is toward an examination of the method by which information is to be collected for two of these sources that focus will now shift. These two sources are (a) the social demographic attributes of each patient; and, (b) their clinical and psychiatric history.

3.1. SOCIAL DEMOGRAPHIC AND CLINICAL-PSYCHIATRIC INFORMATION.

It was noted in the first chapter that information about each of these two indices can be a useful guide to an understanding of which patients are potentially better placed to remain in the community once discharged. The evidence for the role of social demographic attributes in adjustment is qualified. Some studies conclude these variables do have some predictive value (e.g., Bland et al., 1976; Byers et al., 1978; Lorei and Gurel, 1973); others do not (Caton, 1982; Di Scipio and Sommer, 1973; Klein et al., 1978; Munley et al., 1978). Sands (1984), for example, in her examination of the correlates of success and lack of success in deinstitutionalization found that age and cohabitation were the best predictors of success in remaining in the community for a long period of time following discharge. Older people who were living with others were observed to spend the longest periods back home once discharged.

In addition, it has been observed that whether one is single or married, or relatively younger or older can influence, if not partly determine, the uptake of aftercare services once that person returns to living back home. Byers, Cohen, and Harshbarger (1978), for instance, observed that among 129 discharged state hospital patients women were more likely to have received aftercare services once discharged and living back home. However, those patients discharged to their spouse were also most likely to be readmitted, this variable - the person to whom the patient returned to live with - being the best overall predictor of readmission.

In their examination of the compliance with referrals for aftercare among patients discharged from a state mental hospital, Tessler and Mason (1979) found that 3 variables emerged as statistically significant correlates of continuity of care, each with significant independent effects. When the patient, (1) had a diagnosis of schizophrenia; (b) was currently married; and, (c) scored high on the PERI (Psychiatric Epidemiology Research Instrument - Dohrenwend and Dohrenwend, 1978) scale measuring hopelessness/helplessness then s/he was more likely to comply with referrals for aftercare. The role of these social demographic indicators in adjustment after discharge can't be overlooked. It is for this reason that measures of these attributes will be included.

More notably, there is strong evidence for the role of previous clinical and psychiatric history on psychiatric outcome. The strongest predictor of subsequent readmission to hospital is the number of previous hospital admissions (Anthony et al., 1972; Avison and Speechley, 1987, in their respective reviews of the literature). Similarly, the more 'chronic' is the patient's history of 'illness' - of symptoms of distress - the more likely that the 'sick role' will be accepted, since reinforced, and so a decision to consult one's doctor or a psychiatrist at hospital will be more inevitable (Goldberg and Huxley, 1980).

These two sources of information - 'things it would be good to know' - are **standard** sources of information routinely elicited from persons presenting for admission to psychiatric hospital. The information is obtained by the admitting psychiatrist responsible for providing the person with a bed in the hospital. It is supplemented by that collected by the ward's nursing staff. This information is documented in the medical records of each patient. A measure of these two components of the research framework can be obtained by recording routine, formal items of information from each patient's medical records. The form this information takes will reflect that considered most important by previous investigators within the research domain (e.g., Byers et al., 1978; Caton, 1982; Di Scipio and Sommer, 1973; Sands, 1984).

3.2. MEASURES OF SOCIAL DEMOGRAPHY AND CLINICAL/PSYCHIATRIC HISTORY.

Formal measures will be obtained from medical records of:

(a) social demography - comprising information about the patient's age, sex, religious denomination, marital status, current employment status, number of siblings, birth position in family, next of kin.

(b) clinical / psychiatric history - psychiatric diagnosis at admission; number of years previous contact with psychiatry; number of previous in-patient hospitalizations; previous diagnoses (clinical history); average length of in-patient stay; whether receiving drugs as part of treatment; average length of time between previous admissions.

The interactions between these kinds of information and patients' experience of stress, psychological distress, and supportive interactions with others can be examined. It is thought very likely that within the intended 6 month follow-up period some of these interactions will help explain why it is that:

(1) some patients will have had recourse for further hospital treatment;

(2) some patients will have become more psychologically distressed though not to the point that readmission has become necessary (although it is still more likely in time);

(3) some patients will have become less distressed and better able to manage and tolerate (perhaps even to resolve) their symptoms whilst living back home;

(4) some patients will experience little or no difference in their circumstances - their experience of being stressed, psychologically distressed, and socially supported.

For example, it might be observed that an older, married woman with an intimate and dependable husband will experience less severe forms of depression than a younger, single woman with neither an intimate nor a job (e.g., Brown and Harris, 1978). Or, for instance, someone who has a history of more than 5 years contact with psychiatry, whose average length of stay in the community between readmissions is less than 5 months might be more likely to be readmitted than a 'first-time' presenter within the 6 month period under conditions considered stressful.

3.3. SOCIAL DEMOGRAPHY, CLINICAL-PSYCHIATRIC HISTORY, PSYCHOLOGICAL DISTRESS AND READMISSION: A RECAPITULATION.

In the section of this chapter headed, "Introduction to the conceptualization and measurement of life events", attention was drawn to the fact that little had been said of the **details** within patients' lives which come to bear upon their 'adjustment'. This adjustment is conceptualized as a process whereby patients attempt to make sense of their experience (the totality of their experience).

1. The first dependent variable in this investigation is whether or not patients are readmitted to hospital within a 6 month period.

2. This variable was then considered to be best understood as a function of, or the culmination of an interactive process between a number of attributes of that person's total experience. Thus, the likelihood of readmission is **primarily** influenced by the person's experience of symptoms that denote underlying psychological distress, "and demoralization" (Dohrenwend et al., 1980).

3. This psychological distress is itself primarily predicted by - or the consequence of an evaluative process whereby an experienced is engendered of - being stressed.

4. This experience is the product of what Mandler (1983) has termed 'interruptions' to the spontaneous execution of organized actions or thought processes. This interruption is simply, "the disconfirmation of an expectancy or the non-completion of some initiated action" (p. 197). It is when one encounters the "new" and it is "strange" - when "novel events are encountered and (when) the new life situation is discrepant from the old" (p. 201). These interruptions are a fact of "ordinary living" (Lavender and Holloway, 1988). They are the products of our engagement with the world. These interruptions are also, in part, the products of our involvement with ourselves - such that an **external** event (say, the death of one's spouse) is translated into an "**internal representation**" (Brown, 1989). That is, the magnitude of an interruption, whether it continues to be considered as such, depends on its unique meaning to the person confronting it. Following interpretation ("cognitive evaluation", or "effort after meaning") the interruption will either "enter the realm of the known and the liked" (Mandler, 1983), or not. Such "entrance" depends on the unique meaning of the "interruption" to the individual who is "interrupted".

Thus, in final summary, the 'interruptions' to the organized flow of action and thoughts can be regarded to be **influenced** and in most ways moderated by the **details** which have been identified as being "good to know":

1. the patient's **clinical history**;
2. the patient's **employment history**;
3. the patient's **clinical symptom profile**;
4. the patient's '**social functioning**' or '**social support**';
5. the **social demography** of the patient;
6. the patient's characteristic **styles of responding to stressful circumstances.** That is, a measure of 'powerful emotions' such as guilt and guilt (Brewin et al., 1989); attributions of blame and judgements of consen-

sus.

3.3.1. THE *PLACE* OF THE COMPONENTS OF THE FRAMEWORK VIS-A-VIS EMOTIONAL DISTRESS.

These components are perhaps better understood in reference to the description provided by Tomkins (1981) of the course of emotional experience. He writes that emotions, "are aroused easily by factors over which the individual has little control, they are controllable with difficulty by factors that he or she can control, and (they) endure for periods of time that she or he controls only with great difficulty. They are in all these respects alien to the individual." (Tomkins, 1981, p. 323). This quote can help to make more clear the place of these details in the process which, within this research project, has as its 'end-point' the return of the former patient to psychiatric hospital.

1. "Emotions are aroused easily by factors over which the individual has little control. . ."

Emotions which endure are considered to constitute the 'psychological distress' experienced by any person. They are aroused by the experience of interruption to the thoughts and actions in any person's life. This arousal is then subject to "effort after meaning" (Bartlett, 1932) such that sense might be conferred and the arousal explained. If not, the arousal will continue for reasons unknown to the person or known but regarded as outwith, (a) one's locus of control, and/or, (b) one's ability to control. Under these circumstances the experience will arise that one is stressed. This emotion, then, can be considered to be a function of the experience of life stressors within one's life: stressors over which the individual has little control.

2. "Emotions. . are controllable with difficulty by factors that she or he can control. . ."

People try to make sense of their emotional experience - through a process of 'cognitive evaluation' of this arousal. That is, one reflects upon one's emotional experience and makes often tentative conclusions about the meaning of such emotional arousal. Our thoughts on - the cognitive evaluation of - arousal are governed by, one might say, the entire biography of the person. **However, within the present research framework, it is being argued that the likely response of any person to this arousal will be modified, determined in part by**:

(1) the experience of being supported by others - the social support of each person. This will be the focus of the next section;

(2) the experience of 'powerful emotions' (Brewin et al., 1989) such as guilt, shame and self-blame; and,

(3) the judged consensus of these emotion-related events: emotions and judgements that will be the focus of a subsequent section.

3. "Emotions endure for periods of time which she or he controls only with great difficulty."

This sense of control is determined, in part, by factors outwith the person's control:

(1) the social demographic characteristics of each person.

(2) the clinical-psychiatric history of each person.

Additionally, the awareness that one is badly supported **or** without intrapsychic resources **or** feeling too old to be able to do anything about one's circumstances is itself likely to augment the feeling of being stressed and distressed. These “meta-cognitions" (Honess, 1986) will subsequently augment the experience of emotional arousal and of cognitions such as, “I'm feeling stressed" and “I'm feeling really anxious, depressed, and feel there's nothing I can do about it." That is, where there exist no perceived *means* for controlling or resolving the emotional arousal, there will come into being a ‘vicious cycle' by which the subjective experience of distress grows more intense and less tolerable.

This account of the process by which the management of emotional experience is made possible should serve to make a little clearer the hypothesized role of, among other details, the social demographic and clinical-psychiatric components in the framework. However, thus far there has been little mention of what is, in effect, the major focus of this investigation - the experience of what has become known as the ‘social support' of any person. This social support is hypothesized to **modify** the deleterious effects of being stressed on the experience of being psychologically distressed. This omission will now be rectified in the next section.

4. WHAT IT WOULD BE GOOD TO KNOW: SOCIAL SUPPORT.

It is not the intention within this section to detail the reasons for the inclusion of this research construct as part of the framework for organizing knowledge about what goes on when patients are discharged back home after brief periods in the short-term units of psychiatric hospitals. These reasons were outlined and examined in the 1st chapter. They can be summarized thus:

1. the construct 'social support' is a standardized version of the 'social variable' variously termed "social resources" (Byers et al., 1978), "social competence" (Munley and Hyer, 1978) or "social stability" (Fontana and Dowds, 1975): a well-established predictor of psychiatric outcome (Avision and Speechley, 1987; Rushton, 1990).
2. the construct is both theoretically- as well as empirically-grounded, bringing an established literature to the research domain of psychiatric outcome. This provides fairly standard, (i) conceptualization of the construct; and, (ii) instruments for measuring the particular conceptualization.
3. the construct, with its published literature, allows the generation and testing of specific hypotheses about the patient's life back in the community.
4. the construct allows satisfaction of almost all of the eleven ideal outcome criteria proposed by the NIMH task force (NIMH, 1986), and,
5. the construct - the involvements people have with others that can be considered, in whatever way, supportive - has an established role in the 'stress process' triad of health-stress-support.

4.1. CRITICISM OF THE CONCEPT.

Before going on to consider the current conceptualization of social support and how this conceptualization is to be measured (its operationalization), a number of difficulties must be addressed. These were identified in the 1st chapter such that:

1. There is an apparent lack of agreement about the conceptualization of the term 'social support' - i.e., What is meant by the term 'social support'?
2. It follows that there is lack of agreement about what to measure and how to measure it.
3. There has been criticism of measures of support which confuse the measure with psychological distress and stress. That is, 'support' items are said to be contaminated with 'stress' and 'distress' items.

Each of these issues will be addressed in turn. In the course of this, statements will be made about the forms of 'social support' currently thought to be of most value in the address of the central orienting question of this study:

What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?

4.1.1. THE LACK OF AGREEMENT ON THE TERM 'SOCIAL SUPPORT'.

Within this section it will be argued that the lack of agreement on the meaning of the term 'social support' is only apparent. Criticism of the conceptual clarity of the many definitions proposed is, however, very real. It will be seen that most criticism centres around the issue of what can be termed **intentionally supportive** as against what is **unintentionally supportive**: provided indirectly through the fact of being with other people.

There is wide agreement that the term 'social support' is unnecessarily vague to be useful as a research concept. Winefield (1987), for example, writes, "It could . . be argued that the term 'social support' has outlived its usefulness, for many contexts. It may still have value as a generic term for beneficial interactions between one party who is experiencing some kind of difficulty and another who is not a psychotherapist. However in any detailed description or attempted modification of such processes, further specification of the help, form and source seems desirable in order to reduce conceptual confusion." (p. 638). Barrera (1986) cautions that definitions of the term are often so vague or so broad that the concept is in danger of losing its distinctiveness and so its usefulness: "Clarifying the confusion among concepts and reconciling inconsistencies in findings can be facilitated by abandoning global references to social support in favour of more specific terminology." (p. 414).

Careful examination of the many definitions of the term 'social support' demonstrates a quite high degree of agreement about what it refers to. In her review of what is meant by the term social support Parry (1988) summarizes several widely-used definitions of the term. In presenting some of these it will become clear that the term, in many ways, has met with some uniform agreement.

(a) Cobb (1976) defines the term, "information leading individuals to believe they are (1) cared for, (2) esteemed and valued, and that they (3) belong to a network of communication and obligation."

(b) Kahn and Antonucci (1980) define it as "interpersonal transactions that involve (a) the expression of positive affect; (b) the affirmation or endorsement of the person's beliefs or values; and (c) the provision of aid or assistance."

(c) Kaplan, Cassel and Gore (1977) view support as "the degree to which a person's basic social needs are gratified through interaction with others."

(d) Walker, MacBride and Vachon (1977) define it as "behaviour which assures people that their feelings are understood by others and considered normal in the situation."

From these definitions it can be concluded that, "the term social support refers to a range of different psychosocial processes and is not a unitary entity." (Parry, 1988). Rather, social support is better conceived as, "**a label for something which has many components**" (Brown, 1989). What this 'something' and these 'components' might be must be a subject for debate since underpinned by a judgement of value. However, one can make suggestions from those definitions proposed as to the nature and substance of these two basic elements: the 'components' that promote 'something' under the umbrella label 'social support'.

4.1.2. 'SOMETHING'.

The 'something' to which Brown (1989) refers can be considered to be the dependent variable in the component-something proposition: it is the outcome of the components. What this 'something' might be can be surmized from the many definitions adumbrated above. For instance, in Kaplan et al.'s (1977) definition of the label 'social support' their 'something' is "a person's basic social needs" which are met ("gratified") "through interaction with others" (the 'components of the 'something'). Analyzing each definition in turn the 'something' can be considered to be:

(a) basic social needs;

(b) believing oneself to be cared for, esteemed, and valued; and that one belongs with others;

(c) one's beliefs and values (being affirmed and endorsed);

(d) a person's feelings (confirmed as normal; understood by others).

The taxonomy is highly suggestive of a wider-embracing encapsulation of this 'something' proposed by Boyce (1985). Drawing upon the theoretical- and empirical-based work of Erikson (1963), Bowlby (1982), Benedek (1938), Klein (1948) and Ainsworth (1972) he postulates "**an elemental need for stability**" to account for the observed similarity in the effects of various social supports (Boyce, (1985):

> "Such an account would explain parallel effects of the diverse social supports by their common tendency to promote an awareness of the enduring aspects of life experience. In the case of childhood social support, a child's evolving attachment to its social environment would be viewed as a critical element in fulfilling the needs for stability. Further, within such a frame of reference stressful life events could be usefully viewed as acting on health through their capacity to undermine the child's sense of stability and permanence. Social support and life change would thus operate through their common, but opposing, effects on the perception and awareness of stability." (p.161).

Common to the work of Erikson (1963), Bowlby (1969), Klein (1948) and others is an understanding of the role of continuity, stability and predictability in the development of early and subsequent social relations. However, the taxonomy outlined above - "believing (that) one is cared for, esteemed and valued (by others)" and that one "belongs to a network of others" - suggests another, fundamental "social need" - one said by Fromm (1957/1988) to be "the deepest need of man". It is **the need to overcome one's separateness**: "to leave the prison of one's aloneness" (Fromm, 1957/1988). The reasoning underlying this proposition will be presented shortly. It should be emphasised that his conclusion - although perhaps one of several that could be made - is one that is an irrefutable logical consequence of the entire list of proposed 'somethings' outlined above. And although rather grandiose in appearance his analysis nonetheless holds true for these definitions and, in turn, holds them together within a single, more fundamental definition.

Fromm writes:

> "Man is gifted with reason: he is *life being aware of itself*; he has awareness of himself, of his fellow man, of his past, and of the possibilities of his future. The awareness of himself as a separate entity, the awareness of his own short life span, of the fact that without his will he is born and against his will he dies, that he will die before those whom he loves,

or they before him, the awareness of his aloneness and separateness, of his hopelessness before the forces of nature and of society, all this makes his separate, disunited existence an unbearable prison. He would become insane could he not liberate himself from this prison and reach out, unite himself in some form or other with men, with the world outside." (Fromm, 1957/1988, p.16).

It follows that "being cared for, esteemed and valued"; "believing that one belongs to a network of others" and "being able to express and have affirmed or confirmed or endorsed one's emotions and feelings" <u>negates</u> the feeling of separateness, enabling a person to "leave the prison of their aloneness". A feeling of "stability" (Boyce, 1985) and "security" (e.g., Bowlby, 1982; Horney, 1951) would almost certainly follow.

It is for these reasons, based on theoretical and empirical material, that the following definition of Brown's (1989) "something" is now proposed:

The feeling and knowledge that a person has of being stable and secure and thus less alone and separate through constructive engagement with other people (from Boyce, 1985; Fromm, 1957/1988).

This is not to ignore the fact that being with others can render us confused, disillusioned, unhappy, jealous, angry, and feeling misunderstood. Rather, such engagement with other people would be deemed *destructive* rather than constructive. Such negative social encounters might - because relatively more salient in memory - have disproportionate impact on well-being (Coyne and Downey, 1991; Kanouse and Hanson, 1972).

4.1.3. THE 'COMPONENTS' of 'SOMETHING'.

The '**something**' is considered to be this: the feeling and knowledge that a person has of being stable and secure and thus less alone and separate through constructive engagement with other people (from Boyce, 1985; Fromm, 1957/1988).

The next question must be - "What are the '**components**' or the psychosocial processes that contribute to (or, where absent or malfunctioning, detract from) this '**something**'?".

Quoting from Parry (1988), several authors have developed taxonomies of the components that help make a contribution to this 'something' (Barrera, 1986; Caplan, 1974; Cobb, 1976; House, 1981). These can be summarized thus:

1. The <u>expression of positive affect</u> (including information that one is loved, cared for and esteemed);
2. The <u>expression of agreement</u> with (or <u>acknowledging the appropriateness</u> of) a person's belief, interpretation, or feelings; encouraging their open expression. This reflects the position of Reiss and Shaver on intimacy: "the fundamental characteristics of intimacy are the discloser's feelings of being understood, validated and cared for." Derlega, (1984; 1987b) also focusses on the role of self-validation in intimacy;

3. The offer of advice or information, or access to new, diverse information;
4. The provision of material aid;
5. The provision of information that the person is part of a network of mutual obligation or reciprocal help.

To this taxonomy can be added a further component - positive social interaction (Barrera and Ainsley, 1983), or what Rook (1985) terms, "pleasurable companionship" (p. 247). Or rather, this **component** falls outwith the ambit of the label 'social support' as conceived by Rook (1985). This lack of agreement on the precise meaning of the components of what can rightly be termed 'social support' will now be examined. Rook (1985) raises these points in her assessment of the functions of social bonds. These points derive from research on three separate perspectives of this domain: on social support research, loneliness research, and social isolation research.

She writes, "People who are lonely, socially isolated, or without social support are presumed to be vulnerable to emotional and physical problems because they lack something essential that is available only through interpersonal transactions. This focusses our attention on the **content** of social exchanges and the **functions** they serve. In keeping with their different historical origins, the literatures on social support, loneliness and social isolation emphasise somewhat different functions of social bonds" (p. 244). In this way, social support research has a unifying theme concerned with the different **types of help to those who are experiencing stress**, this help provided through being with others. "A variety of behaviours, including emotionally expressive behaviours, may be construed as help-orientated because they are prompted by **awareness of another's problems.**"

It is the instrumental function of social bonds which are emphasised within the literature on social support. However, this is not to say that other essential functions which contribute to the 'something' and which arise through being with others do not exist. Rather, these additional functions are **not** consistent with the conception of social support as "the provision of various types of help or helping behaviours" (p. 245) that are "prompted by awareness of another's problems" (Rook, 1985). These other functions contribute to a sense of well-being, 'components' of the current conception of Brown's (1989) 'something'.

From her review of perspectives of loneliness research, Rook (1985) concludes that such research "calls attention to the value of pleasurable companionship and intimacy in enhancing mental health." This draws on the ideas of Bowlby (1973; 1977a/b; 1982; 1988) and Weiss (1974). These authors uncovered the existence of a need among primate species for attachment and for the security and comfort experienced by those considered to be 'intimately attached' in close bonds with others. "While sociable and intimate interactions may at times serve to provide distraction from stressful problems they more typically serve to enhance mood and feelings of self-worth directly" (p. 247). There are some who regard such sociable and intimate interactions as basic social or human needs (e.g., Fromm, 1957; Sullivan, 1953; Weiss, 1974), the current author included. It follows, then, that those who lack opportunities for companionship and intimacy suffer emotional distress or loneliness.

The third perspective from research on social isolation, reviewed by Rook (1985) emphasises the regulatory functions of social ties which include deterrence from deviant acts and the promotion of healthy behaviour, such as healthy habits. Being embedded in a web of interpersonal influences - that is, being **socially integrated** - helps the individual to achieve compliance with group norms, thus restraining deviant, unsociable acts. Their second function (Durkheim, 1897/1951) is to impart **meaning** to one's existence. The absence of strong interpersonal connections, "contributes to despair, and in extreme cases, to suicide." Correspondingly, having, "a structure and input into daily affairs" might be expected to evince, "stable, health-sustaining behaviour, such as proper diet, exercise, adequate sleep and periods of relaxation." (Rook, 1985).

The salience of these issues to the **choice** of measuring instruments that will be included in this study will become much clearer within the next section of this chapter on "measurement of the current conceptualization of social support". The conception of support offered by Rook (1985), together with the critical perspectives she identifies from research on the functions of social bonds will be seen to **inform** this conceptualization of the 'components' of this 'something' to which Brown (1989) refers.

In their review of studies which have examined the association between stress, social support and well-being, Cohen and Wills (1985) draw a conclusion regarding the attribution of the association to a **main effect** of support or a **buffering effect** of support against stress. "Both conceptualizations of social support are correct in some respects but each represents a different process through which social support may affect well-being" (Cohen and Wills, 1985).

This position serves to illustrate a different **emphasis** in the interpretation of the term 'social support'. Cohen and Wills' (1985) interpretation demonstrates that the meaning of the term 'social support' is often dependent on the convictions of whoever happens to be engaged in research of the concept. For example, what Cohen and Wills (1985) mean by '**social support**' is **not** akin to Rook's less inclusive (1985) definition. Both sets of researchers **do confer** on what is considered important in **social interaction**: interaction which contributes to the current definition of Brown's (1989) "something". They differ only in the labels they ascribe each component of interaction. Rook (1985) is careful to make **distinctions**, like Barrera (1986), between, on the one hand, the components of social interaction that are *intentionally* help-orientated (behaviours), "prompted by awareness of another's problems" (Rook, 1985), and, on the other, those components that promote well-being *unintentionally* through interaction with others, such as going out with someone to the cinema. Only the former types of interaction Rook (1985) considers definitive of 'social support'.

To summarize, among researchers of the global concept 'social support' there can be said to be agreement about the 'components' (Brown, 1989) that go to form the "something" (Brown, 1989). These components should be included in any instrument that purports to measure the functions of social bonds. Where these researchers disagree is on the components that can be considered *exclusive representations* of the term 'social support'. There are those who limit the term 'social support' to mean those provisions exclusively aimed at helping someone perceived to have problems. Others argue that any component of social interaction that could contribute intentionally or not to the 'something' of Brown (1989), defined here as, "the feeling and knowledge of being stable and secure and so less alone and separate through constructive engagement with other people", merits the term 'social support'. These distinctions bear upon the form of the measuring instruments by which these individual components of social bonds are to be measured.

It should be borne in mind throughout this section the current need to preempt confusion about,

(a) the conceptualization of the global concept 'social support' to be made, and so too,

(b) its measurement.

It will be demonstrated in this way that **specific support concepts** may fit unique models (Barrera, 1986) of the process of patient discharge and readmission. This, in turn, will lend less open to interpretation the meaning of the associations identified since each support component will be clearly described. That is, "Because the term 'social support' has been used to refer to each of these aspects of relationships, each must be considered part of the **general domain of social support**." (House and Kahn, 1985).

4.2. WHAT A GOOD MEASURE OF SOCIAL SUPPORT SHOULD ADDRESS.

In their paper charting the development of a new measure of social support, Power, Champion and Aris (1988) comment on the aspects of social support that a "good measure" should address. The aspects they identify can be seen to, (a) summarize what has been proposed thus far about the meaning of the term support; and, (b) serve as an introduction to the next section on **what** to measure and **how** to measure it.

The points they make (p. 349) can be summarized as follows:

1. The scale should be capable of distinguishing between the structural and functional aspects of support.

This refers to the Cohen and Wills (1985) demarcation between (i) the simple **existence** of relationships; and, (ii) the extent to which one's interpersonal relationships provide particular **resources** or **functions**.

4.2.1. THE FUNCTIONS OF SOCIAL SUPPORT.

These will be discussed under the 2nd point made by Power, Champion and Aris (1988).

4.2.2. THE STRUCTURE OF SOCIAL SUPPORT.

Structural aspects denote the existence of more objective indicators of being supported: whether or not, (a) a person is married, single, or divorced; (b) a person belongs to groups of various kinds; (c) a person exists in role-relations with others: husband/wife/partner, best friend, mother, father, neighbour, uncle, aunt, professional person, and the like. Some of these components, listed by House and Kahn (1985) are considered representative of the aspects identified in the literature as **social network** and **social integration**. They make the following, quite critical point, that,

> "It is necessary to consider all 3 aspects of social relations - their quantity, structure, and function - because they are logically and empirically related. Moreover, they may constitute distinctive explanations of the effects of social support or social networks as these terms are used more generally. The existence or quantity of social relationships is a necessary

condition for, and hence a partial determinant of, both the network structure of those relationships and their functional content or qualities. Similarly, network structure may partially determine the functional content or qualities of relationships within the network." (House and Kahn, 1985, p. 85).

Applying this critique to the analysis of the orienting question - What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital? - the following premise can be made. The social support experienced by each patient discharged back home is considered likely to modify the impact of the anticipated and inevitable **interruptions** to their lives. That is, each patient will be subject to what Hoult (1986) terms the "underlying interpersonal stresses" which "persist to precipitate further episodes (of psychological distress)." The experience, (1) that one is stressed, and, (2) that one is distressed will be **modified**, in the first instance, by the basic existence of other people and of social roles: so-called 'structural' components of social support, from which 'functional' provisions might be obtained.

An example will be used to illustrate these points.

AN EXAMPLE.

The patient to be interviewed is a married man, with no children. He has no formal contact with any groups or organizations such as political parties, the church or sports clubs. His hobbies are gardening and exploring the countryside with his wife, and on his own with their dog. He does have a job, however, and socialises with a few colleagues of a Friday evening. He sees his father once or twice each week. They are fairly close. His mother died several years ago.

The **existence** of these social relations will determine the **functional** content or qualities they confer. The provision of Cohen and Wills' (1985) four support resources - esteem, belonging, appraisal, and instrumental - will be from a small, finite number of sources: his wife, his colleagues, his father. Should the main provider of these functions be his wife then any **interpersonal stress** (Hoult, 1986) experienced where she is the person considered responsible will have predictably greater impact on his experience of **distress** - since she might be the man's main source of support. Alternatively, where the "interruption" is the fact of being passed over for an expected promotion at his work the man might be likely to be able to draw on his wife's support to compensate for the loss and disappointment that would almost certainly arise. Such support would be hypothesized to restore his sense of stability, security and so negate the feeling of separateness and aloneness consequent on this kind of disappointment.

2. The functional types of support should at a minimum be divided into the general categories of emotional versus practical support.

In his analysis of the items that comprise the Index of Socially Supportive Behaviours (Barrera et al., 1981), Hill (1987) identified two such dimensions termed, (a) socioemotional support, and (b) material support.

Cohen and Wills (1985) provide definitions and a discussion of four separate **resources** or **functions**:

(a) **esteem** support: the perceived likelihood of a positive comparison when comparing one's self with others;

(b) **informational** support: the perceived availability of someone to confide in and with whom to share one's problems;

(c) social **companionship** support: the perceived availability of social companionship: of people one can do things with;

(d) **instrumental** support: the perceived availability of material aid. Cohen and Wills (1985, p 313).

Winefield (1987) offers another typology. She identifies 8 different kinds of help listed under the main headings, (a) **esteem-enhancing** help (which is **emotion-focussed**); and, (b) **practical** help (which is **problem-focussed**). <u>Esteem-enhancing forms of help are:</u>

1. active listening;
2. empathetic response;
3. distraction (e.g., cheering up);
4. love (and dependence);

These forms of help act to **encourage** the recipient. <u>Problem-focussed forms of help are:</u>

1. unskilled help (e.g., chores, loans);
2. skilled (e.g., surgery);
3. modelling (e.g., by example!);
4. direct (e.g., explanations).

These forms of help serve to **attack** the problem directly.

Winefield (1987) writes, “The distinction between these may shift, however, if, for example, practical help is perceived by the recipient as motivated by care and affection." Such allusion to the interdependence of the support concepts has also been made by Thoits (1983) and will be examined more fully a little later in the chapter.

3. Information about the *quality* of the relationship should be provided by the measure. Specifically, it should provide a measure of the person's perceived *adequacy* of the support s/he receives.

It will be recalled from the review of research on social support in community samples (chapter one) that Henderson et al. (1981) in their investigation of psychiatric disorder amongst a sample of men and women living in Canberra, Australia found that:

1. it was the perceived adequacy of social relationships that was linked to their subsequent morbidity.

2. perceiving social relationships as inadequate was predictive of symptom onset only in the coexistent presence of adversity.

3. the perception of social relationships as inadequate could be a valid expression of how others have behaved toward the respondent.

4. The scale should measure perceived support in preference to received support, because received support may be confounded with levels of stress (e.g., Cohen and Wills, 1985; Wethington and Kessler, 1986).

Perceived support refers to the fact that much of the evidence for the effectiveness of support for health and well-being has been based on subjective self-report measures that ask respondents to evaluate the quality of support available to and experienced by them (Heller and Lakey, 1985; Wethington and Kessler, 1986). Such measures of perceived support, however, do not necessarily reflect actual enacted support since the two are only mildly related (Barrera, 1986; Heller and Lakey, 1985; Heller et al., 1986; Lakey and Cassaday, 1990). In this way, despite Power et al.'s (1988) focus on perceived support, a “good measure" ought to provide, in addition, information about both **subjectively perceived support** and **actual received support** (or ‘enacted' support). This suggestion was also made by Alloway and Bebbington (1987) in their review of the literature on the buffer theory of social support.

4.3. MEASUREMENT OF THE COMPONENTS OF THE GENERIC TERM 'SOCIAL SUPPORT'.

This section will provide information about **how** measurement of social support components in the domain has been achieved. In the section after this a clear statement will be made about the conceptualization of social support that informs the research. A penultimate section will discuss some of the additional criticisms acknowledged in the 1st chapter, together with methods by which these have been tackled. The final part of this section on social support will provide a detailed examination of the instruments with which measures of these components will be obtained.

Given the many definitions of the term ‘social support', it is no surprise to find many types and forms of instrument for measuring the construct. These instruments are intended to assess both the quantitative, structural aspects of social support and the qualitative, functional aspects of support systems (Orth-Gomer and Unden, 1987).

Most social support instruments can be categorized along the dimensions to which House and Kahn (1985) refer, namely whether the instrument is designed to measure:

(1) the existence and quantity of social relations;

(2) the functional content and quality of relationships.

4.3.1. THE EXISTENCE OF SOCIAL RELATIONSHIPS.

In their review of measures of social support, Orth-Gomer and Unden (1987) note that common to scales that provide measures of the existence and quantity of support is their “relative brevity and similarity in contents." (p. 86). House and Kahn (1985) state that such measures are relatively objective and reliable measures of supportive relations which are easy to obtain. This information can be obtained by self-report, behavioural records, and simple observation. “Even if obtained by self-report, information on whether or not patients are married, live alone, or belong to a church or other organizations is generally simple to collect, stable over time and accurate." (House and Kahn, 1985).

That measures of the simple existence and structure of relationships continue to be obtained is because social relationships must exist in some quantity before they can have any structure or any function. In a more extreme position, Syme (1982) argues that it is the mere presence and quantity of relationships that are of moment for health and well-being, not necessarily their structure or functional content.

There is some evidence for the construct validity of these instruments in terms of their relationships with health outcomes. Blazer (1982) and Gove, Hughes and Style (1983), for example, provide evidence that it is the **quantity** of these relationships that largely explains their effects.

INSTRUMENTS - EXISTENCE OF SUPPORT.

Instruments designed to measure the size and structure of any individual's social relationships include:

1. The Social Network Index (Berkman and Syme, 1979);
2. The Social Relationships and Activities Questionnaire (House et al., 1982);
3. The Social Support Scale (Lin et al. 1979);
4. The Social Network Interaction Index (Orth-Gomer and Johnson, 1985).

Information about the reliability and internal and external validity of these scales is also presented by Orth-Gomer and Unden (1987). Reliability and internal validity measures were not available for the scales developed by Berkman and Syme (1979) and House et al. (1982). Internal consistency was tested for the instruments of Orth-Gomer and Johnson (1985) and Lin et al. (1979). Predicted health outcomes ranged across mortality (Berkman and Syme, 1979; House et al., 1982), and psychiatric symptoms (Lin et al., 1979).

4.3.2. THE FUNCTIONAL CONTENT OF SOCIAL RELATIONSHIPS.

The vast majority of studies across the past decade have attempted to measure social support in terms of the functional content of social relationships. House and Kahn (1985) make the valid point that most investigations of social support develop their own scales, “such that there are almost as many different measures as there are studies". Where differentiation does exist among measuring instruments this is made according to:

(a) the **actual quantity and availability** of support versus the **quality and adequacy;**

(c) the **type** of support: the functions provided;

(d) the **perception** of supportive functions and resources versus the occurence of **actual behaviours.**

Most measures focus on the self-report of any individual - concerning their perceptions, experience, and understanding of these support 'components' (Brown, 1989).

INSTRUMENTS - FUNCTIONS OF SUPPORT.

Examples of this type of measuring instrument are reviewed by Orth-Gomer and Unden (1987), and include:

A. Measures of Actual, Supportive Behaviours:

(1) The Inventory of Socially Supportive Behaviours (Barrera et al., (1981);
(2) The Social Relationship scale (McFarlane, 1981).

B. Measures of Support Availability, Adequacy and Type of Support:

(1) The Social Support Index (Bell et al., 1982);
(2) The Interpersonal Support Evaluation List (Cohen et al., 1983);
(3) The Interview Schedule for Social Interaction (Henderson et al., 1980);
(4) The Social Support Questionnaire (Sarason et al., 1983);
(5) The Social Support Questionnaire (Marmot, 1985);
(6) Perceived Social Support (Procidano and Heller, 1983).

Information about their form, reliability and internal and external validity is also presented by Orth-Gomer and Unden (1987). The instruments developed by Barrera et al. (1981), Henderson et al. (1980), Cohen et al. (1986), and Procidano et al. (1983) were tested for both reliability and internal validity, whilst Marmot's (1985) and Bell et al.'s (1982) instruments provide neither. External validity was measured against health outcomes ranging across mortality, depressive symptoms, and other symptoms of psychiatric and psychological distress.

The social support instruments identified by Orth-Gomer and Unden (1987) and reviewed by House and Kahn (1985) demonstrate the common agreement among authors on what are considered important "**existentially-securing**" (Thoits, 1983) **resources** (Caplan and Killilea, 1976; Cobb, 1979; Cohen and McKay, 1984; Cohen and Wills, 1985; Fischer, 1982; Gottlieb, 1978; House, 1981; Kahn and Antonnuci, 1980; Schoefer, Coyne, and Lazarus, 1981; Shumaker and Brownell, 1984; Turner, 1983; Weiss, 1974).

However, no clear statement has yet been made about what is considered to represent this '**rubric**' (Henderson, 1984) - social support. This will now be presented. In doing so it would be wise to bear in mind the cautionary words of House and Kahn (1985) that, "Those interested in measuring and demonstrating the utility of different types of support must attend more to the **specific nature** of the support process *as the nature of the problem requiring support varies.*" The nature of the problem requiring support is the patient's adjustment to life back in the community following discharge from hospital.

4.4. 'SOCIAL SUPPORT': CURRENT CONCEPTUALIZATION WITHIN THE RESEARCH FRAMEWORK.

The experience of 'social support' is the knowledge that one has others to whom one may turn when meeting with **adverse** life conditions. It is also the actual support they provide and the meaning of this support for any individual. This experience is considered to be one of the major factors that will modify the deleterious effects of stress on psychological distress. This will, in turn, modify the likelihood of return to the hospital since such return is predicated by the intense experience of stress and distress that is without apparent means of resolve.

From the previous examination and discussion of the 'components' of the 'label' "social support" considered likely to make a significant contribution to the hypothesized experience of the dependent 'something', one is now in a position to provide a clear description of these components. A person's response to and understanding of a stressful interruption in his or her life will be modified by his or her experience of the following components of social support considered essential for an understanding of the on-going process of patient discharge and readmission - the "revolving door syndrome" (Goldman, Regier & Taube, 1985):

1. THE ACTUAL BEHAVIOURAL TRANSACTIONS RECEIVED from others in one's life: other people around a person in need of help will **act** - doing various things for that person. These behaviours can be specified and measured.

2. THE SUBJECTIVE EXPERIENCE OF 'EXISTENTIALLY-SECURING' SUPPORT PROVISIONS: the sense of belonging, self-worth and self-respect arising through comparison and being with others: the feeling that arises through being supported constructively by others.

3. THE EXPERIENCE OF THE PRESENCE OF *ATTACHMENT* AND *SECURITY* - of being protected and involved intimately with one other person: categorically loved, confirmed in one's self, accepted and understood by one other person. This draws on the work of Weiss (1974) and Bowlby (1982; 1988) on the attachment provision of social relations.

4. THE GENERALIZED SENSE OF BEING *SATISFIED* WITH THE PEOPLE IN ONE'S LIFE: the experience of a person's relational life will engender in that person a measurable **generalized** sense of satisfaction: a sense of things being adequate or not; 'right' or 'not quite right'.

5. THE AVAILABILITY AND ENACTMENT OF FORMS OF *PLEASURABLE SOCIAL ACTIVITY.*

6. THE AVAILABILITY OF PERSONS TO WHOM ONE CAN TURN: Does the person know many people? That is, to what extent is the person 'socially-integrated' (e.g., Rook, 1985)?

In the 'case' example outlined in section 4.2.2., one would be able, using this conceptualization, to understand the man's experience of psychological distress as follows:

The man's response to the interruption in his life - being passed over for promotion - will be partly determined by, among these features documented earlier, his experience of any one or combinations of all six of these “components" (Brown, 1989) of the “generic concept" (Winefield, 1987) **social support**. These many components contribute to the “**something**" (Brown, 1989) that is considered best understood as:

The feeling and knowledge that a person has of being stable and secure and thus less alone and separate through constructive engagement with other people (from Boyce, 1985; Fromm, 1957/1988).

Being passed over for promotion might be expected to leave this man feeling disappointed and let down. He had expected the promotion and did not get it. In seeking to find reasons for his failure he might be likely to feel angry if he believes that,

(a) his boss has overlooked him on the grounds of having spent time in hospital (his clinical/psychiatric history): on what this might imply (“If he cracked up before he may crack up again." He is therefore considered less dependable as a commodity in the workforce);

(b) his colleagues offered no assistance to his attempts to earn promotion. On the contrary, they actively competed for the attention and respect of their shared boss.

In each of these conditions the experience will almost certainly be engendered and felt by the man (a) that he is less secure; (b) that his life is less stable than he had thought; (c) that he is more alone in the world - having to compete with so-called ‘friends' and colleagues, and thus (d) that he is more separate from others. What hope of recovery and adjustment for this man will, in large part, lie in how well he is able to draw upon the support of his wife. Does she provide any of the means for the satisfaction of any one or more of the six components which might work toward the <u>healing</u> of his distress (i.e., of feelings that represent a movement away from security, safety, harmony and union and which emerge in the guise of ‘symptoms' of various kinds).

4.5. BARRERA'S (1986) TRIPARTITE CONCEPTUAL FRAMEWORK OF SUPPORT.

This conceptualization of the components of ‘social support' draws upon ideas covered in a review made by Barrera (1986) of the <u>distinctions</u> between social support concepts, measures and models. Barrera's (1986) major thesis is that the term ‘social support' is too global and insufficiently differentiated to be useful as a research concept. Instead, more specific terminology should be used, replacing abandoned global references to ‘<u>support</u>'. Social support concepts and their operationalizations are organized into three broad categories:

A. **social embeddedness**;

B. **perceived social support**; and,

C. **enacted support** (Barrera, 1981; Barrera, Sandler and Ramsay, 1981; Gottlieb, 1983; Heller and Swindle, 1983).

Each of these will be examined in turn such that their influence on the way in which support has been conceptualized in this study can be demonstrated. In due course, information about the measuring instruments for obtaining these kinds of information will be presented. Additional information will also comprise, (a) the constructs assessed by each instrument; and, (b) clear reasons for their inclusion in the present study.

4.5.1. SOCIAL EMBEDDEDNESS.

This social support concept refers to the network existence and stucture indicators outlined by House and Kahn (1985). Being socially connected is a major component in one's "psychological sense of community" (Sarason, 1974), and, as stated previously, is a necessary condition for the presence and receipt of the qualitative aspects of support (House and Kahn, 1985).

The components within the research conceptualization just outlined in this study that confer with this concept - social embeddedness - are items:

3. The availability of <u>attachment</u> and <u>security</u> - of being protected and involved intimately with an other person: categorically loved, confirmed in one's self, accepted and understood by one other person; and,

6. The availability of persons to whom one can turn: the extent to which a person is "socially integrated" (e.g., Rook, 1985).

4.5.2. PERCEIVED SOCIAL SUPPORT.

Heller and Lakey (1985) offer the hypothesis that, "the effectiveness of support may not reside in any particular behaviour of significant others, but in **how** that behaviour and ensuing relationship are **perceived**." Many measures of perceived support incorporate two dimensions - perceived availability and perceived adequacy of supportive relations (Cohen and Hoberman, 1983; Holahan and Moos, 1981; Procidano and Heller, 1983; Turner et al., 1983). These measures "attempt to capture individuals' confidence that adequate support would be available if it was needed or to characterize an environment as helpful or cohesive." (Barrera, 1986, p.417). According to Barrera (1986) this conceptualization of social support makes sense when viewed as a component of **models of stress and coping processes** (Folkman, Schaefer, and Lazarus, 1979; Lazarus and Launier, 1978; Smith & Lazarus, 1990). These models emphasize:

1. the evaluation and interpretation of situations or 'interruptions' (Mandler, 1983) that are potentially threatening;
2. the calling upon of effective 'resources' that can enable management of the threat.

The components of the current conceptualization which correspond with this second of Barrera's (1986) concepts are the following:

2. The subjective experience of existentially-securing support provisions: the sense of belonging, self-worth and self-respect arising through comparison with and being with others.

3. The experience of the presence of *attachment* and *security*: adequacy items (not availability).

4. The generalized sense of **satisfaction** with the people in one's life: a sense of things being adequate or not; 'right' or 'not quite right'.

4.5.3. ENACTED SUPPORT.

This is perhaps the component described as most in need of investigation by Barrera (1986). It alludes to the **actions** that others perform when they provide assistance to someone. Measures of this part of Barrera's (1986) triad complement the others by assessing what individuals **actually do** that is intended to reassure, comfort, confirm and generate and validate a sense of self-respect and confidence in the other. This component might help a better understanding to emerge of the coping and adjustment process (Gottlieb, 1978; Liem and Liem, 1979; Cowen, 1980). Barrera (1986) writes:

> "Intuitively, the helping behaviours that constitute enacted support are likely to be provided when individuals face adversity, particularly acute stressors. In these cases, measures of enacted support are suitable for gauging the responsiveness of others in rendering assistance when subjects are confronted with stress" (p. 417).

Measurement of this support as it impacts and buffers the experience of **crisis** in people's lives has been advocated (Alloway and Bebbington, 1987) and attempted (Aneshensel and Frerichs, 1982; Carveth and Gottlieb, 1979; Pearlin and Schooler, 1978; Sandler and Barrera, 1984; Brown et al., 1986). Of the six components of support in the current conceptualization, that representative of the enacted support concept are components:

1. The actual, received behaviours between helper and helped.

4.6. A TERMINOLOGICAL DIFFICULTY.

Support can be conceptualized as a number of different components - distinguishable as separate elements within a research framework. However, the significance and meaning of these supportive components - in an existential sense - will not necessarily be separate and distinguishable, relative to each identifiable component. Rather, what is considered more likely is that the 'support' one receives brings one closer to the sense of security, safety, togetherness, and union characterizing the 'something' to which many researchers have alluded and which is encompassed by the definitions proposed by Boyce (1985) and Fromm (1957/1988). This 'support' when 'provided' might not be experienced as such, nor might the individual be aware of it as such. Thoits (1985) examines this issue at some length. It is worthwhile drawing attention to the points she makes such that,

(a) by illustration, some of the major difficulties associated with conceptualization and measurement in this research domain can be identified; and,

(b) the research framework for organizing the 'voluminous information' (Lehman, 1983) involved in research on the factors in psychiatric outcome can also be better understood.

Many of the supportive aspects of being involved in social relationships are essentially 'unintentional by-products':

"Meaning, purpose and inclusion are not offered explicitly or deliberately to him/her by others. Similarly, evaluations from others are most often perceived implicitly - in body language, tone of voice, or the sheer fact of continued or non-continued interaction - rather than in explicit feedback." (p. 64).

This kind of support is what has been referred to as the 'main effects': being with others does us good, irrespective of stress. People feel the benefit of being involved with other people - members of one's own and immediate family, best friends, acquaintances, colleagues. Qualifying this support as 'emotional', "seems to specify the **nature** of the benefits accrued." The support acts to **modify** the experience of emotional arousal and/or psychological distress sometimes consequent on such arousal (i.e., higher-order cognitions and feelings associated with arousal). One need not be conscious of support as such. Nor is the process necessarily known by which the knowledge that one is supported translate into states of relative emotional equilibrium: promoting the experience of being safe, secure, less alone and separate.

Thoits examines this apparent tautology: emotional support results in beneficial emotional outcomes. She writes:

"To state that emotional support has a direct effect upon psychological well-being is to suggest that support in any of its forms operates as an independent variable. Yet when one examines how security, belonging, esteem, and a sense of comparative mastery are obtained when troubles are not present to prompt their direct offer, support ceases to be an independent variable and becomes the (often unintentional) byproduct of a social interactional process, or set of processes." (p.64).

Support, then, is best construed as an **intervening variable**. It arises through involvement with other people and has a beneficial effect on health and well-being (and conversely, arousal and distress). These involvements - Thoits (1985) argues - are most often considered to be 'emotionally supportive'. However, she makes the distinction between the forms of support that might be regarded as true 'emotional support' and those which connote, "a process or set of processes linking social life to emotional experience." For each will be significant subject to the varying circumstances of peoples' lives - whether in need of support or whether enjoying the fruits of being with others without any major 'interruptions' to one's activities to contend with. She writes,

"In my view the phrase 'main effects of emotional support on psychological well-being' signifies 'main effects of on-going social involvements upon emotional well-being.'. . .When significant others intentionally offer reassurance or encouragement to a distressed individual . . . the term 'emotional support' takes on concrete meaning and becomes a measurable independent variable. In this case I would define 'emotional support' as **words** or **deeds** that are intended to alter the damaged self-perceptions of an individual facing stressors." (p. 65).

There is support which might be termed explicit and intentional and support best considered epiphenomenal or unintentional. There is a stricter definition of intentional, explicit support as "the **words or deeds** that are intended to alter the damaged self-perceptions of an individual facing stressors". This definition comes close to that of Rook (1985) who construes support as "the provision of various types of help (that). . occur in response to learning of another's problems. The social context that gives these behaviours their meaning is the revelation of a personal problem." (Rook, 1985, p. 246).

This distinction between the intentional and unintentional (or 'epiphenomenal') forms of support raises an important question: Does the conceptualization of the components of the generic concept 'social support' offered provide the means by which these two forms of support can be identified and measured? Both Thoits (1985) and Rook (1985) make it clear that measures of the epiphenomenal forms of support are much more difficult to obtain since this support is less concrete and so less of "a measurable independent variable" (Thoits, 1985).

4.6.1. ARE THE TWO FORMS OF SUPPORT MEASURABLE?

Where security, belonging, esteem and a sense of mastery are the "unintentional byproducts of a social interactional process, or set of processes" (Thoits, 1985) the measurement of the **actual moments** in which these existential phenomena come into being is quite problematic. When and how do the effects of ongoing involvements with other people translate into emotional and existential experience? Better, it's believed, to consider **two stages** in this process which links **social life** with emotional experience.

A. Stage one.

The first stage is to consider the 'social life' of any individual. This involves measuring what it is that people do and say - the words and deeds - when they are together. This will permit the measurement of the components of 'social life' which, it is thought, come to bear upon the 'individual life'. These happenings - words and deeds - can be regarded as the independent variables. The dependent variables will be what it is the individual carries away with him or herself in terms of an experience of Brown's 'something'. That is, in terms of feeling more stable and secure, less alone and separate from others and estranged from oneself. This 'something', in turn, modifies the experience of psychological distress - a higher-level dependent variable.

The two forms of support can be measured, at least representations of that support. The more objective, intentional form will be represented by the following component of the conceptualization:

1. the actual behavioural transactions between people;

The unintentional forms of support will be represented by these components:

3. the experience of attachment and security: the knowledge that attachment persons are *available.*
5. the enactment of forms of pleasurable social activity.
6. the knowledge that people are available to turn to in general - the degree of 'social integration'.

B. Stage two.

The second stage is to consider the subjective life or "individual life" (Smail, 1987). For regardless of how objective are the facts of social relations (i.e., their basic existence), the psychological consequences of any involvement with others - the emotional and existential benefits of social support - depend on the individual's subjective *understanding*, unique to that individual, of the meaning of these relations. The fact of being involved with others in social relations will always have a significance and a meaning - i.e., "a linkage between the past, present, and future" (MacMillan, 1989) - which is unique to that person. For these reasons it is crucial that attention be paid to the individual's own personal understanding of both overt, emotional support and of those epiphenomenal forms which give rise, in turn, to an experience of emotional well-being.

However, measurement of the ongoing social involvements which contribute, in an epiphenomenal way, to positive states of emotional well-being will not be measured **directly**. Rather, measures will be obtained of each individual's generalized sense of satisfaction in being supported and involved with others (or not, as may be the case). That is, measures will be obtained that approximate to the current existential definition of the term, 'social support'. This form of support will be represented by the following components:

1. the experience of 'adequacy' in close attachment relations.
2. the generalized sense of adequacy in more diffuse attachment relations.

Before tackling the final section of this chapter - on measurement of the support components - one of the difficulties identified in the 1st chapter must be covered, one related to measurement. It has been argued that some measures of support include items which contaminate the construct 'support' with the constructs 'stress' and 'psychological distress'. Though this might be a consequence of the difficulty in this research domain of making clear distinctions between dependent and independent variables - where "emotional support is nowhere but everywhere" (Thoits, 1985) - other additional reasons have been suggested. These will now be examined.

4.7. CRITICISM: CONTAMINATION OF SUPPORT MEASURES WITH STRESS AND DISTRESS.

The issue of confounds is one which has had much attention (e.g., Cohen and Wills, 1985; Depner, Wethington, and Ingersoll-Dayton, 1984; Barrera, 1986; Cutrona, 1989; Lakey and Cassaday, 1990). Specifically, criticism has been levelled at measures of support which are regarded as being confounded with measures of both stress and distress (Cohen and Hoberman, 1983; Dohrenwend, Dodson, Dohrenwend, and Shrout, 1984; Gore, 1981; Heller and Swindle, 1983; Henderson, Byrne, Duncan-Jones, 1981; Thoits, 1982). These issues are reviewed by Barrera (1986) and Cutrona (1989).

Barrera (1986) cites the study by Turner et al. (1983) in which an attempt was made to examine the overlap between items of perceived social support and psychological distress. Using factor analytic methods these authors found that social support and distress items separated into quite distinct factors, with no consistent overlap between the two sets of items. However, Lakey and Cassaday (1990) observed that their measures of perceived support, negative cognition and psychological distress were highly intercorrelated suggesting that all may be reflecting the same underlying construct. They cite Watson and Clark's (1984) proposition that measures of psychological distress and negative cognition typically reflect the meta-construct of negative affectivity. To test this, Lakey and Cassaday (1990) factor analyzed their study variables - distress, negative cognition, and perceived support. They identified two factors. The first appeared to reflect the negative affectivity construct, with dysphoria and trait anxiety loading most highly. Factor two primarily appeared to reflect perceived social support. There was no loading of perceived support on the first factor, negative affectivity. They conclude that perceived support and cognitive personality measures are highly associated, where the relation between psychological distress and perceived support was reduced substantially **but not altogether** when the cognitive personality variables were controlled statistically. The two variables - personality and perceived support - are best considered as, “linked to psychological distress by similiar processes" (Lakey and Cassaday, 1990).

Dohrenwend et al. (1984) reflected the concerns both of Cohen and Wills (1985) and Depner et al. (1984) about the degree of overlap between measures of psychological distress and of stress and social support. This happens when checklist, self-report measures of life events are used - obviating the need for the researcher to be present during assessment. These measures typically include measures about interpersonal discord and social exits (e.g., death, separation, moving town or home). The items are similar to those found in many social support measuring instruments. Confounding is quite possible where the two instruments appear to be measuring the same thing, namely, changes in social relationships (Eckenrode and Gore, 1981; Fontana, Dowds, Marcus and Eisenstadt, 1980; Wallston, Alagna, DeVellis and DeVellis, 1983).

Anticipating these kinds of problems of methodological confoundment of research concepts Depner, Wethington, and Ingersoll-Dayton (1984) suggest the distinct operationalization of key constructs within any intending investigation. That is, the constructs which are the focus of any study should be described and the means by which they will be measured made quite clear. As far as is considered possible every attempt to satisfy this advice has been made within the confines of the research question - the correlates of ‘adjustment' among formerly acutely-disturbed discharged psychiatric patients. The means by which social support constructs are to be measured will be described presently.

In an attempt to test for the degree of overlap of items across measures of distress, stress, and social support, Dohrenwend et al. (1984) asked clinical psychologists (APA) to judge items from a number of measuring instruments. The life-event checklist the Schedule of Recent Experiences (Holmes and Rahe, 1967), Kanner, Coyne, Shaefer and Lazarus' (1981) Hassles Scale and Lin, Dean, and Ensel's (1981) Instrumental Expressive social support scale were judged for their apparent assessment of symptoms of psychological disorder. Ratings were made along a dimension from 1 (almost certainly a symptom of psychological disorder) through 5 (almost certainly **not** a symptom of psychological disorder). Anchor items on either pole were obtained from Langner's (1962) 22-item Checklist and Barrera et al.'s (1981) Index of Socially Supportive Behaviours (the ISSB). As predicted, Langner's items were uniformly rated as **certainly** symptoms, with Barrera's (1981) items filling their predicted role on the opposite end of the continuum - certainly not symptoms. This finding is less surprising in light of the observations made by Lakey and Cassaday (1990). They found that perceived support was correlated with psychological distress, as noted previously. They also found that **enacted support** as measured by the ISSB was **not** correlated with distress. It has been hypothesized that enacted support may operate **indirectly** by contributing to the perception of support availability or by influencing coping behaviour (Lakey and Heller, 1988).

Barrera (1986) summarizes the evidence from studies which have examined the issue of conceptual overlap among items of stress, distress, and support thus: "all social support scales should not be viewed as suspiciously confounded with measures of psychological symptoms. . . there is little basis for arguing that measures of the frequency of socially suportive behaviours or perceived support are conceptually confounded with the occurrence of discrete stress events, even when the stress measure contains items concerning social exits and entrances." (Barrera, 1986, p. 437). Such items can either be excluded where there is overlap with social support items or further probing can identify more precisely the nature of the life-event relative to the source of support (Brown, 1989).

Thus far, a detailed examination has been made of many of the issues in the social support research domain. This has covered most of the difficulties identified in the first chapter. These were:

1. The apparent lack of agreement about the conceptualization of the term 'social support'.
2. The lack of agreement about what to measure and how to measure it.
3. The criticism of measures of support which confuse the measure with psychological distress and with stress.
4. The need for clear conceptualization of the global construct 'social support' according to the purposes and design of the current study.

Each of these criticisms has been examined and detailed suggestions made for their resolution. However, nothing has been presented thus far about how this information is to be measured. The final section of this second chapter will be devoted to what will be a comprehensive account of,

(1) the measuring instruments with which measures will be obtained of the six components of support;

(2) the constructs which these instruments measure; and,

(3) the detailed reasons for the selection and use of each instrument.

4.8. MEASUREMENT OF SOCIAL SUPPORT: MEASURING INSTRUMENTS.

4.8.1. ENACTED SOCIAL SUPPORT: THE BEHAVIOURAL TRANSACTIONS BETWEEN PEOPLE.

A. THE INVENTORY OF SOCIALLY SUPPORTIVE BEHAVIOURS.

The Inventory of Socially Supportive Behaviours (Barrera, Sandler, and Ramsay, 1981) is a 40 item measure of the behaviours which might lead a person to believe that he or she is loved, esteemed and part of a network of communication and mutual obligation. The scale was designed to assess the type and amount of support that an individual receives over a given time-period.

1. Constructs assessed.

A factor analysis of the scale by Barrera et al. (1983) identified four factors which, in turn, appeal to Hill's (1987) classificatory scheme. He identified two broad factors: socioemotional support and material support. The first three of Barrera et al.'s (1983) factors, Directive guidance, Non-Directive support and Positive social interaction correspond quite consistently with the socioemotional support dimension. The fourth factor, Tangible assistance directly corresponds to the Hill subscale, material support.

Overall, the scale purports to measure "the broad diversity of functions that characterize informal social support functions" (Barrera et al., 1981, p.438). It is a measure of administered support, or what Barrera later terms **enacted support** (1986).

The scale developed from a conceptualization of social support as behavioural transactions provided by natural support systems, that is, by the network of individuals known to that person. The content of support functions were analyzed into rational categories, an analysis that involved the review of all those papers whose authors delineated a theoretically-based conceptualization of social support (Barrera et al., 1981). From this analysis was generated the 40 item scale named the ISSB.

2. Reasons for inclusion in the present study.

Conceptualizing social support as a combination of characteristics of social embeddedness, perceived support, and enacted support requires that distinctions be made between the various measures. Within this model of 'social support' the **enacted** part might best be conceived of as the actions that others perform when they render assistance to a focal person. Tardy (1985) referred to behavioral descriptions of support as "enacted" support to distinguish it from "available" support that is measured by scales of perceived availability. Measures of enacted support complement other measures by assessing what individuals actually **do** when they provide support.

Though there are complications surrounding the reliability of recall of supportive actions (the so-called "perceived-received" problem) nevertheless this measure of enacted support is thought most appropriate for purposes of the present study. Short of actually shadowing somebody over a period of time, or requiring them to fill out a daily diary over a **six month** period of their lives, something quite infeasible given the much lower levels of functioning capacity of the population under investigation, this measure provides a **retrospective** evaluation of each person's degree of provision of socially supportive actions.

4.8.2. PERCEIVED SOCIAL SUPPORT: THE EXPERIENCE OF 'EXISTENTIALLY-SECURING' SUPPORT PROVISIONS.

B. THE INTERPERSONAL SUPPORT EVALUATION LIST.

The interpersonal support evaluation list (ISEL) (Cohen, Mermelstein, Kamarck, & Hoberman, 1985) is a 40 item measure of the perceived functional components of social support. The measure consists of 40 statements concerning the perceived availability of potential social resources.

1. . Basic constructs measured by the ISEL.

The ISEL provides multi-item scales that assess the perceived availability of four separate functions of social support:

(a) the "*tangible*" subscale is intended to measure perceived availability of material aid;

(b) the "*appraisal*" subscale, the perceived availability of someone to confide in and with whom to share one's problems;

(c) the "*self-esteem*" subscale, the perceived likelihood of a positive comparison when comparing one's self with others; and,

(d) the "*belonging*" subscale, the perceived availability of social companionship: of people one can do things with (from Cohen et al., 1985).

Each of these supportive components of the total ISEL scale was selected on the understanding that they provided the most comprehensive representation of various social support **roles**. These roles enable an individual to maintain or achieve acceptable levels of well-being in the face of disturbing and conflict-inducing stressors.

2. Reasons for inclusion in the present study.

The ISEL merits inclusion in that it provides a reliable and valid measure of the functions (or resources) provided by any person in a given network. Its functional categories are consistent with those social support typologies presented in various discussions of support and identified by Cohen & Wills (1985).

Power, Champion, and Aris (1988) were earlier quoted. They identified four important aspects of social support that a good measure should seek to address. The second of these stresses the need for **functional** types of support to be divided, at a minimum, into general categories of emotional and practical support, the major distinguishing classification between the various categories of support. The ISEL will provide a measure of the perceived availability of each of these resources (or functions) of social interaction. Observed deficits and satisfactory provision of each will be examined in relation to several indices of the patient's social and psychological experience.

4.8.3. PLEASURABLE SOCIAL ACTIVITY: THE AVAILABILITY AND ENACTMENT OF FORMS OF PLEASURABLE SOCIAL ACTIVITY.

C. THE SOCIAL RELATIONSHIPS AND ACTIVITIES QUESTIONNAIRE.

1. Basic constructs measured by the SRAQ.

The Social Relationships and Activities Questionnaire (House, Robbins, & Metzner, 1982) is a 29-item measure which provides a measure of social relationships and activities which fall into the following four categories:

1. intimate social relationships (marital status, visits with friends and relatives);
2. formal organizational involvements outside of work (going to church or meetings or voluntary associations);
3. active and relatively social leisure (going to classes, lectures, movies, plays, fairs, museums, etc.);
4. passive and relatively solitary leisure (watching television, listening to the radio, and reading).

2. Reasons for inclusion in the present study.

Involvement in social ties and relationships has long been believed to promote health and protect people against disorder and disease (e.g., Berkman and Syme, 1979; Broadhead, Kaplan, James et al., 1983; Durkheim, 1951; House, Robbins, and Metzner, 1982). A large body of research and theory suggests that social relationships providing support and security more generally promote health and protect or buffer individuals against psychosocial stressors and their debilitating impact on health (e.g., Blazer, 1982; Cassell, 1974, 1976; Ganster and Victor, 1988; Kessler & McLeod, 1985). One of the central determinants of this social relationships-health association is the extent to which the individual has access to (and is part of) a network of people. The more embedded (Barrera, 1986) is the person in a network of friends, relatives, and family members, the less likely is s/he to be at risk from situations and modes of thought capable of inducing stress and levels of psychological disturbance.

The SRAQ provides a (relatively crude) measure of the embeddedness of a person in a network or group of persons: (1) the activities they engage in; (2) who they see regularly; and, (3) the degree to which these activities provide each person with a sense of satisfaction and fulfillment.

4.8.4. ATTACHMENT AND SECURITY SUPPORT: (i) THE EXPERIENCE AND PRESENCE OF ATTACHMENT AND SECURITY; (ii) THE GENERALIZED SENSE OF BEING **SATISFIED** WITH THE PEOPLE IN ONE'S LIFE; (iii) THE AVAILABILITY OF PERSONS TO WHOM ONE CAN TURN.

D. THE INTERVIEW SCHEDULE for SOCIAL INTERACTION (ISSI).

The following description of the ISSI is based on information contained in the appendices of the text "*Neurosis and the Social Environment*" (Henderson, Byrne & Duncan-Jones, 1981).

The ISSI is a 52-item semi-structured interview which seeks to assess the availability and perceived adequacy for any individual of a number of facets of social relationships. These consist both of persons and of the provisions obtained through them (Henderson, Duncan-Jones, Byrne, and Scott, 1980). In its present form, the ISSI seeks to establish the **availability** of most of the six provisions of social relationships proposed by Weiss (1974) by ascertaining the availability of persons in specified roles. Questions about **adequacy** follow each of the availability items.

The six provisions first discerned by Weiss are :

1. Attachment, provided by close affectional relationships, which give a sense of security and place.
2. Social integration, provided by membership of a network of persons having shared interests and values.
3. The opportunity for nurturing others, usually children, which gives some an incentive for continuing even in the face of adversity.
4. Reassurance of personal worth, which promotes self-esteem and comes both from those at home and from friends and work associates.
5. A sense of reliable alliance, which is obtained mainly from kin.
6. Obtaining help and guidance from informal advisers when difficulties have to be resolved.

Henderson states that, of the six, **attachment** deserved the greatest representation on the grounds that attachment theory leads one to predict that it will have the strongest association with the development of psychiatric symptoms. Henderson quotes Bowlby's (1967; 1982) position with regard to the most crucial elements in the attachment process:

> In identifying a person's attachment figures, the criteria I regard as most distinctive are whether the person gravitates to them when frightened or in distress and to what extent doing so provides reassurance and comfort.

Weiss (1974), on the other hand, discusses the effects of the **loss** of secure and comforting relationships, or when these become threatened: where mood change often results, with restless behaviour and subjective feelings of loneliness. Both authors draw attention to the activation of attachment behaviour by the departure, or threatened departure, of the discriminated other.

1. Basic constructs measured by the ISSI.

The ISSI provides a measure of the degree to which the patient has any of the following:

1. the *social integration* measure: does the person have available a number of relationships with people in general (superficial and 'acquaintance'-type relationships).
2. the *adequacy of social integration* measure: does the person perceive such relationships to be adequate (i.e., whether there remains a sense of disappointment, dissatisfaction, and deprivation despite or in spite of such contacts).
3. the *attachment* measure: does the person have available more close, intimate, trusting and confiding relationships.
4. the *adequacy of attachment* measure: does the person perceive these relationships, together with the provisions they proffer, to be adequate.
5. the *nonatt* measure: can the person do without a number of facets of attachment relationships which he does not in fact have.
6. the *attrown* measure: the number of attachment persons with whom the patient has recently been having unpleasant interaction or rows.

2. Reasons for inclusion in the present study.

There is an interest in the degree to which persons are involved in on-going relationships that might be termed 'close' or 'strong attachment'. Of particular influence in this respect was the research carried out by Brown et al. (1978; 1986). Their original study of depressed women in the community and of those presenting to psychiatry identified, amongst other things, that the presence of a close, confiding relationship, together with the perception that such relationships were satisfactory greatly reduces the risk of onset of depression (Brown & Harris, 1978). In a refinement of this position Brown et al. (1986) identified that, where relationships involve the individual experience of being "let down", vulnerability levels to stressful circumstances and so to depressive disorder rise accordingly.

The ISSI, with special emphasis on the sense of attachment and security afforded by closer relationships, provides a measure of two basic features of the individual's network of social and interpersonal relationships: (a) the number of persons in different categories of relationship with whom the respondent has contact in daily life; and, (b) an assessment of what it is that these relationships provide for the person (Henderson, Duncan-Jones, Byrne, and Scott, 1980; 1981). It might be regarded as attempting to measure what Fromm (1957/1988) considers to be the deepest need of man - to overcome one's separateness, or what Karen Horney perceived to be the fundamental principle of behaviour for both men and women: the need for security. Thus, if a child is born into an environment which cannot give him or her a feeling of love and safety, for various reasons terrifying 'basic anxiety' forces him or her to obtain reassurance from others. This theme is a most common one running through the work of people from various disciplines. For example, the theologian Martin Buber (1957a) expresses the belief that "*the basis of man's life is twofold, and it is one - the wish of every man to be confirmed as what he is, by men; and the innate capacity in man to confirm his fellow-men in this way*". That is, close, confiding, reciprocal engagements are likely to be the seeds from which the germination of such confirmation and validation can be found.

5. WHAT IT WOULD BE GOOD TO KNOW: ATTRIBUTIONAL STYLE.

5.1. ATTRIBUTIONAL STYLE: THE FINAL COMPONENT OF THE FRAMEWORK.

The final component of the current framework for understanding patient discharge is the patient's style of attribution of the causes of bad or negative events in their lives. This component is hypothesized to play a role in the patient's ‘community adjustment' largely similar to that of social support. That is, the patient's characteristic attributions of the cause of the aversive, interruptive events in his or her life will **interact** with actual experience of negative life-interruptions to modify the *form* of the response thereof: the presence, nature and severity of psychological distress. Before going on to hypothesize predicted responses it's important, first, to provide an account of the theory linking attributional style with depressive experience.

5.2 ATTRIBUTION AND DEPRESSION.

Depression has been conceptualized as a cognitive disorder (e.g., Beck, 1967; 1976). In particular, it has been proposed that depressive symptomatology can be best understood by taking into account the attributions that people use when making sense of the bad and good events in their lives (e.g., Abramson and Sackeim, 1977; Abramson, Seligman, and Teasdale, 1978; Brewin, 1985; Harvey, 1981; Peterson, 1979; Peterson, Semmel, von Baeyer, Abramson, Metalsky, and Seligman, 1982).

The reformulated learned helplessness model of depression (Abramson, Seligman, and Teasdale, 1978) proposes the experience to be the result of exposure to uncontrollable aversive events. Alloy, Abramson, Metalsky, and Hartlage (1988) write, “A proximal sufficient cause of depression is an expectation that highly desired outcomes are unlikely to occur or that highly aversive outcomes are likely to occur and that no response in one's repertoire will change the likelihood of occurrence of these outcomes" (p. 7). The nature of the depressive experience following the aversive events or interruptions is moderated by the causal attributions the person makes for them. There are three hypothesized dimensions of attribution: an **internal/external** one, a **global/specific** one, and a **stable/unstable** one. These attributions promote the experience of depression as follows:

1. If the uncontrollable, aversive events are thought to be caused by oneself (i.e., if there is an **internal** style of attribution) as opposed to something about the situation (external attribution) then depressive experience is more likely. Where internal attributions are used the depressive experience will involve the loss of self-esteem (Peterson et al., 1982).

2. If the uncontrollable, aversive events are attributed to more permanent factors in the person's experience (i.e., **stable** attributions are made) rather than to more transient (unstable) ones, then depressive experience is promoted, particularly long-lasting symptoms.

3. Finally, if the uncontrollable, aversive events are attributed to more pervasive causes (i.e., **global** attributions are made) than to more circumscribed causes (specific attributions) then depressive experience is more likely. This form of depression is more likely to be pervasive.

In summary, the learned helplessness model of depression holds that where internal, stable, and global attributions are made for aversive events or interruptions then depressive experience is the likely result (e.g., Alloy, Abramson, Metalsky, and Hartlage, 1988; Brewin, 1985; Peterson et al., 1982).

In a revision of the theory, Alloy et al. (1988) refer to the reformulated theory of depression as the ***hopelessness** theory of depression*. They suggest that the hopelessness theory hypothesizes the existence of an unidentified 'subtype' of depression - 'hopelessness depression' - "defined in part by its cause" (Alloy et al., 1988). In the theory, two attributional dimensions are critical to an understanding of the formation of 'hopelessness' in the face of aversive events: stable-unstable and global-specific attributions. That is, when making stable and global attributions of the causes of the negative events in one's life more pervasive, long-lasting symptoms of depression characteristic of 'hopelessness' will likely result.

In his review of the relation between causal attributions and depression, Brewin (1985) makes the important point that attributions have considerable **predictive** value and may be involved in the processes of recovery from and coping with depression. The empirical evidence for the role of causal attributions in the so-called 'recovery' or 'coping' models of depression is strongest (Brewin, 1985). The 'recovery' model of depression predicts that once a person is depressed attributions **modify** the **chronicity** of the experience. Thus, where internal, global, and stable attributions are made for the **negative** achievement- or interpersonal-events in one's life the depressive experience will be more chronic. The 'coping' model proposes that external, unstable, and specific attributions for the adverse events in one's life encourages resistance to depression, irrespective of whether or not one is depressed at the time or whether adversity is experienced.

5.3. CONSENSUS JUDGEMENTS: PRE-ATTRIBUTIONAL VARIABLES.

Reviewing evidence for the attributional reformulation of the learned helplessness theory of depression, Brewin and Furnham (1986) proposed that much of the evidence is susceptible to alternative explanation in terms of "preattributional" variables. These variables are "preattributional" in that they part influence or modify the attributions made.

One "preattributional" variable investigated was consensus judgement. Consensus judgements refer to the evaluations people make when faced with success or failure: Do they think that other people are more or just as likely to have experienced such an event **or**is it only themselves? That is, the consensus preattribution will give the person a sense either of (a) being like others; or (b) being different from others. The consequences of these 'preattributions' might also be construed in terms of an experience of the 'something' (Brown, 1989) to which social support contributes. Where one's consensus judgements lead one to feel similar to others then an experience is engendered (more or less) of this 'something': feeling more secure, safer, less alone and separate. However, it is not 'being with others' which promotes this experience but, instead, one's judgement of the consensus of an event. This judgement is based on the individual's knowledge (or lack of knowledge) of others' experience of the aversive event. In addition, it might be hypothesized that judgements of consensus are not restricted to objectively aversive events but also extend to internal, subjectively aversive ones such as feelings and thoughts, particularly 'powerful emotions' like shame and guilt (Brewin, MacCarthy, and Furnham, 1989).

This 'preattributional' variable, consensus judgement, derives from social comparison theory (Festinger, 1954). According to this theory, people evaluate themselves directly by comparison with others - i.e., using consensus information - without specifying the need for any attributional mediation. These judgements are, in turn, partly determined by the person's knowledge of other people's experience of the event or feeling about which consensus judgements are felt necessary. Where there is no knowledge 'to go on' - i.e., no knowledge of the commonality of the experience - that individual will be more likely to consider the event to be a proscribed one. This will be likely to bring him or her to feel less like others - less 'normal'.

When the event or experience (an idea or feeling perhaps) is considered both undesirable and unique to oneself then an experience of depression becomes more likely (Brewin et al., 1989). It might be hypothesized that such circumstances would also promote the experience of forms of psychological distress *other than* depression - anxiety, interpersonal sensitivity, difficulty in coping and the like.

Brewin and Furnham's (1986) test of learned helplessness theory supported these arguments. They suggest that when an individual is faced with negative outcomes depression and self-esteem are greatly influenced not by causal attributions but by consensus judgements. This view is supported by social comparison theory (Festinger, 1954; Tessler and Campbell, 1983) and accords with evidence that depressed persons' comparisons of performance with other people leads them to feel worse off (Lobitz and Post, 1979; Lunghi, 1977). The role that these components are thought to play in the present study will now be described.

5.4. ATTRIBUTIONS, PREATTRIBUTIONS AND PATIENT 'ADJUSTMENT'.

The attributions and preattributions that are made whenever adversity is faced in the patient's life are considered to play a role largely similar to that of social support in the current framework. Like the other details in the patient's life, these attributions function to modify the experience of psychological distress. When faced with 'life stressors' or 'interruptions' the attributions any former patient makes (a) about their cause, and (b) about their uniqueness will influence - even partly determine - the patient's **emotional** response to the events. In this way, the experience of depression or psychological distress will depend partly on the attributions the patient makes for the negative, interruptive events in his / her life. Thus, where the attribution is internal, stable and global then depression is more likely. Where the experience is considered unique to that person - i.e., where consensus judgements are low - depressive and distressing experience is made more likely. Hospital readmission - contingent on this experience of pervasive and uncontrollable psychological distress - can be regarded, therefore, as partly dependent on these attributions that patients typically make about the causes and the uniqueness of the aversive events in their lives.

An attribution or consensus judgement involves (a) thinking about the event - i.e., *evaluating* its causes and its uniqueness relative to others; and (b) coming to a conclusion about the event - i.e., *judging* that it is one thing or another: either proscribed or legitimate. Thus, for example, the event might be judged as being of one's own making, that it will always be around and that it is not something that others seem to experience (internal, stable and low consensus evaluations). The attributions and preattributions about events can be considered representative of the 'cognitive evaluation' component of Mandler's (1983) psychological definition of stress. It is the **outcome** of this evaluation that determines the nature of the emotional response - i.e., the experience of psychological distress - since any event will naturally be first 'interpreted' or 'considered' by the individual (Brown, 1989; Mandler, 1983; Selye, 1956). When the outcome of the evaluation of the event - of the "new and the strange" - is such that it does **not** allow it to "enter the realm of the known and the liked" (Mandler, 1983) then the experience of stress and distress is promoted. Events which are:

(a) considered to be of one's own making, and
(b) not thought to be shared by others but unique to one's self, and which are
(c) disruptive and undesirable

are not thought likely to enter this realm. An experience of psychological distress will likely result.

Attributions are thought likely to modify both the response to aversive life events and the use or mobilization of sources of social support. Attributions of the causes of the aversive events in one's life and 'preattributions' of their generality or uniqueness will influence the ways in which sources of support are used in the following way. When the event is (a) considered unique, not shared by others, and (b) thought undesirable, then an experience of shame and/or guilt might be predicted (Brewin et al., 1989). Under these conditions, one might reasonably suggest that withdrawal from others will take place. Certainly any seeking of support to resolve or make sense of the 'event' will be much less likely than if it were (a) considered more 'normal' - shared by others and (b) not greatly undesirable. This withdrawal will be particularly likely when the event is thought to be of one's own making - i.e., when an *internal* attribution is made. Within the patient sample it's hypothesized that patients will (a) have experienced this sense of being different from others - less 'normal' (Goffman, 1961; Brewin et al., 1989); (b) blame *themselves* for their condition; and (c) withdraw from others as a consequence (Brewin et al., 1989). Including measures of these cognitive variables will allow one to address and provide explanations of why it is that support mobilization within this patient sample is impaired (e.g., Parry, 1988).

These are some of the reasons, then, for including these cognitive variables in the current framework. They should help advance knowledge of the **role** of the social support variables in the ongoing process of recovery and adjustment. Measures of these variables will be obtained by questionnaire - the Attributional style questionnaire (Peterson, Semmel, von Baeyer, Abramson, Metalsky, and Seligman, 1982) and by its modification to include consensus judgements (Brewin et al., 1989) - as well as by specific questions asked of each patient during the course of interview (see chapter four, section 5.2).

5.5. MEASUREMENT OF 'ATTRIBUTIONAL STYLE' AND CONSENSUS JUDGEMENTS.

5.5.1. THE ATTRIBUTIONAL STYLE QUESTIONNAIRE.

This questionnaire consists of 12 hypothetical situations for which subjects state the most likely cause, rating this cause on the dimensions of internal/external, stable/unstable, and global/specific. The 12 situations separate into 4 types: (a) good affiliation events; (b) good achievement events; (c) bad affiliation events; and (d) bad achievement events. Each question is rated on a 7-point scale with appropriate poles. For example, the **internal** question reads: "Is the cause of (the event) due to something about you or to something about other people or circumstances?" Subjects are then asked to circle one of the numbers on the 7-point scale which reads thus:

Totally due to other people **1** **2** **3** **4** **5** **6** **7** Totally due to me.
or circumstances.

An additional rating is made about the importance of each event for the person. After making these ratings on each outcome, subjects additionally make consensus judgements by answering the question, "Would you say an event such as this was more likely to happen to you than to most people you know, or vice-versa?" Possible responses are:

(a) "Much more likely to happen to them"; (b) "Slightly more likely to happen to them";
(c) "Slightly more likely to happen to me"; (d) "Much more likely to happen to me".

The Attributional Style Questionnaire (Peterson et al., 1982) has been reported to possess adequate reliability and validity and is commonly used in research on attribution and depression (Brewin and Furnham, 1986). A measure of internal reliability (Cronbach, 1951) was calculated for the two new scales. Alpha was .64 for consensus on positive outcomes and .52 for consensus on negative outcomes (Brewin and Furnham, 1986).

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INTRODUCTION.

There were four stages that involved setting-up and undertaking the investigation:

1. Submission of a proposal to the Local Ethics Group of the psychiatric hospital for permission to set up the investigation.
2. attending the weekly staff 'kardex' meetings where information about each prospective subject was updated and decisions made about their discharge.
3. arranging and holding interviews with all willing patients and procuring information from their medical records.
4. collating and coding of information.

Any study which claims to investigate the predictive factors in the community adjustment of psychiatric patients must include measures of these factors at two points in time: at a baseline period at discharge from hospital when patients are presumably less distressed, and then again at some period in the future by which time an assessment of the patient's degree of 'adjustment' can be made. A longitudinal design that permits assessment of the factors that are associated with, even causally related to, this 'adjustment' is, then, an imperative in this research domain (e.g., Avison and Speechley, 1987; Brugha, 1991; Gottlieb, 1983; Henderson et al., 1981; Henderson, 1988; Leavy, 1983; Paykel, 1985).

The sample of patients under investigation has already been commented upon in some detail. They were all those patients routinely discharged from the acute admission ward of a local psychiatric hospital in the north-west end of the city of Glasgow. As the number of patients routinely discharged on a monthly basis was relatively small, all patients satisfying the criteria for inclusion were interviewed provided they were both willing and able. No systematic bias in the selection of patients was anticipated other than that ordinarily associated with this highly specific population (Mechanic, 1962, 1963, 1978). That is, the sample of psychiatric patients under investigation was already known to be biased in respect of seeking of treatment and in their evaluation and response to the presence of symptoms of distress (Goldberg and Huxley, 1980; Henderson et al., 1981). These forms of in-built bias were considered a necessary precondition to carrying out research in this field. The generalization of findings can only, necessarily, be restricted to a like population of former in-patients of an acute admission ward of a psychiatric hospital.

1. STAGE ONE: ETHICAL PERMISSION TO CARRY OUT THE STUDY.

This is a longitudinally-designed, repeated measures study whose subjects are people who have been admitted to the ward of a psychiatric hospital for assessment and crisis-intervention who suffer mostly acute forms of psychological distress. These subjects - hereafter referred to as '**patients**' of the short-term acute-assessment ward - were, at the time of interview, under the care and responsibility of the local hospital under the management of the local health board (Greater Glasgow Health Board - GGHB). The nature of the study therefore required that permission be sought from the hospital's 'Local Ethics Group' - the 'West Ethical Committee of the GGHB' - for the study to go ahead. A proposal was submitted to this committee, vetted by the consultant psychiatrist responsible for sponsoring the proposal.

The application to the ethical committee for approval of the clinical research project required details of:

1. the purpose of the study;
2. the procedure;
3. the patients to be included in the investigation;
4. the use of drugs and non-standard products (which did not apply);
5. the financial support for the project; and,
6. the form of consent for patients to fill in (this form is reproduced in appendix E).

Permission for the go ahead of the study was granted by the Local Ethics Group within two months of the submission of the proposal.

2. STAGE TWO: ATTENDANCE OF THE CONSULTANT'S WEEKLY MEETINGS.

The second stage of the project - attending weekly 'kardex meetings' - was essential in order to identify which patients were to be discharged on a week-to-week basis. Only one other permissible source of this information was known - the manager of the ward who could only know who was to be discharged **after** each consultant's respective meetings.

The nature of the study required that patients be interviewed in the hospital immediately before their discharge from record. In order to satisfy the minimal numerical requirements for the use of particular statistical analyses (e.g., multiple regression analysis) it was important to see as many patients on the ward as possible. Sources in the hospital - the consultant, the ward manager and an experienced staff nurse - provided prior information about the average numbers of patients discharged each month from the ward under focus. The ward has four consultant psychiatrists each with places for 10 patients (i.e., 10 'beds'). Permission to interview patients had at this time been granted by just the <u>one</u> consultant - not by any of the others. <u>Projecting from these figures a prior decision was confirmed: to continue interviewing patients for a period of six months</u>. During this time, it was thought that a sufficient number would be seen to render appropriate the use of particular statistical techniques.

The six month period of interviewing in the hospital's ward was followed immediately by the second-wave of interviews which took place in patients' homes in the community. The first patient follow-up interview was six months after the 'time one' interview. Conducting 'time one' interviews in the hospital for any period **over** the six months would have made it necessary to have **overlapping** interviews. That is, patients who were being discharged would have been interviewed in the same period as patients being seen for the second time (in their homes in the community). This was best avoided for practical reasons (advice from both the Department's clinical-based professor and the Department's Head).

The final decision about each patient's discharge was made by the consultant in the course of a weekly 'kardex' meeting with the relevant staff. Present at these meetings were the following:

1. the consultant psychiatrist responsible for the overall management of the patient's treatment;
2. the consultant's junior doctor responsible for the supervision of the patient's day-to-day care;
3. the senior charge nurse on duty;
4. any one staff nurse on duty and who had had contact with the relevant patients;
5. the occupational therapist;
6. the ward's manager;
7. self.

It was at these meetings that any patient would find out whether or not s/he was to be discharged that week or at some later date. In this way, these meetings were essential in order to find out - on a week-to-week basis - which patients could be approached to arrange to interview. **Decisions about discharge are made on this week-to-week basis only**. (Since it was not the concern of this project to investigate the types of information which are used in these meetings to determine suitability for discharge **formal** measures of this 'discharge decision-making' process were not included. However, less formal measures of the types of information used to inform the 'discharge decision-making' process were taken through direct observation and recording. Such observations are potentially informative and might be of some value at a later stage of the project.)

3. STAGE THREE: THE METHOD PROPER.

The third stage of the project constitutes the 'Method' proper: that is, information will be presented about the design of the study, the subjects under investigation and the procedure by which subjects were tested.

METHOD.

3.1. DESIGN.

The design of the project is a longitudinal, within-subjects repeated measures one where patients were interviewed at 'time one' in the hospital immediately before their respective discharge, then again 6 months later at 'time two' follow-up. This six months' period following discharge was chosen for both developmental and practical reasons. The developmental reasons allude to the work of Byers et al. (1978) and Lieberman and Strauss (1986). They identify a number of appropriate periods of time during which change across patients is likely. Measurement within the first few months- where extensive improvement is most noticeable - is preferable although better combined with a longer period of follow-up.

Lieberman and Strauss (1986) and Henderson et al. (1981) provide follow-up information at 2, 4, 6, 8, 10 and 12 months, and 4, 8, and 12 months respectively. Both sets of authors acknowledge the difficulties involved in obtaining information of this quantity and quality. There is, however, general agreement on the efficacy of conducting follow-ups at 6 or 12 months (e.g., Brown, 1989; Henderson, 1988). Any period longer than 12 months renders patients more prone to forgetfulness (e.g., Brown, 1989).

The practical reasons are to do with limited time and resources (discussed in chapter two, section 2.4.4.). A period of 6 months enabled the data-collection stage of the project to be completed over a one-year period. This was essential such that the project could be completed within the funding period allowed. This also gave time for the extensive data-analysis and results write-up to follow. Additionally, it was predicted from 'through-put' figures made available from the ward that a 6-month period would permit a sufficient number of patients to be seen. Accordingly, arrangements were made with the staff on the ward for the author to be present there for a six-month period.

Excepting those patients who were readmitted to the hospital within the six months follow-up period, and those who did not follow-up, all patients originally seen on the ward were re-interviewed at 'time two' in their own homes.

3.2. SUBJECTS.

Subjects of the project were patients routinely admitted to the short-term acute admission ward of a psychiatric hospital (Gartnavel Royal, Glasgow) aged between 21 and 66 with any primary diagnosis excluding organic brain disease who gave their consent to be interviewed. 52 patients were interviewed in the hospital with 14 lost to follow up. With two patients commiting suicide during the 6-month period following discharge the effective follow-up rate was 76%, 38 of the original 52. A description of the patients follows:

SEX.

21 female and 17 male.

AGE.

Between 21 and 66 years with an average of 43 (median - 44). 26% were aged between 21 and 32; 42% between 32 and 52; and 32% between 52 and 66.

RELIGION.

15 Catholic; 17 Protestant; 3 none; and 3 unknown.

MARITAL STATUS.

16 single; 12 married; 6 divorced; 1 separated; 2 widowed; 1 cohabiting.

EMPLOYMENT STATUS.

30 were either unemployed, on long-term sickness benefit, or doing voluntary work (one person). The remainder had a job (4) or were retired (4).

PRIMARY DIAGNOSIS.

14 'Depressions' - 9 'major' and 5 'minor'.

10 'Schizophrenias'.

6 'Manic Depression'.

3 'Alcohol problems'.

5 'Other diagnoses' - e.g., personality disorder; eating disorder; paranoid 'illness'.

NUMBER PREVIOUS HOSPITAL IN-PATIENT ADMISSIONS.

11 - no previous admissions; 7 - one; 2 - two; 5 - three; 4 - four; 1 - five; 2 - six; 6 - more than 10.

LENGTH MOST RECENT HOSPITAL ADMISSION.

Average length of most recent admission was 29 days (median= 16).

PSYCHIATRIC HISTORY.

Number of years since 1st contact with psychiatry:

10 patients - 1st contact; 2 - less than one year; 6 - between one to two years;

7 - between two and ten years; 8 - between ten to fifteen years; 5 - more than twenty years.

3.3. PROCEDURE.

As mentioned previously, attendance of the consultant's "kardex" meetings was essential in order to find out which patients were to be discharged, and when. Following each kardex meeting patients who were eligible for discharge were contacted on the ward and arranged to be interviewed that week. Patients were not known by the researcher before being interviewed except as 'faces' on the ward. However, as time went on - the researcher was on the ward for a period from February 1990 through August 1990 - patients got to know about the 'research psychologist' and did not need too formal an introduction. Each one was introduced to the researcher by one of the nursing staff: in general, this was whoever was present and available at the time. The researcher introduced himself to each patient as follows:

e.g., 'Hello James, my name's Mr. Morrison - David Morrison. I'm a research psychologist working on the ward for a few months. I see anyone who's about to be discharged and ask them a number of questions about how they're feeling and about some of the things that might continue to bother them: where they're going home to; who they're going home to; and some of their views about this. I was wondering if it would be possible to see you and talk about these things with you?'

This first formal introduction to the patient was the first move toward arranging the initial interviews. Additional instructions were given to patients once they had agreed to be seen by the researcher (these are reproduced in appendix D). By staying present and generally 'available' on the ward, the researcher helped to make the formal introduction to each patient less of an ordeal. That is, the researcher made himself available to both staff and patients alike - to chat to or by getting involved in some of the ward's daily activities. It was not unknown for the researcher to be hailed on quite friendly terms by one or two of the patients on his appearance on the ward. In this way, both in-patients and day-patients of the ward not involved in the study alike got to know him informally before the formal introduction.

THE LOCATION: THE ACUTE ADMISSION WARD.

It would be helpful to provide a description of the ward where initial interviews took place. The official 'profile' of the ward is as follows:

"The ward is a 40-bedded mixed-acute psychiatric unit within the grounds of Gartnavel Royal Hospital. The unit was built in 1959. It occupies the upper floor of an extension with the Children's ward below.

The ward has a 40-bed basic complement for 20 male and 20 female patients. Three consultants and occasionally other consultants may request to admit in the ward due to unavailability within their own area. Each consultant has a junior doctor and occasionally a registrar attached."

All patients were interviewed in one of two official 'interview' rooms in the ward: the doctor's room in the male and female wings. Access was granted to these rooms by the consultant responsible to the project. Once the initial interview had been arranged, patients were contacted on the ward immediately before the commencement of the interview. Once in the interview room all patients were read out the form of consent required by the Ethical Committee (see appendix D).

Patients who then agreed to continue were informed that the interview might take more than the one and a half hours stipulated and that an additional interview would be necessary later that same day. All patients who provided their consent to these conditions were interviewed.

3.3.1. THE USE OF A SEMI-STRUCTURED INTERVIEW.

The decision to use a semi-structured interview method for the assessment of the independent and dependent variables in the study was influenced by the following considerations:

1. The alternatives to this form of assessment were (a) to ask patients to fill-in the questionnaires themselves, in their own time, on the ward, but without the presence of the researcher. These questionnaires could

then be handed back to the researcher and any points or issues that required further clarification could be discussed there and then. The second alternative, (b) was to set-up a postal survey, asking patients to fill-in the questionnaires immediately following discharge - once they had returned to their homes. The questionnaires would then be sent back to the researcher within a fixed period of time.

Both methods have obvious weaknesses. Both are purely 'self-report', relying on the patients' own accounts of their pre- and post-discharge experiences, without any kind of method of ensuring 'true' rather than 'false' responding to the items in the questionnaires. The presence of a trained researcher to ask the questions was considered more likely to reduce the rate of false or haphazard responding. That is, logically incongruent and haphazard responding would be immediately recognizable by the researcher trained to conduct the interviews. These incongruent responses could then, at the time of interview, be discussed - between the patient and the researcher. Both alternative methods prevent this form of control.

Another factor not under the control of these methods is the order of presentation of each assessment questionnaire. Where patients are under no obligation to respond to the questions within a finite amount of time - the average 2 hours 15 minutes it took to interview patients - it is more likely that (a) they will fill-in the questionnaires at different - non-standard - times in the day; and (b) they will omit information that presents themselves in a 'poor light' - the so-called experimenter effect' (e.g., Aranson, Ellsworth, Carlsmith and Gonzales, 1990). This is not to suggest that the adoption of the semi-structured interview method guarantees non-biased responding - indeed some might consider that it helps promote it. But in the context of the <u>current</u> research it is considered more likely that patients will not deviate from what is, to one degree or another, already known about them (by the ward staff and on medical records) during the course of interview by someone regarded as 'staff' or who is seen to have some level of authority on the ward (having the **visible** help and supervision of the patients' psychiatrist and of nursing staff).

The semi-structured interview method, then, enables an additional level of control to be introduced to the administration of the investigation - control of the order of presentation of the questionnaires. This helps prevent order effects of a kind likely to introduce systematic bias among patients' responses to the questionnaires.

2. There was a need to prevent dishonest or haphazard responding. Unfortunately, as stated in chapter two (section 1.5.), there is no fullproof method of ensuring that the symptoms experienced by the patient and which have been elicited actually reflect an honest appraisal of the 'contents of consciousness'. One can only depend on the "good faith" (Mair, 1989) of the person responding to the questions asked of him/her: that is, on their honest appraisal of what they consider to be their current condition.

The two alternative methods to the semi-structured interview - lacking the kind of controlled environment and corresponding control of situational and person variables proffered by the semi-structured interview - would almost certainly increase the scope for false, haphazard, or dishonest responding. Thus, although the purely 'self-report' method has advantages in that it can be administered relatively swiftly, responded to without the presence of the experimenter, and at relatively little cost, these are outweighed by the disadvantages.

Chief of these is the complete lack of control over situational variables: control that is enabled by the semi-structured interview method.

However, even the semi-structured interview method does not guarantee that patients will **not** respond dishonestly, haphazardly, and inconsistently to the questions posed by the experimenter from each questionnaire. This issue has been raised elsewhere (chapter two, section 1.5.2.) where a method was reported by which the 'consistency' of a subject's responses can be ascertained. The result of the analysis of the test of 'consistency' - which is considered a proxy for 'honesty' or 'good faith' (Mair, 1989) - carried out using this method is presented at the end of this chapter.

3. A third alternative to the semi-structured interview method was the unstructured interview. Unlike the semi-structured interview, this would not have had as its basis the up-to-date, scientifically reliable and valid questionnaires from which information about the patient's current life circumstances was obtained. Instead, this unstructured interview would have required the development of measures of psychological distress, social support, life events, and of the 'powerful emotions' such as shame and guilt, and of attributions of self-blame that were the focus of the investigation.

This process would have been punitively labour intensive. It would have required extensive research of the appropriate domain, the selection of salient questions to ask leading, eventually, to the design and development of measuring instruments of one's own. The measuring instruments would then have had to be 'piloted' on a large number of subjects - the results from which statistically evaluated with the view to further testing and refinement in an on-going process whose aim would be the attainment of an acceptable, demonstrable standard of reliability and validity. Although this is a good method it was sufficiently labour intensive to render its use in this project quite infeasible.

For reasons alluded to elsewhere (chapter two, sections 1.5. and 2.4.) a decision was made to adopt the semi-structured interview method. Briefly, this method was considered to have the following advantages over the unstructured method:

(a) The questionnaires around which information was drawn had proven standards of scientific reliability and validity.

(b) They were all, with the exception of the measures of 'powerful emotion' which will be discussed presently, measures that are widely used in the research domain.

(c) Unlike the intended unstructured interview, these measures were readily available for use in research endeavours of this kind. They were therefore considered most appropriate in a tightly-budgeted project of this kind which has a strict time-limit for completion. The unstructured method would have been extensively time-consuming and certainly disruptive of the essential <u>organizational</u> and <u>administrative</u> input required of the study.

(d) The use of questionnaires as the basis <u>around which</u> **other** information could be obtained was considered a more acceptable method of investigation. This method would provide information about the patient and his/her circumstances that would complement and perhaps even supplement that obtained by the formal 'self-report' questionnaires. Such information was thought invaluable: where ambiguities in the responses to the formal questions could be 'ironed out' through informal questioning of a kind that would be specifically directed to the particular patient being interviewed. The semi-structured interview, in other words, provided both structured and unstructured information about the patient: this was thought likely to improve the quality of information obtained.

Finally, a set of 'measures' of 'powerful emotion', attributions of self-blame and support-isolation referred to previously were developed and asked of consenting patients. These 'measures' are simply sets of questions about the relevant construct: no claims are made about their scientific properties - their reliabililty and validity - since these were not tested. Clear reference is made to this fact throughout the relevant results sections. That is, the questions were not put to the scientific test of reliability and validity since this would have been too labour intensive and, taking considerable time, this would have preempted their use in the semi-structured interview. Rather than omit the questions altogether, they were included in their 'raw' format.

3.3.2. INTERVIEW PROCEDURE.

1. There was random presentation across subjects of the nine questionnaires. This provided counterbalancing of item-presentation such that the occurrence of systematic bias or 'order effects' of items might be prevented. Patients were asked questions in random order about their experience of social support, psychological distress and consensus judgements. That is, instruments measuring psychological distress were followed by instruments that measure social support, and vice-versa. For example, some patients' interviews involved the following random presentation of measuring instruments:

1. The List of Recent Experiences.
2. The General Health Questionnaire-30.
3. The Interview Schedule for Social Interaction.
4. The Interpersonal Support Evaluation List.
5. The Beck Depression Inventory.
6. The Symptom Checklist-90.
7. The Social Relationships and Activities questionnaire.
8. The Index of Socially Supportive Behaviours.
9. The questions assessing Strong Emotion, Consensus and Self-Blame judgements.

All patients were, however, asked an opening question about their recent experience of life difficulties. This question was asked of patients once they had agreed to take part. They were asked, "Well then, _______, do you remember why it was you came into hospital? Why were things not going so well at the time ?" This was to provide an informal opening to the interview intended to encourage an open-endedness in responding throughout the course of each interview. That is, patients were encouraged to enlarge upon things they said: this allowed them to explore some of the responses they made to questions when they wished to do so. The opening question about what had happened to them before coming into hospital linked in with the administration of the questionnaire on life events, i.e., the questionnaire that measures experience of recent life events.

2. Interviews were semi-structured. Patients were asked questions from formal, structured questionnaires. Although most of the measuring instruments are self-report in format, it was thought more appropriate and helpful for patients to provide them with a copy of the relevant questionnaire to read over whilst formal responses were taken down by the researcher on a separate questionnaire. Questions were read aloud to patients as they themselves read over the question from their own copy. This was considered important in order to prevent false or haphazard responding. The patient's retrospective acount of the recent events in their life were then corroborated against information on medical records and nursing kardex. Contemporaneous verbal reports of psychological distress were also subject to corroboration against medical reports of patient clinical state.

3. As indicated, patients were encouraged to be as open-ended as they pleased in their responding - no attempt was made to rush on to the next question when there was clearly something else the patient wished to say. This helped tune the interviews to the needs of the patient whilst simultaneously providing the researcher with the information that was sought. The only drawback of this kind of approach was the effect it had of extending the length of each interview. The average length of each interview was just over two hours - 2 hours and 15 minutes.

4. A cordial atmosphere, one that was mindful of the patient, was sought and, in almost all cases, was established. The researcher introduced himself to each patient as 'Mr. Morrison - the Research Psychologist on the ward. You can call me David though - I'd prefer it that way if it suits you'. Patients were encouraged to feel free to do as they wished (within reason!) within the confines of the interview. If they wished to get up and go at any point or wanted to smoke or have a cup of tea or coffee they were encouraged to do so. Whenever the patient appeared to be growing tired or distracted s/he was reminded they could leave at any time. Arrangements were then made to see the patient later that day (with the exception of one 7 hour interview conducted over two days). Alternatively, a coffee or tea-break was suggested - which often met with great approval.

Patients were also encouraged to ask questions themselves:

(a) if they weren't sure what was meant by the question;

(b) if they had something they wanted to ask the researcher about his work;

(c) if they had something they wanted to talk about which hadn't come up directly through the course of more formal questioning;

(d) if there was anything else about the interview itself or anything which had cropped up which made them in any way confused or 'not sure' about something.

Each of these factors was considered likely to put the patient at ease. That is, attempts were made to make the interview as informal as possible. This had two purposes: (a) to help recovering patients feel at ease; and (b) to conduct the interviews according to the two principles endorsed by Brown (1989). These were: (i) to show curiosity about everything one is told; and, (ii) to respond as much as possible to what is said as a story. This method was considered more likely to promote honest and true (rather than false) responding: however, it wasn't thought to be a full-proof method. This brings one to the 5th point:

5. Whenever patients appeared to be responding in an inconsistent manner the researcher pursued the meaning of some of the patients' apparently inconsistent responses. Though this happened infrequently, patients were asked to expand upon their reasons for the particular response. On not one occasion was a truly inconsistent manner of response demonstrated. That is, each patient had good reasons for saying what they said within the context of the response provided. Thereafter, those constructs which had been used as measures of consistency but which had proved to be more ambiguous than had originally been thought were removed from the consistency analysis.

6. At the conclusion of each interview all patients were reminded that they would be interviewed on one further occasion by the same researcher 6 months later. They were informed that a covering letter would be sent to them nearer the time to let them know what would be happening. They were told that all arrangements would be taken care of.

Each patient was informed once again that should they wish not to be seen nearer the time that this would have no influence on their treatment and/or continuing care in the community (where received). It was made clear to patients that the researcher had no influence whatever on decisions about discharge and/or about readmission. Instead, it was emphasised that his role was merely to get an idea of the kinds of difficulties faced by patients before and after discharge from the ward. Such observations had no impact on any kind of hospital-based decision to readmit or discharge. This point was stressed in interviews after it became clear in the course of the first few that many patients expressed a fear of being readmitted against their wishes.

3.3.3. OFFICIAL INSTRUCTIONS ON EACH SEPARATE QUESTIONNAIRE.

Separate instructions for each of the 9 questionnaires were read aloud to patients and should, therefore, be included in this section (though available in the appendices for each questionnaire). After reading aloud the instructions for each questionnaire, patients were asked if they understood what had been said to them. When required, instructions were read again and appropriate misunderstandings rectified. These instructions read:

1. The List of Recent Experiences.

"Here is a list of things which might happen to any person in a year. Some of them may have happened to you. Would you please read through the list very carefully as I read through each item with you. As I do so, think back over your own life in the last twelve months, and tell me any (and all) of the items which have happened to you during that time. Just a few of the items ask about things which have happened to someone close to you. I'd like to know about those as well. Remember that however unimportant or trivial you think any item may be, it'd still be really important to know about it if it has happened to you within the past 12 months."

2. The General Health Questionnaire-30.

"In this one I'd like to know if you have had any medical complaints and how your health has been in general over the past week including today. Try to answer all the questions by telling me which you think most nearly applies to you. Remember that I'd like to know about your present and most recent complaints, not those that you had in the past. It's important that you try to answer all questions. However, let's just go through some of them just now and see how you manage. Don't worry if you find you can't answer them all - we'll just move on to the next one."

3. The Symptom Checklist-90.

"In the next ten minutes or so I'll go through a list of problems and complaints that people sometimes have. What I'd like **you** to do is tell me whether or not you have experienced or felt any of the things which I will ask you. I'll ask you how much each of these problems have bothered or distressed you **over the past week including today**. So, when I go through each problem, I'll ask you to tell me how **badly** you have been bothered by each of these problems. To do this, I'll ask you to tell me if you've felt the problem:

1. not at all; **2**. a little bit; **3**. moderately; **4**. quite a bit; **5**. extremely.

Try to think of each answer in tems of:

1. - No, I did not at all experience this problem, through, **5**. Yes, I felt this problem extremely so."

4. The Beck Depression Inventory.

"This questionnaire consists of 21 groups of statements. As you read each group of statements carefully, I'll ask you to tell me the number (0, 1, 2 or 3) of the statement in each group which best describes the way you've been feeling **the past week, including today**. If more than one statement within each group seems to describe how you've been then tell me which ones. **Be sure to read all the statements in each group before making your choice.**"

5. The Interview Schedule for Social Interaction.

"In this questionnaire I'm going to ask you a number of questions about the people you know and how well you know them. I'll ask you if you're happy with the way things are with these people or if you wish things were a little or even a lot different. First, I'd like to get some idea of the people around you in your life. This includes those that are closest to you - your family, friends and neighbours - all the people you may meet from day to day. These first questions will be about people you may know a little, but who are not close friends. Later, I'll ask you questions about people you're much closer to. But for now. . . "

6. The Interpersonal Support Evaluation List.

"This scale will ask you a number of questions about what you think and feel about the contacts you have with other people. These feelings may be about contacts you have with friends, family members, or anyone who has been a part of your life over the past 12 months before your admission to hospital.

I'll ask you to answer either true or false to a number of questions about the sorts of things that may have happened to you before you came into hospital. Sometimes what I say might not be clearly 'true' or 'false' for you. Try to tell me whether it is 'probably true' or 'probably false' to the best of your knowledge."

7. The Index of Socially Supportive Behaviours.

"The following set of questions are designed to get an idea of the number of times in the six months before your admission to hospital thet you were helped by people. This help can be of all kinds. It's important that you think of **anyone** at all who did anything for you in those six months, anything, that is, you might call 'helpful'.

This help might be from members of your family, friends, people you know in your neighbourhood, **or even** members of the health services such as doctors, nurses, health visitors."

8. The Social Relationships and Activities questionnaire.

"In this questionnaire I'm just going to ask you how you spend your days - how you 'fill your time' - the kinds of things you do when you have time on your hands. I'll ask you a number of set questions about 15 or so activities such as visiting others you know, going to the movies, concerts: that kind of thing."

9. The 'Consensus' and 'Internal' (Self-Blame) judgements scale.

"I'm now going to ask you a final set of questions about some of your feelings about some things. These will cover your feelings of, say, guilt, or shame, or self-blame (when you only blame yourself for things). I'll also ask you whether you think other people feel or go through these things or whether you think it's just you. Don't feel that you have to answer every question - just those you think you can or those that you want to. If you don't want to say anything that's fine. Alright?"

3.3.4. MEDICAL RECORDS

Immediately after each interview or part interview medical records were obtained from the Secretarial Office in the ward. Structured information from each patient's records were taken (see appendix A). Additional notes were taken when required.

3.3.5. FOLLOW-UP INTERVIEWS.

38 of the original sample of 52 patients were re-interviewed either when they were readmitted or 6 months after the first wave of interviews. Details of each follow:

(a) READMISSIONS.

All patients readmitted to the ward within the 6 month period of study who were willing to be seen again were re-interviewed using the same battery of questionnaires. Patients were approached to be re-interviewed within 3 days of readmission. This period gave patients time to recover from their more acute forms of distress - a period during which permission to interview was denied, for fairly obvious reasons. There were 3 refusals. All interviews were conducted in the same interview rooms in the ward. In addition to the battery of 9 questionnaires, each patient was also asked what s/he thought were the chief reasons for coming back in to hospital.

(b) 6 MONTH FOLLOW-UP INTERVIEWS.

Home interviews were conducted with 32 patients followed-up 6 months after they were first seen in the ward of the hospital. All patients were sent a covering letter to arrange a date for this interview. The letter was worded such that patients themselves could arrange a date for the interview that suited them. The text of this letter is reproduced as an appendix (appendix E).

Some patients were content to be interviewed at the time suggested; others wrote back suggesting a date which suited them. All patients were then interviewed at the date and time agreed upon. Only one patient was not interviewed in his home - a young solicitor seen in his office. Of the 12 patients lost to follow-up, 3 of these wrote to say they'd rather not be seen again; 3 were not in when arranged (nor subsequently); 3 refused to be seen again in the hospital after being readmitted; and the remainder were not known at the address for correspondence.

All patients were re-interviewed using the same 9 questionnaires. The longest follow-up interview was five hours with an average time of two hours 10 minutes. Not all interviews were conducted on a one-to-one basis with the patient: others - parents, husbands or wives - were also present. To be precise, of the 38 follow-up interviews 6 were readmissions to the ward, conducted on a one-to-one basis; a further 25 home interviews were conducted one-to-one; 3 were conducted with either mother or parents present, and 4 were conducted with the patient's spouse present. Such circumstances were beyond the control of the experimenter: there was either not any additional room-space available in the patient's home or else family members specifically asked to be present. Under these circumstances, the researcher felt obliged to consent with the request.

4. STAGE FOUR: COLLATING AND CODING THE DATA.

The first stage of collating and coding the extensive information was the development of scoring sheets for each questionnaire. Data were to be analyzed using the updated Statistical Package for the Social Sciences for personal computers (SPSS/PC+ version 4.1). All information was therefore coded in numerical form.

Coding of items was carried out by the one (same) researcher responsible for interviewing patients. However, this coding was checked by one additional person - another research student in the department who had no involvement with the project. Once in coded form, all data were transferred to files set up on the SPSS/PC+ package for analysis.

The first wave of analyses will now be discussed in chapter four: the distributions of each of the study's independent variables among patients divided into two groups on the basis of the first criterion of ‘adjustment' - readmission. Before this, however, the result of the test of patients' response consistency will be presented.

5. RESULTS: TEST OF CONSISTENCY OF SUBJECTS' SELF-REPORTS.

The test of the consistency of patients' self-reporting of symptoms of distress and social support required, in the first instance, the analysis of all of the items in all of the questionnaires that specifically measured these indices. This ‘item analysis' was independently carried out by a team of three raters - the author, a senior lecturer in the department and a research undergraduate student.

The team of raters independently identified many categories from the large numbers of items at their disposal (around 250) and came to agreement on thirty. That is, thirty separate categories were identified that consisted of 2, 3 or 4 items that all measured exactly the same construct. Thus, there was a construct of ‘hopelessness', ‘appetite', ‘irritated', ‘physical comfort', ‘private feelings'. Where there was any ambiguity concerning any item, that item was removed. Only those categories whose items were in complete agreement were retained for the analysis. In this way, where one of the items in any category was positively endorsed by the patient all other items in that category had to be similarly endorsed for that person to be consistent. The list of categories is reproduced as an appendix (appendix B).

The next step was to systematically analyze each patient's responses to each item on each of the categories. Where there was any disagreement - where one item was positive and another negative - the patient was rated inconsistent for that particular category. A Sign Test of the data was then carried out to assess the significance of the differences between (a) each patient's consistent and inconsistent response categories, and (b) the sample's consistent and inconsistent patients.

The result of the analysis (table 3.1) demonstrates that patients were highly consistent in their self-reporting of symptoms of psychological distress and of provisions of several components of 'social suport' (31 consistent patients to 7 inconsistent; $p<.01$). Although this does not exclude the possibility that patients consistently responded in 'bad faith' - that is, that they consistently lied or were dishonest - nevertheless the chances of someone being able to maintain this 'lie' in such a consistent manner over so many items (around 250) are not considered great enough to undermine the quality of the result found. That is, the Sign Test of the data is considered to be a powerful test of the consistent honesty or legitimacy of patient's self-reports. That the result of this analysis was significant is regarded as strong evidence for the validity of patients' self-reports and, consequently, of the validity of any results which follow which derive from these self-reports.

TABLE 3.1.

Sign Test of the Consistency of Patients' Self-Reporting of Symptoms of Psychological distress and Social Support.

Patient	consistent	inconsistent	p value	Patient	consistent	inconsistent	p value
Dennis	26	4	**	Mary I	24	6	**
Alastair	20	9	n.s.	Scott	22	7	**
David I	20	7	*	John	27	3	**
Tommy I	22	7	**	Robert	22	8	*
Patricia	26	4	**	Dorothy	25	5	*
Alison	25	5	**	Roseann	20	9	n.s.
Elizabeth I	27	2	**	Sandy	21	9	*
Sarah	23	7	**	James II	21	9	*
Jean	27	2	**	Carol	22	8	*
Derek	21	5	**	Margaret II	13	7	n.s.
Heather	23	6	**	Yvonne	23	7	**
Anne	22	8	*	William	24	6	**
Clare	27	2	**	Tommy II	17	13	n.s.
Iain	21	8	*	Joan	26	2	**
Elizabeth II	26	4	**	MargaretIII	19	8	n.s.
Carole	23	7	**	James II	23	7	**
James	18	7	*	Roy	18	11	n.s.
Callum	21	9	*	Elizabeth III	22	7	*
Margaret I	15	8	n.s.	Mary II	22	3	**

note:

* - p<.05
** - p<.01. Some individual's groups of constructs do not add up to 30 because there was missing data. Missing data reflects the fact that some patients declined to answer some questions.

The Sign Test of the 31:7 difference was significant at p <.01 level of significance (N=38).

CHAPTER FOUR:

OUTCOME - HOSPITAL READMISSION.

RESULTS - FIRST WAVE OF ANALYSES.

WHETHER OR NOT PATIENTS WERE READMITTED TO PSYCHIATRIC HOSPITAL WITHIN SIX MONTHS OF DISCHARGE: The influence of psychiatric history, social demography, life events, social support, and attributions of self-blame, judgements of consensus and felt isolation on outcome **readmission.**

CONTENTS:

CHAPTER FOUR:

RESULTS: FIRST WAVE OF ANALYSES:

OUTCOME- READMISSION.

THE INFLUENCE OF PSYCHIATRIC HISTORY, SOCIAL DEMOGRAPHY, LIFE EVENTS, AND SOCIAL SUPPORT ON OUTCOME **READMISSION**.

CHAPTER INTRODUCTION.

In the first-wave analyses of the data the sample of 38 psychiatric patients discharged from the hospital will be divided into two groups on the basis of the first outcome criterion - **readmission.** That is, the sample will be divided into: (a) those patients who were readmited to hospital within the six-month period following discharge; and (b) those patients who were not readmitted during this period.

Dividing the sample of patients along this outcome criterion enables one to examine the distribution of each of the independent variables in the study for each of the two groups. The purpose of this division is to enable comparison of the distributions of each of the independent variables to be made across the readmitted and non-readmitted groups of patients. In this way, an attempt will be made to identify those variables which are relatively unique to either group: i.e., the distribution of the variables might help to distinguish one group from the other. For example, patients who were currently readmitted to hospital might be expected to have a significantly higher number of previous hospital admissions compared with the patients still living in the community at 6 months (e.g., Anthony et al., 1978; Avison and Speechley, 1987; Goering et al., 1984; Strauss and Carpenter, 1984; Wynne et al., 1978). Or, patients still living in the community six months after discharge might be expected to have experienced more satisfying forms of 'social support' compared with those who were readmitted.

The main purpose, then, of this first-wave analysis of the data is to attempt to identify and examine some of the characteristic features of the patients' experience which might help to explain why it was they were readmitted and why it was they were not. These 'features' or 'variables' are considered to partly determine the course of recovery or deterioration for any patient discharged from hospital. These variables have been delineated at some length in the previous chapter. Briefly, they are:

1. the patient's **clinical history;**
2. the patient's **employment history;**
3. the patient's **clinical symptom profile;**
4. the patient's '**social functioning**' or '**social support**';

5. the **social demography** of the patient;

6. the **stress** which they confront in their day to day lives;

7. the patient's characteristic **style(s) of responding to stressful circumstances**. That is, a measure of components of personality.

The aim, then, of the first wave of analyses is twofold. **First**, one seeks to identify and describe the characteristics that distinguish between the two groups. That is, patients in each of the groups will be expected to differ on some of the independent variables selected for their predictive impact on readmission. Empirical work in the two separate research domains of *psychiatric outcome* and *social support* has demonstrated the predictive utility of these variables (see chapter 1, sections 2.5, and 3.4.). **Second**, one seeks to determine the *significance* of the differences between the two groups on any of the characteristics so identified: that is, are the differences between the two groups statistically significant - attributable to the effect of the independent variable; or are they not significant, reflecting, instead, the impact of random, chance factors not controlled for. Where differences are found to be significant appropriate interpretation of such differences will be made: differences which will help to account, on the one hand, for some patients' return to hospital within 6 months of their discharge and, on the other, for some patients' continued tenure in the community.

NOTE 1: The use of the t-test for independent samples for testing the statistical significance of mean differences between the two groups.

Throughout the course of this 'first-wave' analysis of the results the t-test for independent samples, where appropriate, will be used to test the significance of the differences between the two groups of patients. The argument in favour of the use of this test on data which will be used to compare a group of 6 subjects (those patients readmitted) with a group of 32 subjects (those patients not readmitted) is as follows.

The first assumption to be met when considering the use of the t-test for this sample of subjects - routinely discharged psychiatric patients - is that the samples be a *random selection* from the population. The method of selecting subjects to participate in the study has already been described (chapter three, the design and method section). To reiterate, all patients, irrespective of diagnosis, who were about to be discharged from the hospital ward were approached about their willingness to take part in the study. Only two patients were unwilling to take part in the investigation out of a total of fifty-four who were discharged from the ward during the period of study. The 52 patients who remained and who were subsequently interviewed were simply all those patients who would have been routinely discharged from the ward. The assumption of randomness in the selection of the samples is, then, considered to have been met.

One feature of the data that was not under any degree of control in the study was the unequal size of the samples. In this level of analysis the size of the two groups that will be compared is vastly unequal: only 6 of the 38 patients were readmitted to the ward during the course of the six month period of investigation.

However, although the two groups are vastly different in size (N=6 readmitted patients compared with N=32 non-readmitted) this need not be a barrier to the use of a parametric statistical test such as the t-test for independent samples (e.g., Cohen and Halliday, 1982; Hardyck and Petrinovich, 1969). Only where the two samples have "drastically unequal variances" would the use of this kind of parametric statistical test be made inappropriate: the second assumption for the use of the t-test. In this kind of circumstance an interaction between the number of observations and the inequality of variance becomes possible.

There is a test that can be used to assess the extent to which the variances of the two groups significantly differ - the F-test for the homogeneity of independent variances (see, for example, Bruning and Kintz, 1968; Cohen and Halliday, 1982). This simple test involves computing the variances of each group individually then dividing the largest variance by the smallest. The result of the division is treated as an F value and interpreted by means of an F table (fortunately the statistical package "SPSS" provides this test in the output of any t-test analysis). Where the obtained F value exceeds that found in the F table (with the appropriate degrees of freedom) the assumption of equality of variances will have been violated. Even providing for an apparently 'significant' difference in t-values between the two groups, where the variances are unequal any attempt to infer further from the result of the analysis would be inappropriate (although such a 'significant' difference would be less likely where the variances actally are unequal). It is for these reasons, then, that careful attention will be paid throughout the description of results to the homogeneity of the variances for the two groups of patients. Where the variances are unequal the use of the t-test will no longer be valid.

A final assumption of the t-test is that variables should be measured, at minimum, on an interval scale of measurement. Throughout each succeeding level of analysis of the data for the outcome (or criterion) of readmission it will be seen that each of the independent variables - whether 'life event', 'social support' or 'strong emotion' variables - meets this particular assumption. Where any variable does not meet this assumption - such as with certain psychiatric history or social demographic variables - an appropriate test of such data will be carried out. Alternatively, such data will simply be described, with no attempt to make inferences thereof.

NOTE 2: Multiple Testing.

Throughout chapters four and five several sets of multiple analyses will be carried out. That is, statistical analyses will be carried out of the distributions of several variables - the individual 'life events', the individual symptoms or clusters of 'psychological distress', the individual components of 'social support' and so on. In carrying out such 'multiple tests' of the statistical significance of these distributions of information there is a source of error that must be addressed. It is this: in carrying out multiple tests of this kind (say, 20 t-tests of the significance of the differences between 20 sets of scores on as many variables) there will be the statistical probability that one will find *at least one* of these comparisons *to be statistically significant by chance factors alone.* Thus, according to probability theory, one would expect to find at least one of 20 comparisons to be statistically significant (when the alpha level of statistical significance is $p<.05$ or 1 in 20). In this circumstance, it would be appropriate to set a more stringent level of significance by which a given difference between two distributions of scores on a given variable is deemed statistically significant and therefore not reflecting the influence of mere chance variation. Appropriate advice on this matter (Bruning and Kintz, 1968) states that one should divide the normally acceptable significance level of p<.05 by the number of comparisons being made. Thus, where there are 10 comparisons the probability level should be divided by 10, giving a more stringent statistical significance level of p<.005, and so forth.

However, such changes to what is deemed an acceptable level of statistical significance need only be made under certain conditions. Thus, when *no specific hypotheses* are being put to the test - that is, when there is not a “planned comparison" (Sheridan, 1979; p. 196) - then such changes to the statistical significance level to counter the biasing effects of *chance differences* in such multiple tests should be made. Where specific differences between groups on a given variable *have been hypothesized* no such changes need be made: the appropriate level of statistical significance would continue to be the p<.05 or p<.01 level - subject to the nature of the difference being examined and size of sample (Cohen & Holliday, 1982).

In addition, given that one would expect one comparison in twenty to be statistically significant at the p<.05 level *by chance alone*, where there is *more than one* significant difference among a series of theoretically-related statistical comparisons of mean differences - say, two significant differences, or three, four and so on - the likelihood that such differences reflect the effect of chance factors alone is effectively ruled out. That is, at the most conservative estimate, one would expect **one** mean difference in a series of **twenty** multiple comparisons to be statistically significant by chance alone (and just the one in one hundred when adopting the p<.01 level of significance). As will become clear in the results sections of chapters four and five, these considerations do not apply. Thus, (a) specific one-tailed or two-tailed predictions of differences between groups on given variables are made; and, (b) the number of statistically significant differences found greatly exceeds the number required for there to be evidence of a biasing influence of pure chance factors alone.

The first set of independent variables in the study's ‘discharge revolving-door' model whose distributions will be described and, where appropriate, compared are the social demography and psychiatric history variables.

1. DISTRIBUTIONS OF SOCIAL-DEMOGRAPHY AND PSYCHIATRIC HISTORY ACROSS READMITTED AND NON-READMITTED GROUPS.

1.1. SIZE OF THE SAMPLES: READMITTED AND NON-READMITTED GROUPS.

Of the original sample of 38 patients only 6 patients (16%) were readmitted within the six-month period of investigation. That is, 32 (84%) of the original cohort of 38 patients who were seen at discharge in the hospital were still living in the community at six-months follow-up. This recidivism rate falls below the estimated base rates at 6 months of 30 to 40 per cent found in reviews of follow-up studies of discharged psychiatric patients (e.g., Anthony et al., 1978; Caton et al., 1985; Goering et al., 1984).

This low rate of return could, for example, reflect the influence of a number of hospital-related treatment variables not measured in the study. For example, it could be that more attention was paid within the ward to ameliorating the perceived functional deficits of particular patients prior to discharge. Or, certain patients might have responded well to the assistance provided by, say, the ward's Occupational Therapist prior to discharge, where involvement in group meetings was an essential component of treatment. These forms of influence, however, are <u>not</u> the concern of the current project. Rather, these forms of influence constitute the subject matter of those investigations which have been concerned with the impact on post-hospital adjustment of 'standard' in-patient treatment modalities: the second of the 4 main research foci within the research domain identified by Avison and Speechley (1987). The focus of the current study is on the psychiatric **correlates** of readmission and community tenure, the fourth category of research identified by Avision and Speechley (1987). Within the constraints of the current investigation (see chapter one, section 2.3.) reliable and valid measurement of these other, hospital-treatment forms of influence was not possible.

1.2. **RESULTS:** DISTRIBUTIONS OF **SOCIAL DEMOGRAPHIC** AND **PSYCHIATRIC HISTORY** INDICATORS.

The distributions of the social demographic and psychiatric history indicators for the two samples of patients (N=6 and N=32) are presented in tables 4.1 and 4.2. Very few differences between the two groups of patients can be distinguished. The most notable differences between the two groups relate to the 'psychiatric history' indicators. Specifically, differences between the two groups are most distinguishable on the '<u>length of</u>

TABLE 4.1.

Distribution of **socio-demographic** variables across readmitted and non-readmitted groups.

---

1. READMITTED PATIENTS. (N=6)

AGE
Mean = 40 years.

SEX
3 male and 3 female.

MARITAL STATUS
5 single and 1 married.

EMPLOYMENT STATUS
5 unemployed and 1 doing voluntary work on a part-time basis.

2. NON-READMITTED PATIENTS. (N=32)

AGE
Mean = 44 years.

SEX
14 male and 18 female.

MARITAL STATUS
11 single, 11 married, 6 divorced, 1 separated, 2 widowed, and 1 cohabiting.

EMPLOYMENT STATUS
16 unemployed, 4 employed, 4 retired, and 8 on sickness benefit (for at least 6 months).

TABLE 4.2.

Distribution of **psychiatric history** variables across readmitted and non-readmitted groups.

CLINICAL DIAGNOSIS.

READMITTED PATIENTS - 3 - Schizophrenia; 1 - Manic depressed; 2 - Psychotic illness.
NON-READMITTED PATIENTS - 7 - Schizophrenia; 14 - depression; 5 - Manic depressed; 3 - Alcohol problems; 3 - Other.

No. YEARS SINCE FIRST CONTACT WITH PSYCHIATRIC CARE.

READMITTED PATIENTS - 2 patients - 1st admission; 1 patient - between 1-2 years; 1 - between 5 and 10 years; 1 - more than 10 years; 1 - more than 20 years.
NON-READMITTED PATIENTS - 8 patients - 1st admission; 2 patients - less than 1 year; 5 patients - between 1-2 years; 4 - between 2 and 5 years; 2 - between 5 and 10 years; 3 - more than 10 years; 4 - more than 15 years; 4 - more than 20 years.

No. PREVIOUS ADMISSIONS.

READMITTED PATIENTS - 2 patients - no previous admissions; 1 - one previous admission; 1 - 4 admissions; 2 - more than 10 admissions.
NON-READMITTED PATIENTS - 8 patients - no previous admissions; 6 - one previous admission; 2 - 2 admissions; 5 - 3 admissions; 3 - 4 admissions; 1 - 5 admissions; 2 - six admissions; 4 - more than 10 admissions.

LENGTH CURRENT ADMISSION.

READMITTED PATIENTS - Mean length current admission = 99 days. (One patient's 1 year period of admission greatly increases this average length of stay score). Range= between 27 and 344 days.
NON-READMITTED PATIENTS - Mean length current admission = 44 days. Range= between 7 and 201 days.

LENGTH OF MOST RECENT ADMISSION.

READMITTED PATIENTS - Mean length= 29 days. Range= between 12 and 100 days.
NON-READMITTED PATIENTS - Mean length= 29 days. Range= between 2 and 128 days.

AVERAGE LENGTH OF ALL IN-PATIENT ADMISSIONS.

READMITTED PATIENTS - Mean length= 106 days; range= between 15 and 344 days.
NON-READMITTED PATIENTS - Mean length= 42 days; range= between 6 and 129 days.

AVERAGE LENGTH OF TENURE IN THE COMMUNITY.

READMITTED PATIENTS - Mean length= 16 months. Range= between 2 to 60 months.
NON-READMITTED PATIENTS - Mean length= 31 months. Range= between 3 to 192 months. (Excluding one patient's tenure of 192 months from the calculation, the mean= 23 months).

hospital stay' variables. The mean 'length of current admission' for the readmitted group was 99 days compared with 44 for the non-readmitted group (t=2.00; df=34; p<.05; 2-tailed). However, as the F-test of this result was significant (F=9.26; p<.0001; 2-tailed) indicating violation of the assumption of equality of variances the use of the t-test for this particular comparison is no longer appropriate. A non-parametric test of the datum (using the Mann-Whitney Z-score - converted from the obtained U value, and corrected for ties) was, likewise, non-significant (Z=.9986; p>.05; 1-tailed).

There is a notable similarity between the two groups on the variable '*length of most recent readmission*' (prior to current admission) - both groups averaging 29 days stay. This is consistent with the policy of brief hospitalization practiced by the ward and described by Kirshner (1982). However, that two of the patients have currently spent as long as 201 and 344 days respectively in hospital suggests that something has gone wrong with this policy within the ward of the hospital. Comparing the two groups' scores on '*length of all in-patient admissions*' one finds that readmitted patients, with a mean of 106 days, spend more time, on average, in hospital as in-patients than their current non-readmitted counterparts (mean=42 days; t=2.58; df=34; p<.05). However, the F value was significant - indicating that the variances between the groups were unequal. Excluding the single extreme score of 344 days from the calculation of the mean 'length of all in-patient admissions' for the readmitted group still leaves an average in-patient length of stay of 58 days (2 months) compared with 42 days (just over one month) for the non-readmitted group (although non-significant). The obtained Z-value of 1.38 (converted from the Mann-Whitney U value of 57.5 and corrected for ties) just failed to attain statistical significance (p<.08).

Before going on to examine and compare the distributions of the **second** of these independent variables between the two groups - psychological distress - a preliminary introduction will recall some of the previous work relevant to this question. This introduction will also include an account of some of the expected distributions.

2. DISTRIBUTIONS OF PSYCHOLOGICAL DISTRESS.

2.1. **BRIEF RECAPITULATION** - READMISSION AND PSYCHOLOGICAL DISTRESS.

In chapter one evidence from empirical investigations of the factors associated with ‘psychiatric outcome' was presented. Several studies were identified by Avision and Speechley (1987) that have investigated the predictive role of prior symptomatology on readmission rates. Using readmission as the criterion (or, ‘recidivism' - another term for the percentage of discharged patients who are subsequently rehospitalized) a number of investigators found that measures of level of symptoms or psychopathology at discharge were significantly associated with readmission (e.g., Fontana and Dowds, 1975; Klein, Person, Cetingok et al., 1978; Tessler and Manderscheid, 1982). This type of association is, as Avison and Speechley (1987) state, “not surprising": the experience of intolerable levels of psychological distress being one of the defining criteria for readmission (e.g., Caton et al., 1985; Hoult, 1986). This proposition is argued at some length in the course of section one of chapter two. That is, it is hypothesized that patients who get readmitted to hospital within the period of study will experience significantly higher degrees of severity of psychological distress than those patients not readmitted: such distress significantly determining the criterion ‘readmission'.

Inasmuch as symptomatology is a good predictor of readmission it should also be possible to find a strong, significant association between prior level of symptoms and subsequent level: and, indeed, this has been demonstrated (e.g., Clum, 1978; Mintz et al., 1976). In Clum's (1978) investigation of the role of intrapsychic variables and the patient's environment in prognosis a significant association was observed between symptoms at time 1 and time 2 follow-up: the degree of symptomatic disturbance at time 1 being the best predictor of subsequent time 2 disturbance. This was replicated by Mintz et al. (1976) who found that pretreatment level of symptomatology expectedly anticipated posttreatment level.

The evidence for a relationship between preexisting levels of disorder and subsequent levels is also strong within the domain of research on social support and mental health. Several investigations have demonstrated that whilst support makes a significant contribution to the experience of psychological distress, as one progressively controls for the confounding influence of prior disorder, the <u>magnitude</u> of the associations between support and disorder diminishes: in some instances entirely (Monroe and Steiner, 1986). That is, prior psychological symptomatology has been found to be one of the <u>strongest</u> predictors of subsequent health functioning (e.g., Depue and Monroe, 1985; Dooley, 1985; Monroe, 1983; Monroe and Steiner, 1986; Thoits, 1982; Williams, 1981). This effect has been evidenced after controlling for the effects of social support and life events (Monroe and Steiner, 1986). (It has already been stated that around 9% of the variance in health change scores can be attributed to life events (e.g., Kessler et al., 1985). Only between 1-4% of the variance has found to be attributable to the direct influence of social support factors - Henderson, 1984).

In the light of these findings one might expect to find a similarly strong positive correlation between the patients' experience of psychological distress at time 1 - at discharge, and at time 2 - at 6 months follow-up in the community. That is, the most substantial proportion of the variance in psychological distress experienced 6 months after discharge would, in the light of this knowledge, be expected to be accounted for by variation in prior distress experienced at discharge (e.g., Clum, 1975; Mintz et al., 1975). This prediction, however, assumes a diminished predictive role for the life event and social support components in the patient's life. That is, it would matter less that a person is supported or not by others, or experiencing stressful life conditions, but much more that an intolerable experience of psychological distress is present. An alternative hypothesis would be that those patients who at discharge experience mild to little degrees of psychological distress might be expected to experience a more marked **change** in distress levels when confronted by severe life adversity after discharge. The strength of this association, in turn, will be modified by the nature of the person's experience of the components of 'social support'. For example, under exposure to severe life adversity and with poor, deficient sources of support one might expect a more pronounced rise in levels of distress for such patients compared with those patients already severely distressed at discharge and who experience no such life adversity. The independent effect of prior symptoms on follow-up symptoms controlling for the influence of, say, life adversity and social support components can be examined across the two groups of readmitted and non-readmitted patients through the application of a stepwise multiple regression technique (e.g., Darlington, 1968; McNemar, 1962). This approach to the analysis of the data will be taken in the third and final results chapter of the thesis.

Finally, symptoms of distress across both groups of patients might be likely to recur or persist (e.g., Goering, Wasylenki, Lancee, and Freeman, 1984). That is, few patients are expected to experience a diminution of symptoms by the close of the six-month period of investigation. However, should this be evidenced, care will be taken to identify and describe the distinguishing characteristics. This type of analysis will be described in the second-wave analysis of results in chapter five. That is, patients will be divided into three groups on the basis of the three graded levels of the dependent variable *psychological distress* and comparisons of independents made across patients:

(a) whose symptoms of psychological distress got 'worse' over the six month period;

(b) whose symptoms got 'better' (if applicable);

(c) whose symptoms remained 'the same'.

2.2. GLOBAL PSYCHOLOGICAL DISTRESS - THE 'VINCENT TENTHED' INDEX.

Assessment of the construct 'psychological distress' was made using three separate measuring instruments: (a) the Beck depression inventory - the BDI - (Beck et al., 1978); (b) the General Health questionnaire-30 - the GHQ-30 - (Goldberg, 1972; 1978); and (c) the Hopkins Symptom Checklist-90 - the SCL-90 - (Derogatis et al., 1979). As described by Henderson (1988) these instruments are virtually - though not completely - interchangeable measures "of the same general type" of experiences of psychological distress.

The use of all three measures is justified on at least two grounds. Firstly, the use of all three measures was thought to guarantee the "wider coverage of symptoms and level of severity" of these symptoms advocated by Henderson (1988). Subtle differences in the quality of any individual's distress experience were considered more likely to be 'picked up' with the use of these three instruments. Secondly, a test of the consistency of any individual's responding to questions about their experience of distress was made possible with the use of more than one measuring instrument. That is, the use of three instruments enabled clusters of exactly the same items to be identified and then used to examine each individual's level of consistency (i.e., honesty or dishonesty) in responding to the questions. Where the response to any one item in a cluster (of three or four items) that measured exactly the same symptom was incongruent with any of the other items the individual was considered to be inconsistent for that particular cluster.

However, by using three separate measures of the one construct there is at least one difficulty that needs to be addressed, namely, which one measure should be used as the criterion measure of psychological distress? Although it would be tempting to adopt all three, as a test, for example, of the sensitivity of each in predicting the likelihood of any patient's return to hospital such a task would, apart from anything else, be a laboriously time-consuming one. That is, the already extensive number of independent variables in the study's 'revolving-door' model would have to be compared across all three composite scores provided by each instrument. This is considered a wasteful use of time and resources.

Instead of using the information provided by just one of the measures a method was sought by which information from all three measuring instruments could be incorporated in some way - one which would enable the use of at least some of the information from each measure. One such method is the '**Vincent-Tenth**' one. Using this method, the continuous scales or dimensions along which scores are situated on each of the instruments which measure distress - each scale being different for each instrument - can be standardized. In this way, the score obtained by one instrument becomes directly comparable with the score obtained by another: for the method standardizes the unit measurement of the scale along which scores are situated.

A description will now follow of how this method was used to generate a **global index** of psychological distress - one which derives from the information obtained by all three measuring instruments. This global index is considered to be the most sensitive measure of the level of severity of the patients' symptoms of psychological distress in that it incorporates information from all three instruments (as well as including the assessments made by the author) and will from this point on be used as the definitive measure of psychological distress.

2.2.1. THE CALCULATION OF THE 'VINCENT-TENTHED' GLOBAL MEASURE OF PSYCHOLOGICAL DISTRESS.

The 'Vincent-Tenth' procedure for the calculation of the global index of psychological distress will now follow. The measures of severity of distress that were obtained using the three measuring instruments referred to above - the BDI, the GHQ-30 and the SCL-90 - formed the 'raw data' from which the global index was calculated.

(a) The first step involves identifying the lowest and highest **actual** distress scores obtained for each of the three measuring instruments of distress. For example, the lowest score obtained at discharge on the SCL-90 was 6 and the highest score was 235 (out of 360). That is, the least distressed person scored just 6 on the SCL-90 scale out of 360; the most distressed person scored 235 out of 360. For the BDI, the lowest score was 4 and the highest 40 (out of 63).

(b) The second step is to obtain the figure found by subtracting the lowest score from the highest. Thus, for the SCL-90 this figure is 229 (235 - 6); for the BDI it is 36 (40 - 4).

(c) The third step is to 'tenth' this figure. That is, one divides the figure by 10. Thus, for the SCL-90 the 'tenthed' figure is 22.9 (229/10); for the BDI it is 3.6 (36/10).

(d) The fourth step is to divide each individual's score on each instrument by the appropriate 'tenthed' figure. This process of division standardizes each individual score along a unit dimension of 1 to 10. In this way, the individual who had the highest score on the SCL-90 at discharge (235) will also have the highest score on the 'Vincent-Tenthed' SCL-90 scale. That is, 235 divided by 22.9 equals 10.26. The individual with the lowest score (6) will have the lowest score on the tenthed SCL-90 index - i.e., 0.262 (6/22.9). This process should be repeated for each individual's score on each measuring instrument.

(e) The fifth step is to add together each 'tenthed' distress score for each individual (i.e., the tenthed BDI score; the tenthed SCL-90 score and the tenthed GHQ-30 score) to form a global 'tenthed' index, scored along a dimension of 0 to 30 (i.e., by adding up the 0 to 10 for each of the three scales).

(f) A sixth step that was taken was to add to this global index the assessments of psychological distress made by the author - both at discharge and at follow-up interview. This assessment was already scaled along a dimension of 1 to 10 - that is, the scoring had already been 'tenthed'. This measure of distress was added to each individual's 'Vincent-Tenthed' global index of distress to form a total 'Vincent-Tenthed' global index of psychological distress. This index was scored along a dimension of 0 to 40, with the most severely psychologically distressed those scoring on or around 40. It was this index of psychological distress that was, from this point on, used as the definitive measure of the level of severity of symptoms of psychological distress.

2.3. RESULTS: GLOBAL PSYCHOLOGICAL DISTRESS - DISTRIBUTIONS IN THE TWO GROUPS OF PATIENTS.

There are several ways of approaching the global distress data. Firstly, the two groups' distress scores can be compared to see if there are any differences at discharge . Any difference in global scores might be attributable to the contribution of **specific types** of distress symptoms which will then be tested in a further, secondary level analysis. That is, particular experiences of distress may be more prevalent among the group of patients readmitted. Ward staff would be advised to attend to these experiences prior to 'rubberstamping' the arrangement of any patient's discharge since these distress experiences might well be especially predictive of outcome - readmission. Two-tailed tests will be carried out of the differences in global distress between the groups at discharge. That is, no specific prediction will be made concerning the distribution of the severity of symptoms between the groups at discharge. Patients who get readmitted could either (a) be more distressed at discharge - which would make them more susceptible to the deleterious impact of any subsequent life adversity; or (b) they could be as distressed, on average, but more likely, say, to meet with the kinds of life adversity that threatens their ability to tolerate such distress.

A second type of analysis is to compare the psychological distress of the two groups at follow-up. This would enable the testing of the hypothesis that patients readmitted will be more distressed than those not. That is, a one-tailed test of this datum will be carried out. It would also set pointers for a further, secondary level of analysis which might enable something to be said about the types of distress that distinguish the readmitted from those not. That is, where significant differences do emerge it should be possible to make statements about the types of distress which render readmission more likely or which are more often experienced by someone who has suffered a breakdown and who has required readmission.

Finally, a third type of analysis is to examine the correlations between time 1 distress scores and time 2 distress for each group. This will enable testing of the hypothesis that prior symptomatology is a good predictor of subsequent symptomatology (e.g., Depue and Monroe, 1985; Thoits, 1982).

RESULTS.

Mean distress scores for both groups at discharge and follow-up are summarized in table 4.3. There is little difference between the two groups' experience of distress when they were assessed at discharge. The non-readmitted group have a higher mean psychological distress score than the readmitted group. This difference, however, is not significant (t=1.31; df= 36; p>.05). The discharge experience of distress could be interpreted as reflecting the importance for getting readmitted to hospital of the degree of change through time in symptoms. That is, it might be that patients who were eventually readmitted, having lower average levels of distress at discharge, and who met with a concomitant increase in severity of their symptoms were somehow less prepared for the change.

Those patients not readmitted score remarkably consistently on the global index of distress across time indicating a more stable, albeit chronic experience of distress. A secondary level of analysis will compare the qualitatively different types of distress for the two groups obtained by the three separate distress measures taken. Comparison of the two groups on the increasingly refined measures of distress available from these measuring instruments should add to the explanation of outcome (more precise measures such as interpersonal sensitivity, obsessive-compulsiveness, social withdrawal, anger/hostility, anxiety, depression, hopelessness/helplessness).

Comparison of global distress scores at follow-up (a mean of 28.9/40 for the readmitted against one of 21.3 for those not) reveals support for the hypothesis that patients who are readmitted to hospital do, on average, experience significantly higher levels of severity of psychological distress than those not readmitted (t=1.88; df= 36; p<.05; one-tailed).

The Pearson product-moment correlations for each group for time 1 global distress on time 2 distress (see table 4) provide additional support for the proposition that prior symptoms are a good predictor of follow-up symptoms. That is, a significant amount of the variance in psychological distress over time (6 months) can

TABLE 4.3.

Mean scores and t-tests on **global psychological distress** for the readmitted and non-readmitted groups of patients at Time 1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted group.** (N=32)	**t-test**
time 1	15.316 (40)	19.697	t=1.31; df= 36; n.s. (2-tailed)
s.d.	8.13	7.40	F=1.21; p>.05
time 2	28.900	21.338	t=1.88; df= 36; p<.05 (1-tailed)
s.d.	8.45	9.14	F=1.17; p>.05

TABLE 4.4.

Pearson product-moment correlations for the readmitted and non-readmitted groups of Time 1-Discharge **global distress** with Time2-Follow-up **distress**.

Readmitted group. (N=6)	**Non-Readmitted group.** (N=32)
r = .7003; p= .121; n.s.	r= .5973; p<.001

be accounted for by prior experience of distress (35% of the variance in psychological distress for the non-readmitted group; p<.001). The results for the non-readmitted group are more supportive in this respect where data from a sufficiently large number of cases is used in the calculation of the size and significance of the correlation statistic. In order to control for the independent effect of other independent variables on the amount of explained variance a stepwise multiple regression analysis would be most appropriate. This would control for the effect of these additional variables and give a truer representation of the independent predictive influence of prior distress on the dependent variable outcome, follow-up distress. This analysis will be carried out in a subsequent chapter (six).

2.3.1. SUMMARY - GLOBAL DISTRESS AND READMISSION

At discharge, the two groups' mean level of distress was not significantly different. This suggests that it was not simply the most severely distressed at discharge who were most likely to get readmitted following a short period in the community - a result supported by Caton et al. (1985) in their study of rehospitalization in a group of schizophrenic patients. Indeed, the group of patients more severely distressed at discharge were, on average, those not subsequently readmitted.

The large 'jump' in symptoms for the readmitted patients (from a mean of 15.3 to 28.9 compared with a stable mean across time for the non-readmitted group of 19.6 and 21.3) suggests the occurence of some mediating factor or factors following discharge which would help to account for this 'jump' or change. What this factor or factors might be will be tested in the second and succeeding waves of analysis. These will focus on the groups' experience of the remaining variables in the equation: life adversity, receipt of and satisfaction with the components of social support, and the subjects' consensus of events and experiences.

It remains to be seen whether or not differences exist between the groups at discharge on less global, more precise forms of psychological distress. Should there be differences these would be likely to help to account for subsequent readmission. That is, it could be that particular clusters of experiences such as, say, depression, anxiety or delusional thinking are more likely to increase susceptibility to subsequent breakdown or acute onset of symptoms after discharge. These questions will be examined in a subsequent section.

As predicted, the distress of patients readmitted to hospital was, on average, more pronounced at follow-up than for those not readmitted. However, the occurence of severe and persistent symptoms of psychological distress was common to both readmitted and non-readmitted patients alike (a mean of 28.9 compared with a similarly high mean of 21.3 for those not readmitted within the 6 month period). This is a population, like that of Goering et al. (1984) which was also followed-up over 6 months, “in considerable distress". That is, whilst a small number were eventually readmitted within the 6 month period, it is likely, given the severity of distress across all patients, that a much higher percentage will eventually meet with a similar outcome. For example, Goering et al. (1984) found that two thirds of their patients returned to hospital within 2 years compared with one third at 6 months. As indicated, comprehensive reviews of follow-up studies of discharged psychiatric patients reveal base rates of recidivism of 30 to 40 per cent at 6 months and 65 to 75 per cent within 3 to 5 years (e.g., Anthony et al. 1978; Caton et al., 1985). Although 84% of patients in this study were still living out in the community 6 months after discharge, their distress levels clearly imply that this is not necessarily “synonymous with a patient having recovered " (Clausen and Yarrow, 1955).

Finally, symptoms of global distress at discharge were a good predictor of symptoms at follow-up. That is, how ‘bad' or ‘good' the patient's symptoms are at discharge will strongly influence how ‘bad' or ‘good' they are at some point in the future. By knowing that a patient is, at discharge, quite severely depressed one can be reasonably sure that, say, six months later that patient will be just as severely depressed. It would be helpful, then, to assess the patient's distress at discharge in order to derive a base-line severity level from which a measure of the relative ***change*** in the level of severity of this distress can be identified: the greater the increased change, the more likely will be readmission.

However, the results and this conclusion suggest another thing were one to accept the view that people “conduct themselves the way they do for good reasons" (Smail, 1987) and it is this. Although no formal measure was taken of distress levels when patients were admitted into the hospital it can be presumed that by discharge they have undergone some kind of recovery. And yet, from the results, it is evident that patients have not become fully “better" (a global distress mean of 15.3/40 and 19.7 for the two groups respectively). Or, if one were basing one's judgement of the severity of patients' distress on the criteria employed by Beck in his depression inventory (Beck et al., 1979), a surprisingly high number of patients - **15** of the **38** - would be classified as “moderate to severe" and “extremely severe" **at discharge**. If one accepts the view that each person is distressed **about** something or other - otherwise there would be no distress (e.g., Berscheid, 1985; Brown, 1989; Mandler, 1985; Smail, 1987) - then it follows that with the persistence of symptoms of distress these things which have given rise to the distress still remain. What the results appear to reflect is precisely the state of affairs described by Hoult (1986) whereby the “inappropriate" hospital focus on psychopathology is to the detriment of an understanding of the “underlying interpersonal stresses which have precipitated the symptoms and signs". For this reason these symptoms “persist to precipitate further episodes, which are again only dealt with in terms of psychopathology" (Hoult, 1986).

This is not to suggest that the hospital staff are not ‘doing their job properly' (in fact, it is most probably quite the opposite): that is, that they have not attempted to deal with patients' emotional difficulties. Rather, such attempts, when they merely focus on the symptomatic manifestations of underlying stresses and neglect the psychological and social factors there involved, deal with these difficulties in a largely superficial manner. To use an analogy, dealing only with the person's symptoms of distress and not with the ideas, perceptions and behaviours that underly these symptoms is like clipping off damaged individual leaves from a blighted houseplant without taking care to examine and nurture the soil in which the plant is situated. That is, with the removal of the blighted leaves the plant has the *impression* of good health. However, the *conditions* under which the ugly black spots on the leaves' surface came into being will remain.

The following suggestions are some of perhaps many which could be made about the practical use to which these findings could be put. Thus, a more appropriate and - in the view of this author and others (e.g., Cannon, 1932; Kelly, 1958b; May, 1958, 1961) - more effective form of treatment would attempt to *elicit* *from* patients the kinds of problems they perceive themselves as having. It would seek to address the patient's reasons *why* they view certain areas of their life in this 'self-debilitating' way. This approach would not necessarily guarantee "success" - nor "cure". However, it's believed that such a *focus* would be more fruitful: more likely to bring about more fundamental change within patients in their manner of responding to the distressing events and circumstances which obtain in their lives. This change would be more likely where the patient is encouraged to address the reasons s/he gives for his/her particular predicament.

The process would begin from the point of view of the patient - that is, it would go straight to the heart of the 'problem' - to the person's subjectivity (e.g., Smail, 1984, pp.152-155). Where there is *only* a focus on the dissolution of symptoms - symptoms that are always the symptomatic manifestation of some other higher-order process (e.g., Mandler, 1979) - there might well be engendered within the person a certain way of responding to his/her bodily 'symptoms' which often serves to augment them. This 'way of responding' is a form of appraisal: an appraisal of the uncomfortable sensations of distress: anxiety, sweating, palpitations, feelings of unease, tiredness, feeling sluggish, feeling uninterested in things, feeling heavy, feeling excited and 'overactive'. Three of the most commonly observed forms of appraisal of distress were (a) panic - that the symptoms were 'upon the patient' once again; (b) fear - that the symptoms would get worse - taking or 'toppling' the patient 'over' (for "that's what happened before"); and (c) insecurity - that other people don't seem to get this way or that they won't be able to "handle" the sensations. One woman said she was "afraid (I) was going off the rails again" (Patient Dorothy). Another told me "it's just one step forward and two back - I just feel that I've got nowhere all this time (10 years since her first contact with psychiatry). . . other people always seem to be getting ahead and on with things. It's always been like this" (Patient Carol). This kind of cycle - one that would appear to lie at the heart of the discharge 'revolving-door' cycle, whereby certain bodily sensations 'trigger' certain self-debilitating kinds of thought (or, in Bandura's (1977) words, reduced "self-efficacy") - would need to be broken before any kind of lasting change could take place. This lasting change would undoubtedly, over a period of time, with the appropriate kinds of help and support from professional carers in the community, be likely to lengthen patients' period of stay back in the community following discharge. **These points will be discussed in more detail in the general discussion in chapter seven.**

The remainder of the results section will focus on a selection of these "interpersonal stresses" - life adversity, social support, and consensus judgements. In this way, a better understanding should be possible of the **influence** of these factors on likelihood of getting readmitted or getting symptomatically 'worse'. Given the focus of hospital treatment on the psychopathological manifestations of each 'psychiatric patient' the results suggest that such a focus cannot, on its own terms, be described as 'successful': where 63% of patients scored 15 or more /40 on the global measure of symptoms of distress at discharge. On just what **types** of symptoms patients can be distinguished will be the focus of the next section. That is, given the prevailing '*medical model*' approach to the understanding and treatment of the psychiatric patient in hospital it would be appropriate to attempt to identify the qualitatively different **types** of symptoms, if any, which appear to correlate best with readmission, or, with its complement, community tenure.

2.4. **RESULTS:** SPECIFIC TYPES OF PSYCHOLOGICAL DISTRESS - DISTRIBUTIONS ACROSS BOTH GROUPS.

A similar type of analysis to that for the global distress measure will be made of the different types of distress as measured by the SCL-90 and GHQ-30 (see chapter 2, section 1.7.3.). That is, both groups will be examined on each type of distress experience to identify differences at **discharge** and at **follow-up**. It is not thought necessary to examine the correlations across time of discharge score with follow-up score on each of the separate types of distress. This type of analysis does not add much to an understanding of what it is that makes readmission more likely: it only says, for each group, whether or not the experience of a particular type of distress at discharge is a good predictor of that same experience at some point in the future. T-tests of the differences between groups on discharge and follow-up scores for each type of distress will enable something to be said about the types of distress which make a significant contribution to the likelihood either of getting readmitted or of staying out in the community.

2.4.1. THE SYMPTOM CHECKLIST-90 DATA.

Looking first at the types of distress measured by the SCL-90 (table 4.5) a number of preliminary observations can be made. Firstly, there are no significant differences between the two groups in experience of particular types of distress at discharge. That is, there are no experiences of distress when measured at discharge from hospital which appear to distinguish, in a predictive sense, patients subsequently likely to get readmitted from those not. Thus, it does not appear possible, from the results, to be able to suggest to ward staff responsible for the assessment of patients' suitability for discharge that they should be especially vigilant of those patients experiencing moderate to severe degrees of any particular distress type or 'cluster'.

Secondly, whilst non-readmitted patients' experience of all types of distress is uniformly quite stable over time (no significant increases across time) the patients eventually readmitted undergo significant **change** between discharge and readmission: particularly in somatic complaints, depression, anxiety, anger/hostility, paranoid thoughts and psychoticism. This finding confirms one of the hypothesized distributions made previously - that is, readmitted patients undergo significant change in symptoms such that the **change** becomes intolerable bringing about a need for readmission. The degree of change in symptoms of distress is, then, a good predictor of readmission status. If, at follow-up, the person is significantly more distressed than when last seen then appropriate professional contact with such a person should be increased and appropriate measures taken. For instance, such patients might be encouraged to discuss what it is that is on their mind and troubling them. Or, where this kind of focus is less appropriate, the patient would be encouraged to spend more time with others or, if this were not possible, with the visiting C.P.N., Health visitor or General practitioner. The point to stress is that where marked change in the level of distress is observed, the person is less likely to be able to manage this change; this, in turn, will render him/her more likely to seek hospital asylum to deal with the change. **Change**, then, should alert professional carers to the possibility of

TABLE 4.5.

Mean scores and t-tests on **SCL-90 types of psychological distress** for the readmitted and non-readmitted groups of patients at Time 1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted group.** (N=32)	**t-test** time2: 1-tailed
SCL - INTERPERSONAL SENSITIVITY:			
time 1	9.67 (max=36)	9.69	n.s.
s.d.	9.85	7.02	F=1.97; p>.05
time 1	14.17	11.23	n.s.
s.d.	9.23	7.90	F=1.37; p>.05
SCL - SOMATIC COMPLAINTS:			
time 1	7.67 (48)	7.97	n.s.
s.d.	5.89	6.92	F=1.34; p>.05
time 2	15.33	9.73	t=1.88; df= 34; p=.06.
s.d.	4.32	6.97	F=2.60; p>.05
SCL - OBSESSIVENESS/COMPULSIVENESS:			
time 1	8.67 (40)	10.72	n.s.
s.d.	7.81	8.18	F=1.10; p>.05
time 2	14.83	13.87	n.s.
s.d.	10.12	8.91	F=1.29; p>.05
SCL - DEPRESSION:			
time 1	12.16 (52)	21.45	t=1.77; df= 33; p=.08
s.d.	11.32	11.72	F=1.07; p>.05
time 2	25.83	21.93	n.s.
s.d.	12.33	13.42	F=1.18; p>.05
SCL - ANXIETY:			
time 1	9.67 (40)	12.48	n.s.
s.d.	8.11	7.14	F=1.29; p>.05
time 2	17.33	13.00	n.s.
s.d.	10.63	8.64	F=1.51; p>.05
SCL - ANGER/HOSTILITY:			
time 1	3.17 (24)	3.72	n.s.
s.d.	4.11	4.06	F=1.03; p>.05
time 2	8.33	5.10	t=1.42; df= 34; p=.163.
s.d.	2.73	5.37	F=3.87; p>.05

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TABLE 4.5 (cont'd)

Mean scores and t-tests on **SCL-90 types of psychological distress** for the readmitted and non-readmitted groups of patients at Time 1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted group.** (N=32)	**t-test** time2: 1-tailed
SCL - PHOBIC ANXIETY:			
time 1	6.83 (28)	4.79	n.s.
s.d.	4.45	4.48	F=1.02; p>.05
time 2	7.83	7.06	n.s.
s.d.	8.98	7.08	F=1.62; p>.05
SCL - PARANOID THOUGHTS:			
time 1	3.33 (24)	4.13	n.s.
s.d.	2.94	3.59	F=1.49; p>.05
time 2	10.00	4.77	**t=2.49; df= 34; p=.018**
s.d.	5.29	4.59	F=1.32; p>.05
SCL - PSYCHOTICISM:			
time 1	5.83 (40)	6.34	n.s.
s.d.	5.94	4.97	F=1.43; p>.05
time 2	12.00	5.53	**t=2.56; df= 34; p=.015**
s.d.	8.50	4.98	F=2.91; p>.05

readmission. Appropriate steps would then be taken to intervene.

The differences between the groups in experience of all types of distress at follow-up demonstrate the relatively more intense, severe experience for the patients eventually readmitted. Where one wishes to be able to inform ward staff of important factors prior to arranging any patient's discharge - factors which will indicate how suitable for discharge any patient might be - it is important to propose factors which are of predictive value. However, there were no significant differences between groups at discharge.

The next logical step is to identify the types of experience which distinguish patients eventually readmitted from those not. In this way, differences which are observed can be used in a post-hoc manner to inform the decision-making about patient suitability for discharge. For example, from the results it can be concluded that patients eventually readmitted experience significantly higher levels of two types of distress: paranoid thoughts (t=2.49; df=34; p=.018) and psychoticism (t=2.56; df=34; p=.015). Thus, it might be conjectured that when patients move from somatic complaints and depression and anxiety through to disordered forms of thinking (such a hierarchical configuration of disorder in support of Foulds' (1964, 65) proposed 'hierarchical continuum of personal illness') that this disordered thinking is least tolerable: such patients can manage the somatic complaints, say, and heightened sensitivity but when their thinking gets disturbed, particularly in terms of 'people being out to get you' and 'thinking that something is wrong with your mind', this becomes intolerable. And so this patient presents, or is presented, for readmission.

These two factors can be of predictive value - and inform the decisions made by ward staff - in that any candidate for discharge who presents with moderate to severe levels of these distress experience would automatically be considered less suitable for discharge. That is, given the predominance of this experience among patients eventually readmitted any patient **already** experiencing these forms of distress in the hospital (i.e., disordered thinking) could be regarded as a good candidate for readmission: already 'on the way' to getting readmitted; already susceptible to breakdown and eventual readmission.

2.4.2. THE GENERAL HEALTH QUESTIONNAIRE-30 DATA.

The GHQ data reveal a similar pattern of results to the SCL-90 data (see table 4.6). There are few significant differences between the two groups in experience of symptoms at discharge. That the readmitted patients are significantly less anxious at discharge than those not requiring readmission (t=3.17; df=36; p<.01; two-tailed) could suggest many things. One interpretation, however, seems particularly salient when considering the relatively huge jump in mean anxiety for the readmitted patients from discharge to readmission (3.83 against 7.60; t=3.14; p<.01). Patients who are more likely to get readmitted appear to be less anxious *at discharge*. Patients who remain in the community 6 months after discharge are significantly more anxious at discharge. However, these patients' anxiety levels do, on average, remain consistent across the 6-months (6.44 against 6.38). Given the "readmitted" patients have been just that - readmitted to hospital - this might suggest that their comparatively lower perceived levels of anxiety at discharge are an imprecise reflection of a more unstable emotional condition. That is, there could appear to be less 'caution' in their judgement of their condition - where an inappropriately high level of self-efficacy is in evidence. Or, there might simply be less considered acknowledgement of the extent of their anxiety experience. Given the subsequent jump in this experience after discharge to levels comparable with those patients still in the community, patients would appear to have been (a) less **prepared** for or (b) less willing to acknowledge or (c) less able to deal with the almost inevitable exposure to disruptive events which arouse anxiety. In this way, where patients meet with disruptive life events following discharge those who were readmitted appear to be more adversely affected. They might also have fewer 'ways out' - fewer methods for coping with such adversity. These possibile explanations will be tested for in the course of the following results sections on 'life events' and 'social support'.

The perceived experience of anxiety, however, could also be justified: one might expect a period in hospital to have led to the reduction of more severe symptoms. That there should be such a significant difference between the two groups at discharge might reflect the overriding influence of the degree of change in symptoms on outcome. That is, what appears to be important is not the initial level of anxiety but the degree of change in severity of the experience over time. The greater the degree of change the more likely it is that readmission will occur.

It is highly likely that following discharge patients will have met with severe threat or danger experiences (e.g., Brown, 1989; Finlay-Jones, 1989) and that they have been particularly adversely affected as a consequence. Though no measure was taken, it could also be suggested that the eventually readmitted patients were more susceptible to the deleterious consequences of anxiety. That is, its experience might well have a greater impact on **perceived ability to cope** for some patients than others. Interestingly, of the 6 patients eventually readmitted, none was diagnosed as depressed yet 3 received a diagnosis of schizophrenia. The other 3 were diagnosed as cases of 'manic depression' and 'personality disorder' with a strong 'thought disorder' component. The literature on life events is instructive of these findings whereby the "schizophrenic" person's reaction to moderate to severe life events - particularly those which involve threat or danger - has been found to be more swift and acute than for, say, someone depressed (e.g., Brown and Birley, 1968; Day, 1981; Day, Nielsen, Korten Ernberg, Dube, Gebhart, Jablensky, Leon, Marsella, Olatawura, Sartorious, Stromgren, Takahashi, Wig, Wynne, 1987; Day, 1989).

Secondly, there is a consistent increase in all symptoms for the patients eventually readmitted. This contrasts with a more stable pattern of experiences for those still living in the community at 6 months. Clearly, the relatively sudden increased change in symptoms of distress for the readmitted patients has rendered them less capable of tolerating such symptoms. Those patients not eventually readmitted appear to suffer a more stable and **chronic** experience of distress and appear to be more able to tolerate this (i.e., to stay out in the community).

That the patients eventually readmitted score uniformly lower at discharge on all GHQ factors compared with the patients still in the community provides further support for the argument that they might be less prepared for and more susceptible to the influence of subsequent life adversity. This experience of life adversity with

TABLE 4.6.

Mean scores and t-tests on **GHQ-30 types of psychological distress** for the readmitted and non-readmitted groups of patients at Time 1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted group.** (N=32)	**t-test** time 2= 1-tailed
GHQ - SELF-ESTEEM:			
time 1	.50 (out of 5)	1.37	t=1.59; df= 36; p=.120
s.d.	.83	1.29	F=2.37; p>.05
time 2	2.00	1.41	n.s.
s.d.	1.87	1.54	F=1.47; p>.05
GHQ - SOCIAL DYSFUNCTION:			
time 1	.50 (out of 3)	.75	n.s.
s.d.	1.22	.95	F=1.66; p>.05
time 2	2.2	1.37	t=1.49; df= 36; p=.145
s.d.	.44	1.21	F=7.34; p>.05
GHQ - HELPLESSNESS/HOPELESSNESS:			
time 1	2.00 (out of 5)	2.25	n.s.
s.d.	1.67	1.48	F=1.28; p>.05
time 2	3.8	2.66	t=1.27; df= 36; p=..211
s.d.	1.30	1.92	F=2.19; p>.05
GHQ - ANXIETY:			
time 1	3.83 (out of 8)	6.44	t=3.17; df= 36; p<.01
s.d.	2.78	1.64	F=2.87; p>.05
time 2	7.6	6.38	t=1.11; df= 35; p=.275
s.d.	0.54	2.43	F=19.73; **p<.05**
GHQ - DIFFICULTY IN COPING:			
time 1	2.16 (out of 5)	2.75	n.s.
s.d.	1.91	1.50	F=1.67; p>.05
time 2	4.00	2.91	t=1.41; df= 35; p=.167
s.d.	1.73	1.59	F=1.18; p>.05

note: on all variables, a **high** score reflects **poor** functioning.

which patients meet will now be examined in the next section of results - ‘Life events and readmission'.

2.4.3. **SUMMARY** - SPECIFIC TYPES OF DISTRESS AND READMISSION.

No significant differences were found between the groups on any of the types of distress measured at discharge. Of the two groups of patients, those who were readmitted scored lower on almost all types of distress when measured at discharge.

Whereas non-readmitted patients' experience of each type of distress was consistent across the 6-month sampling period - albeit at levels consistently moderate to high - the readmitted patients' experience underwent significant rises, as expected. However, there were only **two** types of distress which significantly distinguished between the groups at follow-up: paranoid and psychotic symptoms of distress.

3. DISTRIBUTIONS OF *STRESSFUL LIFE EVENTS* ACROSS THE TWO GROUPS.

3.1. BRIEF INTRODUCTION TO THE LIFE EVENT DATA.

By examining the life events with which patients meet one attempts to address the next stated concern of the research project, that is, the concern with the mediating 'sources of stress . .which precipitate or postpone hospital return'. The research domain on life events and illness provides a wealth of detailed knowledge about the association of particular kinds of life event with particular kinds of formal psychiatric diagnosis. For example, as stated in a previous section, patients diagnosed as schizophrenic are more likely than those diagnosed as depressed to suffer acute breakdown in response to events within a short period following exposure - for example, within three weeks (e.g., Brown and Birley, 1968; Day et al., 1987). Among types of psychological distress, the experience of anxiety is most closely related to exposure to severely unpleasant 'dangerous' or 'threatening' life events (e.g., Finlay-Jones, 1981; Finlay-Jones and Brown, 1981; Finlay-Jones, 1989). The experience of depression, on the other hand, as stated in chapter 1 (section 3), often follows exposure to 'loss' events such as separation or the death of close, loved ones (e.g., Brown et al., 1985; Roy, 1978; 1981b; 1981c; Surtees, 1980). (The experience is, however, modified by (a) the presence of close, confiding relationships; (b) the perception of satisfaction with these relationships and with, (c) several 'vulnerability' factors *but only when the experience is present of being under stress* - e.g., Brown and Harris, 1978; Leavy, 1983.)

The results of the analysis of psychological distress would appear to make it reasonable to expect a fairly wide experience of these kinds of event among all patients: loss events, threatening events and acute events of recent onset prior to current admission. What is of major interest at this juncture is how these events distribute between the patients readmitted and those still living in their homes. That is, do particular types of event associate more strongly and significantly with getting readmitted? The current interest, then, is in identifying either (a) what types of event, or (b) how severe these events must be to predict outcome: likelihood of getting readmitted to hospital.

Referring to the somewhat detailed description of the life event literature made in chapter two, a number of possible distributions might be expected. If one assumes (a) that readmission is associated with severe distress - which the results strongly suggest; and (b) that this distress is, in turn, predicated by the experience of 'being stressed', then, according to the central proposition within the life events research domain, (c) this 'stress' experience is, in turn again, predicated by exposure to life events (e.g., Brown, 1989; p.8). That is, "although an event certainly cannot get 'inside' a person until it has in some way been translated (into 'being stressed'), it **does** exist independently of any such translation" (Brown, 1989). Being stressed is, in part, engendered by the experience of interruptive conditions in the world (e.g., Smail, 1984; 1987).

One might, therefore, expect to find several distributions of interest in the data. Firstly, at discharge one would expect quite moderate to severe experiences of life events across both 'readmitted' and 'community tenure' groups alike. Each group's description of their exposure to life events is **retrospective** at this point.

They were asked to recall as best as possible their experience of events within the previous 12 months preceding current admission. Given the nature of the population - about-to-be-discharged psychiatric patients - it would be reasonable to expect a high degree of recent life adversity.

Secondly, again, given the nature of the population under focus, one would expect to find a relatively high prevalence of both acute and chronic events. The population is, by and large, a predominantly chronic one (where only 35% are first-time presenters).

Thirdly, at follow-up, one might expect to find differences in the two groups in exposure to life events with the readmitted group experiencing, on average, more events of greater severity. This assumes that events summate in their impact and that they confer equal degrees of stress upon those so confronted - an assumption that is, however, increasingly less universally accepted (e.g., Brown, 1989; Frijda, 1986; Henderson, 1988; Selye, 1956). This hypothesis can be tested. That is, (a) are there significant differences between the two groups in the number and severity of events; and, if so, (b) what kinds of life event distinguish the two groups? The measuring instrument used in the project - the List of Recent Experiences (Henderson et al., 1980) - enables this type of latter assessment to be made. Particular kinds of event might distinguish the two groups: (a) at discharge - these being of predictive value and so capable of being attended to both during treatment and when assessing suitability for discharge; and (b) at follow-up - where events may be distinguished which correlate with readmission and which could be construed as increasing susceptibility to breakdown and readmission. Patients considered particularly susceptible to the influence of these individual types of event could be singled out for regular follow-up in the community. Should no differences in life events be found then one might reasonably conclude that events do not necessarily impact *particular* kinds of outcome and that attention might therefore be more fruitfully drawn toward the *meaning* of the events for the person experiencing them.

Finally, it would be helpful to identify, for each group, the degree of change in experience of life events from discharge through follow-up. This will enable something to be said about the influence of changing life circumstances - albeit an indirect or moderating influence - on the chosen outcome, readmission. For example, from the original hypothesis it would follow that a significant reduction in the number and objective stressfulness of life events would be expected to correspond with a decrease or amelioration of symptoms of psychological distress. This symptomatic improvement may, in turn, reflect the influence of a reduction in particular kinds of life event which patients are exposed to such as 'interpersonal disharmony' or 'financial difficulties'. These possibilities will be examined through the course of the following results section.

3.2. **RESULTS**: DISTRIBUTIONS OF (i) NUMBER AND (ii) SEVERITY OF LIFE EVENTS.

The first-wave analysis of the life event data will examine the distributions at discharge and follow-up for the two groups of the total number of events and of the severity of these events (table 4.7) without examining particular events.

RESULTS.

Before making comparisons between the two groups a preliminary observation can be made that both groups of patients experienced a high number of events both during the 12 months preceding admission and in the 6 months following discharge. The severity scores of both groups contrasts sharply with the mean severity rates found by Henderson et al. (1981) for a community sample living in Canberra, Australia (62.2 compared with 96.7 and 86.7). The mean severity of the stressfulness of the events for this psychiatric sample (165.8 and 171.7) covering the 12 months preceding admission also contrasts quite markedly with the mean distress rates for the 'anxiety state' sample (mean=128.9) found by Henderson et al. (1981) and for a 'depressed' sample (123.1). It is a population, then, which has undergone and continues to undergo "considerable chronic distress" (Goering et al., 1984).

However, the two groups' experience of life stressors - both the number and the severity of these stressors - is barely distinguishable both at discharge and at follow-up when one might have anticipated a higher number and severity of events for the readmitted patients. Comparisons of the median severity scores does show a slightly higher level of severity of event for the readmitted group (105 compared with 84) - however this was not significant (Mann Whitney Z value of 1.08; n.s.).

However, there is an additional factor which should be taken into account, one which might help to account for the differential outcome. The experience of the stressful life events was, for the readmitted group, within a much shorter period of time. The median length of stay in the community for this group is 11 weeks (mean=11.3) compared with 24 weeks for the non-readmitted (Mann Whitney Z value= 6.05; p<.0005; 2-tailed). Thus, patients who got readmitted to hospital experienced slightly more severe events but within a significantly shorter time-span. The **timing** of the events, then, could account for the different eventual outcome - readmission or not. That is, a succession of stressful events experienced within a short period of time, rather than 'staggered' over a longer period, might diminish the person's ability to safely negotiate and reorient themselves to such stressors: such negotiation and reorientation requiring more time than they were afforded. It could also be that the experience of stressful events makes certain individuals more sensitive and vulnerable to the deleterious effects of any kind of subsequent life 'happening' (e.g., Thoits, 1982).

Additionally, given there were no differences between the groups in both the number and severity of life events it could be that the **response** to the events was influenced by some other factor such as their social support experience or by patients' consensus of the events in their lives. The response might also have been influenced by some **other** predisposing factor within and so perhaps unique to the person, a measure of which, unfortunately, was not obtained but which could nevertheless account for the differential response. This will be addressed in a subsequent section. It could also be that particular types of life event might help to distinguish between the groups. This question will now be addressed.

TABLE 4.7.

Mean **number** and mean **severity** of **life events** for the readmitted and non-readmitted groups of patients at Time1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test**
	MEAN **NUMBER** OF LIFE EVENTS (median in parenthesis):		
discharge	9.4 (10)	8.75 (9)	n.s. (2-tailed)
s.d.	2.88	4.99	F=3.01; n.s.
follow-up	4.5 (4.5)	4.8 (5)	n.s. (1-tailed)
s.d.	2.07	3.09	F=2.22; n.s.

	MEAN **SEVERITY** OF LIFE EVENTS (median in parenthesis):		
discharge	165.8 (134)	171.7 (164)	n.s. (2-tailed)
s.d.	74.01	92.51	F=1.56; n.s.
follow-up	96.7 (105)	86.2 (84)	n.s. (1-tailed)
s.d.	47.54	61.12	F=1.66; n.s.

3.3. RESULTS: DISTRIBUTIONS OF PARTICULAR TYPES OF LIFE EVENT.

There were no significant differences between the groups on any of the individual life events(see table 4.8) as measured by the List of Recent Experiences - neither at discharge nor at follow-up.

Some of the findings are worthy of note. Firstly, whilst particular kinds of life event have been found to correlate with particular types of psychiatric diagnosis (e.g., Day, 1989) there does not appear to be any current significant association between particular kinds of life event and differential outcome. Not one of the separate life events measured by the LRE could distinguish patients eventually readmitted from those not - neither at discharge nor at follow-up. That is, knowing what life events any person has undergone before coming into hospital does not, from the results, appear to be of any predictive value in enabling a more accurate assessment to be made of any patient's suitability for discharge. Nor do any particular kinds of life event appear to associate more strongly with one group compared with the other following discharge.

Secondly, although the readmitted patients experience marginally more acute and chronic events than those patients still in the community this difference is not significant. However, these events were experienced within a much shorter time-span than for the ‘community' group.

Thirdly, there is a statistically significant finding concerning the ‘changes in relations' life event (Mann Whitney Z score=1.74; p<.05; 1-tailed - corrected for ties). Patients still in the community experience relatively more changes in relations during their community tenure. This might be expected given that five of the six readmitted patients were single and not closely attached to anyone, thereby excluding this source of stress from their lives. It doesn't suggest that having changes in relations is necessarily ‘a good thing' - this would depend on the kind of change and on the contentment of those involved in the change. However, it might suggest that simply being involved with other people - albeit in changing relationships, with arguments, conflict and others' behaviour being a problem or worry - rather than being uninvolved completely is more likely to postpone a return to hospital (where the kind of company that is lacking in the patient's life can be found). This suggestion would require a much finer-grain analysis of the content of the ‘changes in relations' across readmitted and ‘community' groups respectively: an analysis that is not, however, within the scope of the current project aims. The result would suggest the appropriateness, however, of the use of measuring instruments such as the ‘Rochester Interaction Record' employed to such effective use by Wheeler and Nezlek (1977) in their examination of sex differences in social interaction.

Fourthly, comparing differences across time within the groups in their experience of each kind of life event a significant finding emerges. Patients eventually readmitted experience no significant change in any of the life events: events are comparatively stable with no exceptional rises or falls from the 12 months preceding admission through the three months, on average, which precede subsequent readmission. However, those patients still in the community on average experience significant **falls** in their experience of illness events (t=4.44; df=26; p<.001), separation events (t=2.29; df=26; p<.05), work-related events (t=3.4; df=26; p<.01), financial difficulties (t=2.27; df=26; p<.05), ongoing worries (t=2.06; df=25; p<.05), acute stressors (t=2.09; df=25; p<.05), and chronic stressors (t=3.89; df=24; p<.001). This could simply be an artefact of the differential time-sampling periods - where the discharge events comprise the previous 12 months compared with

TABLE 4.8.

Mean number and t-tests of **each type of life event** for the readmitted and non-readmitted groups at Time1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
MEAN NUMBER: **ILLNESS** EVENTS (median number in parenthesis) /9:			
discharge	.60 (0)	1.03 (1)	n.s.
follow-up	.16 (0)	.28 (0)	n.s.
MEAN NUMBER: **DEATH** EVENTS (median number in parenthesis) /3:			
discharge	.6 (1)	.6 (0)	n.s.
follow-up	.16 (0)	.14 (0)	n.s.
MEAN NUMBER: **PREGNANCY** EVENTS (median number in parenthesis) /5:			
discharge	.2 (0)	.03 (0)	n.s.
follow-up	.10 (0)	.02 (0)	n.s.
MEAN NUMBER: **CHANGES IN RELATIONS** EVENTS (median number in parenthesis) /15:			
discharge	1.8 (2)	4.3 (2)	n.s.
follow-up	.7 (0)	1.7 (1.5)	Mann Whitney Z value=1.74; p<.05
MEAN NUMBER: **SEPARATION** EVENTS (median number in parenthesis) /6:			
discharge	.60 (1)	.48 (0)	n.s.
follow-up	.3 (0)	. 2 (0)	n.s.
MEAN NUMBER: **HOME CHANGES** EVENTS (median number in parenthesis) /5:			
discharge	1. (1)	.58 (0)	n.s.
follow-up	.3 (0)	.3 (0)	n.s.
MEAN NUMBER: **WORK-RELATED** EVENTS (median number in parenthesis) /13:			
discharge	1.8 (1)	1.8 (1)	n.s.
follow-up	1.0 (1)	.7 (1)	n.s.

continued on next page/

TABLE 4.8 (cont'd).

Mean number and t-tests of **each type of life event** for the readmitted and non-readmitted groups at Time1-Discharge and Time2-Follow-up.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
MEAN <u>NUMBER</u>: **FINANCIAL DIFFICULTIES** EVENTS (<u>median</u> number in parenthesis) /5:			
discharge	.6 (0)	.7 (0)	n.s.
follow-up	0.7 (0.5)	0.3 (0)	n.s.
MEAN <u>NUMBER</u>: **DISAPPOINTMENTS** (<u>median</u> number in parenthesis) /OPEN:			
discharge	.20 (0)	.67 (0)	n.s.
follow-up	.16 (0)	.21 (0)	n.s.
MEAN <u>NUMBER</u>: **WORRIES** (<u>median</u> number in parenthesis) /OPEN:			
discharge	1.6 (1)	1.3 (1)	n.s.
follow-up	1.0 (1)	.78 (0)	n.s.
MEAN <u>NUMBER</u>: **ACUTE** EVENTS (<u>median</u> number in parenthesis) /OPEN:			
discharge	3.8 (3)	2.7 (2)	n.s.
follow-up	2.1 (2)	1.7 (1.5)	n.s.
MEAN <u>NUMBER</u>: **CHRONIC** EVENTS (<u>median</u> number in parenthesis) /OPEN:			
discharge	5.2 (5)	4.5 (5)	n.s.
follow-up	2.5 (3)	2.7 (2.5)	n.s.

<u>note</u>:

F-max tests of each type of life event were carried out as a test of the homogeneity of variances. There was only one significant test - the <u>changes in relations</u> event having significantly unequal variances. All other tests were not significant - i.e., the variances were uniformly equal between the two groups.

the follow-up assessment of 6 months. Setting this qualification aside, however, it could be suggested that patients who returned to hospital experience no kind of **improvement** in adversity whereas the patients still in the community undergo significant improvement in several types of life event. For the readmitted patients it could be that there is no respite from their experience of adversity - comparatively little change in their pre-admission life circumstances takes place following hospital discharge.

Finally, the results could suggest that the group of patients eventually readmitted responded differentially to the whole gamut of events or even to particular kinds of event relative to those still living in the community at 6 months. That is, the same kinds of events might have had a differential impact on the six people readmitted. For example, a single person living alone might be more likely to respond with panic to financial difficulties or with undue fear to ongoing worries compared with someone who has a long-term partner and is able to call upon their support. The **meaning** of the event for the person, rather than the simple presence or absence of a particular number and severity of events, could be the determining factor as argued in chapter two (section 2.2.2. - e.g., Brown, 1989; Mandler, 1983; Selye, 1956). One way of examining the meaning of the life events for each group of patients is to examine those factors in their life which could be considered likely to contribute to a sense of meaning. One such factor, alluded to above, is the role that other people might play in assisting with the management of the impact of symptoms and events. That is, one factor or set of factors likely to contribute to a sense of meaning in the events to which patients are exposed is the 'social support' upon which patients can draw. An analysis of the role of the components of social support on outcome will now be carried out in the 4th section of this chapter.

3.4. **SUMMARY** - LIFE EVENTS AND READMISSION.

There were no significant differences between the groups in their experience of adverse life events - at discharge, as expected, nor at follow-up, somewhat unexpectedly. That is, readmited patients could not be distinguished from non-readmitted by (a) the number of events encountered before admision to hospital and after discharge; nor by (b) the objective severity of these events. Although the readmited patients' overall severity of life events score was higher than that observed for the non-readmitted group this difference was not significant. Excepting the 'changes in relations events', no significant differences between groups were found on any of the individual types of event at discharge nor at follow-up.

The results were discussed with reference to (i) the timing of follow-up interview - where readmitted patients experienced the events within a significantly shorter spell following discharge; and (ii) the sampling period for events - where the time 1 measure covered events experienced during a 12 month period compared with the 6 month period covered by the time 2 measure.

Both groups of patient were found to have met with a greater number of events of greater average severity compared with a community sample (Henderson et al., 1981) suggesting that the two - life adversity and recidivism - are related. Finally, the non-readmitted group of patients underwent significant improvement in several types of life event - improvements not found among readmitted patients .

4. DISTRIBUTIONS OF SOCIAL SUPPORT ACROSS THE TWO GROUPS.

4.1. BRIEF RECAPITULATION: THE 'COMPONENTS OF SOCIAL SUPPORT'.

The distributions of each of the six components of the global construct 'social support' will be compared across readmitted and non-readmitted groups. To recap, these components are:

1. The behavioural transactions between the patient and others which can be 'objectified': someone who listens, reassures, advises, agrees, confirms;
2. The experience of existentially-securing support provisions: e.g., knowing there are others around with whom the patient can compare him/herself favourably; others with whom the patient can work through worries; others who give the patient a sense of belonging;
3. The experience of the presence of attachment and security from one other person: categorically loved, confirmed in one's self, accepted and understood by one other person;
4. The generalized sense of being satisfied with the people in one's life: both intimates and friends/ family;
5. The availability and enactment of various forms of pleasurable, social activity;
6. The availability of persons other than partner to whom the patient can turn.

Relevant material from the literature on the role of social suport has been described quite fully in chapter one, section 3 and in chapter two, section 4. Briefly, comparing readmitted patients with those still living in the community after 6 months, one might expect to find the following kinds of distribution. Firstly, there should be a relatively skewed distribution of scores towards the lower levels on most support components for <u>all</u> patients. That is, the available reviews of social support among clinical populations (e.g., Alloway and Bebbington, 1987; Brugha, 1991; Froland et al., 1979; Leavy, 1983; Paykel, 1985) strongly suggest that the support available to this population is uniformly low, with an emphasis on non-family ties, with fewer different sources of friends, fewer long-term friends and less interaction with family, friends, and relatives.

Secondly, one should expect the readmitted group of patients to have even lower scores on particular support components. For example, given that 5 of the 6 patients were of single status could suggest that these patients have few intimate attachments and concomitant deficits in a sense of belonging and in socioemotional and material forms of support. This, however, presumes that these patients are both single <u>and alone</u>, without non-partner-based forms of support. This will be tested. However, one should be mindful of the fact that no specific analysis of the different components of support identified, conceptualized and measured in this research project has previously been attempted for a group of formerly-hospitalized psychiatric patients. In this way, one can only observe, describe and possibly make inferences about the results of the data-analysis.

Each of the six components of social support will now be examined for the readmitted group and the non-readmitted group.

4.2. RESULTS: DISTRIBUTIONS OF SOCIAL SUPPORT COMPONENTS ACROSS READMITTED AND NON-READMITTED GROUPS.

4.2.1. BEHAVIOURAL TRANSACTIONS.

This component was measured using the Index of Socially Supportive Behaviours (the ISSB) of Barrera et al. (1982). It provides a global score, and two sub-scores: actual socio-emotional support and actual material support.

The global scores for both groups are uniformly low as anticipated (see table 4.9). That is, both groups - all patients, whether readmitted or not - received little actual support from others before they were hospitalized nor again after discharge. There were no significant differences between the two groups at discharge nor at follow-up. The index - actual support received - does not appear to enable predictions to be made about what might happen to particular patients after discharge: whether or not they will be at specific risk of subsequent breakdown and readmission.

Similarly, the distributions of the ISSB sub-scores socioemotional and material support (in table 4.10) reveal no significant differences between the groups. Both groups score uniformly low on both indices - both at discharge and at follow-up. Each group receives (a) little material support from others: e.g., help with money; being loaned something needed; and (b) little socioemotional support: e.g., being told by someone how they felt/what they did in a similar position; being told by someone else that they feel close to them or that they'll always be around.

The stability of scores across time for all patients also suggests that this lack of actual support receipt from others is an on-going, chronic condition among this population. Patients, it will be recalled, were asked to recall the moments they had been helped by others both for the 6 months preceding admission and for the 6 months afterwards. That no significant change in this form of support is observed across a 6-months time-span suggests a longer-term stability in the uniformly low levels of this support.

4.2.2. FUNCTIONAL PROVISIONS: PERCEIVED BELONGING, SELF-ESTEEM, PROBLEM-APPRAISAL, AND TANGIBLE/MATERIAL SUPPORT.

The information for these variables was obtained from the Interpersonal support evaluation list (Cohen et al., 1985). This questionnaire provides a total, global perceived support score and 4 sub-scores:

(a) the "tangible" subscale is intended to measure perceived availability of material aid;

(b) the "appraisal" subscale, the perceived availability of someone to confide in and with whom to share one's problems;

TABLE 4.9.

Means, Ranges and t-tests of **global actual supportive behaviours** score for readmitted and non-readmitted groups at time1 and time2.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test**
	global 'actual' support transactions: /40		
discharge	15.8 (10-26)	17.1 (2-33)	n.s. (2-tailed)
s.d.	6.30	9.62	F=2.33; n.s.
follow-up	14.5 (5-25)	17.8 (6-36)	n.s. (1-tailed)
s.d.	10.47	7.24	F=2.09; n.s.

TABLE 4.10.

Means, Ranges (in brackets) and t-tests of **actual 'socioemotional' and 'material' support** for readmitted and non-readmitted groups at time1 and time2.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
	socioemotional 'actual' support transactions: /26		
discharge	11.6 (6-19)	12.3 (2-23)	n.s.
s.d.	4.76	6.63	F=1.94; n.s.
follow-up	11.2 (4-18)	13.4 (2-23)	n.s.
s.d.	7.80	4.91	F=2.52; n.s.
	material 'actual' support transactions: /14		
discharge	4.2 (1-7)	4.7 (0-11)	n.s.
s.d.	2.13	3.42	F=2.59; n.s.
follow-up	3.2 (1-7)	4.4 (0-13)	n.s.
s.d.	2.87	3.33	F=1.34; n.s.

(c) the "self-esteem" subscale, the perceived likelihood of a positive comparison when comparing one's self with others; and,

(d) the "belonging" subscale, the perceived availability of social companionship: of people one can do things with (from Cohen et al., 1986).

RESULTS.

Before discussing the results for the ISEL it should be pointed out that of the 6 patients eventually readmitted, all but one were single, the 6th one being a married woman with a very dependable husband ("My husband's Sam and we met in hospital: he's always about the house and I can depend on him; we've always been like this: for over 10 year now!" - Patient Patricia). Of the other patients, 2 were young males, one of whom was homeless. The other had recently returned to his home after being 'thrown out' for stealing. A further 2 were schizophrenic women, one with no contact with anyone other than a daily home-help, the other living on her own and a 'regular' of the hospital's assessment ward. The sixth patient was a 50 year-old man without friends and estranged from his family (although he told me that this was how he wanted things to be, "I'm not interested in other people; I've never got on with others, they never seem to have the same interests as me: it really doesn't bother me that I'm on my own for that's how I want it"). This description of the patients (a fuller one can be found in appendix C) should help to provide a more rounded appearance to the details of the results. The influence of the one, domestically-settled, married woman's scores to the overall mean scores for the readmitted group should be borne in mind.

As would be expected for this population all patients score uniformly low on all sub-scales (table 4.11). Only on the 'tangible' assistance scales do both groups score on or higher than 5/10. It should also be kept in mind that these scores represent 'perceived' assessments of each of the 'provisions': that a patient **perceives** him or herself to have available many sources of tangible support does not necessarily mean that they actually **receive** a lot of this kind of support 'provision'. (The result of the analysis of ISSB items bears this out). However, this 'perception' could have strong bearing on eventual outcome, regardless of whether it coincides with the actual support received (e.g., Lakey and Heller, 1985).

There is a significant difference between the groups in their perception of the availability of 'tangible' support at discharge with the readmitted perceiving lower levels. This would be expected given the make-up of the readmitted sample. It would suggest that during assessment for suitability for discharge any patient who has few sources of this kind of support be more closely followed-up after discharge.

The two groups also differ on the 'appraisal' (p=.08) and 'belonging' (p=.06) forms of support at discharge - differences that just fail to attain statistical significance. That is, the patients who were readmitted perceive less of a sense of belonging in their relations with others and also perceive themselves as having fewer people with whom to confide and share problems. This result would be more convincing had differences been significant at the p<.05 alpha level of significance. There are also no significant differences at follow-up.

TABLE 4.11.

Means, Ranges (in brackets) and t-tests of 'ISEL' **perceived interpersonal support sub-scores** for readmitted and non-readmitted groups at time1 and time2.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
	a higher score= a higher level of support **'perceived' self-esteem support : /10**		
discharge	5.0 (2-7)	5.0 (0-10)	n.s.
s.d.	3.46	2.96	F=1.36; n.s.
follow-up	3.8 (3-6)	4.0 (1-8)	n.s.
s.d.	1.33	2.40	F=3.27; n.s.
	'perceived' appraisal support : /10		
discharge	4.3 (1-7)	6.0 (2-10)	t=1.56; df=35; p=.06
s.d.	2.16	2.38	F=1.22; n.s.
follow-up	4.6 (3-9)	5.9 (1-10)	n.s.
s.d.	2.13	2.32	F=1.19; n.s.
	'perceived' tangible support : /10		
discharge	5.0 (1-10)	7.6 (3-10)	t=2.15; df=35; p=.022
s.d.	2.35	2.15	F=1.94; n.s.
follow-up	6.0 (1-10)	7.8 (4-10)	n.s.
s.d.	2.71	2.72	F=1.10; n.s.
	'perceived' belonging support : /10		
discharge	3.7 (1-9)	5.4 (0-10)	t=1.43; df=35; p=.08
s.d.	2.94	2.70	F=1.18; n.s.
follow-up	5.2 (2-8)	4.9 (0-10)	n.s.
s.d.	2.56	3.1	F=1.46; n.s.

TABLE 4.12.

Means, Ranges (in brackets) and t-tests of ISEL **global perceived interpersonal support** scores for readmitted and non-readmitted groups at time1 and time2.

	Readmitted group. **(N=6)**	**Non-Readmitted** group. **(N=32)**	**t-test** time2: 1-tailed
	global 'perceived' interpersonal support : /40		
discharge	18.5 (8-33)	24.0 (8-38)	t=1.5; df=35; p=.07
s.d.	9.39	8.03	F=1.37; n.s.
follow-up	22.1 (12-29)	22.7 (7-36)	n.s.
s.d.	6.46	7.47	F=1.27; n.s.

TABLE 4.13.

Mean availability and mean difference (t-test) analysis of the '**availability of close-attachments**' measure for readmitted and non-readmitted groups at Time1 and Time2.

	Readmitted group. **(N=6)**	**Non-Readmitted** group. **(N=32)**	**t-test** time2: 1-tailed
	mean 'availability of close-attachments' (range in brackets): **/8**		
discharge	4.6 (3-7)	4.54 (0-8)	n.s.
s.d.	1.63	2.15	F=1.75; n.s.
follow-up	3.8 (1-8)	4.7 (0-8)	n.s.
s.d.	2.31	2.50	F=1.17; n.s.

Global ‘perceived interpersonal support' scores for each group - in table 4.12 - are uniformly low on this measure. The two groups' mean scores (18.5 and 24.0 at discharge and 22.1 and 22.7 at follow-up) contrast with the mean scores of 32.9 and 34.4 found by Cohen et al. (1985) for a general population sample in Oregon. The Oregon data suggests (though figures are not available) a mean score of between 8 and 8.5 on each ‘provision', figures significantly greater than those observed for all patients in the sample. That is, all patients - both those readmitted and those not - have significantly **less** (a) perceived availability of material aid; (b) perceived availability of someone to confide in and with whom to share one's problems; (c) perceived likelihood of a positive comparison when comparing one's self with others; and, (d) perceived availability of social companionship compared with a community sample.

In turn, the ISEL global score identifies a difference just failing to attain statistical significance between the groups of patients at discharge who are at greater risk of getting readmitted within a 3 to 6 month time-span (t=1.5; df=35; p=.07). The only apparent explanations for the subsequent increase in mean global scores for the readmitted patients are either that the increase in one schizophrenic woman's total score - reflected in her involvement with a local voluntary organization - makes a highly significant, unrepresentative contribution to the calculation of the mean (where a Mann Whitney U test of the datum yet revealed no significant difference); or else it could be that there was an error in subjects' reporting of this form of support. (However, this last point - the consistency of subjects' responding - has already been tested and can all but be ruled out as an explanation of the results: see chapter three, section 5).

4.2.3. **ATTACHMENT SUPPORT**: (i) AVAILABILITY.

Measures of availability of close attachment figures were obtained using the ISSI (Henderson et al., 1980). However, the ‘availability of close attachments' measure obtained by the ISSI has received some criticism (e.g., Brown & Bifulco, 1985; Henderson and Brown, 1988). The instrument includes measures both of close ties or attachments and more diffuse relationships. This ostensible ‘contamination' of the two subtly different forms of attachment support has been suggested as one of the reasons for the difference in results obtained by the two sets of authors in their studies of social support and life adversity in community samples (see chapter 1, section 3.4.1.). For these reasons the section that covers the analysis of ‘attachment support' will incorporate **both** information based upon the original ISSI ‘availability of attachments' variable as well as information based upon a modification of this measure. This modified measure carefully distinguishes between the attachment available from one significant attachment partner, and that available from any one attachment figure - where there is no partner.

RESULTS.

The first analysis deals with the measure of attachments obtained by the original AVAT (Availability of attachments) measure of the ISSI.

The rates of availability (see table 4.13) for all patients, regardless of outcome status, compare unfavourably with the rates for theCanberra sample of Henderson et al. (1981). That is, the psychiatric patients have significantly fewer available sources of close attachment support (4.6 and 4.5 for the patients compared with a mean score of 6.6 across all age groups in the Canberra, community sample). Bowlby's (1982; 1988) thesis concerning attachment and security in human primate species would suggest that this sample of patients is one particularly prone to feelings of insecurity and of loneliness. It would follow that they will subsequently be prone to the *deleterious consequences* both of adverse life experiences - where the close, intimate support buffers against their impact - and of experiences of psychological distress. The distributions of life events and of distress, in particular, for both groups are supportive of this claim.

However, there are no significant differences as one might expect between the groups in <u>availability</u> of attachments neither at discharge nor at follow-up. This result strikes one as somewhat surprising given the make-up of the readmitted group. Only one of the patients was known to have a close attachment <u>partner</u>, and very few had any particular attachment <u>figure</u>. Most received ‘close' support - as measured by the AVAT measure of the ISSI - from much more <u>diffuse relations</u>. For example, the schizophrenic woman who works on a voluntary basis reported this kind of support as coming from the people she worked alongside: none of whom, however, knew her well enough to drop in to see her at her flat. One of the young men, the homeless one, reported that this kind of support came from other ‘drop-outs' like himself.

There is a criticism, then, to be made of the “AVAT" measure of the ISSI measuring instrument of Henderson et al. (1981). This AVAT measure would appear to allow the inclusion of the support of people with whom the patient can, for example, ‘talk with frankly, without having to watch what you say'; or with whom s/he ‘can go to who isn't involved in an otherwise upsetting event, and tell them just how you feel'. However, with the AVAT measure of the ISSI the *people* who provide these forms of support need not necessarily be important and securely-attached *partners* or *figures* who have been well-known to the patient over a number of years, or even months: they might, and in many cases evidently are, casual acquaintances.

In order to test the hypothesis that the readmitted group have fewer available sources of **close** attachment - both attachment *partners* and attachment *figures* (i.e., any one, dependable intimate other than a long-term partner) - a modification was made of the AVAT measure. Firstly, patients were separated into those who have a long-term attachment partner and those who do not. Secondly, where there was no partner, patients were then scored according to whether or not they have any <u>dependable</u> attachment *figure* (measured by another ISSI item) other than a long-term partner. Such a person was considered to be <u>closely</u> attached: what the AVAT measure purports to be a measure of. In addition, the item ‘<u>satisfaction</u> with close attachment partner' (items 26B and C) was scored in its own right. Item 29C - ‘*Do you wish the person who knows you very well as a person didn't know you quite so well, better, or is it about right?*' - was used as an index of the construct ‘satisfaction with close attachment <u>figure</u> or <u>partner</u>': i.e., for patients with a partner or with a dependable figure. The results from the analysis of the modified “close attachments" variable can be viewed in tables 14 and 15.

As expected (see table 4.14) a difference close to significance does exist between the groups in availability of close attachment *partner* (chi-square=1.55; df=1; p=.10; 1-tailed). The size of the percentage for each group supports the result from the AVAT measure, namely that the groups - all patients, but the readmitted in particular - are relatively more insecurely-placed compared with a general population sample (of N=704) in Canberra.

The results for availability of ‘attachment *figure*' (table 4.15) are even more striking. Two thirds of the readmitted patients have no specific attachment figure of any kind. This contrasts with the figure for the *non*-readmitted group of 16% (chi-square=4.74; df=1; p<.05; 1-tailed). That is, 84% of the patients who were not readmitted within the 6 months have at least one attachment person in their lives - whether *partner* **or** other *figure* (e.g., mother, best friend or sibling). The modified variable - availability of attachment figure - appears, then, to be a relatively good predictor of eventual readmission. Those patients who had no attachment figure **of any kind** are significantly more likely to get readmitted within a 6-month period following discharge from hospital. This finding will be more fully explored in the final, seventh chapter.

4.2.4. ATTACHMENT SUPPORT: (ii) SATISFACTION.

A measure of this component of the social support conceptualization - component 5 - is provided, first, by the ADAT% (per cent adequacy of close attachments) construct of the ISSI.

RESULTS.

Satisfaction levels are very low for all patients (see table 4.16). They compare most unfavourably with the Canberra sample mean-percentage satisfaction score across all age groups (50% and 49% compared with 81%; see Henderson et al., 1981, p.45). Additionally, the satisfaction levels among the psychiatric sample are also much lower than those obtained for the depressed and anxiety-state groups (who score 71.5% and 65.5% respectively) of Henderson et al. (1981).

Secondly, dissatisfaction, as measured by the ADAT% items, does not appear to be a good predictor of readmission. There are no significant differences between groups.

The results of the test of each group's satisfaction with their attachment **partner** or **figure** is presented in table 4.17. Where there is no attachment **partner**, subjects were asked whether, ‘they wished there were someone they were sharing their life with, or do you prefer to be unattached right now?' (item 25C). Item 29E of the ISSI asks patients a similar question relative to close attachment **figure**. This provided all subjects with a single ‘adequacy' score, whether they actually had a partner or figure, or not. Where patients said they ‘preferred to be unattached' or ‘did not wish there was someone who knows them very well as a person' they received a positive score.

The results suggest that dissatisfaction with close attachment figures is associated with increased risk of get-

TABLE 4.14.

Percentage availability and chi-square analysis of close-attachment **partner** for readmitted and non-readmitted groups.

	Readmitted group. **(N=6)**	**Non-Readmitted** group. **(N=32)**	**chi-square** 1-tailed
	mean % availability of one close-attachment partner:		
discharge/follow-up	17 (i.e., 1 patient from 6)	44 (14 / 32)	chi-square = 1.55; df=1; p=.10

TABLE 4.15.

Percentage availability and chi-square analysis of close-attachment **figure** for readmitted and non-readmitted groups.

	Readmitted group. **(N=6)**	**Non-Readmitted** group. **(N=32)**	**chi-square** 1-tailed
	mean % availability of one close-attachment figure:		
discharge/follow-up	33 (i.e., 2 from 6)	84 (27 / 32)	chi-square = 4.74; df=1; p<.05

note: chi-square values shown are calculated using Yate's Correction.

TABLE 4.16.

Mean adequacy and t-test analysis of the ADAT '% **adequacy** of **close-attachments**' measure for readmitted and non-readmitted groups at Time1 and Time2.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
	mean % '**adequacy of close-attachments**' (range in brackets):		
discharge	50% (16-98)	49% (0-98)	n.s.
s.d.	32.56	30.62	F=1.13; n.s.
follow-up	51% (14-98)	53% (0-98)	n.s.
s.d.	34.08	29.73	F=1.31; n.s.

TABLE 4.17.

Mean no. patients (as a %) who said they were '**satisfied with close-attachments**' across readmitted and non-readmitted groups at Time1 and Time2.

	Readmitted group. **(N=6)**	**Non-Readmitted** group. **(N=32)**	**chi-square** time2: 1-tailed
Percentage patients satisfied with 'close-attachment figure' (actual no. in brackets):			
discharge	50% (3 / 6)	41% (13 / 32)	n.s.
follow-up	0% (0 / 6)	37.5% (12 / 32)	chi-square=3.28; df=1; p=.035

ting readmitted to hospital: none of the patients eventually readmitted were satisfied with their attachment figures or with not having an attachment figure of any kind. However, only 12 of the 32 non-readmitted patients were satisfied with their attachment figures - a small percentage compared with the Canberra sample distributions (although these are based on the original ADAT%, and not the modified ADAT% score). That is, there were 20 patients not eventually readmitted who were similarly dissatisfied with their attachment figures. It could well be that these patients are at potentially greater risk of getting readmitted. This would have required following-up these patients for a longer period of time, something not feasible given the time constraints.

4.2.5. **PLEASURABLE SOCIAL CONTACT**: (i) WITH FRIENDS AND (ii) WITH FAMILY.

This variable is measured by the Social Relationships and Activities questionnaire (House et al., 1982). The two constructs that will be examined are the two basic measures: (a) frequency of contacts with family; and, (b) frequency of contacts with friends. The constructs measure the amount of time the patient socializes with his/her family or friends. The constructs are scaled as follows:

1 = didn't do this at all ‘In the past 3 months' (at discharge) / ‘since discharge from hospital' (at follow-up);
2 = once or twice in the past 3 months;
3 = about once per month;
4 = about once or twice per month;
5 = about once per week;
6 = more than once per week.

RESULTS.

All of the patients - irrespective of outcome - pass little time each month socializing with their **friends**. On average, they see their friends only once per month (see table 4.18). There are no significant differences between the two groups at discharge nor at follow-up. Further comment on this result will be made in the general discussion chapter (seven). Suffice it to say that the pattern of social withdrawal observed among all patients is indicative of a population that is poorly “socially integrated" (e.g., Henderson et al., 1981; Brugha, 1991). That is, they know few people whom they can turn to in time of need, as well as few they can call on to go out with or “socialize". This would render them susceptible to what Weiss (1974) termed “social loneliness" - the absence of which is a prerequisite for healthy functioning; the presence of which renders the person vulnerable to feelings of distress and to their deleterious consequences. This would appear to be highly characteristic of the sample of patients interviewed.

TABLE 4.18.

Mean frequency of **contacts with friends** and t-tests of mean differences across time1 and time2 for readmitted and non-readmitted groups of patients.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
	mean no. 'contacts with friends': /6		
discharge	3.6	3.0	n.s.
s.d.	2.33	2.08	F=1.25; n.s.
follow-up	2.0	3.1	n.s.
s.d.	2.00	3.10	F=1.18; n.s.

TABLE 4.19.

Mean frequency of **contacts with family** and t-tests of mean differences across time1 and time2 for readmitted and non-readmitted groups of patients.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
	mean no. 'contacts with family': /6		
discharge	2.0	2.75	n.s.
s.d.	1.67	1.87	F=1.26; n.s.
follow-up	2.75	3.9	t=1.07; df=32; p=.15
s.d.	1.70	2.04	F=1.43; n.s.

The rate of contact with **family** for both groups, particularly for the patients readmitted, is a little lower than for contact with friends (see table 4.19). The patients still in the community at 6 months saw their families on average only <u>once per month</u> in the 3 months preceding admission. However, this subsequently rose to an average <u>once or twice per month</u> following discharge. The patients eventually readmitted saw their families on average only once or twice **per se** in the 3 months preceding admission, and only once or twice again during their brief tenure in the community after discharge.

However, the variable - contact with families - does not significantly distinguish patients at discharge nor at follow-up although there was a difference, in the expected direction, that just failed to attain statistical significance.

That all patients spend such little time with their families and friends would appear to suggest that all the patients have very few people available to whom they can turn. This would also appear to be slightly more pronounced for the readmitted patients. This hypothesis will now be tested as part of the results section for the next component of the social support conceptualization - ‘availability of persons in general to whom the patient can turn'.

4.2.6. SOCIAL INTEGRATION - (i) AVAILABILITY.

This component of the support conceptualization is measured by the ISSI construct AVSI ‘availability of social integration' (Henderson et al., 1981). It is described more fully in chapter 2, section 4.8.4..

BRIEF RECAPITULATION.

The component reflects the view that well-being is promoted through involvement with people other than one's long-term intimate partner (e.g., Henderson et al., 1981; Henderson, 1988; Weber, 1964; Weiss, 1974). Weiss (1974), for example, proposes two forms of subjective loneliness: emotional and social. The fulfillment of just one of these does not compensate for a lack in the other - each form of loneliness requires separate fulfillment. The presence in one's life of a close-attachment intimate is thought to help prevent the experience of emotional loneliness. In the case of social loneliness, its fulfillment requires the presence of and involvement with people other than this close, intimate partner.

From the on-going analysis of results, one would expect all the patients in the sample to know and be involved with comparatively fewer friends than the Canberra general population sample of Henderson et al. (1981). However, one also wishes to test the hypothesis that the readmitted group of patients' have fewer people to turn to compared with the group not readmitted. This hypothesis is suggested by the results from the analysis of the previous - fifth - component in the framework: frequency of contacts with friends (presuming, that is, that the amount of time passed with others is related to the amount of people with whom time can be passed).

RESULTS.

As expected, all psychiatric patients have few people in general to turn to who could provide support when needed (see table 4.20). The means for the two groups of around 4-4.5 and 4.7-5.5 compare with the Canberra general population mean of 9.6 (this does not include the mean score of 6.35 for those aged 65+ in this sample, since only 1 of the patients in the current sample was of comparative age). The results would suggest that 'when things go wrong' all patients have fewer people to turn to for support. This, of course, is almost certainly something to do with being in receipt of psychiatric help: having fewer friends and seeing them less frequently could be, and almost certainly is, a prodromata of their condition. Indeed, in the general discussion section at the end of this chapter some reasons for the patients' withdrawal from others will be suggested.

No significant differences between groups were observed at discharge nor at follow-up. All patients know few people who, for example, 'depend on them for care and attention'; 'really appreciate what you do for them' (which didn't actually apply in the majority of cases); 'are known well enough to borrow things from or ask small favours'; or, 'can be turned to in times of difficulties'. This was observed across groups: there is no support for the hypothesis that readmitted patients have fewer people to turn to compared with the patients still in the community. That is, these patient appear only to socialise slightly less with those they do know compared with their non-readmitted counterparts: it does not appear to be the case that the readmitted group know fewer people than the other patients; they only see them less frequently (which is to say 'hardly ever' compared with the non-readmitted's "a bit more than 'hardly ever'").

4.2.7. SOCIAL INTEGRATION - (i) SATISFACTION.

The results (table 4.21) demonstrate that the patients in the sample - regardless of outcome status - are comparatively dissatisfied with not knowing many people to whom they would be of value (according to the descriptions provided earlier). That is, they appear dissatisfied with **not** knowing someone who, for example, 'depends on them for care and attention'; who 'really appreciates what you do for them'; or who is 'known well enough to borrow things from or ask small favours of'. The range of mean scores for the groups of between **6.8** and **9.8** compares poorly with the mean ADSI score of **13** for the general population sample of Henderson et al. (1981).

The analysis of this kind of satisfaction - with more diffuse relations - together with that for satisfaction with close, intimate relations appears supportive of the conclusion made by Henderson et al. (1981) in their study of the role of social relations on neurotic symptom onset. They found that support 'adequacy' (or satisfaction) rather than 'availability' predicts subsequent morbidity. Given the high levels of severity of psychological distress experienced by the psychiatric patients in the sample it is perhaps no surprise - and supportive of Henderson et al. (1981) - that patients' satisfaction with both close and more diffuse relations is so compara-

TABLE 4.20.

Mean availability and mean difference (t-test) analysis of the '**availability of social integration**' measure for readmitted and non-readmitted groups at Time1 and Time2.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
mean 'availability of general attachments' (range in brackets): **/15**			
discharge	4.5 (0-9)	5.5 (0-14)	n.s. (2-tailed)
s.d.	3.88	4.14	F=1.14; n.s.
follow-up	4.1 (0-8)	4.7 (0-14)	n.s. (1-tailed)
s.d.	4.16	4.65	F=1.23; n.s.

TABLE 4.21.

Mean availability and mean difference (t-test) analysis of the '**satisfaction with social integration**' measure for readmitted and non-readmitted groups at Time1 and Time2.

	Readmitted group. (N=6)	**Non-Readmitted** group. (N=32)	**t-test** time2: 1-tailed
mean 'satifaction with general attachments' (range in brackets): **/17**			
discharge	6.8 (2-14)	8.4 (2-16)	n.s. (2-tailed)
s.d.	4.35	4.51	F=1.08; n.s.
follow-up	9.8 (7-13)	8.8 (0-15)	n.s. (1-tailed)
s.d.	2.38	3.96	F=2.76; n.s.

tively low. However, no attempt is being made to propose 'cause' and 'effect': given the nature, experience and chronicity of the patient sample it would be inappropriate to attempt statements of this kind. Rather, what **can** be said is that in the ongoing recovery of patients from acute psychiatric breakdown, as they try as best they can to get on with their lives in the community, not being satisfied with their relations with 'general' others does not appear to be particularly associated with outcome - readmission. Rather, dissatisfaction with the people they can turn to appears to be more of a **universal** experience amongst this psychiatric sample. This would appear to render them subsequently vulnerable to the deleterious effects of distress - something which was found by Henderson et al. (1981). This, in turn, would suggest an increased susceptibility to breakdown and to eventual readmission within a slightly longer period of time (e.g., within 1 year to 18 months).

Finally, the increase in the mean satisfaction of 'social integration' across time of the group readmitted should be noted. This appears somehow unexpected - irregular even. However, when one observes more closely the distribution of satisfaction scores for the 6 patients in this group a satisfactory explanation does emerge. Of the six patients, two of them were markedly more satisfied with their relations with others (compared with their satisfaction levels at discharge) when they were re-interviewed within days of their return to hospital. It was clear, however, from the reasons they gave for finding themselves back in hospital that their satisfaction with others in general was not particularly "buffering" against the kinds of psychological distress they were experiencing at the time. That is, both patients were 'satisfied' with this type of support - but this was of little consequence in the face of the distressing thoughts with which they were preoccupied. It might help to give a fuller explanation of this statement.

Both patients, chronic schizophrenic women who were well-known to the ward (with more than 10 years previous contact), had met with an **increase** in the availability of other people in general to turn to following hospital discharge. One had resumed voluntary work both with a local charity shop and also with the local Girl Guides group. The other, completely on her own in a high-rise flat, welcomed back the services of a Home-Help for the first time in several months. This service had, before then, been something she'd come to take as granted in her otherwise lonely life. It appears to be for these reasons that both women, quite appropriately, answered in the affirmative to the 'are you satisfied with. .?' question relative to the items, 'is there someone who really appreciates what you do for them' or who is 'known well enough to borrow things from or ask small favours of'. That is, the measure taken of this construct would indicate an increase in this kind of satisfaction. However, such satisfaction was not, for these patients, any buffer against the kinds of thoughts with which they had become preoccupied. Indeed, it could be proposed that these thoughts might have been engendered in some way through being around these other people. The 'thoughts' with which the patients - both women - were preoccupied were remarkably similar. Both women felt they had been 'taken over' by an evil spirit. One of the women felt herself trapped in an "evil bubble" - unable to escape the damaging thoughts contained therein. These thoughts or "voices" "told her" she was evil and that she must kill herself.

The other woman, the old woman living in the high-rise block of flats, felt herself "in the grip" of an evil spirit - a "grip" that held her attention for periods during the follow-up assessment (conducted in the hospital).

This spirit also "told" this woman she was evil and that she "couldn't be trusted". Like the other woman, this spirit "told" her to do away with herself.

With thoughts like these preoccupying each woman, the impact of her felt satisfaction with forms of "social integration" support on her feeling of being "psychologically unwell" (Henderson, 1988) was, perhaps not surprisingly, quite minimal. That is, these patients' "satisfaction" with this kind of support had little impact on their getting readmitted to hospital. All other patients' reporting of 'satisfaction with others to turn to' revealed a decrease or little to no change in satisfaction.

4.3. SUMMARY - 'SOCIAL SUPPORT' AND READMISSION.

The results of the analysis of all six 'social support' components can be summarised thus:

1. **behavioural transactions**: no significant differences between groups were observed at discharge nor at follow-up. Low levels of actual support were observed across both groups. However, the 'most' supported of the readmitted group was still objectively 'low' scoring just 25 out of 40. Among patients who were still living in the community some were observed to receive up to 37 out of the 40 kinds of actual support measured by the ISSB (Barrera et al., 1981).

2. **perceived functional provisions**: Patients who were still living at home 6 months after discharge reported on average significantly higher levels of tangible support at discharge compared with the readmitted group of patients. Although differences were observed between groups in the expected direction on all the remaining provisions - self-esteem, problem appraisal and sense of belonging - these were not found to be significant.

3. **close attachment support**: (i) availability: Analysis of the 'AVAT' measure of the ISSI (Henderson et al., 1980) revealed no significant differences between groups at discharge nor at follow-up in their 'availability' of close attachments. Both groups - all patients - had fewer available sources of close attachment support compared with the community sample of Henderson et al. (1981).

The results obtained from the modification of this measure suggested by Brown and Bifulco (1985) showed that only one of the six patients readmitted to hospital had a close attachment **partner** compared with 14 of the 32 patients not readmitted. And whilst 84% (27 of 32) of patients who were not readmitted had at least one attachment **figure** in their lives with whom they could confide feelings, only 2 of the 6 patients eventually readmitted knew someone who took on this role for them (chi-square=4.74; df=1; p<.05; 1-tailed).

3. **close attachment support**: (ii) satisfaction: The two groups as a whole were much less satisfied with their close attachments (or, more appropriately, with having few to no close attachments) than a community

sample (a mean of 50% compared with 81% - see Henderson et al., 1981). However, no significant differences between the groups were observed. Instead, both groups of patients appear to be equally **very** dissatisfied with their close attachments - a feature that has been found among other samples of psychiatric patients (e.g., Froland et al., 1979; Leavy, 1980). However, when all patients were asked the 'adequacy' question from the 'starter' question - "Do you have a single, lasting relationship - someone you intend to go on sharing your life with or not?" - significant differences between the groups at follow-up assessment were observed. Whereas only 12 of the 32 readmitted patients (37.5%) said they felt "certain they were satisfied with this relationship" or that they "preferred to be unattached right now" **none** of the 6 readmitted patients felt this way. That is, all were dissatisfied with not having someone with whom they could share their lives.

4. **pleasurable social contact**: All patients, irrespective of outcome, spend strikingly little time with their friends and family. They see them, on average, about once per month or less. The result confirms a style of life among psychiatric populations characterized by marked withdrawal from others and from public life (e.g., Goffman, 1961).

Although no significant differences between groups were found, the pattern of results was as expected with the patients still living in the community seeing their friends and family more frequently. The results are discussed with reference to the work of Rook (1985).

5. **social integration**: (i) availability: No significant differences were observed between groups at discharge nor at follow-up. Instead, both groups were equally poorly socially integrated, scoring, on average, between just 4 and 5 out of a maximum 15 on this measure. The result suggests that all the patients lack the numbers of people from whom support of any kind might be obtained: something which increases their vulnerability to the chronically disabling conditions which are seen to obtain in their lives. The measure did not, however, distinguish between groups on the outcome measure, readmission.

6. **social integration**: (i) adequacy: No significant differences were observed. Both groups were comparatively dissatisfied scoring on average between just 7 and 8 on the measure whose maximum is 17. The result is discussed and a claim made, on a general level, that (a) the patients are not satisfied with not knowing many people to whom they may turn in periods of crisis or to whom they are of value; and (b) this might suggest that patients would prefer to be more involved than they are with others.

5. DISTRIBUTIONS OF *CONSENSUS JUDGEMENTS, SELF-BLAME ATTRIBUTIONS* AND *'ISOLATION* ACROSS THE TWO GROUPS.

5.1. BRIEF INTRODUCTION.

Unfortunately, as described earlier (chapter three) it was not possible to obtain assessment of patients' styles of attribution from interview. Instead, each patient was sent a copy of the Attribution Style Questionnaire (Peterson et al., 1982) to fill out in their own time. Unfortunately there was a very poor response - only 18 of the patients sending back the questionnaire. (A further 8 patients reported great difficulty in making sense of the questionnaire and so did not, since could not, fill it in).

However, an additional measure of the patients' 'consensus' of the events in their life was obtained at discharge interview. This measure was not, however, obtained from a scientifically-tested measuring instrument. As a consequence its reliability and validity remain in question. However, the results of the analysis of these data - for around 25 of the 38 patients - will now be presented, with the due qualifications in interpretability.

5.2. THE MEASURING 'INSTRUMENT'.

The 'instrument' was simply a set of questions which were considered appropriate to the population under focus. They were devised by the current author, influenced by the ideas expressed by David Smail in his texts, 'Taking Care: an Alternative to Therapy' (1987), and 'Illusion and Reality: the Meaning of Anxiety' (1984). In these texts, Smail argues that to understand individual distress one needs to view and understand the world from the point of view of that individual: a position taken by 'Personal Construct' theorists (e.g., Bannister and Fransella, 1986; Mair, 1989) within the wider existentialist 'movement' (e.g., Maslow, 1962; May, 1958, 1961). This requires attention to that individual's experience of shame and guilt within the realm of their experience, as well as to their attributions of blame for the distress. In doing so, one is much more likely to move toward an understanding of the **patient's** understanding of his/her predicament. 'Therapy', if it need be so addressed, should then help to move the patient gradually toward a better understanding of the **universality** of their distress experience: that is, of the '**consensus**' of their distressing experience of the world. This distressing experience, Smail argues, is an **appropriate** response to make: for the world can indeed be a very distressing place, particularly when one takes care to attend to and reflect on the damage we, as humans, daily inflict on one another - see chapter one of 'Taking Care' (1987).

The questionnaire has five sections: focussing on each patient's experience of shame, guilt, blame, consensus, and sense of isolation. Each section has the same questions, substituting the term shame, guilt, blame, and consensus for each. Thus, the set of questions for the 'self-blame' felt by each patient reads thus:

A. SELF-BLAME.

Do you blame yourself mostly for: 1. The (odd / 'bad') feelings you have?

" 2. The (odd / 'bad') thoughts you have?

" 3. the (odd / 'bad') things you've done?

" 4. being in a mental hospital?

" 5. the problems you feel you might cause others around you?

Each question has the following response key:

0 not at all; 1 a little bit; 2 moderately; 3 quite a bit; 4 extremely

The questionnaire is reproduced in appendix A. For each of the other categories of experience, the title of each question reads thus:

B. CONSENSUS: "Do you think that most other people just haven't experienced. . . "

C. SHAME: "Do you feel ashamed of. . . "

D. GUILT: "Do you feel guilty about. . . "

Finally, patients were asked a set of questions on their experience of 'isolation'. The questions read thus:

E. ISOLATION.

1. Do you feel you have anyone whom you can share your most worrying problems with?
2. Do you feel that the problems you have are the sorts of things that happen to other people?
3. Do you feel that the sorts of problems you have:
    1. others just wouldn't understand?
    2. others just wouldn't be able to help you with?
    3. others might make you feel uncomfortable if you were to try to get them to understand?
4. Is there anyone you wish you could share your deepest worries with?

The results for the analysis of some of these data will now be presented.

5.3. RESULTS.

5.3.1. CONSENSUS JUDGEMENTS.

There was just one significant difference between the groups in consensus judgements: readmitted patients considered themselves to be like most other people in experiencing hospital admission (t=2.56; df=19;

p=.02). Those patients **not** eventually readmitted had a median response of 'quite a bit' agreement to the question, i.e., 'Do you think that most other people just haven't experienced being in a mental hospital?'. The median response of the readmitted patients to this statement was 'not at all'.

No other significant differences were observed. That is, the consensus judgements of patients do not appear to be a good predictor of readmission. It should also be noted that the very small number of patients in the readmitted group (N=4 on consensus judgements) renders analysis of the results fraught with the accusation of over-interpretation - particularly with the increased error this involves. It is for this reason - the small number of readmitted patients compared with non-readmitted (where N=18-24 across all items) which renders somewhat inappropriate the drawing of conclusions - that very little further statistical inference of these data will be attempted. Instead, this information will be more fully examined in relation to the next level of outcome: the experience of psychological distress. Here, the spread of this outcome variable across all patients - those whose symptoms of psychological distress 'got better', 'got worse', and 'stayed the same' - will make comparisons across the 3 groups more appropriate.

However, before going on to the next major wave of analysis - the examination of the influence of the independent variables on the outcome **psychological distress** - one or two additional results from these data, where there is a more acceptable number in each group to enable summary description, will be presented.

5.3.2. SELF-BLAME.

The results of this analysis revealed just the one significant difference: the readmitted group of patients blamed themselves more severely for having done some of the 'bad/odd' things in their life. What these 'odd/bad' things are would, it is argued, be a matter for the patient to uncover and discuss through the course of treatment with the psychiatrist, psychologist or nurse in whose care s/he has been placed. That is, the current measure can only imply the existence of deeper, more involving (e.g., Brewin et al., 1989) forms of distress. It does not purport to reveal their true nature. However, although no **formal** analysis was attempted of the non-structured information that was obtained through sitting with patients and questioning, listening, and taking notes of **their** stated concerns over periods of time (which enabled some time for almost enlightened reflection) this information is reproduced in appendix C. From this information, something of the 'bad/odd' things that evidently continue to trouble most of the patients can be surmised.

There were no other significant differences on this type of variable. The readmitted patients blamed themselves more for their 'bad/odd' thoughts and feelings; the patients still in the community, in turn, blamed themselves more for 'being in hospital' and 'for the problems they feel they might have caused others'.

5.3.3. ISOLATION.

Summary descriptions of these data follow (table 4.22). No attempt will be made to test for significance.

TABLE 4.22.

Actual figures for each **isolation** question across readmitted and non-readmitted groups..

	Readmitted group. (N=5)		**Non-Readmitted** group. (N=19-23)	
1. Do you feel you have anyone whom you can share your most worrying problems with?				
	YES	NO	YES	NO
	3	2	12	11
2. Do you feel that the problems you have are the sorts of things that happen to other people?				
	YES	NO	YES	NO
	4	1	8	11
3. Do you feel that the sorts of problems you have:				
A. others just wouldn't understand?				
	YES	NO	YES	NO
	4	1	15	7
B. others just wouldn't be able to help you with?				
	YES	NO	YES	NO
	3	2	15	7
C. others might make you feel uncomfortable if you were to try to get them to understand?				
	YES	NO	YES	NO
	5	0	19	4

There were roughly as many patients who report having someone with whom they can share worrying problems as those without. There are no marked differences within groups. Interestingly, when one observes who this someone is, among readmitted patients all 3 report the 'psychiatrist' (although one woman included her husband too). Among patients not eventually readmitted the 'psychiatrist' is also frequently reported as the one fulfilling this role (4/12).

Perhaps surprisingly, four of the five patients who were readmitted felt that the sorts of problems they have 'are the sorts of things that happen to most people'. That is, they appear to have a quite high consensus regarding the existence of their problems. However, this does not mean that they have a high degree of consensus about perception of their own and others' ability to cope: only that their problems, as they stand, are not wholly unique to themselves. Among non-readmitted patients there were slightly more who did not consider their problems to be the experience of others. However, the difference is not significant. It will be interesting to examine, within this group, the distribution of patients whose symptoms of distress stayed the same, relative to those who got worse. This will be attempted in the next wave of analysis.

A majority of all patients, regardless of outcome, felt that 'others just wouldn't understand' the sorts of problems they have (70%). This would appear to imply a feeling of despondency and alienation, where most patients do not feel that others would be able to understand their problems: **nor, indeed, *actually* understand them.** (That is, an immediate response of many of the patients to this question was just this: i.e., "they (other people they know) don't understand!!".)

A similarly high percentage (66%) also feel that 'others just wouldn't be able to help them' with the sorts of problem they have. This might also help to explain the relative lack of frequency in seeing others which characterizes this psychiatric sample. That is, patients might not seek out support or be in receipt of support because they feel that 'others just wouldn't understand', or 'be able to help with' their problems anyway. This would suggest a movement toward **withdrawal** and **despair**. Their response could also suggest that, whilst in receipt of formal care and treatment in the hospital from the psychiatric services, this care does not appear to be working (The distribution and severity of distress scores at discharge across all patients tends to support this). That is, the help that patients 'receive' does not appear to engender a feeling or 'the impression' of being understood.

Taking as a benchmark the current definition of support - as "the feeling and knowledge that a person has of being stable and secure and thus less alone and separate through constructive engagement with other people (from Boyce, 1985; Fromm, 1957/1988)" - together with the definitions proposed by both Buber (1957) and Walker, MacBride and Vachon (1977), the findings suggest that the patient does not appear to be truly '**supported**'. That is, the results suggest that s/he does **not** have the satisfaction (a) of 'being confirmed as what s/he is by others' (Buber, 1957) or, similarly, (b) of being 'assured that their feelings are understood by others and considered normal in the situation'. Feelings and knowledge of being stable, secure and so less at a remove from other people are as remote from these people's lives as is the availability and enactment of the various measured components of 'social support'. Indeed, the fact of being in a mental hospital and so at a form of remove from other people on the basis of having certain feelings is immediately disconfirming of them!

The analysis of this measure with distress as the outcome should be of interest in identifying the association of 'being misunderstood' with 'distress'.

Finally, 86% of all patients agreed that others might make them feel uncomfortable if they were to try to get them to understand the sorts of problems they have. This question attempted to suggest a simplistic reason for the patients' perception that they would not be understood by others or that others wouldn't be able to help. The simplistic 'reason' put forward, that there would be a feeling of discomfort in trying to approach an understanding with someone, appears to be an experience that is somewhat universal among the sample. Among all 19 patients who said that 'others just wouldn't understand' their problems 17 of them (89%) affirmed that others might make them feel uncomfortable if they were to try to get them to understand. What the cause of the discomfort might be and why trying to get someone to understand is viewed in this way is not measured by the questionnaire.

A richer discussion of these results will be made in the final, seventh chapter.

5.4. SUMMARY - CONSENSUS JUDGEMENTS, SELF-BLAME ATTRIBUTIONS, ISOLATION AND READMISSION.

The most notable finding was all patients' general consensus on (a) feeling that others wouldn't understand the sorts of problems they have; (b) feeling that others wouldn't be able to help them with such problems; and (c) feeling that they'd feel uncomfortable in trying to confide their problems with other people. The results are discussed with reference to the global concept 'social support'.

6. GENERAL SUMMARY.

The sample of 38 routinely discharged psychiatric patients was divided into two groups on the basis of the first of the study's outcome criteria - hospital readmission. The distribution of each of the study's independent variables were then compared between the groups - that is, between (a) the group of patients who returned to the hospital within the 6-month study period, and (b) the group of patients who were still living in the community at 6-months. The purpose of this analysis was to identify and examine the characteristic features of the patients' experience which would help to explain why it was that some patients returned to hospital and some did not.

The results of the analysis of each independent variable - demographic and psychiatric, life event, 'social support' and attributions of self-blame and consensus judgements - are presented for discussion. In general, the two groups of patients were barely distinguishable in their experience of each of these 'revolving-door' outcome indicators. Rather, **each group** - all the routinely discharged psychiatric patients - **was characterized by:**

(a) markedly high levels of severity of psychological distress <u>both</u> at discharge and at follow-up;

(b) markedly high numbers of severely distressing life events experienced before admission and after current discharge;

(c) markedly low levels of all components of 'social support';

(d) lengthy previous contact with the psychiatric hospital;

(e) a marked feeling of isolation from other people regarding the problems they face.

Patients who returned to hospital could, however, be distinguished from *patients still living at home* at the six-month follow-up period in the following ways:

(i) their experience of adverse life events showed less improvement during the 6-month period (and less) after discharge compared with the non-readmitted group;

(ii) their experience of symptoms of psychological distress had undergone significant deterioration compared with the more stable, though chronically severe experience among non-readmitted patients;

(iii) only two of the six patients who returned to hospital had any form of close attachment **person** in their lives - whether *partner* or *figure* - compared with 27 of the 32 patients who did not return within 6 months;

(iv) none of the 6 readmited patients were satisfied with their close attachments status, preferring, instead, to be closely or more securely attached with someone in a secure, lasting relationship.

CHAPTER FIVE:

OUTCOME - PSYCHOLOGICAL DISTRESS:

THE SECOND WAVE OF ANALYSES:

WHETHER PATIENTS' SYMPTOMS OF PSYCHOLOGICAL DISTRESS 'STAYED THE SAME', 'DETERIORATED', OR 'IMPROVED': The influence of psychiatric history, social-demography, life events, social support, and experiences of self-blame, guilt, consensus and isolation on psychological distress.

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4.3. **SUMMARY** - 'SOCIAL SUPPORT' AND PSYCHOLOGICAL DISTRESS.

5. DISTRIBUTIONS OF CONSENSUS JUDGEMENTS, SELF-BLAME ATTRIBUTIONS, FEELINGS OF SHAME, GUILT AND 'ISOLATION' ACROSS THE THREE GROUPS.

5.1. **RESULTS:**

5.1.1. FEELINGS OF SHAME.

5.1.2. FEELINGS OF GUILT.

5.1.3. SELF-BLAME ATTRIBUTIONS.

5.1.4. CONSENSUS JUDGEMENTS.

5.1.5. ISOLATION.

6. GENERAL SUMMARY.

CHAPTER FIVE:

OUTCOME - PSYCHOLOGICAL DISTRESS.

THE SECOND WAVE OF ANALYSES:

WHETHER PATIENTS' SYMPTOMS 'STAYED THE SAME', 'DETERIORATED', OR 'IMPROVED': The influence of psychiatric history, social-demography, life events, social support, and experiences of self-blame, guilt, consensus and isolation on psychological distress.

CHAPTER SUMMARY.

The second-wave analysis of the data will attempt to examine the influence of the factors in the 'discharge revolving-door' model on the second outcome indicator: psychological distress. The structure of this wave of analyses will be largely similar to the first results wave. That is, statistical tests of the data will be carried out among groups of patients, where each group represents a particular category of the dependent variable criterion '**change** in symptoms of distress through follow-up'. There will be three groups of patients: (a) a group of patients whose symptoms showed relatively **little change** from discharge through follow-up; (b) a group whose symptoms **improved**; and, finally, (c) a group whose symptoms of distress **deteriorated** across the six-months' timespan of the study.

This outcome indicator has been selected for the simple reason that readmission, the first of the study's dependent variables, is best predicted by the presence and severity of psychological distress. This fundamental proposition has been made and returned to throughout the course of the thesis, particularly in chapter 2, section 1.3. The results of the current analysis of this type of datum were in support of this argument, where it was found that patients who got readmitted within the 6 months were significantly more distressed than those still in the community at 6 months (see chapter 4, section 2). In short, it's believed that patients whose symptoms of distress undergo deterioration during the course of follow-up will be more susceptible to "breaking down", a breakdown which, in turn, makes a return to hospital more likely.

The purpose of this second-wave analysis of the data is to attempt to identify and examine those factors in the model which correlate most strongly with either (a) deterioration in symptoms of psychological distress; or (b) with improvement in symptomatic distress. Dividing patients into groups on the basis of the outcome criterion 'psychological distress' - into those whose symptoms (a) remained the same; (b) improved; and (c) deteriorated - enables one to examine and compare all the other variables in the study across these groups. In this way, an attempt can be made to identify those variables which significantly **differ** between the groups:

differences which could help to explain **why** some patients' symptoms of distress (a) deteriorated during the 6 months following discharge; (b) improved, or (c) remained the same.

Patients whose symptoms improve are more likely to stay in the community (e.g., Hoult, 1986; Sommers, 1988). Those whose symptoms deteriorate are more likely to get readmitted (e.g., Fontana and Dowds, 1975; Tessler and Manderscheid, 1982). The experience of distress is strongly associated with increased risk of hospital readmission. It is reasonable, therefore, to attempt to examine the differences between the three groups in the distributions of the independent variables in the framework where, it's believed, particular types of experience will significantly distinguish them. These types of experience are likely to be of predictive utility, enabling, say, patients who are susceptible to a negative change in distress to be identified and singled out for particular kinds of help, both within the hospital and after discharge where an essential element of this 'care in the community' might more appropriately be more intensive 'after-care' (Solomon, Davis and Gordon, 1984).

1. DISTRIBUTIONS OF PSYCHIATRIC HISTORY VARIABLES AND SOCIAL DEMOGRAPHIC VARIABLES ACROSS THE THREE GROUPS.

1.1. HOW THE GROUPS WERE DERIVED.

Throughout the remainder of this chapter the experiences of three groups of patients will be under focus: (a) patients whose symptoms improved, (b) patients whose symptoms deteriorated and (c) patients whose symptoms underwent little change across the 6 months sampling period. All groups were composed of patients who were selected on the basis of their global distress score, referred to in chapter four, section 2.2. The derivation of two of the groups is self-evident: patients whose severity of symptoms score was higher at follow-up and those whose severity of symptoms score was lower. The third group, the patients whose level of symptoms remained more or less the same, is composed of patients whose unit change in symptom score was less than or equal to three units on the total global index scored out of 40.

1.2. **RESULTS**: DISTRIBUTIONS OF PSYCHIATRIC HISTORY VARIABLES AND SOCIAL DEMOGRAPHIC VARIABLES.

There were 12 patients (32%) whose symptoms of distress underwent little change in severity across the 6 months sampling period. Just 8 of the 38 patients (21%) underwent an improvement in their experience of distress following discharge. The patients whose symptoms of distress underwent significant deterioration in severity from discharge to follow-up were in the majority with 18 of the 38 patients (47%) getting 'worse'.

TABLE 5.1.

Distribution of **socio-demographic** variables across 'same', 'better' and 'worse' groups of patient.

---

1. 'SAME' PATIENTS. (N=12)

AGE
Mean = 45years.

SEX
5 male and 7 female.

MARITAL STATUS
3 single; 5 married; 2 divorced; 1 separated and 1 cohabiting.

EMPLOYMENT STATUS
6 unemployed; 2 employed; 2 retired, and 2 on sickness benefit.

2. 'BETTER' PATIENTS. (N=8)

AGE
Mean = 38 years.

SEX
2 male and 6 female.

MARITAL STATUS
3 single, 1 married, 3 divorced and 1 widowed.

EMPLOYMENT STATUS
5 unemployed, 1 employed and 2 retired.

2. 'WORSE' PATIENTS. (N=18)

AGE
Mean = 44 years.

SEX
10 male and 8 female.

MARITAL STATUS
10 single, 6 married, 1 divorced and 1 widowed.

EMPLOYMENT STATUS
10 unemployed, 1 employed, 6 sickness benefit and 1 voluntary work.

TABLE 5.2.

Distribution of **psychiatric history** variables across 'same', 'better' and 'worse' groups of patient.

CLINICAL DIAGNOSIS.

SAME GROUP: 6 depression, 2 schizophrenia, 1 manic depression, 2 alcoholic and 1 other.
BETTER GROUP: 3 depression, 3 schizophrenia, 1 manic depression and 1 alcoholic.
WORSE GROUP: 5 depression, 5 schizophrenia, 4 manic depression and 4 others.

No. YEARS SINCE FIRST CONTACT WITH PSYCHIATRIC CARE.

SAME GROUP: 6 patients - 1st admission; 1 patient - less than 1 year; 1 - more than 10 years; 2 - more than 15 years and 2 - more than 20 years. MEAN=7 years.
BETTER GROUP: 1 patient - 1st admission; 3 patients - between 1 to 2 years; 2 patients - between 2 to 5 years; 1 - more than 10 years; 1 - more than 20 years. MEAN=5 years.
WORSE GROUP: 3 patients - 1st admission; 1 - less than one year; 3 patients - between 1 to 2 years; 2 patients - between 2 to 5 years; 3 patients - between 5 to 10 years; 2 - more than 10 years; 2 - more than 15 years; 2 - more than 20 years. MEAN=7 years.

No. PREVIOUS ADMISSIONS.

SAME GROUP: 6 patients - no previous admissions; 1 - one previous admission; 1 - 3 admissions; 1 - 5 admissions; 1 - 6 admissions; 2 - more than 10 admissions. Mean=3 admissions.
BETTER GROUP: 1 patient - no previous admissions; 3 - one previous admission; 1 - 2 admissions; 2 - 3 admissions; 1 - 4 admissions. Mean= 2 admissions.
WORSE GROUP: 3 patients - no previous admissions; 4 - one previous admission; 1 - 2 admissions; 2 - 3 admissions; 3 - 4 admissions; 1 - 6 admissions; 4 >10 admissions. Mean= 4 admissions.

LENGTH CURRENT ADMISSION.

SAME GROUP: Mean length current admission = 50 days. (Excluding one patient's 201-day period of admission greatly reduces this average to 37 days). Range= between 13 and 97/201 days.
BETTER GROUP: Mean length current admission = 49 days. Range= between 12 and 128 days.
WORSE GROUP: Mean length current admission = 57 days. (Excluding one patient's 344-day period of admission greatly reduces this average to 39 days).Range= between 7 and 127/344 days.

LENGTH OF MOST RECENT ADMISSION.

SAME GROUP: Mean length= 25 days. Range= between 14 and 45 days.
BETTER GROUP: Mean length= 45 days. Range= between 14 and 45 days.
WORSE GROUP: Mean length= 35 days. Range= between 2 and 101 days.

AVERAGE LENGTH OF ALL IN-PATIENT ADMISSIONS.

SAME GROUP: Mean length= 44 days; range= between 11 and 97 days.
BETTER GROUP: Mean length= 56 days; range= between 16 and 129 days.
WORSE GROUP: Mean length= 40 days; range= between 6 and 127 days.

AVERAGE LENGTH OF TENURE IN THE COMMUNITY.

SAME GROUP: Mean length= 23 months. Range= between 4 to 54 months.
BETTER GROUP: Mean length= 33 months. Range= between 5 to 120 months.
WORSE GROUP: Mean length= 24 months. Range= between 2 to 60/192 months.

1.3. SUMMARY DISCUSSION: THE DISTRIBUTION OF PSYCHIATRIC HISTORY VARIABLES AND SOCIAL DEMOGRAPHIC VARIABLES ACROSS GROUPS.

The social demographic information does not appear to be instructive of change in psychological distress (see table 5.1.). No significant differences between groups were identified on any of these variables.

The differences between groups on the psychiatric history variables (table 5.2.) 'number of previous admissions' (non-significant) and 'average length of tenure in the community' (Kruskal-Wallis test value H=4.43; p<.05; 1-tailed; corrected for ties) are supportive of what has been described as a 'given' elsewhere in this thesis (chapter 1, section 2.4.). This states that the more often a patient has been admitted to hospital for psychiatric treatment (and the longer the in-patient stay) the more likely it is that that patient will return (e.g., Anthony et al., 1978; Avison and Speechley, 1987; Goering et al., 1984). Concomitantly, the fewer times a patient has previously been readmitted the less time that patient will subsequently be likely to spend in hospital. The results suggest that where improvement in symptoms did take place this was among patients (a) whose mean number of previous admissions was lower, and (b) whose average community tenure was around 10 months to a year significantly longer than patients who got worse or stayed the same.

The result alludes to the role played by what is known as 'institutionalization' (e.g., Friedman, 1985; Goffman, 1961; Gottesfeld, 1977; Test and Stein, 1978) in recidivism. That is, it is quite possibly, though not necessarily, the case that those patients who come back again and again to the ward could be described as becoming or being 'institutionalized'. This implies that their thinking has become fixed in a particular 'set'. That is, through the course of successive hospital admissions the person 'grows' - or, rather, 'diminishes' - to view him/herself as 'a psychiatric patient or person' (e.g., Thoits, 1985b). Gottesfeld (1977), for instance, writes, "The longer he is in hospital, the more dependent he is on the hospital; and the more likely that his career will be that of a mental patient".

The view the person holds of him/herself might be likely to consist of feelings (a) of being dependent on other 'professional experts' for 'expert treatment'; and (b) of being relatively helpless until helped, by the expert, usually through the use of medication and non-directive support. Such 'institutionalized' ways of construing do not necessarily follow: they are, however, as stated clearly by these authors, rendered more likely through repeated readmissions. It is, then, a possible explanation that requires further exploration. The role of 'institutionalization' in readmission and psychological distress will be more fully examined in chapter seven.

2. THE EXPERIENCE OF PARTICULAR *TYPES* OF PSYCHOLOGICAL DISTRESS ACROSS THE 3 GROUPS.

In the first-wave analysis of the data an attempt was made to identify the types of psychological distress which were experienced in comparatively greater degree of severity by the group readmitted. Where differences were observed at discharge between groups these were said to be of predictive value, enabling patients who are more susceptible to acute breakdown to be identified prior to discharge. Where differences in distress types or 'clusters' were observed at follow-up these differences were said to be of help in a retrospective way.

Patients who got readmitted were found to be significantly more likely to experience severe forms of thought disorder at follow-up: their thinking significantly more paranoid and more psychotic relative to patients still living in the community. It was argued that patients who already experienced these forms of distressing cognitions prior to discharge would be more susceptible to subsequent breakdown once discharged back home. In this way, the types of distress on which differences were observed at follow-up were considered to be useful prognostic indicators and so helpful to ward staff when assessing patient suitability for discharge. In addition, where patients are followed-up by community psychiatric personnel this type of information would also be useful for assessing likely breakdown. Patients who had developed whatever form of 'susceptible' distress could be singled out for particular treatment: e.g., lengthening the home visit to talk about things which were distressing to the patient; resolving to do something about these things together; listening, confirming feelings, and suggesting ways of coping.

In this results section there will be an examination of the differences among the three groups in their experience of particular forms of psychological distress. No attempt will be made to examine differences on the global measure of distress since patients would obviously be expected to differ having been divided on just this basis! However, it does not necessarily follow that the three groups' experience of particular types of distress will be similarly different. All groups' experience of distress types could be spread comparatively evenly across clusters, such as depression, anxiety, somatic preoccupation, paranoid thoughts, interpersonal sensitivity, suicidal thoughts and the like. However, where one group's experience of distress types is significantly more marked than the others' - whether at discharge or at follow-up - it would suggest that this experience is, in some way, related to outcome - whether this be with improvement, deterioration, or stabilization of distress.

2.1. RESULTS: DISTRIBUTIONS OF SCL-90 SYMPTOM TYPES.

The first point to note is the absence of significant differences at discharge in the experience of types of distress across groups (table 5.3). This suggests that there is no specific contribution of any particular type of distress as measured at discharge to subsequent, 6-month follow-up global distress. The contribution of one type would not appear to supercede the contribution of another. Thus, it does not appear possible, from the results, to suggest that when a patient's suitability for discharge is being assessed that his/her subsequent global distress can be predicted by knowing that the patient's distress experience has, say, a particularly high 'de-

TABLE 5.3.

Mean scores and anovas of **SCL-90 types of psychological distress** for the ‘same', ‘better' and ‘worse' groups of patients at Time 1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** (1-tailed: Time 2)
SCL - INTERPERSONAL SENSITIVITY: /36				
time1	11	11	9	n.s.
time2	11	5	15	F=5.08; df=2,33; p=.01
Multiple Range Test: LSD procedure				
‘Worse' group significantly more severe than ‘Better' group at follow-up.				
SCL - OBSESSIVENESS COMPULSIVENESS: /40				
time1	13	9	10	n.s.
time2	14	7	16	F=3.2; df=2,33; p=.05
Multiple Range Test: LSD procedure				
‘Worse' group significantly more severe than ‘Better' group at follow-up.				
SCL - SOMATIC PREOCCUPATION: /48				
time1	9	9	7	n.s.
time2	11	5	12	F=3.9; df=2,33; p=.03
Multiple Range Test: LSD procedure				
‘Worse' and ‘Same'group significantly more severe than ‘Better' group at follow-up.				
SCL - DEPRESSION: /52				
time1	23	24	17	n.s.
time2	22	9	29	F=7.9; df=2,33; p=.001
Multiple Range Test: LSD procedure				
‘Worse' and ‘Same'group significantly more severe than ‘Better' group at follow-up.				
SCL - ANXIETY: /40				
time1	13	14	11	n.s.
time2	13	4	18	F=8.2; df=2,33; p=.001
Multiple Range Test: LSD procedure				
‘Worse' and ‘Same'group significantly more severe than ‘Better' group at follow-up.				

continued on next page/

TABLE 5.3 (cont'd).

Mean scores and anovas of **SCL-90 types of psychological distress** for the 'same', 'better' and 'worse' groups of patients at Time 1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** (1-tailed) (1-tailed: Time 2)
SCL - ANGER/ HOSTILITY: /24				
time1	4	5	3	n.s.
time2	6	1	7	F=3.9; df=2,33; p=.03
Multiple Range Test: LSD procedure				
'Worse' group significantly more severe than 'Better' group at follow-up.				
SCL - PHOBIC ANXIETY: /28				
time1	5	5	5	n.s.
time2	7	2	10	F=3.6; df=2,33; p=.04
Multiple Range Test: LSD procedure				
'Worse' group significantly more severe than 'Better' group at follow-up.				
SCL - PARANOIA: /24				
time1	4	4	4	n.s.
time2	4	4	8	F=3.0; df=2,33; p=.06
Multiple Range Test: LSD procedure				
'Worse' group more severe than 'Better' and 'Same' group at follow-up - but n.s.				
SCL - PSYCHOTICISM: /40				
time1	8	7	5	n.s.
time2	4	3	10	F=5.7; df=2,33; p=.01
Multiple Range Test: LSD procedure				
'Worse' group significantly more severe than 'Better' and 'Same'group at follow-up.				

note:

Bartlett tests of the homogeneity of variances among groups were carried out, none of which was found to be significant.

pression' or 'anxiety' component. This was also found where the outcome was readmission: i.e., there do not appear to be any particular types or clusters of distress experienced at discharge which could be used to predict likely outcome of subsequent distress.

At follow-up, as one would expect, significant differences in types of distress do emerge. Patients who got 'worse' (not surprisingly) experienced significantly more severe degrees of all types of distress compared with patients whose global symptom score underwent improvement during the course of living back home. Patients whose symptoms improved during community tenure experienced an improvement in **all** types of psychological distress, bar paranoid thoughts, relative to the other two groups. That is, the contribution to the improvement in global distress was uniformly across all types of psychological distress.

In particular, the improvement in 'depression', 'anxiety' and 'somatic preoccupation' for the patients whose global symptoms 'improved' after discharge is especially pronounced, significantly lower than both 'Same' **and** 'Worse' groups (F=7.9; df=2,33; p=.001 for depression; F=8.2; df=2,33; p=.001 for anxiety; and F=3.9; df=2,33; p=.03 for somatic preoccupation: all tests one-tailed). This might suggest that patients whose symptoms of depression, anxiety, and somatic preoccupations undergo significant improvement after discharge are more likely to remain for longer periods in the community. However, this presupposes the stabilization for all patients of all other kinds of experience in the patient's life after discharge: in life events, social support, and experience of shame, guilt, consensus, and isolation. Throughout the course of this thesis it has been argued that the distress experienced by any patient cannot, truly, be understood in isolation from these other factors. For these reasons, the results of the analysis of the influence of these factors on the change in distress experienced across all three groups will be presented for examination in later sections of this chapter.

Patients whose global symptoms of distress underwent deterioration after discharge experienced a uniform deterioration across **all** types of distress. However, their thinking has become significantly more severely 'psychotic' (F=5.7; df=2,33; p=.01) and close to significantly 'paranoid' (F=3.0; df=2,33; p=.06) after discharge compared with both 'Same' and 'Improved' groups of patients. This would suggest that when assessment is being made of patients' suitability for discharge that any patient particularly severe in paranoid and psychotic thinking (between 8-12/24 on the paranoid subscale, and between 10-12/40 on the psychoticism subscale) **prior** to discharge should be considered more "**at risk**' and singled out for particular attention. This attention might be best focussed on the amelioration of these experiences for the patient and might most fruitfully involve addressing some of the reasons for these thoughts with the patient.

This kind of treatment might best be supervised and led by the psychiatrist responsible for the patient. That is, the psychiatrist is the figure with the greatest authority on the ward and might be expected to ask the kind of questions which are required, and in the kind of surroundings - i.e., individual, private consultation - which might improve patients' openness to talk about these things. (Rather than through informal chatting in the corridor of the ward with a nurse or in a tv room. However, this too, depending on the person involved, might also continue to be an acceptable alternative).

Informal discussion with the ward manager as well as informal observation of 'what happened on the ward' does make it clear that when any, and most, patients are feeling really bad then it is the attention of 'their' 'doctor' - i.e., the psychiatrist - that is the first thing demanded. When patients feel really bad they want to see the psychiatrist - no-one else will do. (Although this was simply 'an observation' made of what happened on the ward - and one which has not been put to any kind of scientific test - it would, however, be suggested that were this proposition to be tested through the use of reliable and valid measures of such forms of communication that its' proof would almost certainly be demonstrated. This would render more valid the suggestion for treatment of those patients especially paranoid and psychotic and still in the ward. However, without the appropriate methods of control the observation can only stand as a 'personal' one, albeit one shared by the ward manager and by those members of nursing staff with whom correspondence was made.)

Another point to observe and one which was also made in the first results chapter is the comparatively high severity of distress (a) among all patients at discharge; and (b) among all patients bar those who improved after discharge. The population sample under focus can be described as one in "considerable distress" (Goering et al., 1984). Among patients who "improved" after discharge, improvement was such that their experience of symptoms of distress would be considered 'normal' in the general population (see Derogatis et al., 1974).

2.2. **RESULTS**: DISTRIBUTIONS OF **GHQ-30** SYMPTOM TYPES.

Patients whose symptoms improved after discharge experienced an improvement across all five symptom factors (Huppert et al., 1989) measured by the GHQ-30 (table 5.4.). Their experience of all five symptoms was significantly less severe than both groups of patients whose global distress remained the same or got worse. That is, the 'improved' group of patients were significantly less socially withdrawn (F=5.9; df=2,33; p=.01), feeling significantly less helpless about further improvement (F=7.2; df=2,33; p=.01), held themselves in significantly higher esteem (F=6.5; df=2,33; p=.01); and were significantly less anxious (F=8.00; df=2,33; p=.001) and experienced significantly less difficulty in coping (F=9.8; df=2,33; p=.001).

These results are supportive of one of the central hypotheses of the thesis: that patients whose distress becomes highly severe and without apparent means of resolve (i.e., without any felt ability to cope) are more susceptible to breakdown which leads to readmission. The hypothesis implies that patients whose distress is not severe and whose difficulties in coping are at a minimum will be less susceptible to breakdown: an implication supported in particular by the results for the group of patients whose global symptoms improved after discharge. Indeed, these patients' symptoms of distress may have improved partly because they experienced no felt *difficulties in coping*. However, it might also be that where a stronger feeling of, say, depression or helplessness is engendered a felt ability to cope will diminish accordingly. This 'degree of change', it is

TABLE 5.4.

Mean scores and anovas of **GHQ-30 types of psychological distress** for the 'same', 'better' and 'worse' groups of patients at Time 1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
GHQ-SOCIAL DYSFUNCTION: /3				
time1	1.0	.5	.6	n.s.
time2	1.8	.3	1.7	F=5,9; df=2,33; p=.01
Multiple Range Test: LSD procedure				
'Worse' and 'Same' group significantly more severe than 'Better' group at follow-up.				
GHQ-DEPRESSION/HELPLESSNESS: /5				
time1	2.6	2.1	1.9	n.s.
time2	2.8	1.0	3.6	F=7.2; df=2,33; p=.01
Multiple Range Test: LSD procedure				
'Worse' and 'Same'group significantly more severe than 'Better' group at follow-up.				
GHQ-SELF-ESTEEM: /4				
time1	1.5	1.0	1.2	n.s.
time2	1.6	0	2.1	F=6.5; df=2,33; p=.01
Multiple Range Test: LSD procedure				
'Worse' and 'Same'group significantly more severe than 'Better' group at follow-up.				
GHQ-DIFFICULTY IN COPING: /5				
time1	3.0	2.5	2.4	n.s.
time2	3.2	1.2	3.8	F=9.8; df=2,33; p=.001
Multiple Range Test: LSD procedure				
'Worse' and 'Same'group significantly more severe than 'Better' group at follow-up.				
GHQ-ANXIETY: /8				
time1	6.2	6.7	6.0	n.s.
time2	7.0	4.0	7.4	F=8.0; df=2,33; p=.001
Multiple Range Test: LSD procedure				
'Worse' and 'Same'group significantly more severe than 'Better' group at follow-up.				

note:

Bartlett tests of the homogeneity of variances among groups were carried out, none of which was found to be significant.

argued, will be influenced by the patient's experience of life events, social support, and sense of shame, guilt, and self-blame about the distress experienced, and sense of isolation from others' help. The improvement in all GHQ-30 types of distress experienced by the 'globally improved' group makes the succeeding waves of analysis that much more interesting. For it will be interesting to see if this group's improvement is reflected in any of the study's explanatory factors: life events, social support, or 'powerful emotion' (Brewin et al., 1989).

One other significant finding that should be noted is the concomitant severity of distress among the 'globally worse' group of patients. They are more severely anxious, feel more helpless, experience greater difficulties in coping and hold themselves in very low esteem compared with the 'same' and 'improved' groups (although such differences are significant compared only with the 'improved' patients). This experience is <u>most</u> severe: their scores on the helplessness factor, the anxiety factor, and the difficulty in coping factor are close to <u>maximum</u>. If one were to accept the hypothesis that the more severely distressed the patient is the more susceptible to breakdown s/he will be, then the levels of distress-severity experienced by this group suggest that many are as close as can be to the breaking point: i.e., from when things are just bearable to when things become impossibly intolerable. It would be interesting to find out just how many of the most severely distressed patients who did not get readmitted at 6 months nevertheless returned within one year.* (see footnote.)

2.3. **RESULTS**: DISTRIBUTIONS OF '**BECK DEPRESSION INVENTORY**' SYMPTOM TYPES.

There are 21 separate symptoms and attitudes measured by the revised BDI (Beck et al., 1979) for assessment of the severity of depression in clinical populations. It would be intensely time-consuming to produce an exhaustive analysis of each separate item across all patients at both discharge and follow-up. This will not be attempted. Instead, some of the more informative features of these data will be presented for discussion.

2.3.1. Differences at **discharge** assessment.

No significant differences between the groups on any of the 21 symptoms and attitudes were distinguished at discharge assessment. It's becoming clear that whilst psychological distress best distinguishes patients on the outcome 'readmission', nevertheless the **prior** level of the distress does not distinguish patients more at risk of subsequent swift readmission nor does it distinguish those likely to undergo subsequent <u>change</u> in experi-

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NOTE:

As of 14 02 92: of a further eight patients who were subsequently readmitted to the ward by **12 months** following original discharge (giving a 12-month recidivism rate of around 40%) **six** of these patients were in the "worse" group at the six-month period.
The figure lends yet further support for the hypothesis that readmission is most strongly predicted by level of severity of psychological distress.

ence of distress.

2.3.2. Differences at **follow-up** assessment.

The object of this exercise is to try to identify the types of symptom or attitude measured by the BDI which are experienced in relatively greater severity by patients whose global symptoms of distress underwent deterioration after discharge. Particular symptoms might solely distinguish those who 'got worse'. These symptoms could then be used by professional staff - either in the hospital or in the community - to identify the degree of severity of the patient's distress. Any items which are the sole domain of those who 'got worse' and which are a part of the patient's current distress experience would indicate to the CPN or GP 'following-up' the patient that s/he is at particular risk of breakdown. This would then alert these professionals to the need to provide particular attention to the needs of that patient.

RESULTS.

There are four BDI items which successfully distinguish the patients whose global symptoms deteriorated from those whose symptoms 'improved' or 'stayed the same': self-condemnation, suicidal wishes, difficulty making decisions, and finding work an effort (see table 5.5). That is, patients whose global distress experience underwent significant <u>deterioration</u> after discharge can be distinguished from all other patients by their experience of these four items: condemning themselves significantly more for their condition (F=5.9; df=2,35; p=.006), feeling significantly more suicidal (F=4.9; df=2,35; p=.01), having significantly greater difficulty making decisions (F=7.9; df=2,35; p=.001), and finding work significantly more of an effort (F=14.4; df=2,35; p=.0001). All tests were one-tailed.

The results would appear to indicate that a particular level of severity of these symptoms or attitudes are the sole domain of someone who has undergone marked deterioration since being discharged. These symptoms could be used by hospital or community psychiatric personnel as particularly sensitive indicators of how 'well' the patient 'is doing' following discharge: where any patient scores more than the minimum on any one or more of these symptoms it would be suggestive of a state of being that has become "demoralized" (Dohrenwend and Dohrenwend, 1980) rendering more likely subsequent breakdown and readmission for that patient. Although the results are only <u>suggestive</u> of these practical forms of treatment-intervention they do indicate that particular experiences of distress (or depression) are associated with <u>significant</u> deterioration and increased likelihood of hospital readmission.

There are four additional symptoms which appear to distinguish between patients whose global distress <u>improved</u> after discharge and those whose distress stayed the same or got much worse. The 'improved' group were significantly **less** (a) pessimistic (F=6.5; df=2,35; p=.01), (b) sensitive of disappointment in their lives

TABLE 5.5.

Mean scores and oneway analyses of variance of selected **BDI symptoms of depression** for '**same**' '**better**' and '**worse**' groups of patients at **Time2-Follow-up.** (High scores represent poorer functioning.)

SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
BECK ITEM - PESSIMISM: /3			
1.3	.5	1.7	F=6.5; df=2,35;p=.01
Multiple Range Test: LSD procedure			
'Worse' and 'Same' group significantly more severe than 'Better' group at follow-up.			
BECK ITEM - SENSE OF DISAPPOINTMENT: /3			
1.6	.1	1.6	F=7.9; df=2,35;p=.001
Multiple Range Test: LSD procedure			
'Worse' and 'Same' group significantly more severe than 'Better' group at follow-up.			
BECK ITEM - SELF-CONDEMNATION: /3			
.7	.4	1.4	F=5.9; df=2,35;p=.006
Multiple Range Test: LSD procedure			
'Worse' group significantly more severe than 'Better' and 'Same' groups at follow-up.			
BECK ITEM - SUICIDAL WISHES: /3			
.0	.1	0.7	F=4.9; df=2,35;p=.01
Multiple Range Test: LSD procedure			
'Worse' group significantly more severe than 'Better' and 'Same' groups at follow-up.			

continued on next page/

TABLE 5.5 (cont'd).

Mean scores and oneway analyses of variance of selected **BDI symptoms of depression** for '**same**' '**better**' and '**worse**' groups of patients at **Time2-Follow-up**. (High scores represent poorer functioning.)

	SAME group. (N=12)	BETTER group. (N=8)	WORSE group. (N=18)	**anova** time2: 1-tailed
BECK ITEM - IRRITABILITY: /3				
	1.2	.3	1.3	F=7.4; df=2,35;p=.002
Multiple Range Test: LSD procedure				
'Worse' and 'Same' groups significantly more severe than 'Better' group at follow-up.				
BECK ITEM - SOCIAL WITHDRAWAL: /3				
	.9	.0	1.1	F=5.7; df=2,35;p=.01
Multiple Range Test: LSD procedure				
'Worse' and 'Same' groups significantly more severe than 'Better' group at follow-up.				
BECK ITEM - DIFFICULTY MAKING DECISIONS: /3				
	.9	.4	1.9	F=7.9; df=2,35;p=.001
Multiple Range Test: LSD procedure				
'Worse' group significantly more severe than 'Better' and 'Same' groups at follow-up.				
BECK ITEM - FINDING WORK AN EFFORT: /3				
	1.1	.6	1.9	F=14.4; df=2,35;p=.0001
Multiple Range Test: LSD procedure				
'Worse' group significantly more severe than 'Better' and 'Same' groups at follow-up.				

(F=7.9; df=2,35; p=.001), (c) irritable (F=7.4; df=2,33; p=.002), and (d) withdrawn from others (F=5.7; df=2,35; p=.01). The results indicate that where there is no evidence of disturbance in these four areas of thinking, feeling and behaviour that an overall improvement in psychological distress is likely. That is, it does not appear to be significant whether or not patients experience symptoms such as mood change, a sense of guilt, crying more, insomnia, loss of appetite, weight loss or somatic preoccupation. These symptoms are experienced comparatively equally across all patients - whether global distress improved, remained the same, or got worse after discharge. However, the eight symptoms or attitudes identified in the analysis appear able to distinguish among the three groups, particularly those whose global distress 'improved' and those whose distress 'deteriorated'. These symptoms appear to be particularly sensitive indicators of degree of adjustment. It follows that they might best be adopted for use in the on-going assessment of patients by hospital or community staff when assessing suitability for discharge or when assessing adjustment at periodic follow-up.

This latter statement needs some clarification. Throughout the course of the current author's attendance of the consultant's 'Kardex/Discharge assessment' meetings in the short-term assessment ward of the psychiatric hospital a consistently-adopted form of assessment was noted. Patients were uniformly asked by the consultant psychiatrist whether they experienced two purportedly 'key' symptoms: whether they had difficulty sleeping and whether they had experienced loss of appetite. These purported to aid the assessment of the severity of current distress or depression (and so suitability for discharge). However, the results of the current analysis would indicate that such questioning does not help to distinguish among patients' severity of feelings of distress. Rather, these types of symptoms appear to be widespread across all types of patient. What the current results could be interpreted as suggesting is that the psychiatrist would be better advised to ask questions about the patients' experience, instead, of the eight symptoms or attitudes which have been found to distinguish between patients in terms of degree of adjustment or deterioration. The most significant of these were: (a) self-condemnation, (b) suicidal wishes, (c) difficulty making decisions, and (d) finding work an effort. Further discussion of this issue will be made in the seventh chapter.

2.4. SUMMARY - TYPES OF DISTRESS AND GLOBAL PSYCHOLOGICAL DISTRESS.

There were no significant differences between groups in their experience of types of distress at discharge. However, at follow-up, the 'Improved' group of patients scored significantly lower on all SCL-90 and on most (bar 'social dysfunction') GHQ-30 types of distress compared with their discharge assessment. Those patients whose 'global' distress score significantly deteriorated following discharge were found to be significantly more distressed across all symptom types.

The 'improved' group of patients' severity of symptoms of depression, anxiety and somatic preoccupations were significantly less severe than both 'Same' and 'Worse' groups of patients at follow-up. This group could also be distinguished from the other two groups at follow-up in their experience of all the symptom types measured by the GHQ-30: significantly less severe on the measures of social dysfunction, depression/helplessness, self-esteem, difficulty in coping and anxiety. On the other hand, the patients whose overall global symptom score deteriorated after discharge were found to be significantly more psychotic and paranoid in their thinking compared with both 'Improved' and 'Same' groups of patients.

Analysis of the Beck Depression inventory data distinguished four symptoms which were significantly more severe among the 'Worse' group of patients - (a) self-condemnation, (b) suicidal wishes, (c) difficulty making decisions, and (d) finding work an effort. Four symptoms were significantly less severe among the 'Improved' group - (a) pessimism, (b) sensitivity to disappointment in their lives, (c) irritability, and (d) withdrawal from others.

The results suggest that certain types of symptoms or attitudes held by patients are related to overall improvement or deterioration in the level of severity of psychological distress.

3. LIFE EVENTS AND PSYCHOLOGICAL DISTRESS.

This level of analysis asks 'what is the influence of the experience of life events on change in global symptoms of distress?' That is, the experience of distress does not simply occur in a vacuum - it's argued that it is partly 'brought on' by the experience of hardship and of on-going forms of experience which can be considered 'stressful'.

3.1. RESULTS: DISTRIBUTIONS OF MEAN *NUMBER* AND *SEVERITY* OF LIFE EVENTS ACROSS THE THREE GROUPS.

There were no significant differences between the groups in both mean number and mean severity of experiences of life events at discharge assessment - covering the previous 12 months - nor at follow-up assessment (table 5.6). The results for the number of events experienced would suggest that this relatively cruder assessment of life adversity has little **predictive** power. That is, knowledge of the number of life experiences an individual meets with immediately before or immediately after discharge does not appear to aid prediction of the patients' distress experience following discharge.

A more interesting finding emerges from the analysis of the life event severity data. There were no significant differences in the mean 'objective' severity of life events between groups. Instead, falls in the average objective severity of life events were observed for all groups during the six months and less following discharge from the hospital. However, the most significant fall is experienced by the group whose symptoms of distress improved after discharge. The improvement is quite dramatic (a mean of 198 at discharge compared with one of 72 at follow-up, 6 months later: $t=3.52$; $df=7$; $p<.001$). The severity of life events for this group compared with the others during the 12 months preceding admission was the most pronounced and so it could be that the degree of improvement in life event severity made a significant contribution to overall well-being. By comparison, the patients whose global distress underwent significant deterioration after discharge experienced much less degree of change (i.e., improvement) in life event severity. Their objective life event severity mean score of 104 is greater, but not significantly greater, than both 'same' and 'improved' groups (a 'Least Significant Difference' test was made of this datum but failed to reach significance).

It seems reasonable to make the following suggestion about what might have happened to these two groups in the period following discharge. The 'improved' group of patients had met with severe life adversity prior to getting admitted to the hospital's short-term acute-case assessment ward. Among all three groups, their adversity was, on average, the most objectively stressful. However, after discharge this group experienced, on average, half as many life events compared with the previous year. These events could also be described as less objectively stressful. Indeed, there is a significant fall in mean severity of events for the group ($t=3.52$; $df=7$; $p<.001$). This significant fall in objective stress might be construed by the patients in the group as be-

TABLE 5.6.

Mean **number** and total **severity** of **life events** for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
MEAN **NUMBER** OF LIFE EVENTS:				
discharge	7	10	9	n.s.
follow-up	4	4	5	n.s.
MEAN **SEVERITY** OF TOTAL LIFE EVENT EXPERIENCE:				
discharge	148	198	175	n.s.
follow-up	78	72	104	n.s.
change=	**- 70**	**- 126**	**- 71**	
sig.=	p<.01	p<.001	p<.01	

ing a relative improvement on the life conditions of the previous year.

For the group whose global distress deteriorated, however, a different kind of interpretation is suggested. These patients experience much less improvement in the stressfulness of the events with which they meet after discharge. During the previous 12 months their experience of life events was almost as severe as the 'improved' group. However, there is little real improvement in their experience of life adversity after discharge. Indeed, the mean objective stressfulness of the events with which they meet after discharge is the highest across all three groups. In addition, these events are experienced by the group within a 5 month period compared with a 6 month period for the other two groups. This could lead patients to perceive, quite correctly, that no improvement in their life conditions has taken place over the course of a year. This would be expected to engender the sense of "demoralization" (Dohrenwend et al., 1980) referred to earlier. That is, the chronicity that appears to be the hallmark of these patients' life circumstances could be expected to engender this sense of "demoralization" - the sense of hopelessness which renders them more vulnerable to considering these circumstances "intolerable - without apparent means of resolve". These interpretations, of course, remain suggestive: no firm conclusions can be drawn at this stage.

Finally, the extremely high degree of severity of life events experienced by all groups should be borne in mind. As referred to earlier, this sample from the population of all psychiatric patients is one in "considerable distress" (Goering et al., 1984).

3.2. **RESULTS:** PARTICULAR KINDS OF LIFE EVENT: IMPACT ON PSYCHOLOGICAL DISTRESS.

The next stage of the analysis seeks to identify the kinds of event, if any, which might be a more predominant experience of patients whose symptoms improved or deteriorated during the course of their lives back in the community. Only the 'changes in relations' events distinguished the experience of readmitted patients from those still at home at follow-up. Recalling evidence from the domain of research on life events and mental health one might expect the following distributions. Firstly, there might be expected to be an improvement in the experience of life events - as a whole and individually - among patients whose global distress improved after discharge. This view proposes that health or distress is influenced by exposure to events which induce the feeling of 'being stressed' (e.g., Brown, 1989; Brown and Harris, 1978; Selye, 1956). Consequently, where distress is predicated by an experience of 'being stressed' it would then follow that where there is little exposure to adverse, "interruptive" experiences (e.g., Mandler, 1983) there will be less experience of 'being stressed'. A reduction or certainly little deterioration in experience of psychological distress should, in turn, follow.

In like manner, it would be reasonable to hypothesize that patients whose global distress underwent severe deterioration after discharge would have been exposed to more severe life adversity during this period. However, as stated in the previous results chapter, this hypothesis presumes that the impact of events and of the stress they confer is additive: that is, the more events the greater the distress. It does not include an assessment of the meaning of the events for the patient, something which is now considered essential to an understanding of the life event-health linkage (e.g., Brown, 1989; Henderson, 1988; Selye, 1956).

The role that experiences of particular kinds of life event play in effecting change in global distress will now be examined.

RESULTS.

The most striking feature of these results is the complete absence of significant differences between the three groups in their life event experience both at discharge and at follow-up (table 5.7). This would indicate that there are no particular kinds of event which can be distinguished at discharge assessment which correlate with subsequent degree of change in severity of symptoms of psychological distress. That is, the results would not make it possible to suggest to ward staff responsible for any patient's discharge assessment of the increased risk of subsequent distress deterioration for patients who have recently undergone particular life experiences. It does not appear to be the case, for example, that any patient who has experienced, say, separation or financial difficulties within the previous 12 months should be especially closely followed-up after discharge (since this experience would have been regarded as rendering deterioration in severity of distress more likely).

One important feature of the results which should be kept in mind is the unequal time-periods after discharge during which events were experienced for all three patient groups. The 'same' and 'improved' groups' experience of events is for a 6-month timespan after discharge. The group of patients whose distress 'got worse' after discharge experienced these events within a much shorter period of time - during an average 5 months' period following discharge.

It could be conjectured that the experience of stressful events for this group came about much sooner following discharge and it is this relatively *swift resumption* of the stressful conditions, rather than the more gradual resumption observed for the others, that underlies the subsequent deterioration in felt distress. On the other hand, it seems more likely that the *interpretation* of the meaning of these same events radically influenced the response (given that there was only a non-significant one month's difference between the groups in the time during which events were experienced). This issue will be discussed at greater length in the seventh chapter, the general discussion chapter.

TABLE 5.7.

Mean number and anovas of **each type of life event** for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
MEAN NUMBER:	**ILLNESS** EVENTS (median number in parenthesis) /9:			
discharge	1.18 (0)	.9 (1)	.8 (1)	n.s.
follow-up	.3 (0)	.5 (0)	.2 (0)	n.s.
(sig.change across time)	p=.01	n.s.	p=.05	
MEAN NUMBER:	**DEATH** EVENTS (median number in parenthesis) /3:			
discharge	.3 (1)	1.5 (1)	.5 (1)	n.s.
follow-up	0 (0)	0 (0)	.4 (1)	n.s.
sig.change=	n.s.	n.s.	n.s.	
MEAN NUMBER:	**CHANGES IN RELATIONS** EVENTS (median number in parenthesis) /15:			
discharge	1.2 (1)	10.6 (3)	3.0 (3)	n.s.
follow-up	1.5 (1)	1.5 (1)	1.6 (2)	n.s.
sig.change	n.s.	n.s.	p=.05	
MEAN NUMBER:	**SEPARATION** EVENTS (median number in parenthesis) /6:			
discharge	.4 (1)	.5 (0)	.7 (1)	n.s.
follow-up	.2 (0)	.3 (0)	.2 (0)	n.s.
sig.change	n.s.	n.s.	p=.05	
MEAN NUMBER:	**WORK-RELATED** EVENTS (median number in parenthesis) /13:			
discharge	1.7 (1)	2.4 (0)	1.3 (1)	n.s.
follow-up	.5 (0)	.8 (0)	.8 (0)	n.s.
sig.change	p=.05	p=.05	n.s.	

continued on next page/

TABLE 5.7 (cont'd).

Mean number and anovas of **each type of life event** for the '**same**', '**better**' and '**worse**' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
MEAN NUMBER:	**FINANCIAL DIFFICULTIES** (median number in parenthesis) /5:			
discharge	.4 (1)	1.1 (1)	.7 (1)	n.s.
follow-up	.4 (0)	.4 (0)	.5 (0)	n.s.
(sig.change across time)	n.s.	p=.07	n.s.	
MEAN NUMBER:	WORRIES (median number in parenthesis) /OPEN:			
discharge	1.3 (1)	1.6 (1)	1.5 (1)	n.s.
follow-up	.7 (1)	.7 (1)	.9 (1)	n.s.
(sig.change across time)	n.s.	n.s.	n.s.	
MEAN NUMBER:	ACUTE EVENTS (median number in parenthesis) /OPEN:			
discharge	2.4 (2)	3.2 (3)	3.2 (3)	n.s.
follow-up	1.1 (1)	2.2 (2)	2.1 (2)	n.s.
(sig.change across time)	n.s.	n.s.	n.s.	
MEAN NUMBER:	CHRONIC EVENTS (median number in parenthesis) /OPEN:			
discharge	4.2 (4)	4.4 (4)	4.7 (4)	n.s.
follow-up	2.8 (2)	1.6 (1)	3.0 (3)	n.s.
(sig.change across time)	p=.02	p=.02	p=.05	

note:

Time 1 anovas - 2-tailed; Time 2 anovas - 1-tailed.

The Bartlett test of the homogeneity of variances was carried out on all tests. None was significant.

Changes in particular kinds of life event took place for all three groups. That change was observed was not that surprising given that the discharge measure included a measure of events that covered the previous 12 months whereas the follow-up measure covered a 6-month period and less.

Significant differences were observed for all groups in their experience of chronic events. However, the patients whose symptoms 'got worse' after discharge still manage to experience an average three chronic events (i.e., events lasting more than one month) during their average 20 weeks' stay back home. This compares unfavourably with the mean of 1.6 for the group of patients who 'improved' after discharge and would imply the persistence of the more chronic, disabling conditions suggested earlier. The patients whose symptoms 'improved' after discharge experienced significant falls in experience of work-related events, financial difficulties, chronic strains and further falls in all other kinds of event. This group's symptoms appeared to have improved with the experience of fewer stressful events in their life. The 'stable' group experienced significantly fewer work-related events, illness events, and chronic events. However, very little can be said about this group given their experience of events demonstrates no observable pattern.

It could well be that each group of patients' experience of life events was moderated by their experience of the other two sets of components in the study's 'discharge revolving-door' model: social support and experience of self-blame, consensus, and isolation. The next section of results will examine the relative association of the 'social support' components with change in global symptoms of distress.

3.3. SUMMARY - PARTICULAR TYPES OF LIFE EVENT AND PSYCHOLOGICAL DISTRESS.

There were no particular kinds of life event which were more predictive than others of subsequent improvement, stabilization, or deterioration in psychological distress. No significant differences between groups on any of the separate kinds of event at discharge assessment nor at follow-up were observed.

Significant differences within groups were found in their severity of events over time, the most significant observed for the 'Improved' group. Although these differences were as expected - given that each measure covers a separate time-period: covering the 12 months before admission but just the 6 months after - the largest change in severity of the events experienced was among 'Improved' patients suggesting a close relation between the experience of stressful events and the course of distress.

4. SOCIAL SUPPORT AND PSYCHOLOGICAL DISTRESS.

4.1. RECAP: SOCIAL SUPPORT COMPONENTS AND OUTCOME - PSYCHOLOGICAL DISTRESS.

The analysis of the moderating impact of 'social support' components on change in psychological distress will be largely similar to that made for the first of the study's outcome criteria - readmission. The distribution of each of the six components of support experienced by the patients in the sample will be compared across the three groups: those whose global distress 'improved; those whose distress underwent little change, and those whose distress markedly deteriorated during tenure in the community after discharge.

The purpose of this type of analysis is to attempt to identify the differences, if any, in the experience of 'social support' which are capable of **distinguishing** the patients at discharge who are more likely to undergo significant improvement in symptoms of psychological distress following discharge or significant deterioration in symptoms following discharge. That is, the direction of the analysis is toward the uncovering of sensitive **predictors** of subsequent outcome. In the previous results chapter this was readmission; in the current chapter, psychological distress. By examining the distributions of these variables across the three groups of patients suggestive differences are thought likely to emerge. These can then be tested for significance using appropriate statistical tests.

In addition, statements can be made about the influence of particular components of support on the experience of psychological distress in a retrospective way. That is, in post-hoc fashion, it should be possible to identify particular kinds of support experienced at follow-up by patients whose symptoms improved, remained the same, or got worse. In this way, where important differences emerge, it would be possible to advise that this kind of information be used for assessment of particular patients' (a) suitability for discharge or (b) need for close follow-up.

The support components that will be examined are described in detail in chapter 2, section 4. A reminder of these six components follows. They are:

1. The behavioural transactions between the patient and others which can be 'objectified': someone who listens, reassures, advises, agrees, confirms;

2. The experience of existentially-securing support provisions: e.g., knowing there are others around with whom the patient can compare him/herself favourably; others with whom the patient can work through worries; others who give the patient a sense of belonging;

3. The experience of the presence of attachment and security from one other person: categorically loved, confirmed in one's self, accepted and understood by one other person;

4. The generalized sense of being satisfied with the people in one's life: both intimates and friends/

family;

5. The availability and enactment of various forms of pleasurable, social activity;
6. The availability of persons other than partner to whom the patient can turn.

4.2. RESULTS:

4.2.1. BEHAVIOURAL TRANSACTIONS: 'ACTUAL' SUPPORT RECEIVED.

This component of social support reflects the 'actual' support received by patients since being discharged. The groups of patients might be distinguishable by the amount of actual help they received from others after getting discharged where, for instance, the improvement in 'global distress' for the 'improved' group might be related to a greater amount of actual help. Concomitantly, there might emerge a significant lack of actual help for those patients whose global symptoms deteriorated.

The first point to observe is the comparatively low levels of actual support received by all groups - regardless of whether their global distress 'improved', 'stayed the same', or 'got worse' (see table 5.8). The range of support from 13 to 20 is much lower than that observed for normal, general populations (Barrera et al., 1981). This low level of support is also relatively stable across time for all groups. And whilst patients whose symptoms improved during the course of discharge receive most actual support among the three groups, this difference is not significant. The results would suggest that neither prior level of actual support received nor current level - measured after discharge - is a good predictor of degree and direction of change in global symptoms of psychological distress. This variable does not distinguish among groups - neither at discharge nor at follow-up when one might have expected the 'improved' group to have improved because they were in receipt of greater amounts of support. The change in global distress, then, does not appear to be subject to explanation by the amount of actual support received.

The results of the analysis of the sub-scales of the ISSB (measuring actual 'socioemotional' and 'material' support) found no significant differences between the groups in either material or socioemotional forms of support (see table 5.9). No one group's change in symptoms can be accounted for by the dominant influence of receiving, say, actual emotionally-supportive help as opposed to actual material forms of support. The results might also provide an explanation of why the groups' experience of distress is so comparatively high. That they receive little in the way of these forms of assistance in their daily lives is consistent with the experiences of general psychological distress that are prevalent among this population. In other words, were they in receipt of high levels of actual support from others they might be expected to be considerably less distressed given what is known about the role of social support in moderating the impact of stressful circumstances on subjective distress. Where social support has a "buffering" or a "main effect" on stressful circumstances so

TABLE 5.8.

Mean number and anovas of **Total Actual support** received for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	BETTER group. (N=8)	WORSE group. (N=18)	anova time2: 1-tailed
mean total 'actual' support transactions: /40 (high score= high amount of support)				
discharge	13	20	17	n.s.
follow-up	17	19	17	n.s.

TABLE 5.9.

Mean number and anovas of Actual **Socioemotional** and **Material** support received for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	BETTER group. (N=8)	WORSE group. (N=18)	anova time2: 1-tailed
ISSB- ACTUAL SOCIO-EMOTIONAL SUPPORT SCORE: /26				
discharge	10	14	14	n.s.
follow-up	13	14	14	n.s.
ISSB- ACTUAL MATERIAL SUPPORT SCORE: /14				
discharge	3	6	5	n.s.
follow-up	4	6	4	n.s.

note:

The Bartlett test for homogeneity of variances was carried out on all tests. None was significant.

distress will be reduced. Lacking such support the individual is more susceptible to the disabling effects of stressful circumstances on mental health. In this way, the results of the analysis are quite consistent with what else is known about this population.

In summary, the variable 'actual support received' does not appear to be a good predictor of the course of recovery or deterioration in the experience of psychological distress following discharge. What might be more explanatory of the course of distress is the patients' <u>perception</u> of support, rather than <u>actual</u> support received. For example, Heller and Lakey (1985) propose that perceived support is the more critical of the two, its effectiveness residing not in any particular behaviour of significant others, "but in how that behaviour and ensuing relationship are perceived". The two constructs have been found to be only mildly related (e.g., Barrera, 1986; Heller and Lakey, 1985; Heller et al., 1986; Wethington and Kessler, 1986). This would suggest that though actual support was not shown to correlate with distress, perceived support might yet have an influence.

The next set of results will examine the ability of the "perceived support" measure to predict the course of recovery or deterioration in distress for the three groups.

4.2.2. **FUNCTIONAL PROVISIONS**: PERCEIVED BELONGING, SELF-ESTEEM, PROBLEM-APPRAISAL, AND TANGIBLE/MATERIAL SUPPORT.

The means and analyses of variance of 'total' perceived interpersonal support for the 'same', 'improved' and 'worse' groups of patient are presented (table 5.10). As predicted, patients who perceive themselves to be **more** interpersonally supported at discharge are the **most** improved - 6 months after discharge from hospital - in terms of experiencing less severe psychological distress. However, this 'improved' group's score is not significantly higher than the 'same' and 'worse' groups at discharge.

At follow-up, this 'improved' group perceive themselves to be significantly more interpersonally supported than the group whose global symptoms of distress underwent marked deterioration (A Least Significant Difference test: p<.05). It would have been informative to have obtained a measure of perceived interpersonal support for all patients when they were newly admitted to the ward. In this way, it would have been possible to test for the extent of improvement <u>whilst in hospital</u> for the 'improved' group. That is, the level of 'perceived support' in this group (and in all others) was remarkably stable across the six months' period. This perception, however, might have undergone considerable improvement whilst in hospital for the 'improved' group. This would suggest one explanation for the recovery of these patients after discharge. That is, at discharge this group might have been undergoing steady improvement in their perceptions of others' support, reflecting, perhaps, the benefits accrued from being in the hospital ward. Through the course of time passed living back home this perception could conceivably have translated into improved 'states of mind': of mental

TABLE 5.10.

Mean number and anovas of **Total 'Perceived' interpersonal support** for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
ISEL- TOTAL PERCEIVED INTERPERSONAL SUPPORT SCORE: /40 (high score= high level of support)				
discharge	21	27	22	n.s.
follow-up	21	28	21	F=2.5; DF=2,34; P=.10

note:

The Bartlett test for homogeneity of variances was carried out on all tests. None was significant.

well-being in general, and, concomitantly, of lessened psychological distress. The other two groups' perception of interpersonal support is also stable across time: i.e., it is consistently though not significantly lower than the group of patients whose symptoms improved.

With respect to the distribution of the four perceived interpersonal support provisions, just two significant differences between groups were observed (table 5.11). At follow-up, the 'improved' group of patients had a significantly greater (a) perceived sense of belonging than the 'worse' group (LSD; p<.05; F=3.1; df=2,34; p<-05; 1-tailed), and (b) a greater perceived likelihood of a positive comparison when comparing themselves with others - i.e., the 'self esteem' component - (LSD; p<.05) . However, on none of the other perceived support provisions were there any differences - at discharge nor at follow-up.

Looking at distributions of scores across all four provisions the 'improved group', as anticipated, score uniformly higher than both 'same' and 'worse' groups: both at discharge and more markedly at follow-up. With respect to the 'self-esteem' provision, the 'improved' group score significantly higher at follow-up than the 'worse' group. Whilst it would not be claimed that improvement in severity of global distress is **caused** (a) by having a greater likelihood of making a positive comparison when comparing oneself with others, and (b) by perceiving a greater availability of people one can do things with (a stronger felt 'sense of belonging') it could be suggested that such perceptions, indeed such support provisions, are **closely related** to improvement. Where there is **no** evidence of recovery in distress experience, indeed where there is deterioration in psychological distress, there were observed to be concomitant **low** levels of the 'self-esteem' and 'sense of belonging' provisions (of between 3 to 5/10).

That there are very few significant differences between the groups at discharge makes it less appropriate to state that these kinds of support provisions are necessarily good predictors of subsequent recovery. Although there were differences, with the 'improved' group higher on all indices relative to 'same' and 'worse' groups, these differences were not significant. All that can be said at this stage is that for the groups whose symptoms of distress stabilized (at low levels of well-being) or deteriorated the perception of all types of support provision were uniformly low - at discharge and at follow-up, with a significant drop, after discharge, in level of 'likelihood of positive comparison' amongst 'deteriorated' patients (t=2.42; df=15; p=.029; 2-tailed). Amongst the group of patients whose global distress improved, higher levels of all kinds of perceived interpersonal support were found. With a much larger sample of patients such apparently small differences in each of the support provisions at discharge and at follow-up might very likely attain significance. For these reasons it is important to note the *kinds* of differences which did actually emerge.

The contribution of each of these 'perceived support' provisions to the amount of explained variance in psychological distress will be examined in chapter six.

TABLE 5.11.

Mean number and anovas of **'Perceived' interpersonal support provisions** for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
ISEL- 'BELONGING' SCORE: /10				
(high score= high level of support)				
discharge	4.4	5.8	5.3	n.s.
follow-up	4.0	7.0	4.7	F=3.1; DF=2,34; P<.05
ISEL- 'SELF-ESTEEM' SCORE: /10				
discharge	4.9	5.6	4.8	n.s.
follow-up	4.0	5.4	3.3	n.s.
ISEL- 'PROBLEM-APPRAISAL' SCORE: /10				
discharge	5.3	6.6	5.5	n.s.
follow-up	5.4	7.0	6.0	n.s.
ISEL- 'TANGIBLE HELP' SCORE: /10				
discharge	6.8	8.7	6.8	n.s.
follow-up	7.6	8.4	7.3	F=2.5; DF=2,34; P=.10

4.2.3. **ATTACHMENT SUPPORT**: (i) AVAILABILITY OF CLOSE ATTACHMENTS.

The first set of results uses the information provided by the ISSI of Henderson et al. (1980) and will focus upon the influence of availability of close attachments on the course of recovery or deterioration in global distress. Were the simple availability of persons with whom one is closely attached a central determinant of global psychological distress there would be expected to be differences between the three groups on this variable, with the 'worse' patients most likely to experience significantly less availability. This presumes that such close attachment has a buffering impact on ongoing stressful conditions (e.g., Brown and Harris, 1978; Cobb, 1976; Leavy, 1983; Newton, 1988). However, Henderson et al. (1981) did not observe a significant effect of **availability** on subsequent development of neurotic forms of distress, but only, instead, for attachment **adequacy**.

It might well be the case, given the nature of this population sample - of recently discharged psychiatric patients - that what has been observed previously with community samples and student samples does not hold for this highly self-selective population. It has already been observed across both readmitted and nonreadmitted groups of patients that distributions of simple availability of close and more general attachments is much lower than that found in community samples (from Henderson et al., 1981). For this reason, it might be unlikely to find differences among the groups since the majority of patients **already** tend toward the lowest levels.

RESULTS.

Several observations can be made (see table 5.12). Firstly, the distributions of simple availability of close attachments is significantly lower in comparison to the Canberra population sample of Henderson et al. (1981) : the range of means between 3.8 and 5.5 compares with a mean of 6.6 for the Canberra sample. That is, the population as a whole, as described in the previous results section, has much less availability of close attachments. Where evidence has previously highlighted the increased vulnerability of persons deficient in close, intimate associations with others to the experience of depressive symptoms (e.g., Brown et al., 1978; Roy, 1978; 1981b; 1981c; Surtees, 1980) so something of the reasons for the chronic, persistent forms of distress experienced by this population emerge. That is, all groups evidence markedly low availability of close, intimate support: that they experience significantly high degrees of severity of distress, both at discharge and during the course of living back home after discharge, is, in the light of these findings, hardly surprising.

Secondly, there were no significant differences in experience of availability of close attachments between groups at discharge nor at follow-up: all were uniformly low. There is no evidence of greater availability of attachments for the 'improved' group, nor of any kind of improvement within this group across time. That is,

TABLE 5.12.

Mean availability and mean difference (anova) analysis of the ISSI '**availability of close-attachments**' measure for 'same', 'better' and 'worse' groups at Time1 and Time2.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
	mean 'availability of close-attachments' (range in brackets): **/8**			
discharge	4.5 (1-7)	4.8 (1-8)	4.5 (0-7)	n.s.
follow-up	5.5 (2-8)	4.8 (2-8)	3.8 (1-8)	n.s.

TABLE 5.13.

Mean availability and mean difference (anova) analysis of the ISSI '**adequacy of close-attachments**' measure for 'same', 'better' and 'worse' groups at Time1 and Time2.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
	mean % 'adequacy of close-attachments':			
discharge	46	48	53	n.s.
follow-up	56	53	51	n.s.

the fall in distress for this group would not appear to be explicated by the simple experience of close attachments in their lives. On the other hand, there is a small drop in availability of close attachments for the 'worse' group, a change which is not observed for any of the other groups: the result suggesting that the availability of close attachments for these groups is relatively stable across a six-month period. However, the small rise in availability of attachments for the 'same' group, like the drop in attachments for the 'worse' group was not significant.

The results strongly suggest that 'availability of close attachments' is not a particularly good predictor of subsequent recovery or deterioration in psychological distress (which itself best predicts readmission). What impact the patient's perceived sense of adequacy of these close attachments has on course of distress after discharge will now be examined.

4.2.4. **ATTACHMENT SUPPORT**: (i) ADEQUACY OF CLOSE ATTACHMENTS.

The first level of analysis of the ISSI 'adequacy' data will focus upon satisfaction with close attachments. In a section following, attention will be focussed on the second 'adequacy' construct measured by the ISSI - satisfaction with the other people in one's life other than close attachments.

The results (table 5.13) might appear quite puzzling. The most satisfied group at follow-up were those patients whose symptoms of global distress underwent little change through tenure in the community after discharge. It could be that this group were relatively 'relieved' at the consistency of their distress experience and that this, somehow, was reflected in increased satisfaction with their close, loved ones. That is, these patients might have expected their condition to have been a lot worse after so many months out of hospital. That "things hadn't got any worse" might have engendered an appreciation for the patient of the people in his/her life. However, this kind of interpretation can only be somewhat suggestive.

A second point to note is the uniformly low level of satisfaction across all distress groups. Their average satisfaction levels - of around 46 to 56% - compare poorly with the Canberra general population sample referred to in the previous chapter (see Henderson et al., 1981). The average level of satisfaction for this group was around the 70-80% mark. Thus, it could be added that not only does this sample have few available close contacts but that their satisfaction with this condition (expressed by the per cent satisfaction score which includes assessment of satisfaction with **not** having any close attachments) is very low indeed. This population, it is becoming increasingly clear, is one not only in "considerable distress" (Goering et al., 1984), but one which is incredibly deficient in various types of social support: actual support, perceived interpersonal support, attachment support, and, as the results demonstrate, satisfaction with this condition of being unsupported. It is perhaps quite reasonable that the patients in the sample - given their consistently **low** support scores and **high** life event and psychological distress scores across time - find themselves in the distressing conditions in which they are embroiled.

Finally, it appears once again to be the case that this particular variable, adequacy of close attachments, is not a good predictor of the course of recovery or deterioration in psychological distress among this sample of psychiatric patients. That is, no significant differences between groups on this variable, neither at discharge nor at follow-up asessment, were observed.

4.2.5. **PLEASURABLE SOCIAL CONTACT** - (i) WITH FRIENDS AND (ii) WITH FAMILY.

This component of the social support conceptualization is included for the simple reason that amount of time spent in pleasurable activity with friends or family has been found to contribute to well-being and even to reduce mortality (e.g., Berkman and Syme, 1979; Broadhead, Kaplan, James et al., 1983; Durkheim, 1951; House, Robbins, and Metzner, 1982). The SRAQ (House et al., 1982) provides a relatively crude assessment of (a) the amount of time spent with family and with friends; and (b) the satisfaction with this sociable contact with family and with friends.

Amongst the three groups of patients under focus, were this kind of support to have the effect that has been demonstrated by these authors, it might be expected that either (a) the 'improved' group of patients spend more time socializing with their family or friends; or that (b) the 'worse' group spend significantly less time with friends and family in sociable forms of activity. This hypothesis presumes an important, determining role for this kind of support on the recovery or deterioration of global distress.

Although there were no significant differences between groups in mean amount of time spent with friends at discharge nor at follow-up - suggesting that contact with friends is a poor predictor of change in global distress after discharge - a number of features of the data are worth pointing out (see table 5.14). Firstly, the groups do not pass much time per month with friends, on average about just once or twice in the 3 months preceding follow-up assessment and, at most, just once or twice per month. It should be kept in mind that such levels of contact with friends are extremely low, giving some flavour of the extent of their withdrawal from other people.

Secondly, at follow-up, differences were observed which were in the expected direction but which were not statistically significant. Thus, the group who experienced improvement in global distress after discharge was the most socially active with friends during the follow-up period. They were the only group who increased the amount of time spent with friends during the course of getting on with their lives after being in hospital. The other two groups saw friends marginally less during this period - on average once per month compared with twice per month for the 'improved' distress group. It is, however, hardly a remarkable improvement and

TABLE 5.14.

Mean availability and mean difference (anova) analysis of the SRAQ **contacts with friends** measure for 'same', 'better' and 'worse' groups at Time1 and Time2.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
mean contact with friends: /6				
discharge	2.7	3.1	3.2	n.s.
follow-up	2.6	4.1	2.6	n.s.

TABLE 5.15.

Mean availability and mean difference (anova) analysis of the SRAQ **contacts with family** measure for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
mean contact with family: /6				
discharge	3.8	2.1	2.1	F=3.3; DF=2,31; P<.05
follow-up	4.9	4.1	2.7	F=4.7; DF=2,31; P<.01

note:

The Bartlett test for homogeneity of variances was carried out on all tests. None was significant.

is, as indicated, suggestive of the relatively greater degree of social withdrawal which elsewhere has been shown to be characteristic of this population (e.g., Newton, 1988).

With respect to the variable 'amount of pleasurable time spent with family', a number of simple observations can be made (see table 5.15). Firstly, the group whose global distress was stable across time (i.e., consistently high) on average saw members of their family once or twice per month preceding admission **rising** to about once per week after discharge. The 'improved' group of patients saw members of their family just once or twice in the months preceding admission **rising** to about once or twice per month after discharge. The group whose distress increased after discharge on average saw members of their families only once or twice in the months preceding admission but **rising** to <u>just</u> once per month after discharge.

The amount of time spent socializing with members of one's family was significantly highest for the 'same' group both at discharge (F=4.7; df=2,31; p<.05) and follow-up (F=3.3; df=2,31; p<.01). At discharge, the difference between the 'same' and **both** 'improved' and 'worse' groups in amount of time spent with family was significant (LSD; p<.05). However, at follow-up both 'same' **and** 'improved' groups spend significantly more time with members of their families compared with the 'worse' group (LSD; p<.05).

The results could be interpreted as suggesting that the more time the former patients spend with their families the less likely they will become more severely psychologically distressed, as though seeing members of one's family on a somewhat regular basis 'buffers' these patients against such forms of deterioration in experienced distress. For the 'improved' group in particular the increase in amount of time spent socializing with members of their families corresponds with their improvement in symptoms. For the 'same' group of former patients, it could be that the modest increase in amount of time spent with family sufficiently 'buffers' them against subsequent deterioration. However, this would suggest that any fall in this kind of pleasurable activity might have a correspondingly marked impact on their level of well-being. That is, the group might just 'manage to get by' through maintaining such contact with their families: but should this contact be taken away then the fine line between maintaining a tolerable level of psychological functioning and being unable to tolerate the emotional distress might disappear altogether.

Finally, the 'worse' group of former patients evidence very little time spent with family either preceding admission nor in the months after discharge. These patients were significantly more likely (than those patients whose symptoms of distress improved or stabilized and who passed significantly more time with their families after discharge) to become more severely distressed in the months following discharge.

4.2.6. SOCIAL INTEGRATION - (i) AVAILABILITY.

In the previous results chapter the suggestion was made that both readmitted and non-readmitted groups' relatively little amount of time spent with friends, and to a lesser extent family, was perhaps a direct reflection of the possibility they had few people with whom to engage in pleasurable, social activity. Given the similarly low levels of contact for all three current groups with both friends, in particular, and with family (particularly for the 'worse' group) this lack of contact could be partly due to this 'not knowing many people'.

It could be possible, then, that all groups, particularly those patients whose symptoms of distress underwent especially marked deterioration following discharge, lack what is known as 'social integration' (e.g., Durkheim, 1897/1951; Henderson et al., 1981; Rook, 1985). Being embedded in a network of mutual obligation and interpersonal influence, it's argued (e.g., Rook, 1985), promotes "stable, health-sustaining behaviour"; helps the individual to achieve compliance with group norms thus restraining deviant, unsociable acts and helps impart meaning to one's existence (Durkheim, 1897/1951). Not being socially integrated "contributes to despair, and, in extreme cases, to suicide" (Rook, 1985).

In the next section, the distributions of groups' scores on the ISSI "availability of social integration" measure will be examined with these considerations in mind. Given the distributions of scores among readmitted and non-readmitted groups, a very low level of social integration can be expected. However, it remains to be seen in what ways these scores redistribute across all three groups of former patients: those whose global distress improved, those whose distress remained the same, and those whose distress significantly deteriorated.

Throughout this analysis it should be borne in mind that all of the patients in the sample, being who or what they are - i.e., "psychiatric patients" - are already a highly selective population. That is, from what is known of psychiatric populations in general (e.g., Brugha, 1991; Froland et al., 1979; Leavy, 1982; Paykel, 1985; Turner, 1979; 1981) very low levels of 'social integration' could be described as already characterizing the group. The question in which current interest lies is the extent to which the lowest levels of integration are experienced by patients whose global distress underwent severest deterioration following discharge. The results of this analysis are presented in table 5.16.

As expected, very low levels of social integration are common among all three groups (table 5.16). The mean scores compare with that of 9.6 for a community sample (Henderson et al., 1981, and referred to in the previous results chapter). Among all patients, then, there are few people other than the person closest to them (and, for many, there is not even this one person) with whom they could engage in sociable activities and general day-to-day interaction. The sample as a whole stands, in this way, at greater risk of engaging in less sociable, more deviant and self-destructive forms of behaviour (e.g., Rook, 1985). And it would follow from Durkheim's (1897/1951) conception of the **value** of sociable interaction that the group, as a whole, are much more likely to veer toward despondency and despair in their lives through the lack of a meaningful form of involvement with many others. The patients in the sample evidence a uniform lack of availability of others who, for example, ‘depend on them for care and attention'; or who ‘really appreciate what you do for them'; or who ‘are known well enough to borrow things from or ask small favours'; or who ‘can be turned to in times of difficulties'. With this uniform lack of availability, the corresponding presence of despair and despondency among the sample can be seen to be a painful - yet reasonable - response.

No significant differences among the groups were found at discharge nor at follow-up. Once again, this would indicate that another variable - ‘social integration' - is not a good predictor of the course of recovery or deterioration in global distress. However, a number of changes at follow-up are worthy of note. Those patients whose symptoms improved experienced an increase in the mean integration score. This difference was very small, only 1 point out of 15 and not significant. The group whose symptoms remained unchanged through community tenure evidence little change in their availability of people for whom they are of value. However, the group whose symptoms grew markedly worse across the six-month period after discharge show a significant drop from a mean of 6.4 to just 4 on the social integration measure (t=2.34; df=17; p<.05; 2-tailed). This would indicate that with fewer people available or with simply less availability of the kinds of ‘integration' and ‘being valued' experiences that characterize this ISSI measure, there is a corresponding, perhaps concomitant, experience of more severe psychological distress.

4.2.7. **SOCIAL INTEGRATION** - (i) ADEQUACY.

One of the most striking results to note from this analysis (presented in table 5.17) is the significant increase in satisfaction during community tenure for the group of patients whose global distress improved after discharge: from a mean of 7/17 to 11/17 (t=2.4; df=7; p<.05; 2-tailed). The result could suggest one of two things. Either the improvement in global distress came about through the significant decrease in the severity of the stressful circumstances in these patients' lives following discharge (and relative to the 12 months preceding admission) which was **then** reflected in greater levels of satisfaction with the people in their life for whom they are of value or on whom they can depend in times of difficulties. Or, it's possible that the greater degree of satisfaction with the other people in their life was engendered, perhaps, by the weakened experience of life stress: this enabling them, perhaps, to appreciate being around other people more. This feeling of satisfaction and appreciation of others, in turn, might have helped bring aboutthe improvement in experience of distress, toward levels of mental well-being.

Standing back - for a moment - from the results, it seems reasonable to suggest that logical terms such as ‘cause' and ‘effect' would be especially difficult to isolate from the conditions which apply in these peoples' lives. This is not to say that there are not logical, consequential sequences of action and perceptive response

TABLE 5.16.

Mean availability and anova of the **'availability of social integration'** measure for the 'same', 'better' and 'worse' groups of patients at Time1-Discharge and Time2-Follow-up.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
mean 'availability of social integration': /15				
discharge	4.6	4.0	6.4	n.s.
follow-up	4.9	5.2	4.0	n.s.

TABLE 5.17.

Mean satisfaction and mean difference (anova) analysis of the **'satisfaction with social integration'** measure for 'same' 'improved' and 'worse' groups at Time1 and Time2.

	SAME group. (N=12)	**BETTER** group. (N=8)	**WORSE** group. (N=18)	**anova** time2: 1-tailed
mean 'satifaction with social integration': /17				
discharge	9.0	7.0	8.0	n.s.
follow-up	9.0	11.0	8.0	n.s.

note:

The Bartlett test for homogeneity of variances was carried out on all tests. None was significant.

in their lives. The patients' response to the conditions which obtain in their lives - both 'outside' and 'inside' their heads - will be logically consistent (it's argued) with their **interpretation** of these conditions. Such individual interpretation of external conditions Rowe, (1991), construes as an 'internal network' of logic which is in constant interaction with the 'external network', "constantly interpreting the external network, while the external network constantly impinges on the internal network and demands that (it) creates meanings which relate to the external network" (p. 3). Were all forms of influence on this 'logical response' capable of being known and measured then, from an empiricist point of view, interpretation of the information obtained from such measurement would not be necessary. The results would account for themselves. However, precise measurement of this kind in this domain of study in particular has yet to be achieved. With respect to the current set of results, this would suggest that any attempt to identify the precise moment when the impact of the life event was felt as an increase in well-being which in turn led to a greater sense of satisfaction is not possible with the kinds of measures and timeperiods with which and in which this study deals. For these reasons the interpretations of results offered can only be tentative - not prescriptive.

The average satisfaction scores for the other two groups do not change across time. For the 'worse' group of patients this might appear somewhat incongruent were one to take the view that distress and satisfaction are mutually inter-dependent, where a change in one implies a change in the other. The results would appear to suggest that the group's experience of distress either (a) was not related to satifaction with the other people in their lives: to feeling valued and suchlike; or (b) was related to satisfaction but something else, perhaps something not measured in the study, over and above simple satisfaction with other people, exerted a comparatively greater influence on their experience of, say, anxiety, depression or sensitivity. From the results of the analysis any clear-cut interpretation does not appear possible. However, in a subsequent results chapter several stepwise multiple regression analyses will be carried out. These will regress each of the study's independent variables on the dependent global psychological distress: for the sample as a whole in (a) a longitudinal analysis of the predictors of global distress; and in (b) a cross-sectional analysis to identify the variables that correlate most strongly with global distress. This type of analysis will enable more to be said about the relative influence of each separate factor on subsequent level of severity of psychological distress.

Finally, excepting the 'improved' group of patients' level of satisfaction at follow-up with the other people in their life, both 'same' and 'worse' groups of patients, as well as the 'improved' group at discharge display comparatively low levels of satisfaction. The average scores of between 8 and 9 compare poorly with the mean ADSI score of 13 for the general population sample of Henderson et al. (1981). Given the comparatively low levels of satifaction or adequacy with 'social integration' it is no surprise that such high levels of severity of psychological distress are experienced by this sample. This conclusion is supported by Henderson et al. (1981), a study referred to in the previous results section. That is, the development and maintenence of distress is influenced as much, if not more, by the *adequacy* of one's attachments - both close and more diffuse - than by their simple availability. However, as mentioned earlier in this section, this still leaves open to interpretation the stability in satisfaction scores for the group whose global distress significantly deteriorated after discharge.

4.3. SUMMARY - 'SOCIAL SUPPORT' AND PSYCHOLOGICAL DISTRESS.

The results of the analysis of all six 'social support' components can be summarized thus:

1. **behavioural transactions**: No significant differences between groups at discharge nor follow-up. That all groups received low levels of actual support would imply a deficiency of 'crisis' support during the 'life event-disruptive' period that was evidenced among all but the 'improved' group of patients following discharge.

2. **functional provisions**: Patients who were the most interpersonally supported were the least severely psychologically distressed at discharge and follow-up. However, this difference was not significant.

At follow-up, the 'Improved' group have a significantly greater (a) perceived sense of belonging than the 'Worse' group, and (b) likelihood of making a positive comparison when comparing themselves with others. The 'Worse' group, on the other hand, undergo a significant fall in 'likelihood of positive comparison' (when comparing themselves with others) following discharge: the only significant fall observed. The two kinds of interpersonal support 'perception' or 'provision' (depending on one's interpretation of the information obtained by the ISEL) - (a) sense of belonging and (b) sense of feeling good about oneself relative to others - appear to be closely related to symptomatic recovery.

3. **availability of close attachments**: No significant differences between groups. Although the 'Worse' group experience a drop in availability at follow-up this was not significant.

4. **adequacy of close attachments**: No significant differences between groups. All groups' scores on this variable were remarkably consistently low - around the 50% mark.

5. **pleasurable social contact**: No significant differences between the groups at discharge on the variable 'contact with friends': all spend very little time with friends - about once per month. At both discharge and follow-up, the group whose level of severity of symptoms remained the same through time spend significantly more time with their families. However, at follow-up, both the 'Same' <u>and</u> 'Improved' group spend significantly more time with their families compared with the 'Worse' group.

6. **social integration availability**: No significant differences between groups. The sample - as a whole - is characterized by extremely low levels of availability of other people to, for example, care for, be appreciated by, and to turn to in times of difficulty.

The 'Worse' group is the only one to undergo a significant drop in this availability implying an important role for this form of support in the symptomatic deterioration of patients.

7. **social integration adequacy**: All groups were considerably unsatisfied with this condition. However, no significant differences between groups were observed following discharge. Only the patients whose level of severity of symptoms of psychological distress improved following discharge were found to be significantly more satisfied with this form of support. The result suggests an association - but not a causal relation - between improved level of satisfaction with the people in one's life and general symptomatic recovery.

5. DISTRIBUTIONS OF *CONSENSUS JUDGEMENTS*, SENSE OF *SHAME*, *GUILT*, *SELF-BLAME* AND *ISOLATION*: THEIR ASSOCIATION WITH PSYCHOLOGICAL DISTRESS.

Information about the nature of the measuring instrument with which measures of these highly complex feelings and cognitions about individual experience were obtained has already been outlined in some detail in the previous results chapter (chapter four, section 5.2). Rather than extend unduly the remainder of this chapter no more introduction to the nature of this analysis save the most essential will be made.

The purpose of the analysis is to identify the association of particular forms of cognition or feeling with the type of change in global psychological distress. Where patients' symptoms of distress underwent deterioration after discharge there might be expected to be more severe forms of shame, guilt, self-blame, and lack of consensus experienced by this group. On the other hand, the group whose symptoms improved during follow-up might be expected to experience less shame, guilt, and self-blame relative to the severely distressed group. However, it is where such distributions significantly differ from those expected that particular attention will be paid.

5.1. RESULTS:

5.1.1. FEELINGS OF SHAME.

The first of the ‘powerful emotion' variables to be examined is shame: shame about (a) the odd/bad feelings patients have; (b) the odd/bad thoughts patients have; (c) the odd/bad things patients have done; (d) being in a mental hospital; and (e) the problems patients feel they might have caused others.

The most significant finding to emerge from the analysis of ‘shame' results is the consistently higher scores for the group whose global distress deteriorated after discharge (table 5.18). This would indicate that a stronger sense of shame - about themselves, about being in hospital and about the problems they feel they may have caused others - is characteristic of patients whose distress ‘got worse' after discharge. They are significantly more ashamed (LSD test; $p<.05$) than the ‘improved' distress patients about (a) the ‘odd/bad' feelings and (b)‘odd/bad' thoughts they have, and (c) about being in a mental hospital. The results imply that the former patients' feelings of shame about themselves correlate with course of recovery or deterioration in distress.

The group whose symptoms of distress remained unchanged through follow-up scored consistently lower than ‘worse' patients and consistently higher than ‘improved' patients. That is, as hypothesised, there was a remarkably consistent pattern of shame experienced by the three groups distinguished by the degree and direction of change in experience of global psychological distress after discharge. The most ashamed were the most distressed; the least ashamed were least distressed and the people who were still as distressed at follow-

TABLE 5.18.

Mean scores and anovas on **SHAME variables** for 'same', 'improved' and 'worse' groups at Time2-follow-up.

	SAME group. (N=8)	**BETTER** group. (N=4)	**WORSE** group. (N=10)	**anova** 1-tailed
shame about **feelings**: /6	1.1	.2	2.0	
LSD test: 'worse' higher than 'better'; p<.05.				
shame about **thoughts**: /6	1.1	.2	2.2	F=3.7; df=2,19; p<.05.
LSD test: 'worse' higher than 'better'; p<.05.				
shame about **things done in past**: /6	1.4	.8	2.2	n.s.
shame about **being in mental hospital**: /6	0.6	0.0	1.3	n.s.
LSD test: 'worse' higher than 'better'; p<.05.				
shame about **problems caused others**: /6	2.0	1.0	2.4	n.s.

up as they were when assessed at discharge were, on the whole, "a little bit ashamed" about their feelings, thoughts and things done, rising to "moderately" for the problems they'd caused others.

The experience of shame appears to play some kind of role in the change through time in experience of global psychological distress. At this stage, one can only conjecture on what this role might be. For example, although it would seem reasonable to suggest that the experience of shame is itself a form of experience of psychological distress, nevertheless the role of this experience in the development and maintenance of other types of distress still remains one for conjecture. That is, if one takes the view that 'shame' is a more ***central*** experience - relative to feeling anxious, depressed, overly-sensitive, and withdrawn - then, given the course of change in these symptoms across all groups, the experience of shame would appear to be one that exerts a strong influence. That is, the most distressed group experience highest levels of shame, and so on.

Statements about 'cause and effect' can not be made from the information available. It could be that the experience of shame precedes the distressing experiences. (For example, shame about having been in a mental hospital then brings about an experience of anxiety, or shame about past experiences of 'breaking down' brings about increased levels of anxiety or paranoid thoughts.) Or, the distressing experiences could engender a stronger sense of shame: i.e., distressing 'feelings' and 'thoughts' by which the former patients are preoccupied *bring about* a heightened experience of shame. This, in turn, might bring about more severe experiences of depression, anxiety, paranoid thoughts, and the like. It seems most reasonable to suggest that the two - shame and distress - 'feed back' into each other in a kind of 'spiral'. In this way, one could say that the 'worse' patients were on a downward spiral; the 'improved' patients on an upward spiral. The 'stable yet distressed' group would appear to be moving more slowly than the 'worse' group on the downward spiral.

5.1.2. FEELINGS OF GUILT.

As there were no significant differences of any kinds between groups in their experience of guilt none of the results of this analysis will be presented. However, observation of the data demonstrates that the experience of guilt across all groups is in the expected direction, with the 'worst' patients most guilty; the most 'improved' patients least guilty, and the 'unchanged' group in-between. However, these differences did not reach statistical significance.

5.1.3. SELF-BLAME.

Although there were no significant differences between groups (see table 5.19) the pattern of self-blame is as expected with the 'worse' group of patients scoring consistently higher than the 'same' and 'improved' groups. Thus, there could very well be an association between deterioration in psychological distress and the extent to which patients blame themselves for their feelings, thoughts, getting into hospital, and causing prob-

TABLE 5.19.

Mean scores on **SELF-BLAME variables** for 'same', 'improved' and 'worse' groups at Time2-follow-up.

	SAME group. (N=8)	**BETTER** group. (N=4)	**WORSE** group. (N=10)	**anova**
self-blame about **feelings**: /6				
	1.5	2.2	2.5	n.s.
self-blame about **thoughts**: /6				
	1.8	2.0	2.5	n.s.
self-blame about **things done in past**: /6				
	1.8	1.3	3.0	n.s.
self-blame about **being in mental hospital**: /6				
	1.2	.7	1.8	n.s.
self-blame about **problems caused others**: /6				
	1.7	1.2	2.7	n.s.

note:

Anovas - 1-tailed.

lems for others around them. Patients whose symptoms of global distress significantly deteriorated after discharge respond most often that they blame themselves “quite a bit"; the “same" group blame themselves “moderately" on average, whilst the “improved" group blame themselves, on average, just “a little bit".

Interestingly, the group whose symptoms of distress improved during the course of follow-up blame themselves slightly more than the group whose symptoms remained unchanged for feeling and thinking the kinds of things they do. However, they blame themselves less for ‘things done', ‘being in hospital', and ‘the problems they may have caused others': responding ‘a little bit' compared with ‘moderately' for the ‘same' group and ‘quite a bit' for the group whose distress was most pronounced.

It might be that the first two questions deal more with facets of experience that are under greater degree of control. That is, ‘improved' patients blame themselves more for experiences which could be perceived as being more within their control. Being in hospital and the things they have done in the past and the problems they might have caused (but not currently causing) others could be considered less within the realm of their current responsibility than facets of experience within themselves (i.e., ‘feelings' and ‘thoughts'). That is, the group whose distress improved through time might have been better able to attain a sense of **perspective** on the experiences which lie within their control relative to those which do not. Someone who is extremely distressed, for example patients in the ‘worse' group, might be hypothesized to be more likely to blame themselves and feel shame and guilt about both experiences within their control and those over which they have little to no control whatsoever. This would support the contention that, “unhappiness (distress) **seems** to stem from **inside** myself because that is where I feel it" (Smail, 1987). The more distressed the person, according to Smail, the more likely s/he is to regard the cause of that distress as being something within themselves. The results could suggest that patients whose symptoms of distress had undergone improvement were more able to attribute the cause of some of the problems in their life - the things they've done, the problems caused others, being in a mental hospital - to factors outwith their control. They were less likely than those whose distress was significantly more pronounced to blame themselves for these factors in their life.

5.1.4. CONSENSUS JUDGEMENTS.

There were also no significant differences between groups in their judgements of the consensus of these facets of their experience (table 5.20). The data for the group as a whole demonstrate that patients do believe at least ‘a little bit' that their feelings, thoughts, and being in hospital are “just not experienced by other people". However, the lack of consensus is perhaps not as marked as one would have expected. Certainly, the results do not allow any statements to be made about the likely course of recovery or deterioration in psychological distress. Patients, whether their global distress improved, remained unchanged or got much worse through

TABLE 5.20.

Mean scores on **CONSENSUS JUDGEMENT variables** for 'same', 'improved' and 'worse' groups at Time2-follow-up.

	SAME group. (N=8)	**BETTER** group. (N=4)	**WORSE** group. (N=10)	**anova**
consensus about **feelings**: /6 - **n.b.** high score= low consensus.				
	1.6	1.5	1.8	n.s.
consensus about **thoughts**: /6				
	2.1	1.5	1.8	n.s.
consensus about **things done in past**: /6				
	2.5	1.7	2.6	n.s.
consensus about **being in mental hospital**: /6				
	2.5	2.0	1.8	n.s.
consensus about **problems caused others**: /6				
	1.1	.8	2.0	n.s.

note:

Anovas - 1-tailed.

TABLE 5.21.

Actual figures for each **ISOLATION** question across 'same', 'improved' and 'worse' groups.

	SAME group. (N=8-10)	**BETTER** group. (N=5)	**WORSE** group. (N=11-13)
1. Do you have anyone you can share your most worrying problems with?			
YES	5	3	7
NO	5	2	6
2. Do you feel that the problems you have are not the sorts of things that happen to other people?			
YES	4	3	5
NO	4	2	6
3. Do you feel that the sorts of problems you have:			
A. others just wouldn't understand?			
YES	6	3	10
NO	4	2	2
B. others just wouldn't be able to help you with?			
YES	7	3	8
NO	3	2	4
C. others might make you feel uncomfortable if you were to try to get them to understand?			
YES	7	4	13
NO	3	1	0

the course of tenure in the community could not be distinguished in a *significant* way by their judgements of consensus.

5.1.5. ISOLATION.

One of the first things to note are the responses to the second question which strongly suggest that patients neither significantly possess nor significantly lack a consensus about their experiences of distress (see table 5.21). Rather, there are as many patients who feel that 'their problems are not the sorts of things that happen to other people' as there are those who don't.

A lack of consensus might account for the difficulties experienced by patients in mobilizing support when it is needed (recalling the very low 'actual' support received by patients). Feeling that others do not share one's difficulties could reasonably lead to withdrawal from others through a sense of shame and guilt about the kinds of problems they experience. If one does not feel that others share one's problems one might be less likely to try to discuss them or seek advice with others.

Although 10 of the 12 'Worse' patients feel that the sorts of problems they have 'others just wouldn't understand' this difference, relative to the distributions on this variable for the other two groups, is not significant. Indeed, across all 'isolation' measures, no one group scores significantly lower or higher than another. Rather, as described in this section in the previous results chapter, all patients' experience of being isolated is remarkably high. This is most marked for the "Do you feel that the sorts of problems you have others just wouldn't understand?" and the "Do you feel that the sorts of problems you have others might make you feel uncomfortable if you were to try to get them to understand?" questions.

More detailed description and discussion of these data is available in section 5.3.3. of the previous results chapter (four). All that can be said about the distributions of the data when comparing patients in terms of the course of recovery or deterioration in their distress is that no significant pattern of distributions was discernible.

6. GENERAL SUMMARY.

The second-wave analysis of the data examined the influence of the factors in the 'discharge revolving-door' model on the second outcome indicator: psychological distress. Patients were separated into three groups on the criterion of '**change** in symptoms of distress through follow-up': (a) a group of patients whose symptoms showed relatively **little change** from discharge through follow-up; (b) a group whose symptoms **improved**; and, finally, (c) a group whose symptoms of distress **deteriorated** across the six-months' timespan of the study.

The outcome indicator was selected for the simple reason that readmission, the first of the study's dependent variables, is best predicted by the presence and severity of psychological distress. The purpose of the second-wave analysis was to attempt to identify and examine those factors in the model which correlate most strongly with either (a) deterioration in symptoms of psychological distress; or (b) with improvement in symptomatic distress.

There were - perhaps surprisingly - few significant differences among the three groups on any of the 'revolving-door' variables. This could be more a function of the sample - formerly hospitalized psychiatric patients - than of any insensitivity, imprecision or considered inapproriateness of the variables selected to represent 'adjustment'. That is, the sample is characterized (perhaps definable) by excessively **low** levels of support availability and receipt and concomitant **high** levels of life adversity and severity of psychological distress. Consequently, differences - moreover significant differences - between groups were comparatively rare. However, some differences were observed among the groups. These can be summarized thus:

1. Among the patients in the sample, those whose global severity of distress markedly deteriorated during the six months following discharge could be distinguished from those patients whose symptoms stayed the same or got better on the distress symptoms or attitudes: (a) paranoid thinking, (b) psychotic thinking, (c) self-condemnatory thinking, (d) suicidal wishes, (e) difficulty making decisions and (f) finding work an effort. This group's experience of these symptoms or attitudes was significantly more severe implying a close relation between the two - significant deterioration in overall well-being and these six symptoms.

2. Patients whose overall symptoms grew less severe following discharge experienced the most significant fall (relative to patients who grew 'Worse' or 'Stayed the Same') in the level of stressfulness of the life events with which they met during the six-month period following discharge. That is, compared with the other groups, the group that 'Improved' after discharge encountered fewer events of significantly less objective stressfulness.

3. Patients whose distress grew more severe following discharge have a significantly lower (a) 'sense of belonging' and (b) likelihood of making a positive comparison when comparing themselves with others, relative to 'Improved' and 'Same' groups. The 'Worse' group is the only one of the three to undergo a significant drop in this form of support provision following discharge. This group, then, is characterized by (a) a sense of not belonging; and (b) a condition of not being able to feel good about themselves when they look around at others to see how they are doing **by comparison**. Moreover, where patients' symptoms have got worse this coincides with significant falls in this form of support "perception".

4. Patients whose symptoms grew worse had significantly less contact with members of their families following discharge compared with the other two groups.

5. This group of patients also experienced a significant drop in the availability of 'social integration': of the type of support availability characterized by being among other people: (a) to whom one can turn in times of difficulty; (b) by whom one can be appreciated;and (c) by whom one is cared for. The other two groups' experience of this form of support improved through the course of time.

6. The group of patients whose symptoms recovered during their tenure in the community were significantly more satisfied with the availability of this form of support ('social integration') compared with (a) their level at discharge; and (b) the other two groups of patients. There would appear to be a relation between satisfaction with the non-close-attachment figures in these patients' lives and general well-being.

7. The 'Worse' group of patients were significantly more ashamed about (a) their 'odd/bad' feelings; (b) their 'odd/bad' thoughts; and (c) being or having been in a mental hospital, compared with the group of patients whose symptoms had improved by follow-up.

A general discussion of the findings will be provided in the seventh chapter.

CHAPTER SIX:

THE THIRD WAVE OF ANALYSES:

PREDICTORS AND CORRELATES OF PSYCHOLOGICAL DISTRESS.

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2.4. SUMMARY.

1. MULTIPLE REGRESSION ANALYSIS OF THE VARIABLES IN THE 'REVOLVING-DOOR' MODEL ON COURSE OF PSYCHOLOGICAL DISTRESS.

1.1. INTRODUCTION.

Having identified differences in the experiences of distress, life events, social support, and on the psychiatric/ demographic factors among patients in the sample relative to the two selected outcome criteria - readmission and psychological distress - the next step that will be taken is to examine the relative predictive influence of these experiences on subsequent psychological distress. That is, the design of the study - a 'prospective' or 'longitudinal' one - makes it possible to examine the effect on change through time in the dependent variable 'psychological distress' brought about by a number of other, 'predictor' variables.

This kind of analysis is made possible through the use, among other statistical techniques, of multiple regression analysis. In the 'hierarchical' regression method, for example, independent variables are added to a regression equation in an order predetermined by the researcher. Variables are added at each step, in single steps, and the increment in R square at each step is taken as the component of variation attributable to that variable. In such manner, the intention of this multiple regression analysis of the predictors of psychological distress is to build up a picture: a picture which will help account for the change in psychological distress across the 6-month follow-up period; a picture whose details are the individual variables chosen to represent elements of the process of community adjustment. The regression analysis helps compose these details: identifying which variables working in which combinations produce the "best" picture - accounting for the largest proportion of variance in the dependent, psychological distress.

The central, orienting question of the study asks "*What sources of stress and/or support combine to precipitate or postpone the routinely discharged psychiatric patient's return to the hospital?*". The first two waves of analysis of the data suggested one or two plausible reasons for this return. Firstly, one of the strongest predictors of readmission identified was prior severity of psychological distress, assessed at discharge. Although the severity of the experience of life events was not capable of distinguishing between groups on the dependent readmission nor on psychological distress, nevertheless a strong, severe, objectively distressful experience of life adversity was noted among all patients. Given the strong relation between the experience of distress or 'psychological well-being' and life events previously uncovered (e.g., Kessler et al., 1985) it would seem reasonable to suggest that the experience of life events, in this study, might also be expected to account for a significant proportion of the variance in subsequent distress. This would also accord with the ideas expressed throughout this study about the interdependent relation between forms of stressful experience and the experience of symptoms of underlying psychological distress (chapter two, section 2.2 and 2.3).

As well as examining the relative contribution of these two forms of influence on the criterion - psychological distress - the **central** concern of this section will be to identify the relative predictive influence of the 'social support' components measured at discharge on distress experienced at follow-up. That is, one of the major aims of the study is to examine what **predictive** influence the **lack** of 'social support' has in exacerbating states of psychological distress, the obverse of mental well-being. Multiple regression analysis, with its ability to analyze the variance for one variable into components or parts attributable to the action of two or more variables, is the appropriate test for this kind of question (e.g., Brugha, 1991; Lehman, 1983; McNemar, 1962). For in addition to separating into components the comparative influence of each of the independents in the regression equation on the dependent or criterion variable, the technique also allows control of the effects of the independents on each other. In this way, it should be possible to examine more clearly the comparative influence of each of the study's 'revolving-door' factors on psychological distress through the use of the standardized regression coefficients for each variable. For example, it would seem reasonable to suggest that patients' 'perceived' support score is partly attributable to the experience of both 'actual received' support and 'close' or 'general attachment' forms of support. Regression analysis is able to separate out the proportion of variance solely attributable to any one individual variable (say, 'perceived' support) whilst simultaneously controlling for the amount of variance within that variable attributable to other variables in the equation (e.g., 'actual' and 'attachment' support). Where an attempt will be made to identify the relative **predictive utility** of individual variables in explaining variation in the criterion, psychological distress, the selection and use of the multiple regression technique is considered highly appropriate. For it will enable clearer statements to be made about the contribution to the course of deterioration or recovery in psychological distress that is made by specific forms of experience among patients who have recently been discharged from the acute assessment ward of a psychiatric hospital. An answer to this question remains one of the central aims of this study.

1.2. THE REGRESSION EQUATION.

1.2.1. INTRODUCTION.

One of the first steps required for an analysis of this kind is the development of a regression equation. That is, it is helpful to begin with a model of the kinds of factors or experiences which within the research domain have already been found to make a significant contribution to the variance in the predicted variable. The **model** of the 'revolving-door' process - whereby patients who get discharged from brief periods of stay in psychiatric hospital return within months to between 1-2 years of discharge - has been elucidated at some length throughout this entire thesis (particularly chapter two) and should be relatively clear by now. However, to recapitulate, the kinds of experience that have already been found to be predictive of course of recovery or deterioration in psychological distress were identified from two research domains. Firstly, material was drawn from the domain of research concerned with the uncovering of predictors or correlates of psychiatric outcome. Several good predictors were identified:

1. the patient's clinical history;
2. the patient's employment history;
3. the patient's clinical symptom profile;
4. the patient's 'social functioning';

5. the social demography of the patient.

In addition, evidence from the review of studies of the relationship between social support and various forms of psychological distress among community samples demonstrated that support modifies the stressfulness of objective circumstances which has corresponding impact on the experience of psychological well-being (e.g., Cohen and Wills, 1985; Cohen and Syme, 1984; Kessler, Price and Wortman, 1985; Reis, 1984). From this research domain were identified these important kinds of information:

1. the 'social support' experience of each subject;
2. the objectively stressful events with which subjects meet in their daily lives;
3. the patients' degree of consensus about events and 'distress' experiences in their life, as well as the extent to which they blame themselves for these circumstances, feel guilt and shame about these circumstances, and feel isolated from other people (e.g., Brewin et al., 1989).

No attempt will be made to go into any further detail about the reasoning behind the conceptualization and measurement of these components which form the current regression equation since this is considered appropriately met elsewhere (see chapter two, relevant sections).

Before introducing these variables - which will be included in separate regression equations in a step-by-step manner - it's important to describe another method by which the regression equation may be developed and one of the reasons why this was not chosen.

One simple way of identifying which variables to include in the regression equation is to set-up beforehand a correlation matrix, where each of the independent variables are correlated with the criterion. Those variables which yield the highest correlations are then selected for inclusion in the equation in the belief that those with the highest independent correlation with the criterion somehow best predict it. However, this is an erroneous assumption (e.g., McNemar, 1962). For this kind of selection tends to capitalize on correlations which might be high because of sampling fluctuations (see McNemar, 1962, ch.11, p.185). Indeed, an interesting paradox of multiple correlation, one noted by McNemar (1962), is that it is possible to increase prediction by making use of a variable which shows no, or low, correlation with the criterion, provided it correlates well with a variable which does correlate with the criterion. That is, through the use of the '*correlate first then select for inclusion*' method of developing the regression equation there is a danger of excluding from the analysis variables which might appear to be poor predictors, but whose effect is just as important but mediatory. For these reasons this method was avoided.

1.2.2. THE EQUATION.

The analysis will consist of several stages in which each of the study's variables will be regressed on follow-up experience of psychological distress. The order of entry of these variables into the analysis is as follows:

1. The first variable to be included in the regression equation is the prior experience of psychological distress. Its inclusion at this stage is predicated by the fact that psychological distress or severity of 'mental illness' is most frequently identified as the best predictor of subsequent distress (e.g., Depue and Monroe, 1985; Dooley, 1985; Monroe, 1983; Monroe and Steiner, 1986; Thoits, 1982; Williams, 1981).

With reference to the reasoning outlined in some detail for the inclusion of measures of this kind in the study (see chapter two, section 1) it was argued that the outcome, readmission, was most strongly predicted by the patient's experience of psychological distress. That is, patients get readmitted to hospital when the severity of their experience of psychological distress becomes intolerable and without apparent means of resolve (e.g., Hoult, 1986; Paykel, 1985; Paykel & Dowlatshahi, 1988). It seems reasonable to suggest that the prior level of distress experienced by patients when they are discharged will be a good predictor of their level of severity of distress at any subsequent period. This might arise, in turn, through the inappropriate focus within the hospital on patients' psychopathology which reduces to a minor role both their experience and the <u>management</u> of the experience of the <u>underlying</u> interpersonal stresses which give rise to the distress.

2. The second variable will be the stressful events with which patients meet and which are considered to contribute to on-going experiences of distress.

3. The third set of variables in the equation will be the patient's experience of 'social support'. Since the current conceptualization of support incorporates several components of this "global construct" (Winefield, 1987) each of these will be added to the equation as follows:

3.1. The perceived support variable.

3.2. The close attachment support variables: both (a) availability; and (b) adequacy.

3.3. The general attachment support variables: both (a) availability; and (b) adequacy.

3.4. The 'actual received' support variable.

3.5. The sociable activity variable.

4. The psychiatric history variables will be added next to the equation since they have been strongly identified as predictive of both readmission and psychological distress (e.g., Anthony et al., 1978; Avison and Speechley, 1987; Rushton, 1990). The variables are added to the equation at this stage since, should their relation with distress be great, their contribution to the proportion of variance in the dependent should be manifest regardless of point of entry (McNemar, 1962). Inspection of the standardized regression coefficients will also reveal the extent to which the variation in other variables can be accounted for by, say, the average amount of time in the community patients have spent between admissions. That is, the independent contribution of these other variables - life adversity and social support - to the criterion will be <u>reduced</u> should their influence be mediated by their psychiatric history.

5. Finally, the patient's age and current employment history will be added to the equation. These have been found to make a contribution to the variance in the criterion but, since the evidence for this contribution is somewhat mixed (e.g., Bland et al., 1976; Byers et al., 1978; Caton, 1982; Klein et al., 1978; Lorei and Gurel, 1973; Munley et al., 1978), this variable will be added at the last.

It would have been appropriate to have included the ‘personality' variables measured in the study. However, since there is missing data on these measures for 17 of the 38 patients their inclusion would greatly have increased the likelihood of sampling error. That is, with only 21 cases and almost as many variables in the regression equation there is a strong possibility of greatly reducing the real significance of any obtained multiple R. For under these circumstances, the multiple correlation coefficient would be subject to a positive bias, the magnitude of which would depend on the degree to which the number of variables in the equation approaches N. The possibility of this kind of bias should also be kept in mind throughout the entire results analysis where the sample size (N=38) is sufficiently small relative to the number of variables that will be added to render less significant the real significance of any multiple regression coefficient found. One method of checking for this kind of error is to ascertain the significance of the multiple correlation coefficient by inspection of the significance of the F ratio from the analysis of variance. In this way, less doubt will be placed on the significance of the multiple correlation coefficient found.

1.2.3. STEPWISE METHOD.

The following description of this method draws upon material in the SPSSX User's Guide (SPSS Inc., 1986). The STEPWISE method of selecting variables for the equation was used. This method removes the variable with the largest probability of F if this value is larger than POUT. The SPSS (Statistical Package for the Social Sciences) Stepwise regression method uses both PIN and POUT criterion for entry and removal. If the criterion for entry (PIN) is less stringent than the criterion for removal (POUT), the Stepwise method can cause the same variable to cycle in and out, over and over, until the maximum number of steps is reached. The default value for POUT - i.e., the probability of F-to-remove - is .10. In this process, variables must pass both tolerance and minimum tolerance tests to enter and remain in a regression equation. ‘Tolerance' is the proportion of a variable's variance not accounted for by other independent variables in the equation. The minimum tolerance associated with a given variable not in the equation is the smallest tolerance any variable already in the equation would have if the given variable were included.

The STEPWISE method recomputes the equation without the first removed variable, and the evaluation process is repeated until no more independent variables can be removed. Then, the independent variable that has the smallest probability of F and which is not in the equation is entered if the probability value is smaller than PIN and if the variable passes the tolerance tests. Next, all variables are again examined for removal. This process continues until no variables in the equation need to be removed and no variables not in the equation are eligible for entry, or until the maximum number of steps has been reached.

Throughout the remaining results section great emphasis should be made of the fact that the PIN value was reached on every regression analysis after including the variable prior global psychological distress. That is, only one variable satisfied the minimum tolerance criteria specified by the STEPWISE method of SPSS: prior psychological distress. All subsequent variables were 'forced in' to the equation through the application of the ENTER method of the SPSS multiple regression analysis technique. Thus, the correspondence between the standardized regression coefficients and the multiple R may not appear to add up in some cases. This reflects the method by which any variable, after the inclusion of prior psychological distress, was included into the equation. Unfortunately this was the only known method available using SPSS.

1.3. RESULTS.

1.3.1. STEP 1. PRIOR LEVEL OF PSYCHOLOGICAL DISTRESS.

TABLE 6.1.

Hierarchical regression analysis of Follow-up Global Psychological distress on Prior level of Global Psychological distress for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.50555	.2555	8.182	12.36	1,36	p=.001	.5055

RESULTS AND DISCUSSION.

The result of this first step in the regression analysis would appear to be in support of the proposition that prior level of severity of psychological distress contributes significantly to the variance in this same variable when measured at a subsequent date after discharge from hospital. Specifically, the prior experience of distress - measured within days prior to patients' discharge from hospital - makes an independent contribution of around 25% to the variance in global distress measured 6-months later. Since the purpose of this primary regression analysis is to identify the predictive influence (rather than cross-sectional association) of factors in the 'revolving-door' model on subequent course of recovery or deterioration in distress the result would appear to suggest that prior level of distress is a good predictor of subsequent distress. The result of the analysis of variance for this first step in the equation is supportive of this statement (F=12.36; df=1,36; p=.001).

The result lends itself to some speculation. Earlier, it was suggested that the reason **prior** psychological distress has been identified as such a good predictor of **subsequent** level of symptomatic distress is because it signifies the presence of other, underlying stresses and difficulties. Where these 'underlying interpersonal stresses' (Hoult, 1986) are given much less emphasis and where attention, instead, is focussed almost exclusively within the patient's mind on the relief of symptomatic distress and disturbance (for "that is where it is **felt**" - Smail, 1987) so it might come as little to no surprise to find that prior distress so well predicts subsequent distress. That is, the psychological distress experienced by patients could appear to be afforded only **cosmetic** treatment, where the symptoms of distress, which denote the presence of other precursive difficulties, are rendered less physically painful through the ingestion of pharmacological, physiognomically-oriented substances. These offer symptomatic relief. However, where there is little or no concomitant focus within the ward on the patient's deeper, more chronic underlying difficulties the fuse, one might say, has been ignored ready to be sparked back into life by some untreated difficulty met with whilst 'going back about life' in the community.

This interpretation of the result receives strong support in the literature from both Hoult (1986) and Smail (1984) in his attempt to "remove some of the mystery which surrounds psychological distress" (p.1). He writes, "In many of the institutions we have established for the longer-term care of social casualties. . . the care we in fact offer is almost always of the objectifying rather than 'subjectifying' kind. Usually, certainly, there is no lack of the kind of concern and good will which most of us would probably hope to receive in these circumstances, but what *is* often lacking is any recognition of the subjective needs of people whose only real hope of salvation is (like all of us) to be able to stand in an *active* relation to the world in a way which lends *meaning* to their existence" (ch.9, p.178). He continues, "We attempt (and inevitably fail) to repair objects rather than help the development of subjects; in trying to 'normalize' those who arouse our compassion we inadvertently deny them the significance of their own experience. . " (p.179). Thus, when a patient's *real subjective* difficulties such as "interpersonal stresses" (Hoult, 1986) have not been examined - but are neglected in favour of forms of treatment that provide swifter but more superficial change - the real difficulties which give rise to the distressing experience are likely to remain. The high levels of severity of distress experienced by patients *at discharge* appear to confirm this. Further, more severe distress is more likely to follow, predicted by the recurrence of some of these on-going, certainly unresolved and clearly abundant "underlying interpersonal stresses" (Hoult, 1986, p.137). The levels of severity of distress observed at follow-up appear to confirm this too.

On the same subject, Jackson and Cawley (1992), practicing psychiatrists, write, "a treatment plan aimed at 'normalizing' the patient as rapidly as possible with the help of medication may run into difficulties if it is not accompanied by examination of the process of regression." They see regression in psychotic states, "as a return to the level of functioning reached at the time when things began to go seriously wrong because traumatic events or conditions resulted in privations and deprivations, causing normal psychological development to be arrested." (Jackson and Cawley, 1992, p. 42). They continue, "Looked at in this way, much disturbed behaviour can be considered as the raw material on which the professionals have to work, material with important diagnostic, prognostic and therapeutic significance." (p.42). In a future in which, as they say, "in-patient units are progressively reduced in size and more exclusively focused on brief admissions for neuroleptic medication and early discharge" - a statement supported both by Raftery (1992) in his analysis of the provision of mental health services in the U.K., as well as by the current findings - the instruction of Jackson and Cawley (1992) to accompany purely medical treatments of patients with ways that involve listening and attempting to understand them, because they found it could work, is one, perhaps surprisingly, finding increasing support (e.g., Kavanagh, 1992).

It might be helpful to provide an illustration of the role played by "underlying interpersonal stresses" in creating or maintaining psychological distress. The patient's difficulties might, for instance, involve not having many friends with whom s/he can both get out of the house and do things with. This, in turn, might be caused by the patient's lack of confidence in him/herself in approaching 'new' people and in attempting to engender and maintain friendship. Without human contact the person's well-being will be at risk. Relevant treatment ought to attend to these deficits - that is, to the patient's lack of confidence and 'social incompetence' and would work toward ameliorating their disruptive impact on his/her life. However, what would usually happen with such a patient on the ward is this. Following the stabilization of his/her symptoms of underlying psychological distress through the ingestion of one or other pharmacological substance the patient would be encouraged to take part in various non-problem-confrontational ward activities. These would include, say, sitting-in on current affairs "discussions" with the Occupational Therapist; or participation in relaxation and art classes and in pottery or "home skills" groups. Although these might be of value whilst patients are still on the ward, where patients are *not* consistently followed-up once discharged and given *transitional* assistance in getting more involved in similar types of activities *back in the community* in conjunction with the use of neuroleptic medication, then the criticism that patients are just being "dumped" back home would appear to have some justification.

It might also be said that these forms of 'treatment' do not appropriately target the real needs of the patient. Rather, they continue to reflect the view that such activities 'are a good thing': i.e., that by getting patients involved in different activities somehow they get 'better'. This view was succinctly expressed by the ward's general manager who opined: "you've got to keep them busy - that way they have no time to mope about things". In this way, the staff on the ward gain a sense of 'having done their bit' to help the patient 'come out' of their self-obsessive ruminations. However, the *reasons* for the patient's current need for hospital treatment - for a period of 'asylum' (Wing, 1990) from the evidently intolerable world - tend to remain unexamined.

Where the "underlying interpersonal stresses" which gave rise to the current need for this period of asylum are **not** attended to they remain: dormant, one might say; ready to often explode back into life under the appropriate conditions. These conditions - highly stressful life circumstances; lives with poor support that is perceived as such; and a heightened sensitivity to their deleterious influence - appear to be the hallmark of this particular patient sample. That prior distress is such a good predictor of the course of psychological distress after discharge lends itself to these kinds of interpretation. That is, the distress felt by patients following discharge would appear to be somewhat <u>imminent</u>. It is predicted by their heightened vulnerability - such as (a) not having many friends to go out and do things with, and/or (b) lacking in self-confidence around others. These vulnerabilities of patients, at least within the hospital, would not appear to be adequately nor appropriately attended to.

The second variable added to the equation was the variable 'life stress'. This variable provides a measure of the objective severity of the events with which patients' met during the 12 months preceding hospital admission. That is, the measure pertains to the 12 months leading up to - and so helping to give rise to - the current period in hospital: a period which, for patients who were interviewed at discharge, was about to come to an end with discharge. The purpose of including this particular measure of 'life events' into the regression equation is to identify the predictive contribution of prior experience of life stress on the course of psychological distress experienced after discharge. Does knowing how objectively stressful a patient's circumstances were during the 12 months prior to hospital admission help to predict how severely distressed that patient will be during the course of the 6 months following discharge from hospital?

1.3.2. **STEP 2.** OBJECTIVE SEVERITY OF STRESSING LIFE EVENTS BEFORE DISCHARGE controlling for: (a) PRIOR DISTRESS.

TABLE 6.2

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on Prior level of Global Psychological distress and Prior Objective Life Event Severity for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	Significance F.	Beta
.5949	.3539	7.862	5.84	p=.003	.585 - distress
					.215 - stress

The increase in multiple R brought about by adding the patients' experience of objectively stressful life events to the equation, controlling for prior distress, is around 10%. That is, the combined effects of both prior severity of global distress and exposure to objectively stressful life circumstances, working jointly, make a contribution of 35% to the proportion of variance in subsequent global distress. The standard regression coefficients reveal that of the two variables one standard deviation unit change of prior psychological distress would introduce the greater change in subsequent psychological distress relative to life events. That is, prior distress exerts the greater predictive impact (beta=.585; p<.001) on the course of recovery or deterioration in global distress controlling for the moderating impact of objectively stressful circumstances (beta=.215; n.s.).

DISCUSSION.

The effect of including the variable 'objectively stressful life events' in combination with prior psychological distress is to add around 10% to the amount of explained variance in course of global distress after discharge. This is a quite striking result in that it reflects just the amount of variance - 9% - in general psychiatric symptomatology previously found attributable to life events amongst community samples (e.g., Rabkin and Struening, 1976; Andrews and Tennant, 1978). Thus, the effect of the experience of life adversity on experience of symptoms of distress is as pronounced for a sample from a psychiatric population as it is for community samples. This is highly interesting, for it helps support the view put forward by Avison and Speechley (1987) that an understanding of what happens to psychiatric patients after discharge can be gained through the application of models of the 'stress process' previously only examined in relation to 'normal' community samples.

They wrote (1987), that "theoretical models of psychological distress in the general population might be of use in studying adjustment among discharged patients". The results of the second step of the regression analysis would appear to strengthen the validity of their proposition. A small but significant amount of variation in course of distress (F=7.86; df=2,33; p<.01) was attributable to the added influence of life events in combination with prior distress.

The prior experience of objectively stressful circumstances in the patients' lives appears to continue to exert a deleterious impact on the patients' experience of, one might say, 'peace of mind' (Pirsig, 1974). That is, the experience of distressing symptoms that follow discharge do appear to be partly attributable to the prior experience of stressful circumstances throughout the year preceding admission. This could, in turn, be suggested as supportive of the view that the 'underlying interpersonal stresses' with which the patient has been dogged throughout the preceding year have not been adequately attended to. If they had been - that is, if these stresses were a central focus of treatment on the ward - then one could make the assumption that such stresses ought not to continue to exert such a deleterious impact on the patient's experience of 'peace of mind' subsequent to discharge. However, that experience of life events does make this significant contribution to the amount of explained variance in course of global distress seems to suggest (a) that the events do indeed exert this deleterious impact, controlling for prior global distress; and (b) that this experience is, in some way, not being attended to, or, if it is, then this attention does not appear to be having the effect intended: it doesn't appear to be working. Why this might be so must be a matter for continued debate. Without formal measures of the precise, sometimes subtle forms of influence on any patient's recovery through his/her period of treatment on the ward speculation about the cause of the failure to remedy patients' 'coming to terms' with their objective life circumstances becomes very open-ended.

What can be said at this stage, however, and something that has met with agreement elsewhere (e.g., Hoult, 1986) is that too little attention is paid on the ward to patients' experience of these types of difficulty. Instead, the focus remains on the 'symptoms' with which patients are bedevilled. As these are quite excruciating for most patients, their **relief** is more readily construed as an indication of recovery: a belief held stongly by both professional worker and patient. Indeed, it could be suggested that it is a belief in part *engendered* by the professional worker (i.e., through repeated attention to symptoms of malaise: "How are you feeling today? Any better? Do you still have. . the headaches, . . difficulties sleeping, . . problems in concentrating, . . loss of appetite, . . dizziness, . . palpitations. . ?"). That is, the focus of any interaction with the patient (observed though not formally measured by the author) was frequently the patient's experience of **feeling**, felt, self-evidently within that person. Where there was no experience of one symptom or another then the inference was made - and, more importantly, **expressed** - that "things must be looking up then", or, "well, you're much better today then, eh? 'We' must get you out soon!".

The lack of attention to "underlying interpersonal stresses" comes about not through ignorance of them. Professional carers, rather, are often unable to provide the kinds of support and care they almost certainly wish to within a system of healthcare that places emphasis on ever increasing 'turnover' (Raftery, 1992). Like doctors in general practice, acute wards are 'victims' of their own success: the more that people become aware of their (ill)health and of facilities designed to promote good health the more they will use these facilities. With huge demand for limited ‘beds', professional carers are forced into compromise: having to juggle the needs of one person with those of another. It is undoubtedly for these and other reasons - for such enforced compromise - that valued forms of treatment that would more appropriately examine these “underlying interpersonal stresses" are not able to be carried out. Thus, someone with a particular need takes the place on the ward of someone whose need is judged to be less severe. Storr (1961/1991) perhaps best summarizes this dilemma. He writes, “no psychiatrist should be ruled by his own therapeutic enthusiasm or by the well-meaning therapeutic hopes of others into promising treatment for social deviants which he cannot carry out. Thus, because he believes that a criminal or an alcoholic, or a psychopath or a psychotic might be helped by a full-scale analysis of fifty minutes five days a week, he should not agree to his confinement in a mental institution where he will get, if he is lucky, a ten-minute interview once a week." (pp. 299-300).

It seems reasonable, then, to suggest that in many instances patients' real ‘underlying stresses' and strains are not dealt with adequately and that, moreover, the prevailing forms of thought concerning ‘success' held by staff on the ward render such attention unlikely in the future. That is, where both staff and patients have learned to construe ‘success' in treatment as the removal or temporary relief of the patient's **symptoms** of psychological distress, where ‘recovery' is evidenced - which is not infrequent and even relatively swift given the powerful, somnambulizing effect of pharmacological substances such as say, diazepam or largactil - it grows less likely that attention will be paid to the real difficulties of which the distress felt is simply **symptomatic**. This is because such patients will be discharged to make way for the many people ‘knocking on the door of the ward' who will be judged to have greater need. Thus, on a purely “help for the most needy"-basis, symptomatically-recovered patients are released to make way for patients in comparatively greater distress.

1.3.3. **STEP 3**: PERCEIVED SUPPORT AT DISCHARGE controlling for: (a) PRIOR DISTRESS; and (b) OBJECTIVELY STRESSFUL LIFE EVENTS.

The third set of variables added to the equation - ‘forced in' by use of the ENTER method - were those ‘social support' variables classed within the research domain as ‘perceived support'. That is, the four constructs measured by the Interpersonal Support Evaluation List (Cohen et al., 1985) and which measure the patient's ‘subjective perception' (hence the variables' description) of four types of support provision - what Thoits (1985) has termed 'existentially-securing' provisions - were added to the equation.

Although measures obtained from these variables are described as ‘perceptions' their intercorrelations with more objective indices are in the expected direction. For example, the ‘sense of belonging' construct would be expected to correlate highly with the <u>availability</u> of close and/or general attachment measures (obtained from the ISSI - Henderson et al., 1980) as it describes the existence of people with whom one can do things. This was found (r=.52; p<.001). Similarly, the correlation of the ‘perceived' tangible support measure of the ISEL with the tangible (or material) support measure of the Index of Socially Supportive Behaviours (Barrera et al., 1982) is also high (r=.46; p<.01) as one would expect given their high degree of similarity. That is, although these measures might be described as 'perceived' support constructs, they do appear, nevertheless, to be quite representative of the 'existential' provisions which they purport to measure: matching actual availability or receipt of the forms of support considered to contribute to such existential conditions.

The result suggests that the combined influence of prior distress, prior experience of life events and perceived 'support' provisions or functions accounts for 41% of the variance in course of global distress after discharge (table 6.3). The separate contribution of patients' perceived availability of support provisions increases the amount of explained variance by around 5% on the combined distress and life events. Thus, the perceived availability of the four provisions of support does appear to be mildly predictive of subsequent psychological distress. That is, where there is less (a) perceived availability of material aid; (b) perceived availability of someone to confide in and with whom to share one's problems; (c) perceived likelihood of a positive comparison when comparing one's self with others; and (d) perceived availability of social companionship then there can be expected to be a greater likelihood of an experience of psychological distress.

TABLE 6.3.

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on Prior level of Global Psychological distress, Prior Objective Life Event Severity,and Perceived Support Provisions for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	Significance F.	Beta
.6425	.4128	8.149	2.71	p<.05	.589 - distress
					.071 - stress
					-.056 - appraisal
					-.184 - tangible
					.085 - belonging
					-.051 - self-esteem

Again, the most significant contribution to the explained variance is made by prior distress. Most notably, including these support variables in the analysis greatly reduces the independent contribution of objective life events to subsequent distress. The most significant support provision appears to be 'tangible' support, that is, the provision of forms of support such as 'loans of money', 'help with daily chores', 'someone you can go and stay with when things get difficult'.

DISCUSSION.

The result of this step strongly suggests that, even when controlling for the effects of prior global distress and life event experience on course of distress, the patients' perceptions of being interpersonally-supported continue to make a contribution to the amount of explained variance in subsequent distress. That is, when assessing the patient's prior distress, previous experience of objective life events and perceptions of being provided with particular forms of support from others at one point in time the power of prediction of subsequent course of global distress rises, accounting for around 41% of the variance in subsequent global distress.

It is worth examining the meaning of this result more closely. The increase in multiple R from 35% to 41% through adding the perceived support variables to the equation suggests that these variables exert a significant, albeit mild, influence (F=2.71; df=7,27; p<.05) over subsequent experience of psychological distress.

The result could appear to support the view that "the effectiveness of support may not reside in any particular behaviour of significant others, but in how that behaviour and ensuing relationships are perceived" (Heller and Lakey, 1985). That is, the patient's perception of these forms of support - whether this perception is an accurate reflection of 'objective circumstances' or not - contributes to the course of subsequent global psychological distress. This suggests that when assessment of any patient's suitability for discharge is being made that measures of these perceptions of interpersonal support should be incorporated since they have this valuable predictive function. Where patients are found to be deficient in any particular interpersonal support provision, particular attention should be paid to these deficiencies prior to discharge. That is, where deficiencies are seen to have an adverse effect on subsequent global distress it would be appropriate to attempt to isolate and focus attention on these deficiencies.

Such attention might best be directed toward finding ways with the patient that help either to (a) minimize the impact of these deficiencies; or (b) counter the deficiencies by finding ways of making the best use of all the sources of support available to that patient. For example, it might be that the patient is especially deficient on the (a) tangible support, and (b) belonging support constructs measured by the ISEL. That is, the patient has few people to whom s/he can turn for material, practical kinds of help (e.g., help with shopping; for the provision of somewhere other than 'within their walls' to go to during the day to help them get out of the house). Nor has the patient many people with whom s/he can do things with such as go and visit for a chat and cup of tea; with whom s/he is invited to do things with; or with whom s/he can relax and have lunch with. Appropriate 'treatment' for this patient would, in the first instance, be to find out which people the patient does actually know. These might be members of his/her family, or infrequently-seen old friends or acquaintances. The next step would be to address some of the reasons why the patient doesn't see or doesn't want to see these people. This might involve the uncovering of particular conflicts and grievances and/or concomitant 'bad feelings' between both or all parties involved. This would obviously require conversing with the relevant parties concerned. Such conversation would be focussed toward the understanding and resolution of these conflicts or grievances. Or it might require explanation of the reasons for the patient's gradual withdrawal through time as the course of the patient's 'illness' (or, perhaps more appropriately, as the erosion in the patient's confidence in him/herself as a fit and 'normal' person) becomes more chronic.

With the agreement of all parties, a community psychiatric nurse or social worker or perhaps some friend or neighbour (who is not so intimately involved but who, nevertheless, is acquainted with both parties) could help to ameliorate the felt difficultes and make sure that continued contact between parties is maintained based on this new understanding of the conditions that gave rise to the disturbance. However, where this transition is not effected, the patient who is about to be discharged or who has recently been discharged could be closely followed-up by professional services and appropriate support provided when necessary. This might involve getting the patient more involved in local groups in the community, or, helping the patient, in turn, to provide help to other disadvantaged people in the community, such as physically-disabled people, the elderly, even other formerly-hospitalized chronic mental patients. The focus of these kinds of support would be on the amelioration of the patient's perceived deficits: deficits which, from the result of the third step of the current regression analysis, make a significant contribution to change in experienced global distress after discharge.

To summarize, the inclusion of the ‘perceived support' variables - measured at discharge - to the regression equation, controlling for prior distress and objectively stressful life events during the 12 months preceding admission contributed an additional 5-6% to the amount of variance in subsequent psychological distress. The standard regression coefficients demonstrate once again that of the three variables, one standard deviation unit change of prior distress would introduce the greater change in subsequent psychological distress relative to the other variables. The variable with the second most significant impact on subsequent distress, when combining these three types of experience, appears to be the patient's perceived ‘tangible support' (beta=.184; n.s.). That is, its effect, when examining the effects of these three types of experience working together, is greater than that of prior life event experience: a highly interesting finding. This suggests that having people around to whom the patients could turn for practical kinds of help exerted a stronger impact on subsequent distress than the presence of objectively stressful life circumstances prior to admission. Once more, the proposition referred to earlier by Heller and Lakey (1985) appears to attract support from this result. That is, what appears to be quite important for subsequent distress is the patient's perception of the behaviours and events in their life, and not just their actual occurence.

1.3.4. **STEP 4**: AVAILABILITY OF CLOSE ATTACHMENTS controlling for: (a) PRIOR DISTRESS; (b) OBJECTIVELY STRESSFUL LIFE EVENTS; and (c) PERCEIVED SUPPORT PROVISIONS.

TABLE 6.4.

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on Prior level of Global Psychological distress, Objectively stressful life events, Perceived support and Close Attachment support for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.6606	.4364	8.07	2.88	7, 26	p<.05	.6809 - distress
						-.2975 - appraisal
						.1024 - stress
						-.1628 - tangible
						.0708 - belonging
						-.0401 - esteem
						.3047 - attachments

The effect of adding the 'close attachments' variable to the equation is to add only around 2% to the amount of explained variance in course of distress. That is, the combined effect of all these variables working jointly accounts for around 43% of the variance in course of psychological distress experienced after discharge. However, closer examination of the standard regression coefficients (beta values) shows that after prior distress the next most significant predictor of subsequent distress is availability of close attachments (beta=.3047; n.s.). That is, when controlling for the correlations of all the variables with each other (perceived support, life events and availability of close attachments) it can be observed that one standard deviation unit change of availability of close attachments would introduce the greater change in subsequent psychological distress relative to both life events and perceived support.

DISCUSSION.

The results suggest that the effects of perceived support are, in part, mediated through having available close attachments. This would be in support of some of the suggestions for treatment put forward in the previous discussion section. That is, a person's perception of the four types of provision measured by the ISEL will have greater chance of improvement through much closer contact with people with whom s/he has some form

TABLE 6.5

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on Prior level of Global Psychological distress, Objectively stressful life events, Perceived support, Close attachment support, Adequacy of close attachments and Availability of general attachments for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.7819	.6113	6.97	4.19	9, 24	p<.01	.7384 - distress
						-.2182 - appraisal
						.3254 - stress
						-.2606 - tangible
						-.1550 - belonging
						-.1104 - esteem
						.2812 - attachments
						-.0931 - adequacy
						.6012 - gen.attach.

TABLE 6.6.

Intercorrelations of Distress, Life events, Perceived support and Availability and Adequacy of Attachments with Availability of Social Integration.

Correlations with:	AVAILABILITY OF SOCIAL INTEGRATION.
distress at follow-up	.046
life stress preceding admission	.467**
isel - sense of belonging	.601**
isel - problem-appraisal	.280*
isel - tangible assistance	.398**
isel- reflected self-esteem	.465**
availability close attachments	.302**
adequacy close attachments	.011

note:

* - p<.05; ** - p<.01

of contact. Closer attachments, it was suggested, might help to provide the patient with a greater sense of belonging; may be more likely to provide him/her with more practical, 'everyday' forms of support, and might also provide the patient with the means for discussion of some of the more strenuous worries in his/her life. The result of this step of the analysis is strongly supportive of these suggestions, indicating that the patient's perceptions are a function of their availability of close attachments. However, it should also be noted (once again) that the most significant contribution to the proportion of variance in subsequent distress is made by prior experience of distress. This is the only significant standard regression coefficient ($p<.02$) and suggests the strong role of prior experience of symptoms of distress on subsequent severity of symptoms.

1.3.5. **STEP 5**: ADEQUACY OF CLOSE ATTACHMENTS controlling for: (a) PRIOR DISTRESS; (b) OBJECTIVELY STRESSFUL LIFE EVENTS; (c) PERCEIVED SUPPORT PROVISIONS; and (d) AVAILABILITY OF CLOSE ATTACHMENTS.

Adding the 'adequacy of attachments' variable to the equation has no effect of adding to the variance in course of psychological distress. This was perhaps unexpected. Henderson et al. (1981) in their study of the development of neurosis among a community sample found that people's attachment 'adequacy' and not 'availability' was the most significant predictor of neurosis onset. Evidently, amongst this more chronic, psychiatric patient sample, for whom symptoms of psychological distress can hardly be described as being of recent onset, the influence of adequacy of attachments on subsequent distress is much less pronounced than that attributable to the simple **availability** of close attachment relationships.

Given the significant contribution of simple availability to the experience of subsequent distress it will be interesting to examine next the effect on the power of the equation by adding the second 'availability' variable: availability of social integration. Is the amount of variance in subsequent global distress increased by including measures of the patient's availability of people who 'depend on them for care and attention'; 'really appreciate what you do for them'; 'are known well enough to borrow things from or ask small favours'; or, 'can be turned to in times of difficulties'?

1.3.6. **STEP 6**: AVAILABILITY OF GENERAL ATTACHMENTS controlling for: (a) PRIOR DISTRESS; (b) OBJECTIVELY STRESSFUL LIFE EVENTS; (c) PERCEIVED SUPPORT PROVISIONS; (d) AVAILABILITY OF CLOSE ATTACHMENTS; and (e) ADEQUACY OF CLOSE ATTACHMENTS.

RESULTS AND DISCUSSION.

The effect of adding the availability of 'social integration' variable to the equation is to contribute a substantial 17-18% to the proportion of variance in subsequent global distress accounted for by the combined influence of the distress, life stress and other support variables (table 6.5). The size and direction of the standard regression coefficient suggests that after prior distress the variable with the strongest predictive impact on subsequent distress is this availability of 'social integration' variable. The direction of the standard regression coefficient suggests that the more available is the 'social integration' component of the patient's experience the more distressed the patient will be six months after discharge.

This might appear somewhat confusing. That is, having people around who depend on the patient; people who 'they can go to who aren't involved and tell them how they feel'; 'who they could visit at any time without waiting for an invite'; 'people who could come round to their home at any time and take things as they find them'; or 'people they can turn to in times of difficulties' correlates most significantly (sig. T=.003) with course of subsequent psychological distress. However, what appears to be happening is this. The variable with the most significant standard regression coefficient (beta=.738; p=.002) on subsequent distress is prior distress. This suggests that of all the variables in the equation one standard deviation unit change of prior psychological distress would introduce the greater change in subsequent psychological distress. The second most significant variable is availability of social integration. That is, the availability of social integration appears to exert a strong influence over the distributions of the other variables in the equation, such that the effects of these variables are **mediated** through this 'integration' variable.

Thus, the effects on distress of the perceived support provisions - belonging, esteem, tangible aid, and appraisal of problems - appear to be mediated by this variable, social integration. One might describe this 'social integration' variable as a 'suppressant' (McNemar, 1962). The effect of a suppressant variable was referred to a little earlier in the chapter. Its effect might help to explain the result of this particular step in the regression analysis. It's worth pondering over this point in some detail.

McNemar (1962) refers to this paradox in the development and testing of different steps of a regression equation. He writes, "an interesting paradox of multiple correlation is that it is possible to increase prediction by utilizing a variable that shows no, or low, correlation with the the criterion, *provided* it correlates well with a variable which does correlate with the criterion." (p.186). Such a variable is described as a "suppressant". That is, its contribution to the explained variation in the dependent variable is exerted through shared variance with the other independents in the equation. This effect can be seen in table 6.6.

The variable 'social integration' would appear, then, to fit McNemar's (1962) description of a "suppressant" variable. That is, 'social integration' correlates very poorly with the measure of subsequent global psychological distress (r=.046). However, it correlates well, and in the expected direction, with the perceived support variables: where the **more** available are other people in the patients' lives the significantly **greater** (a) the sense of belonging (r=.601); (b) the ability to appraise problems (r=.280); (c) the amount of tangible assistance from others (r=.398); and (d) the likelihood of gaining a good sense of one's worth and value when comparing oneself with others (r=.465). However, there is a paradox with this variable, and it is this. The more available are other people in the patients' lives the more likely it is that they will have undergone severe forms of objectively stressful life events during the preceding 12 months (r=.467). The paradox appears to be the dual, conflicting role of other people in the patient's life. On the one hand they confer these supportive provisions which purport to engender a sense of "existential-security" (Thoits, 1985). On the other, their presence is associated with greater degrees of severity of stressful life circumstances. The net effect, one might say, is to augment the experience of symptoms of global psychological distress, augmented and deteriorated through the course of tenure in the community - back in their homes in their local neighbourhoods - following discharge from hospital.

This finding is a highly fascinating one for it suggests that **both** the problems experienced by patients and their solution can be found and begun to be managed through examining more closely the nature and content of the patients' interactions with the people around them. That is, the patient's 'support network' (the people with whom s/he is acquainted) both reassures, guides and emotionally supports **and yet** it is also associated with the experience of more objectively stressful events in the patient's life preceding hospital admission. It might imply that where the events with which patients meet are discussed with the agreement of the persons intimately involved that some kind of platform exists on which to resolve the patient's otherwise sense of "aloneness, insecurity, and lack of safety": the resolution of which true support has been suggested as providing (see chapter two). That is, it would appear to be the case that for patients there is as much **destructive** as **constructive** "engagement with other people" thus giving rise, on the whole, to a feeling of being poorly supported. There is **less** "feeling and knowledge that the person has of being stable and secure and thus less alone and separate" (from Boyce, 1985; Fromm, 1957/1988). However, the presence of other people does appear, also, to be constructive: providing these "existentially-securing" provisions. This is the paradox!

That the variable 'availability of social integration' has a higher standard regression coefficient than that for life events (beta=.601 compared with beta=.325 for life events) suggests that the importance of this variable precedes that for life events. Interestingly, the only variables whose beta coefficients reach significance in this equation are prior distress (beta=.7384; p=.002), availability of social integration (beta=.6012; p=.003) and life events (beta=.3254; p<.05). That is, the most significant contribution to the proportion of variance in global distress is made by the joint combination of these three variables. This would appear to suggest that by knowing (a) how severely distressed the patient is at discharge; (b) the extent of the availability of other people in the patient's life; the extent to which they are "socially integrated" (e.g., Durkheim, 1897/1952; Rook, 1985); and (c) the level of severity of the objectively stressful circumstances in the patient's life during the 12 months preceding admission, one can predict with a certain degree of certainty (F=4.19; df=9, 24; P<.01) around 61% of the variance in the subsequent distress experienced by the patient after discharge. Or, perhaps more appropriately, by taking measures of these kinds of information at <u>discharge</u> one can be sure of going more than a little of the way toward being able to <u>predict</u> just how severely psychologically distressed any patient might be after s/he is discharged from the hospital.

NOTE: ADEQUACY OF SOCIAL INTEGRATION.

Since the effect of adding the variable '<u>adequacy</u> of social integration' to the regression equation was to add more or less nothing to the explanatory power of the equation this step in the equation will not be discussed in any great detail.

Interestingly, however, the variable correlated highly with the other ISSI adequacy measure, 'adequacy of attachments' (r=.713; p<.001). This finding appears supportive of the claim of Henderson et al. (1981) that the two adequacy measures of the ISSI measure a generalized sense of "wanting more". That is, the two meas-

TABLE 6.7.

Hierarchical regression analysis of Follow-up Global Psychological distress on Prior level of Global Psychological distress, Objectively stressful life events, Perceived support, Close attachment support, Adequacy of close attachments, Availability and Adequacy of general attachments, and Frequency of sociable activity for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.8313	.6911	7.43	2.73	13, 16	p<.05	.7723 - distress
						.2225 - appraisal
						.6561 - stress
						-.2891 - tangible
						-.2984 - belonging
						-.0294 - esteem
						.4026 - attachments
						-.1941 - adequacy
						.7654 - gen.attach.
						-.1824- ad.gen.att.
						-.2256 - friends.
						-.0795 - family

ures do not appear to be distinguishable from each other, but reflect instead a general sense of adequacy or satisfaction with relationships in general.

1.3.7. **STEP 7: FREQUENCY OF SOCIABLE ACTIVITY** controlling for: (a) PRIOR DISTRESS; (b) OBJECTIVELY STRESSFUL LIFE EVENTS; (c) PERCEIVED SUPPORT PROVISIONS; (d) AVAILABILITY OF CLOSE ATTACHMENTS; (e) ADEQUACY OF CLOSE ATTACHMENTS; (f) AVAILABILITY OF GENERAL ATTACHMENTS and (g) ADEQUACY OF GENERAL ATTACHMENTS.

RESULTS AND DISCUSSION.

The result of the inclusion of the variables 'frequency of time spent with friends' and 'frequency of time spent with family' is to add around 8% to the predictive power of the equation (see table 6.7). That is, according to the result of this step of the regression equation, 69% of the variance in course of global psychological distress among all patients in the sample can be attributed to variation in prior distress, prior life stress, perceived support, attachment support (both availability and adequacy) and frequency of sociable interaction with friends and family working together. Inspection of the standard regression coefficients reveals an expected correlation between the 'sociable activity with friends' variable (beta=-.2256; n.s.) and subsequent distress. That is, the more often patients are engaged in pleasurable, sociable interaction with friends and acquaintances following discharge the less subsequently distressed they are likely to become. Its contribution relative to the other variables in the equation is, however, quite small. Once again, the three most significant contributors to likely change in subsequent distress are prior distress, availability of general attachments, and experience of objectively stressful life events prior to admission.

Interestingly, the fourth relatively most significant contributor to any deviation unit change in prior distress is the patient's 'availability of attachments' (beta=.4026; n.s.). Thus, the evidence would appear to point toward the strong influence on course of recovery or deterioration in psychological distress of patients' 'availability' of attachments of <u>any</u> kind. That is, it appears to be that <u>through these attachments</u> the life stresses and perceptions of being supported and also of participating in pleasurable interaction with others is <u>mediated</u>. This, of course, could be an over-interpretation of the results of these analyses. However, the interpretation that is suggested by the result of this analysis would appear to 'hold together' (Brown, 1989). The current of the patient's distress can, in other words, be felt most strongly through his/her involvements with others. From the first two waves of analyses of the data, it can be suggested that these involvements do confer satisfaction on the patient **but in very low degree**. That is, the patients, on the whole, receive little <u>actual</u>support from others; perceive themselves also to be very poorly supported; and spend very little time in pleasurable sociable interaction with friends or family. As a result, one might say, the patients draw little sense of satisfaction from these comparatively <u>un</u>supportive relations.

The involvements with others, then, also lead patients to feel dissatisfied. This dissatisfaction must be viewed in a context that includes life circumstances which are significantly more objectively stressful than those observed among a community sample (e.g., Henderson et al., 1981): a stressful experience that is uniformly high across all patients in the sample. The assessments of patients' **satisfaction** with these attachments - both close and more diffuse - revealed a uniformly low level. Taking these two factors into consideration, a much clearer picture would appear to emerge. The attachment relations in patients' lives occupy a central role in, one might say, their 'support matrices' - providing the **basis** from which actual supportive aid, existentially-securing provisions, and pleasurable sociable interaction are obtained or simply 'felt'. Where there is great dissatisfaction with these attachment relations the 'fuse', referred to a little earlier in this chapter, can be seen to be **exposed** - ready to be lit by some distressing event in their lives, or by some distressing thought or feeling. Most importantly, where there is **already** a deficiency in this area of the patient's life - remember, all patients scored, on average, significantly lower on the 'social integration' measure than, say, the Canberra community sample (Henderson et al., 1981) - this renders the other elements in the patient's support matrix that **less** secure. There appears, in other words, to be an overriding influence of having and being involved in intimate or more diffuse attachment relations with others over other forms of social support in predicting subsequent level of severity of psychological distress measured at a six-month point following hospital discharge.

1.3.8. A FINAL STEP.

In a final step of the analysis three sets of variables were added to the regression equation: (a) the actual received support variables; (b) the psychiatric history variables; and (c) the patient's age and employment history. However, since missing data were noted for several patients the size of the sample under investigation reduced from 38 cases to only 26. As this was, effectively, reducing the number in the sample to something around 70% of its actual size it was considered inappropriate to go into great detail on the results of the findings.

Another difficulty with so small a sample relative to the number of variables in the regression equation (n=19) was a danger of commiting a sampling error. That is, when the sample size is so small relative to the number of variables in the equation the standard error of the multiple regression coefficient will yield an underestimate of the error. In turn, there will also be what is known as 'shrinkage' of the multiple correlation coefficient. That is, as the size of the sample approaches the number of variables in the equation the value of the multiple R always approaches unity. This suggests that when the number of variables in the equation is large relative to N, the real significance of the multiple r becomes less certain. That is, there will be greater likelihood of positive bias. McNemar (1962) suggests that where there is doubt about the significance of the multiple r from the standard error, the best way of ascertaining the significance is by examination of the analysis of variance in the variables. In the following, final step of the regression equation, careful attention will be paid to these points.

RESULTS AND DISCUSSION.

Although the increase in multiple R might suggest a highly powerful model, accounting for around 82% of the variance in subsequent global psychological distress, the qualifications that must be made in interpreting the result place its validity in doubt (table 6.8). That is, (a) the size of the sample (N=26) accounts for only 68% of the total patients interviewed in the study, and to whom the preceding analyses refer; (b) the sample size relative to the number of variables in the equation has increased the possibility of 'sampling error' - where 19 variables have been included in an equation predicting the variance in distress for only 26 patients, a low ratio that must question the validity of the multiple R found; and (c) the inspection of the significance of the F ratio for the analysis of variance showed the multiple R to be non-significant (F=1.87; df=18,7; p>.05).

TABLE 6.8.

Regression of all time-1 variables on time-2 global psychological distress.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.
.9099	.8280	8.07	1.87	18, 7	p>.05

With these qualifications in mind it was not considered appropriate to add anything further to this discussion other than the briefest comment on the size and relative influence of the standard regression coefficients for the variables newly added to the equation. Firstly, none of the coefficients for the (a) actual support received variables; (b) psychiatric history; or (c) age and employment variables was significant. Secondly, the highest coefficient among the three sets of variables was of the size .3072 for the variable 'actual material help received' - received during the 6 months preceding admission. None of the other variables had coefficients greater than .20 suggesting a lesser role for these variables in the patient's experience of global psychological distress following discharge from hospital. However, these results, requiring such caution in interpretation, are not considered representative of the preceding steps in the regression analysis. It would, therefore, be inappropriate to dwell upon the result .

1.3.9. ANOTHER TEST OF THE PSYCHIATRIC HISTORY VARIABLES.

In an attempt to try to test more fully the explanatory power of the psychiatric variables - which have been found to be good predictors of subsequent readmission and psychological symptomatology (e.g., Anthony et al., 1978; Avison and Speechley, 1987) - a regression equation was set up which added the psychiatric variables to those variables previously found to contribute most to the power of the equation in predicting subsequent psychological distress. That is, the psychiatric history variables were added to the equation including (a) prior distress; (b) prior life event exposure; (c) availability of social integration; (d) availability of close attachments and (e) perceived support provisions.

RESULTS AND DISCUSSION.

Recalling the multiple R of .61 found for the equation which did not include the psychiatric history variables, the net effect of adding this information is to add 4-5% to the amount of variance in subsequent global psychological distress attributable to the effect of patients' prior distress, life event, social support and psychiatric history variables working jointly (table 6.9).

TABLE 6.9.

Hierarchical regression analysis of Follow-up Global Psychological distress on Prior level of Global Psychological distress, Objectively stressful life events, Perceived support, Attachment support and Psychiatric history variables for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.
.8178	.6681	7.07	3.48	11, 19	p<.01

These psychiatric experiences have made as influential a contribution to the change through time in patients' experience of psychological distress as the 'perceived support' experiences of all patients. This supports the finding that a history of contact with psychiatric services will continue to exert a significant impact on *subsequent* health and functioning where "the past (can be seen to) drive(s) the present" (Avison and Speechley, 1987). However, the size and significance of the standard regression coefficients of the psychiatric variables - (a) average length of all in-patient admissions; (b) length of current admission; and (c) average length of tenure in the community between all in-patient admissions - are uniformly small (no greater than .19, with average community tenure only .0812) and non-significant. The variables making the largest and most significant contribution to any standard unit change to subsequent global distress continue to be prior distress, availability of social integration, objectively stressful life events and one of the perceived support variables, appraisal of problems (beta=-.407; n.s.).

1.4. SUMMARY.

The various steps of the first multiple regression analysis identified the best predictors of subsequent severity of experience of psychological distress to be, in descending order of size of change in contribution to the variance in distress, as follows:

1. prior level of severity of psychological distress measured at discharge - accounting for around 25% of the variance in subsequent distress.
2. level of 'social integration' : the extent to which the patient knows and is involved in sociable interaction

with non-partner friends and acquaintances - accounting for around 18% of the variance in distress.

3. prior level of severity of life events experienced during the 12 months preceding last admission - accounting for around 10% of the variance in distress.
4. actual, pleasurable contact with friends and family - accounting for around 8% of the variance in distress.
5. perceived “existentially-securing" support provisions - accounting for around 5% of the variance in distress.
6. previous contact with psychiatric services - accounting for around 5% of the variance in distress.

The findings will receive more detailed discussion in the final chapter.

2. SECOND MULTIPLE REGRESSION ANALYSIS:

CROSS-SECTIONAL ANALYSIS OF FOLLOW-UP INFORMATION.

2.1. INTRODUCTION.

The second step-by-step multiple regression analysis will be a **cross-sectional** analysis, focussing on the associations between the time-2 variables and the time-2 measure of global psychological distress. That is, measures taken at follow-up of the patients' experience of objectively stressful life circumstances, components of social support, and additional psychiatric 'aftercare' variables will be regressed on patients' follow-up experience of global symptoms of psychological distress.

The purpose of this analysis is to attempt to identify the types of independent variable which associate best with the criterion variable psychological distress. Any variables which are identified will not be considered predictive of global distress. Rather, any independent variable whose variation accounts for a significant proportion of the variation in the dependent, psychological distress, will be regarded as sharing a common link with the dependent. Thus, where there is change in the dependent - psychological distress - an attempt will be made to identify the corresponding change - in both degree and direction - in the independents: life events, social support and psychiatric aftercare. That is, to what extent does the change in psychological distress correspond with a unit increase or decrease in any of the study's independents?

The major question of this type of analysis is simply "what combined sources of stress and/or support measured at follow-up help to account for the change in severity of global psychological distress, measured at follow-up?". In the course of this analysis the effect of the **intervening** experience of life events, social support, and psychiatric aftercare on patients' level of severity of global distress experienced at follow-up will be examined. In the course of "going about their lives" back home in the community following discharge some patients will return to face the circumstances and conditions which helped bring about the recent period in hospital. The purpose of this analysis is to attempt to identify what **kinds** of change in what kinds of experience through time *correlate* best with the severity of symptoms of psychological distress experienced by patients.

2.2. THE REGRESSION EQUATION.

The regression equation will be of a similar type to that developed in the first major regression analysis. The order of entry of each of the independent variables will be almost identical to that in the first equation. However, one major change will be made. After including the variable 'objectively stressful life events' the next step of the analysis will incorporate the 'availability' indices from the ISSI: firstly, the 'availability of social integration' variable, then the 'availability of close attachments' variable. This earlier inclusion is considered justified by the consistent finding from the preceding regression analysis which identified a major, contributory influence of these variables on the course of global psychological distress.

The order of entry of the independents in the regression equation is, then, as follows:

1. The first step of the analysis will examine the influence on subsequent global psychological distress of the objectively stressful life events with which patient met during the course of the six months following discharge.

2. The second set of variables in the equation will be the patient's experience of 'availability of social integration', followed by 'availability of close attachments'.

3. Each of the additional 'social support' variables will be included as follows:

   3.1. The perceived support variables.

   3.2. The close and general attachment 'adequacy of support' variables.

   3.3. The sociable activity variables.

   3.4. The 'actual received' support variables.

4. The psychiatric 'aftercare' variables will finally be included. There are two kinds of information: the number of times during the 6 months preceding follow-up that the patient had been in contact (a) with his/her GP; and (b) with his/her consultant.

Previous research has identified an important contribution to patients' mental well-being and 'successful adaptation' to life back in the community of continued contact with what is known as 'aftercare' services following discharge (e.g., McCrainie and Mizell, 1978; Solomon, Gordon, and Davis, 1984; and Solomon, 1986-87). For example, a general finding has emerged that length of tenure in the community will be prolonged where patients continue to be in contact with formal, professional 'aftercare' services. These variables will be included in the last step.

The results of the step-by-step inclusion of each of these variables into the equation will now be presented.

2.3. RESULTS.

2.3.1. STEP 1: OBJECTIVELY STRESSFUL LIFE EVENTS.

RESULTS AND DISCUSSION.

The result of this first step in the regression analysis is essentially similar to what one would expect from a straightforward product-moment correlation between two variables (see table 6.10). Thus the Pearson coefficient of r=.416 between the two variables translates into a multiple R of .17. Expressed in another way, 17% of the variance in the criterion, course of psychological distress, is attributable to variation in the patients' experience of objectively stressful life events during the six months following discharge. Thus, as expected, the association between the two variables is moderately high where the more severe the patient's experience of stressing life circumstances following discharge the more psychologically distressed s/he is likely to become.

TABLE 6.10.

Hierarchical regression analysis of Follow-up Global Psychological distress on follow-up Objectively stressful life events for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.4163	.1733	8.60	6.71	1,32	p<.01	.4163 - stress

The true, independent impact of the experience of life events on subsequent distress cannot be inferred from this first step in the regression analysis since the moderating impact of other potentially influential experiences has yet to be examined. That is, in order to assess the real contributory impact of the patients' experience of life events it is necessary to introduce the other variables to the equation. In this way, the intercorrelations between the variables can be controlled for. This then allows for examination of the true proportion of variance in the dependent independently attributable to the variable in question, in this case, ‘life events'.

However, to conclude this short discussion, the result of this analysis does appear to be in support of the propositions made throughout section two of the second chapter, namely, that the experience of psychological distress is partly determined by the presence of objectively stressful life events. Such events can be termed ‘stressful' when they engender within the person experiencing them, a sense of ‘being stressed': that is, an experience (a) that one has little to no control over the noxious circumstances; and (b) that the circumstances are undesirable, and perhaps also (c) that the events show no sign of immediate nor even subsequent resolve.

From this result one can conclude that the objective stressfulness of life events - even without an assessment of the real **meaning** of these events for the person experiencing them - are implicated in the course of recovery or deterioration in experience of global psychological distress for psychiatric patients recently discharged from hospital.

2.3.2. STEP 2: AVAILABILITY OF 'SOCIAL INTEGRATION' controlling for (a) OBJECTIVELY STRESSFUL LIFE EVENTS.

In the previous regression analysis (section 1, current chapter) the purpose was to identify the types of independent variables in the 'revolving-door' model of patient discharge most **predictive** of subsequent severe distress. From this analysis, the variable 'availability of social integration' was found to make the second most significant contribution to the explained variance in distress, controlling for the effect of the other variables in the equation. It is for this reason that in the current cross-sectional regression analysis this variable will be added as the second step in the equation after life events. The purpose of the analysis is to examine the increment in R square attributable to availability of social integration: i.e., Does having other people available with whom patients can get involved make a significant contribution to the severity of the experience of global psychological distress 6 months after patients have left hospital?

TABLE 6.11.

Hierarchical regression analysis of Follow-up Global Psychological distress on follow-up Availability of social integration, and Objectively stressful life events for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.4990	.2490	8.33	5.14	2,31	p<.01	.4215 - stress
						-.2751 - soc.integn.

RESULTS AND DISCUSSION.

Adding the measure of patients' 'availability of social integration' to the equation increased the amount of variance in subsequent distress attributable to the combined effect of this variable with life events by around 7% to 24%. Given the percentage increase of 18% in R square found attributable to this variable in the <u>first</u> major regression analysis, the relatively smaller increment found in this result was somewhat surprising. Inspection of the beta regression coefficients demonstrates that of the two variables, life events and availabililty of social integration, that with the most significant contribution to subsequent distress is life events (beta=.4215; p<.01, compared with beta=-.2751; n.s.). That is, one standard deviation unit change of objectively stressful life events would introduce the greater change in subsequent psychological distress relative to availability of social integration. This cross-sectional analysis, then, appears to suggest a more significant role for the stressful events in the patient's life at the time of measurement of global distress.

The contribution to the amount of variance in distress made by the 'social integration' variable is still, however, moderately large and significant. It suggests an important place within the patients' lives of having and being involved with other people on experience of psychological distress. The direction of the beta regression coefficient also suggests that, during the 6 months following admission, the fact of having more and being involved more in relationships with other people had a net positive effect. That is, the more available were other people with whom patients could be termed 'socially integrated' the less psychologically distressed were patients, on average, likely to be. The conclusion arrived at in the previous regression analysis whereby a 'destabilizing paradox' appeared to be in evidence - where being around more people had **both** auspicious **and** deleterious consequences for patients - would still hold. However, across all patients after discharge the net effect of the 'availability of social integration' element in their lives appears, on average, to partly 'fend off' severe experience of psychological distress.

In the succeeding steps of the analysis part of the reason for this positive effect might emerge. That is, it could be that being involved with more people confers on patients some of the other components of support that were identified and measured in the study. Thus, it could be conjectured at this point that (a) greater degrees of, say, actual support were received by patients through their involvement with others; or (b) a stronger sense of belonging was engendered which helped lessen the severity of distressing symptoms.

N.B.: AVAILABILITY OF CLOSE ATTACHMENTS.

The result of the next step of the analysis - inclusion of the simple 'availability of close attachments' variable - added less than 1% to the amount of explained variance in subsequent global psychological distress. This could suggest that a general effect is in evidence of simple availability of attachments - of any kind. That is, it could be suggested that the proportion of variance in distress contributed by the two 'availability' measures is, more or less, indistinguishable. That is, there is a shared variance between 'availability of *general* attachments' and 'availability of *close* attachments' *relative to subsequent experience of global psychological distress* (the pearson product-moment correlation of .467 between the two variables is supportive of this claim).

2.3.3. STEP 3: PERCEIVED INTERPERSONAL SUPPORT PROVISIONS controlling for (a) AVAILABILITY OF 'SOCIAL INTEGRATION'; (b) AVAILABILITY OF CLOSE ATTACHMENTS; and (c) OBJECTIVELY STRESSFUL LIFE EVENTS.

The next step in the analysis included the 'perceived support provisions': (a) the perceived availability of material aid; (b) the perceived availability of someone to confide in and with whom to share one's problems; (c) the perceived likelihood of a positive comparison when comparing one's self with others; and (d) the perceived availability of social companionship.

RESULTS AND DISCUSSION.

The result of this step in the regression analysis is presented in tables 6.12 and 6.13. There was an interesting development in which the first variable entered using the STEPWISE method of inclusion changed from objectively stressful life events to the interpersonal support component 'perceived likelihood of a positive comparison when comparing one's self with others' (table 6.12). This was the only variable to satisfy the strict tolerance limits for inclusion in the equation set by this method.

TABLE 6.12.

Hierarchical regression analysis of Follow-up Global Psychological distress on follow-up 'Perceived likelihood-positive comparison' controlling for attachment availability and objective life events for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.6430	.4135	7.13	21.85	1,31	p<.0001	-.6430 - esteem

The result of the first 'stepwise' inclusion into the equation of the 'self-esteem through others' variable demonstrates the incredibly marked independent contribution of this variable to the amount of variance in distress experienced by patients six-months after discharge. That is, 41% of the variance in subsequent experience of psychological distress can be attributed to the variance in 'perceived likelihood of a positive comparison when comparing one's self with others.'

That none of the other variables in the equation satisfied the minimum tolerance criteria for stepwise entry into the equation after the inclusion of 'self-esteem through others' would appear to indicate that a significant proportion of the variance in all the other variables in the equation is shared with this variable, referred to as the ‘self-esteem through comparison with others' provision of the ISEL. It suggests that this variable's influence somehow ‘overshadows' that of the other variables in the equation (this can be ascertained by inspection of the beta regression coefficients in table 6.13). Its contribution to the amount of variance in subsequent distress is such that the previously identified influence of some of the other variables in the equation on distress can be attributed to these variables' shared variance with this variable, ‘self-esteem through social comparison'.

TABLE 6.13.

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on follow-up All ‘perceived' support provisions, Availability of close attachments and social integration, and Objectively stressful life events for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.7228	.5225	7.16	3.90	7, 25	p<.01	-.5080 - esteem
						.0320 - tangible
						.2162 - stress
						-.1802 - appraisal
						.1582 - close attach.
						.2033 - soc.integn.
						-.2627 - belonging

The result of this step in the analysis reveals the overall contribution of the perceived support, attachment support, and life event variables to the amount of variance in subsequent severity of psychological distress to be moderately large: 52% of the variance in distress is attributable to variation in the independents (F=3.9; d.f.=7,25; p<.01). Examination of the standard regression coefficients (beta weights) for this equation demontrates the major contribution of the patients' ‘perceived likelihood of a positive comparison when comparing themselves with others' (beta=-.5080; p<.01). That is, one standard deviation unit change of ‘perceived esteem through others' would introduce the greater change in subsequent psychological distress relative to the other variables in the equation. The second most significant contribution to the explained variance in distress is made by the perceived support provision ‘sense of belonging' (beta=-.2627; n.s.) followed by objectively stressful life events (beta=.2162) and social integration (beta=.2033).

The result of this analysis could suggest the following interpretation. The patients' experience of global psychological distress at follow-up can be said to be influenced by the following. Firstly, when patients **compare** their circumstances with others and their ability to cope therein and there arises from this form of comparison a sense that they are not coping well with life - that they are not doing as well as others in a similar position (which is what the variable concerned provides a measure of) - then a more severe experience of symptoms of psychological distress is likely to follow or attend such comparison. Thus, patients who respond in a **negative** way to items such as, (a) 'most of my friends are more interesting than I am'; (b) 'in general, people don't have much confidence in me'; (c) 'I think that my friends feel that I'm not very good at helping them solve problems'; or (d) 'I am able to do things as well as most other people', are likely to be more distressed. In addition, that a patient suffers such poor comparison renders him/her much more likely to be distressed than if, say, s/he perceived there to be a deficit in the amount of practical support they receive. Where there is a deficit in this form of 'self-esteem' support *it really does matter*: patients who lack this opportunity to, one might say, "feel good about themselves in the eyes of others" are most psychologically distressed - feeling "bad about themselves".

Secondly, patients who have a poor 'sense of belonging' were also more likely to be experiencing more severe symptoms of psychological distress when assessed at follow-up. That is, patients (a) who don't 'regularly meet or talk with members of their family or friends; or (b) who 'have no-one who takes pride in their accomplishments'; or (c) who, 'If they decided on a Friday afternoon that they'd like to go to a movie that evening wouldn't be able to find someone who'd go with them' were found, on average, to be more distressed at follow-up when experiencing this absence of belonging in their lives. In both cases - whether (a) being reflected badly in one's self by others; or (b) perceiving, since, in most cases, actually knowing that one has few people to whom one is a best friend or trusted confidant - these 'perceptions' undoubtedly become more salient particularly where there is an attendant experience in their lives of severely disruptive objectively stressful life events.

The moderately low standard regression coefficient for the 'availability of social integration' measure (beta=.2033) would still suggest a moderately influential independent role of this experience on the patients' subsequent global distress. However, its high intercorrelation with the 'esteem through comparison with others' variable (r=.475) would appear to account for a large amount of its shared variance with global distress. Indeed, the 'esteem through others' variable shows uniformly high intercorrelations with all other variables (see table 6.14). This would support the claim made a little earlier that a significant proportion of the variance in all the other variables in the equation is shared with this variable.

Although this form of regression analysis does not claim to be able to identify predictors of the course of recovery or deterioration in symptoms of global psychological distress for patients, nevertheless an important statement can be made about the possible **practical** value of this result. The central thrust of this investiga-

TABLE 6.14.

Intercorrelations of Follow-Up Distress, Life events, Perceived support variables and Availability of Attachments with 'Perceived likelihood of a positive comparison when comparing one's self with others'.

Correlations with:	PERCEIVED SENSE OF SELF-ESTEEM THROUGH OTHERS .	
distress at follow-up	-.643***	
life stress preceding admission	-.456**	
isel - sense of belonging	.499**	
isel - problem-appraisal	.422**	
isel - tangible assistance	.274**	** - p<.01
availability close attachments	.414**	*** - p<.001
availability general attachments	.475**	

tion, it will be recalled, was to identify the sources of stress and/or support which combine to precipitate or postpone the patient's return to the hospital. The result of the current analysis suggests that a clear statement can be made about at least one of the sources of information professional workers responsible for the patients' care ought to include in any routine assessment of patients' suitability for discharge. This source of information - 'perceived sense of self-esteem through comparison with others' - is seen only to correlate with the experience of distress at follow-up. Advice on its practical use in these settings, therefore, can only be made in a 'post-hoc' fashion. That is, in practical terms, patients who are either:

(a) still on the ward and who are being assessed for suitability for discharge; or,

(b) back living in the community after discharge,

and who score markedly low on this support provision - 'self-esteem through others' - might be regarded as being highly susceptible to the experience of severely distressing symptoms of psychological malaise. This experience is likely to render a period in hospital more likely when that distress becomes intolerable and without apparent means of resolve: indeed, the result suggests that being unable to gain a reflected sense of one's worth through comparison with other people might itself be 'intolerable'.

Given the large and significant independent contribution of this experience to explained variance in global distress at follow-up, it would make sense to incorporate this type of information into the planning and assessment of patients' discharge from hospital. Patients who could be regarded as being especially susceptible to developing symptoms of psychological distress after discharge would be those low scorers (how low would depend on the patient concerned and on what is known of the nature of his/her relationships with other people). An in-depth discussion of this result will be provided in the concluding chapter.

N.B.: ADEQUACY OF (a) CLOSE ATTACHMENTS, and (b) SOCIAL INTEGRATION.

As the net contribution of adding the ISSI **adequacy** measures to the equation was to add only 2% (from 52% to 54%) to the explained variance in global distress measured at follow-up this step in the analysis will not be discussed in any detailed way. Although the Pearson product-moment correlation between 'adequacy of social integration' and psychological distress is relatively high (r=-.472; p<.001) its correlation with 'perceived self-esteem' (r=.622; p<.0001) would appear to account for its relatively small independent contribution to variance in distress. That is, the amount of shared variance with the variable 'perceived self-esteem through comparison with others' appears to 'subsume' any marked independent effect that patients' 'adequacy of attachments' might have had, controlling for these other variables in the equation.

The F value of 2.95 for this step in the analysis was significant (p<.02) and renders more secure this result of the combined influence of all these support and life event variables on global distress measured at follow-up.

2.3.4. STEP 4: FREQUENCY OF PLEASURABLE SOCIABLE ACTIVITY controlling for: (a) PERCEIVED INTERPERSONAL SUPPORT PROVISIONS; (b) AVAILABILITY OF 'SOCIAL INTEGRATION'; (c) AVAILABILITY OF CLOSE ATTACHMENTS; (d) ADEQUACY OF ATTACHMENTS and (e) OBJECTIVELY STRESSFUL LIFE EVENTS.

RESULTS AND DISCUSSION.

Although the increment in R square of just .2 to .56 from adding the 'frequency of sociable interaction with friends and family' variables to the overall equation is comparatively small, nevertheless the result of this step deserves closer scrutiny (see table 6.15). The result would suggest that the variation in patients' experience of all the support variables (minus the 'actual support' indices) working together with objectively stressful life events accounts for around 56-57% of the variance in global psychological distress at follow-up.

The relative contribution of the independents to the explained variance in the criterion, course of psychological distress (see beta weights), reflects a continued, major role for the patients' 'perceived sense of self-esteem through comparison with others'. The effect of adding the 'frequency of sociable interaction' variables to the equation is to reduce the size of its independent contribution from beta=.5080 to beta=.3352. However, this variable continues to have the most significant influence on the variance in subsequent distress. The next relatively most significant variable also continues to be patients' 'sense of belonging' (beta=.3034), followed by adequacy of social integration (beta=.3135) and stressful life events (beta=.2316). These variables, taken together, would appear to suggest a more significant role for more qualitative features of the patient's support experience on their subsequent experience of distress. That is, the results show there to be a relatively stronger contribution to the amount of variance in global distress of the '**perceived** support' components: (a) a sense of belonging; (b) perceived sense of self-esteem through others; and (c) adequacy of social integration.

This is not to overlook the relative contribution of the more structural features of patients' 'social support' experience (e.g., the 'availability of social integration' variable has a comparatively high beta weight of .2291 - almost as large as the contribution made by the variable 'objectively stressful life events') Rather, the result of the current step in the regression analysis suggests that of the two forms of 'social support', the relatively greater contribution to any unit change across time of psychological distress is made by the non-quantitative, more qualitative and functional forms of support. Where any patient had (a) a poorly reflected sense of esteem through others; (b) lacked a strong sense of belonging; and (c) perceived inadequacy in their general, more diffuse relations with others **then** s/he was likely to experience more severely distressing symptoms of psychological malaise when assessed at follow-up. This is not to say that the experience, say, of lack of 'social integration' did **not** have any impact on subsequent experience of symptoms of distress. Rather, the rela-

TABLE 6.15.

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on follow-up All 'perceived' support provisions, Availability and Adequacy of close attachments and social integration, and Objectively stressful life events for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.7534	.5676	7.80	2.27	11, 19	p<.05	-.3352 - esteem
						.0602 - tangible
						.2316 - stress
						-.0587 - appraisal
						.2011 - close attach.
						.2291 - soc.integn.
						-.3034 - belonging
						-.0713 - friends
						-.1415 - family
						-.3135 - adeq.soc.int.
						.1072 - adeq.close.att.

tive contribution of this fact of their 'social support' experience was less marked.

The result could, however, suggest that there might be some degree of confounding between measures of the dependent variable and measures of the independents. That is, the criterion, global psychological distress, could be regarded as being sufficiently similar in conceptualization to the 'perceived support' variables to incorporate in its definition and measurement just these forms of 'support' with which it has been found to be most strongly associated. However, this interpretation of the results is considered unlikely. It has been argued at some length (chapter two, section 4.7) that measures of all the variables in the study were carefuly selected to avoid just this kind of contamination. For example, the Interpersonal Support Evaluation list (Cohen et al., 1985) was selected for its high reliability, validity and independence from other constructs such as psychological distress and 'social competence' (see Cohen et al., 1985). The validity and reliability of the other support measures have been reported elsewhere (chapter two, section 4.8.).

In addition, carefully designed research on the issue of confounds - between measures of, say, social support and psychological well-being - has been carried out which concludes that such contamination is merely apparent. For example, Turner (1983), in his attempt to examine the overlap between items of perceived support and psychological distress found that the two separated into quite distinct factors with no consistent overlap. In another factor analytic investigation of the overlap between perceived social support items and psychological distress, Heller and Lakey (1990) identified two distinct factors. The first appeared to reflect a 'negative affectivity' construct (previously identified by Watson and Clark, 1984). The second factor reflected perceived support. In addition, there was no loading of perceived support on the first factor, negative affectivity. These authors concluded that 'perceived support' and personality can be best considered "linked to psychological distress by similar processes" (Heller and Lakey, 1990). From the result of the previous step in the analysis it seems plausible to suggest that some similar kind of link between more functional forms of social support and psychological distress has been identified. What that linkage might be will be considered in the concluding chapter. However, for now it remains to be stressed that the possible interpretation of there being simple contamination between measures of social support and psychological distress is almost certainly not justified on the grounds that (a) careful attention was paid to just this issue when selecting measures to include in the study; and (b) evidence from research that has examined this issue strongly suggests the distinctiveness of support constructs relative to distress.

2.3.5. STEP 5: ACTUAL SUPPORT RECEIVED controlling for: (a) PERCEIVED INTERPERSONAL SUPPORT PROVISIONS; (b) AVAILABILITY OF 'SOCIAL INTEGRATION'; (c) AVAILABILITY OF CLOSE ATTACHMENTS; (d) ADEQUACY OF ATTACHMENTS; (e) OBJECTIVELY STRESSFUL LIFE EVENTS and (f) FREQUENCY OF PLEASURABLE SOCIABLE ACTIVITY.

This variable was included in the equation in an attempt to identify what happens to the severity of patients' experience of distressing symptoms when they are in receipt of actual help from others during their tenure in the community following discharge. That is, does actually receiving help - and not 'perceiving' the provision of various forms of help - correlate with a less severe experience of psychological distress at follow-up?

RESULTS AND DISCUSSION.

Before discussing this result it would perhaps be appropriate to raise the topic once again of sampling error. That is, one of the difficulties associated with having so small a sample of patients (N=38) relative to the number of variables in the regression equation (n=13) is the danger of commiting a 'sampling error'. To recapitulate, this is when the sample size is so small relative to the number of variables in the equation that the standard error of the multiple regression coefficient might likely yield an underestimate of the error. In turn, there will also be what is known as 'shrinkage' of the multiple correlation coefficient. That is, as the size of the sample approaches the number of variables in the equation the value of the multiple R always approaches unity. McNemar (1962) makes the important point that when the number of variables in the equation is large relative to N, the real significance of the multiple r is questionable. That is, there will be greater likelihood of positive bias. McNemar (1962) suggests that where there is doubt about the significance of the multiple r from the standard error, the best way of ascertaining the significance is by examination of the analysis of variance in the variables. As the F-ratio in table 6.16 was found to be significant for this step in the analysis (p<.05) the validity of this result can be accepted with a greater degree of certainty. That is, there was a significant contribution when adding the 'actual support received' information to the equation (which included patients' experience of life events and all other 'social support' components) such that the amount of explained variance in psychological distress at follow-up increased by around 9% to 65%.

At this stage in the regression equation an increment in r square of .09 (or 9%) would indicate the relatively significant contribution of the 'actual support received' variables to the variance in psychological distress. The independent contributions to the global distress experience are worthy of comment. The most significant contributor - relative to the other variables in the equation - is no longer 'perceived self-esteem through others' but the actual support variable 'actual emotional help received' (beta=.5281). However, the **only** variable to satisfy the minimum STEPWISE tolerance criteria for this step in the equation continued to be the 'perceived self-esteem through others' variable (F=20.6; df=1,29; p<.0001). This suggests that its continued independent effect - controlling for the variance in all other variables - is such that, over and above all other support or life event experiences, any standard unit change of 'perceived self-esteem through others' will introduce the greater change in patients' experience of psychological distress.

TABLE 6.16.

Hierarchical regression analysis of Follow-up Global Psychological distress on follow-up ‘perceived' support provisions, Availability and Adequacy of close attachments and social integration, Frequency of sociable interaction, Actual Support Received and Objectively stressful life events for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.8063	.6501	7.42	2.43	13, 17	p<.05	-.4531 - esteem
						.0420 - tangible
						.0766 - stress
						-.3591 - appraisal
						.0608 - close attach.
						.3221 - soc.integn.
						-.3218 - belonging
						-.0856 - friends
						-.1160 - family
						-.1781 - adeq.soc.int.
						.1250 - adeq.close.att.
						-.3026 - actual material
						.5281 - actual emotionl

The contribution to the explained variance in psychological distress made by the 'actual emotional support received' variable appears to qualify this one, too, as a "suppressant" (e.g., McNemar, 1962 and referred to earlier). The intercorrelations of all the variables in the equation with the 'actual **emotional** support' variable (table 6.17) strongly suggest a "suppressant" role for this variable. Thus, the variable 'actual emotional support' correlates very poorly with global psychological distress at follow-up (r=-.094). However, its correlations with all other variables (excepting adequacy of close attachments) are uniformly high, significant and in the expected direction. This reflects precisely the role of the "suppressant" as elucidated by McNemar (1962). Where patients have been emotionally supported by others during the six months after admission they were also, for example, more likely to (a) have a stronger sense of belonging (r=.547); (b) have the ability to appraise problems (r=.505); (c) gain a good sense of their worth and value when comparing themselves with others (r=.460); and (d) be more involved in pleasurable sociable interaction with friends (r=.451).

This is a most instructive finding for it suggests that patients who are fortunate enough to be emotionally supported or sustained by others - actually given emotional support by others whilst living back home - are more likely to be 'adjusted' in terms of their assessment on a number of distress and support measures 6-months after their discharge from hospital. That is, there appears to be some form of '*translation*' from the *act of support* to the perception of *being supported*, i.e., from **being helped** to **'feeling less alone and separate from others'**. Patients who receive actual help from others are more likely to perceive themselves to be more 'interpersonally supported' and are more likely to perceive their more diffuse attachments to be adequate. This suggests that by 'providing' patients with emotionally-supportive forms of support their experience of other forms of support is likely to improve. And although the correlation between 'actual emotional support' and psychological distress is low (r=-.094) nevertheless its contribution to the explained variance in distress is comparatively large and significant. The influence of this variable, then, may not be direct. Instead, it appears to be mediated through its shared variance with the other support variables in the equation.

From a practical point of view, this result would appear to support the view that more appropriate emotion-based forms of support be provided patients both (i) when they are on the ward - in preparation for discharge, and (ii) when they are living back in the community, when such forms of support might more positively transfer when it is most needed. That is, this kind of support, actual emotional support, will be most valuable when it is needed: that is, when the support received meets the needs of the person (Cohen and Wills, 1985). In another context it has been referred to as "crisis-support" (e.g., Alloway and Bebbington, 1987; Brown et al., 1985). It is the kind of support that meets the needs of the person concerned at the time of the crisis. From the result of this step of the analysis, it can be concluded that patients who experienced greater amounts of this form of help were more likely to reveal greater degrees of 'adjustment' on most of the other components of support measured in the study. Although there was no **direct** correlation between the receipt of 'actual emotional support' and distress experienced at follow-up, the indirect impact of this variable on dis-

TABLE 6.17.

Intercorrelations of Distress, Life events, Perceived support, Frequency of sociable interaction and Availability and Adequacy of Close and General Attachments with Actual Emotional Support.

Correlations with:	ACTUAL **EMOTIONAL** SUPPORT.
distress at follow-up	**- .094**
life stress after admission	.165**
isel - sense of belonging	.547**
isel - problem-appraisal	.505**
isel - tangible assistance	.547**
isel- reflected self-esteem	.460**
availability social integration	.557**
availability close attachments	.373**
adequacy close attachments	-.037
adequacy social integration	.236*
frequency sociable activity - friends	.451**
frequency sociable activity - family	.282*

note: * - p<.01; ** - p<.001.

tress is strongly suggested both by its significant contribution to the explained variance in distress as well as by its high intercorrelations with the other variables in the equation. In addition, that there was no direct relation between 'actual emotional support' and psychological distress experienced at follow-up might be expected where the 'buffering' effect of this form of help on feelings and symptoms might have subsided after the **matching** of the need with support had been met. That is, the timing of the measurement of the symptoms with the support received might have been some way after the moments of its strongest impact. Further discussion of this point will be extended in a concluding chapter.

2.3.6. FINAL STEP 6: AFTERCARE CONTACT controlling for: (a) PERCEIVED INTERPERSONAL SUPPORT PROVISIONS; (b) AVAILABILITY OF 'SOCIAL INTEGRATION'; (c) AVAILABILITY OF CLOSE ATTACHMENTS; (d) ADEQUACY OF ATTACHMENTS; (e) OBJECTIVELY STRESSFUL LIFE EVENTS; (f) FREQUENCY OF PLEASURABLE SOCIABLE ACTIVITY and (g) ACTUAL SUPPORT RECEIVED.

The purpose of this step of the analysis is to examine the relative contribution to patients' psychological distress experienced at follow-up made by contact with 'professional' sources of support. The two variables - the amount of times during the preceding 6 months the patient had been in contact (a) with his/her GP; and (b) with his/her consultant - might be expected to have a positive influence on the patient's experience of distressing symptoms. Those patients who more often saw their GP or consultant would be expected to experience either less severe distress or to be more likely to remain in the community for longer periods after discharge - since such formal contact might be expected to enable the patient to better manage their distress (e.g., McCrainie and Mizell, 1978; Solomon, Gordon, and Davis, 1984). That is, a general finding has emerged that, for example, length of tenure in the community will be prolonged where patients continue to be in contact with formal, professional 'aftercare' services. The result of the final step in this cross-sectional regression analysis is presented in table 6.18.

RESULTS AND DISCUSSION.

The result of this analysis was not significant (F=1.96; df=15,14; p>.05). Consequently, any statements made regarding the relative contribution of the individual independents to the variance on psychological distress must be duly qualified. It is likely that with such a small sample of subjects (N=38) relative to the number of individual variables entered in the equation that the significance of the analysis was diminished. This might suggest that with a larger sample - something in the region of 2 to 300 patients - there would have been much less likelihood of the kind of sampling error evidenced in this step of the analysis. As a consequence, there will be less detailed interpretation of the result.

TABLE 6.18.

Hierarchical regression analysis (method=enter) of Follow-up Global Psychological distress on follow-up 'perceived' support provisions, Availability and Adequacy of close attachments and social integration, Frequency of sociable interaction, Actual Support Received, Objectively stressful life events and Psychiatric Aftercare Contact for all psychiatric patients.

Mulitiple R	R Square	Standard Error	F-ratio	df	Significance F.	Beta
.8234	.6781	7.52	1.96	15, 14	p>.05	-.4745 - esteem
						.1074 - tangible
						.0675 - stress
						-.2791 - appraisal
						.2140 - close attach.
						.2138 - soc.integn.
						-.3995 - belonging
						-.1063 - friends
						-.2849 - family
						-.3504 - adeq.soc.int.
						.1119 - adeq.close.att.
						-.3105 - actual material
						. 7853 - actual emot'nl
						.1648 - GP contact
						-.2666 - consultant "

The first point to note is the relatively small increase in r square of 2% brought about by the addition of the psychiatric aftercare variables. That is, this experience would not appear to add significantly to the amount of variance in distress over and above the 'social support' and 'life event' variables previously entered. This might suggest that these variables share variance with the other variables in the equation which, in turn, accounts for the proportion of explained variance in psychological distress.

The intercorrelations of the aftercare variables with the social support and life event variables demonstrates an interesting pattern suggestive of the findings of the regression analysis (table 6.19). As found in previous studies (e.g., Sands, 1984; Tessler and Mason, 1979) patients who were more socially integrated or who had more close attachments were more likely to have been in contact with their GP (r=.312; r=.344) and with their consultant (r=.233; r=.197). However, this contact does not correlate strongly with the patients' perceptions of being interpersonally supported. Indeed, the correlation of r=**minus** .187 between 'contact with consultant' and 'perceived likelihood of a positive comparison when comparing one's self with others' suggests that such contact may have deleterious consequences for patients! For example, patients' satisfaction with their close and more diffuse relations is also more likely to be lower where there is greater contact with the consultant.

There is also the very strong possibility that patients who are in contact with 'their' consultant are already dissatisfied with their relations and are already reflected poorly by others. Interestingly, patients in greater contact with their consultant during the six-month period after discharge were also more likely to experience more severe degrees of distress when assessed at follow-up. This contrasts with the correlation between 'contact with GP' and experience of distress (r=-.035; n.s.) suggesting that patients who more often see their GP are slightly less distressed at follow-up. These results might also suggest that the patients who 'pass through the filter' from 'primary care' under the responsibility of the GP to 'secondary care' under the responsibility of the psychiatrist (Goldberg and Huxley, 1980) are more likely to be the more severely "psychologically unwell" (Henderson, 1988). That is, these patients are already dissatisfied with their relations; experience greater degrees of objectively stressful life events; and, one would say 'as a result', experience more severely distressing symptoms of psychological malaise and so present more often to the consultant.

The effect on the standard regression coefficients is to increase the relative contribution of the patients' experience of 'actual emotional support' over the six-months to any likely unit change of psychological distress experienced over the same time-span. The most significant contributor to explained variance in global distress continues to be 'perceived sense of self esteem through others' - the only variable to satisfy the strict minimum tolerance criteria for STEPWISE entry into the equation. All other variables were entered using the less strict 'ENTER' method of SPSS. Other significant contributors to change in global distress over the six-months continue to be (a) sense of belonging, (b) adequacy of social integration, and the other 'actual support' variable (c) actual material support received.

TABLE 6.19.

Intercorrelations of Distress, Life events, Perceived support, Frequency of sociable interaction and Availability and Adequacy of Close and General Attachments and Actual Received Support with Psychiatric Aftercare.

Correlations with:	G.P. CONTACT	CONSULTANT CONTACT.
distress at follow-up	**- .035**	
life stress after admission	-.063**	
isel - sense of belonging	.038**	
isel - problem-appraisal	.292*	
isel - tangible assistance	.020**	
isel- reflected self-esteem	.016**	
availability social integration	.312**	
availability close attachments	.344**	
adequacy close attachments	.165	
adequacy social integration	.548*	
frequency sociable activity - friends	-.127**	
frequency sociable activity - family	-.095*	
actual emotional support	-.157	
actual material support	-.164	

However, to conclude, the result of this step in the analysis should not be overly emphasised. As there is evidence of a sampling error with a non-significant F ratio of 1.96 (df=15,14; p>.05) the significance of the multiple correlation must be placed in doubt. Accordingly, much less emphasis should be placed on this particular step of the regression analysis.

2.4. SUMMARY.

The various steps of the second - cross-sectional - multiple regression analysis identified the most significant contributors to the explanation of the variance in the follow-up experience of psychological distress, in descending order of size of contribution, to be:

1. perceived likelihood of a positive comparison when comparing one's self with others (reflected self-esteem) - making an independent contribution of around 40% to the explained variance in psychological distress measured at follow-up.

2. actual emotional and material forms of support actively received after discharge - making an independent contribution of around 9% to the explained variance in psychological distress measured at follow-up.

3. perceived ‘sense of belonging' and ‘ability to appraise problems through the help of others' - accounting for around 8% of the explained variance in psychological distress measured at follow-up.

4. experience of objectively stressful life events after discharge - making an independent contribution of around 5-8% to the explained variance in psychological distress measured at follow-up after controlling for the effect of the other independents in the equation.

5. availability of contact with both close and more diffuse attachments after discharge - accounting for around 3-4% of the variance in psychological distress after controlling for the effect of the other independents in the equation.

The significance of these findings to an explanation of the central, orienting question of this investigation will be explored in detail in the following, concluding chapter.

CHAPTER SEVEN.

GENERAL DISCUSSION.

chapter summary.

1. FACTORS THAT ASSOCIATE WITH OUTCOME “READMISSION": THE RESULTS OF THE FIRST WAVE OF ANALYSES.

1.1. PSYCHIATRIC INDICATORS.

1.2. SOCIAL DEMOGRAPHIC INDICATORS.

1.3. STRESSFUL LIFE EVENTS.

1.4. SOCIAL SUPPORT.

1.5. ‘POWERFUL EMOTION' - SHAME, GUILT; ‘COGNITIVE APPRAISAL' - SELF-BLAME, CONSENSUS JUDGEMENTS.

2. FACTORS THAT ASSOCIATE WITH OUTCOME “SEVERITY OF SYMPTOMS OF PSYCHOLOGICAL DISTRESS": THE RESULTS OF THE SECOND WAVE OF ANALYSES.

2.1. PSYCHIATRIC INDICATORS.

2.2. SOCIAL DEMOGRAPHIC INDICATORS.

2.3. EXPERIENCES OF SPECIFIC TYPES OF PSYCHOLOGICAL DISTRESS.

2.4. STRESSFUL LIFE EVENTS.

2.5. SOCIAL SUPPORT.

2.6. ‘POWERFUL EMOTION' - SHAME, GUILT; ‘COGNITIVE APPRAISAL' - SELF-BLAME, CONSENSUS JUDGEMENTS.

3. THE THIRD WAVE OF ANALYSES: THE REGRESSION ANALYSES.

3.1. THE FIRST REGRESSION ANALYSIS.

3.2. THE SECOND REGRESSION ANALYSIS.

3.3. CONCLUSIONS.

CHAPTER SEVEN:

GENERAL DISCUSSION: THE KINDS OF EXPERIENCE THAT (a) HELP TO PREDICT OR (b) ASSOCIATE WITH 'PSYCHIATRIC OUTCOME': DEFINED AS READMISSION AND PSYCHOLOGICAL SYMPTOMATOLOGY.

Chapter Summary.

The preceding results chapters - four through six - have dealt in some considerable detail with the results of each of the successive waves of analyses. Each chapter provided a description of the results together with discussion of the meaning of any particular finding within its appropriate context: for example, within the context of the outcome variable 'readmission to hospital' or of the outcome 'deterioration, stability or improvement in severity of symptoms of psychological distress'. However, there yet remains the **general discussion** of these results within the broader context of the study whose aim was to find answers to the question "What factors predict or associate with successful community adjustment among routinely discharged psychiatric patients ?".

The purpose of this more encompassing discussion will be the examination of the more salient results of the analyses with specific reference to the central, orienting questions addressed by the project and which were adumbrated in the first chapter. These are:

1. "What sources of stress and/or support combine to precipitate or to postpone the routinely discharged psychiatric patient's return to the hospital?"
2. In "postponing" or "precipitating" rehospitalization: what sources of stress and support associate with *symptomatic* recovery or relapse - a 'necessary condition' for rehospitalization (Caton et al., 1985).
3. In examining the "sources of support", what are the (a) structural features and (b) the processes contained within these structures that associate with symptom recovery or relapse?

With this framework in mind, some of the more salient findings of the foregoing analyses will be examined and their implications discussed. The current focus, then, will be restricted to those results which are informative of the study's original questions and therefore considered worthy of further elucidation or special attention. These results will be discussed and interpreted by drawing upon relevant material from the twin research domains from which the ideas for the project came into being. That is, explanatory material will be drawn (a) from research whose concern is the identification of the social, social-psychological and psychiatric correlates of adjustment among patients routinely discharged from mental hospitals, and (b) from research that has examined the linkages among life stress, social support and mental health.

The theoretical and practical implications of some of the findings will be attended to and appropriate suggestions will be made about the future direction that research in this domain could fruitfully take.

1. FACTORS THAT ASSOCIATE WITH OUTCOME "READMISSION": THE RESULTS OF THE FIRST WAVE OF ANALYSES.

1.1. PSYCHIATRIC INDICATORS.

In chapter one, strong evidence was presented for two sets of factors that associate with 'community adjustment' - whether defined as readmission, community tenure, or any of the other outcome criteria identified by Avison and Speechley (1987). These were (a) the previous amount of time spent as a patient in psychiatric hospital, and (b) the patient's "social" experience - whose operationalization was not, unfortunately, made standard across studies. The results of the first wave of analyses revealed moderate support for the influence of these two factors on the outcome criterion 'readmission'. Discussion of the 'support' findings will follow in section 1.4.

With respect to the independent variable 'number of previous hospitalizations', the non-significant differences that emerged between the readmitted and non-readmitted group of patients could reflect the relative low power of this particular test: working with data from a group of six patients compared with another group of thirty-two entails less power than were the two groups to be equal and greater in size (e.g., Sheridan, 1979). Unfortunately (somewhat self-evidently), there was no control over this form of influence.

Two differences, however, were found between the groups on the 'psychiatric' indicator variables, wherein (a) readmitted patients' average length of current hospital stay was greater compared with the non-readmitted patients, and (b) readmitted patients had spent significantly longer average lengths of stay in the ward as in-patients previous to the current admission compared with the patients not readmitted within the six-month study period. Although the first of these differences just failed to attain statistical significance both, however, do confer with previous research which has demonstrated an effect of "the past driving the present" (e.g., Anthony et al., 1978; Avison and Speechley, 1987; Goering et al., 1984; Strauss and Carpenter, 1984; Wynne et al., 1978).

The result was discussed with reference to the work of Seligman (1975) and Goldberg and Huxley (1980). Thus, any person (a) who has been helped in a psychiatric hospital and who has returned there, repeatedly, for further help; and (b) who requires more than one month in hospital to recover or simply to have a good rest (e.g., Wing, 1990), might become likely (c) to learn to think that such help is the only viable kind available: i.e., that it is their best - certainly until now most dependable - choice, and (d) more likely to be drawn to the hospital because they derive some satisfaction and/or compensation from being there. In this way, it becomes more likely that they will return to hospital for help when they feel they can't cope on their own without it: where the hospital, and what this means to a returning patient, becomes, one might say, the "secure base" (Bowlby, 1982). It suggests, too, that the former patient, through the course of repeated hospital readmissions, is becoming more and more dependent on this source of help and, "the more likely that his career will be that of a mental patient" (Gottesfeld, 1977) where otherwise s/he may be more resourceful or resilient. That is, s/he could, though not necessarily, become more likely to consider a return to hospital as "the only solution" to their current distress rather than consider any other form or source of coping (e.g., Folkman et al., 1986; Smith and Lazarus, 1990). Such continued return - the "revolving-door syndrome" (Goldman, Regier, and Taube, 1980) - would be expected where this "cognitive set", that is, where what's commonly known as "institutionalization" (e.g., Friedman, 1985; Goffman, 1961; Gottesfeld, 1977; Scull, 1977), a form of basic dependency, has become learned by the patient.

Goffman (1961), for instance, refers to the work of Schneider (1947) and Bushard (1957) in drawing out the meaning of this term. In their rehabilitation work with mentally unstable army recruits, they demonstrated that withdrawal from duties, and "any implication that the problem stems from remote or imponderable situations, is due to disease or is based upon considerations which are not immediate and amenable to mastery" (Bushard, 1957; cited by Goffman, 1961, p.311) can bring about isolation on the part of the sick person and "increasing confirmation of his being different". A little later in this chapter there will be a more detailed examination of some of the experiential consequences that this associated form of thinking - i.e., that believing oneself to be different from others - can have for the psychiatric patient: emotional consequences that are, it will be suggested, an intrinsic part of the related phenomenon "the past (e.g., behaviour) driving the present" (e.g., Avison and Speechley, 1987). Specifically, the concept of the **working model of self** (e.g., Bowlby, 1973, 1980, 1982, 1988) will be introduced and incorporated into a discussion which will be based upon the third wave of analyses of the results: the predictors and correlates of follow-up psychological symptomatology. These "working models", it will be seen, play an important mediating role between the person's actual interpersonal experiences and their impact on his/her coping ability and adjustment (Graves, Phil, Mead and Pearson, 1986; Hazan and Shaver, 1987; Kobak and Sceery, 1988; Main, Kaplan, and Cassidy, 1985; Sarason, Pierce, Shearin, Sarason, Waltze and Poppe, 1991).

In sum, the differences between the groups on the 'psychiatric history' indicators provide moderate support for the commonly identified effect of the "past driving the present". This effect can, it's believed, most reasonably be explained by recourse to the well-documented literature on the influence of dependency -inducing, institutional modes of care on the coping abilities of the patient (e.g., Goffman, 1961; Ramon, 1988). Although no specific evidence is available, it is also suggested that the patient's 'working model' of self will become increasingly refined through the course of repeated return to hospital for treatment and asylum. Such working models (e.g., Sarason et al., 1991) might conceivably account for the effect commonly known as “institutionalization" whereby the patient's “illness" grows “chronic": the patient becoming, in some cases inappropriately, dependent on the in-patient services for help and security of care whenever intolerable experience ensues. The working models of self of such formerly hospitalized psychiatric patients might be likely to consist of perceptions of one's differentness, incompetence, helplessness, and inadequacy when experiencing certain kinds of feeling and thought: feelings and thoughts which infringe upon and impede current behavioural functioning, constituting Goffman's proposed “closed system in need of servicing" (Goffman, 1961, p.328). This issue will receive greater attention a little later in the chapter.

1.2. SOCIAL DEMOGRAPHIC INDICATORS.

There were no significant differences between groups on these indicators. That five of the six patients who returned to hospital within the six month study period were single (not married) will, it's believed, merit more approriate discussion in the context of ‘close attachments' under the ‘social support' indicators section to follow. The result accords with some previous research which has uncovered an important, buffering influence of marital status on rehospitalization where it associates with ‘good' outcome (e.g., Sartorious et al., 1977).

1.3. STRESSFUL LIFE EVENTS.

The analysis of this form of influence revealed no significant differences between the two groups: (a) in the number and (b) in the objective stressfulness of life events encountered, nor (c) on any of the individual types of event such as ‘financial difficulties' or ‘separation events' - neither at discharge nor, unexpectedly, at follow-up.

One factor which was considered important in the interpretation of this somewhat unexpected finding was that the readmitted patients' experience of the stressful life events was within a significantly shorter period of time. The average length of stay in the community for this group was significantly lower than patients not eventually readmitted. That is, patients who got readmitted to hospital experienced greater accumulated severity in their life events but within a significantly shorter time-span. The **timing** of the events, then, could account for the different eventual outcome. That is, a succession of stressful events experienced within a significantly shorter period of time, rather than ‘staggered' over a longer period, might diminish the person's ability to safely negotiate and reorient themselves to such stressors: such negotiation and reorientation requiring more time than they were afforded.

It might also be that certain individuals more than others were more sensitive and vulnerable to the deleterious effects of any kind of subsequent life 'happening' (e.g., Brugha, 1991; Thoits, 1982). Thus, life events that are less objectively stressful - and perhaps seldom interpreted as such by most people - become interpreted in this way. Such interpretation (one might say apparently 'faulty interpretation') would imply that some form of 'coping threshold' has been exceeded. What follows is this: any kind of life 'happening' might be more likely to be considered "interruptive" (Mandler, 1983): disruptive of a person's anticipated daily life experience and considered unmanageable - incapable of being adapted to.

Another explanation for the findings was also suggested, namely, that the patients' **response** to the events could have been influenced by some other factor such as their social support experience or by the adjudged consensus of the events in their lives. These features will receive discussion in due course. In addition, however, the patients' response might also have been influenced by some other predisposing factor, perhaps unique to the person, a formal measure of which, unfortunately, was not obtained but which could nevertheless account for the differential response (such as "self-efficacy" - Bandura, 1977, alluded to in the last paragraph).

Another such factor referred to in the second chapter (section 2.5.3.) was the wider context (e.g., Weber, 1964) within which the event is embedded within any patient's life. That is, there was a specific acknowledgement of the importance of addressing and measuring the meaning of an event to the person experiencing it (e.g., Brown, 1989; Frijda, 1986; Mandler, 1983; Selye, 1956). Among these authors, Brown (1989) in particular has been most vehement in his criticism of measuring instruments which merely assess the gross number and severity of the life events with which people meet to the exclusion of measurement of the meaning of the events for the person experiencing them. The findings from this study's analysis would appear to be in support of this criticism where no significant differences between groups were found on any of the relatively crude, 'non-meaning' assessments obtained. The explanations that were suggested reveal little of the underlying influences which brought about the differential outcome - only that the experience of life events for readmitted patients was within a significantly shorter period of time following discharge compared with patients still living in the community at follow-up. In addition, it should be added that the average number and severity of the stressful events encountered by all patients, irrespective of outcome, was significantly higher than that observed among 'normal' community-based populations (e.g., Henderson et al., 1981). That is, following discharge back into the community patients resumed lives of exceptional adversity lending support to the original hypothesised association of life adversity with outcome (whether 'readmission' or, as will be seen, 'course of severity of psychological distress'). Further evidence for this hypothesis can be found in an earlier study of the factors predictive of rehospitalization in a chronic schizophrenic sample (Caton et al., 1985). These authors concluded that "stress is a key predictor of rehospitalization". The current findings do not, as they stand, lend themselves to much further interpretation - other than that suggested - as to the reasons why some patients returned to hospital whilst others did not.

However, a more open-ended and more detailed informal measure of each patient's experience of life events was obtained at both interviews. This information was obtained by adopting Brown's (1989) suggestions regarding the acquisition of more sensitive information about any person's life events. That is, efforts were made to approach each patient's account of their experience of life adversity thus: (a) to show curiosity about everything told, and (b) to respond as much as possible to what is said as a story. Brown (1989) continues:

> "This involves, for example, looking out for possible links between answers, although they may be far apart in the interview. Or, to give another example, a certain hesitation in a reply should be followed by another question along much the same lines if there is any hint that the respondent has something extra to impart. But, curiosity will often need a focus, and so the interviewer, as already noted, is encouraged to react to what is said as if it were a story. The decision to stop asking questions is then not so much settled by coming to the end of a list of standard questions, but by the feeling that the material makes sense or hangs together." (pp. 24-25).

This approach is undoubtedly open to criticism, particularly in respect of the reliability of measurements. However, its use has led to the accumulation of detailed findings which have uncovered subtle features of people's experience of life adversity which subsequent investigators can follow up on, albeit with more adequately tested measuring instruments. Brown, Adler, and Bifulco (1988), for example, in their study of the life events and difficulties associated with recovery among a chronically-depressed sample of women identified two kinds of event that affected recovery. The first was a reduction in an ongoing difficulty of any kind. The other was a fresh start of some kind: any event or decision that helped the woman feel more hopeful about a better future. A complementary study by Oatley and Perring (1991) investigated the psychological and social factors affecting recovery from psychiatric breakdowns among persons of recent onset of psychiatric problems. They found that "chronicity" - whether or not symptoms of recent onset continued to be experienced six months later - was best predicted by (a) the experience of having plans for the future which did not work out; (b) internal, stable and global attributions about the events considered to have been the cause of certain psychological symptoms; and (c) the persistence of on-going difficulties.

Given the significantly more severe experience of symptoms of psychological distress among readmitted patients compared with patients still living in the community (chapter four, section 2.3.), the two studies mentioned suggest the occurrence of several types of life event experienced by patients who returned to hospital within the six months' follow-up. Thus, readmitted patients might be: (a) unlikely to have experienced any kind of reduction in on-going difficulties - rather, these are likely to have persisted; (b) unlikely to have made a fresh start of some kind (although this hypothesis will be put to a more appropriate test in section two of this chapter in which the life events of patients whose symptoms of distress improved after discharge will be examined); and (c) likely to have experienced the 'fall-through' of any one plan following initial assessment.

Although it was not feasible (since highly exhaustive of space and time!) to compare each readmitted patient's more detailed experience of life events with each patient not similarly readmitted, an examination of the six readmitted patients' on-going difficulties and life events was nonetheless made with refererence to the above classificatory system. Full details of each readmitted patient's on-going difficulties and 'happenings' (Oatley and Perring, 1991), together with 'symptomatically recovered' patients' events, are reproduced in appendix C.

This informal analysis of the patients' life events and difficulties by the author and two departmental colleagues revealed the following:

Readmitted patients': (1) persistent difficulties.

All of the patients readmitted within the six month period continued to experience difficulties which had been identified at the first - discharge - assessment. For some, these persisting difficulties overlap with the experience of plans which have gone wrong. The patient 'Thomas', for example, was already disappointed at discharge when he was informed by the hospital's resident Social Worker that efforts to secure him new accommodation had been unsuccessful. On discharge he returned to the flat from whence admitted almost one year previously. This flat Thomas described as "damp and filthy" - a place that had poor associations in his memory: a place to which he would return exhausted from a long day's work and where he would sit on his own and drink himself into a stupor that was both sedating and "unlock(ed) my mind into a new way of seeing things". The prospect of returning there had, at the initial assessment, filled Thomas with immense perturbation and dismay. That he went back to live there following discharge after continued pressure on the social work department (on Thomas' as well as the ward manager's part) to find him alternative accommodation represented not just the persistence of a difficulty, but also the disappointment, even at discharge, of one of his plans, indeed a plan which would have entailed making something of "a fresh start".

For many of the patients who were readmitted the nature of the persistent difficulty was interpersonal - involving people to whom they were or had been close. 'John', for example, was a young 22 year-old patient who had received a diagnosis of paranoid schizophrenia on his return to hospital and who had overheard this classification. He expressed great concern to me that he was being labelled thus: that "It wasn't fair. They don't understand things at all!! It's not me - it's my family: that's the problem". The account given by John of the difficulties and events which precipitated his successive admissions confirms their source: his family and their modes of interaction and communication. However, there appears to be a basic element of distrust and suspicion among all family members - the foundations of which are suggested by their actions together.

Another patient, 'David', had been 'kicked out' of his flat for refusing to go along with the house rules. He would return 'stoned' or inebriated late at night and create a disturbance. Otherwise, during the day, he would 'play' his guitar (which is to say 'madly twang the strings and sing a bit'!) and get on the nerves of the other people living in the Social Work accommodation. That he attacked a visiting Social Worker and currently faces charges of assault was reflected in his removal from the flat. There was a period of just four days between leaving the flat and returning to the hospital. His first admission to the ward had also been part predicated by being homeless: as a result he'd wander the streets, frequenting pubs, 'getting stoned' and becoming known to the police who would not infrequently stop and question him.

Thomas' estrangement from his family continued. He and his sisters have been out of touch since Thomas criticised one of his sister's daughters as being "a little ugly terror: and I'm not going to take it back, for that's just what she is."

The full details of these on-going difficulties are reproduced in appendix C. Suffice to say that <u>all</u> patients who were readmitted within the six month period were found to have experienced "chronic" difficulties that persisted from the period preceding first admission through follow-up in the community.

Readmitted patients': (2) fresh starts.

The 'fresh start' is defined as "a new event or decision that gave the person some cause for hope that the future might become better" (Brown et al., 1988). The informal analysis identified just the one patient who could be considered to have met this criterion - patient Elizabeth. (Although two of the patients had intended to begin or had actually begun something 'new', their disappointment or 'fall-through' qualifies them in the third category of event: 'plans that had fallen through'.)

At the discharge assessment, Elizabeth had resolved to get involved once more in her formerly active life, (a) as a Girl Guide administrator, and (b) as a Salvation Army volunteer. This she managed, at first, resuming her former activities with enthusiasm. However, within three months of discharge she had become increasingly tense, moody, and depressed. The death of her close friend - now three months in the past - continued to preoccupy her thoughts. The attitude of her parents - who she sees each weekend - continued to rattle her: "They tell me to 'pull myself together'; 'to get on with it' But I just can't. It makes me feel so helpless. It really upsets me." There was evidence in this of an element of 'overstimulation' (e.g., Dohrenwend and Egri, 1981; Wing and Brown, 1970) - through an increase, after discharge, in her voluntary activities. And evidence, too, of the element 'overcriticism' (e.g., Leff and Vaughn, 1985) - by her parents, and by <u>herself</u>: (a) where she blamed herself for her (unknown) involvement in her friend's death; and (b) for being unable 'to pull herself together and get on with it'. Whatever the 'cause' - which, in the research domain of life events and schizophrenia, is "more speculative. . neither obvious nor straightforward" (Day, 1989) - the third event which perhaps best predicted Elizabeth's return to hospital was the onset of greatly feared thoughts: 'voices' which 'told' Elizabeth she was 'an evil woman and that she must kill herself' (exactly the judgement and demand made by the other schizophrenic patient Sarah's 'voice'). Incidentally, these three elements, which together provide a plausible account of the determinants of Elizabeth's relapse, are remarkably similar (identical even) to the three elements identified by Dohrenwend and Egri (1981) that are considered to play a primary aetiological role in the development of schizophrenic disorders. These are, (a) the death of comrades; (b) the threat of severe physical harm to the subject; and (c) the disruption of social supports. The result supports the evidence for a contributory effect of critical and negative 'overstimulation' on schizophrenic florid symptom relapse. Patient Elizabeth's 'fresh start' was itself a disappointment by time of readmission: a plan that had fallen through.

Readmitted patients': (3) plans that had fallen through.

Excluding Elizabeth, who does, however, have a legitimate claim to be included in this category, a further three of the six patients underwent the disappointment of witnessing the fall-through of their plans. The fall-through of Thomas' plans for alternative accommodation and the dissolution of David's new 'home occupier' status - the offer of the flat having been arranged to allow David to move there on discharge - have received sufficient attention. Another young male patient, John, had also been through the experience of homelessness, having been kicked out of his home by his father after he'd admitted to having stolen his mother's jewellery to finance his drug habit. At discharge assessment he told me that his sister, living in Wiltshire, had asked him if he'd like to go and stay with her. Intending to get away from the family (which he saw as his problem; which he said he'd have to kill 'to get out') this plan, however, fell through when his sister announced that she was, instead, coming back to live in Glasgow. The persistent problems continued - criticism from his father, overconcern on his mother's part, and bullying by his older brother, each of which adding to John's unpredictability - eventually helping to bring about John's second admission to the ward.

The analysis of these events serves merely to supplement the information obtained through the use of the formal, questionnaire measure - the List of Recent Experiences (Henderson et al., 1980): no claims are made that it should supercede such information. This supplementary information was merely observational and less scientifically-precise in its measurement. These qualifications aside, the information does, however, help suggest the association, (a) of certain types of event, and (b) of persisting difficulties that become chronic (or which are already chronic) with the outcome, hospital readmission. A more appropriate analysis would compare the nature of these difficulties for patients who were readmitted within the six month follow-up period with those patients who were not. The current description of events and difficulties is thus more suggestive than certain, presented with the intention of contributing to the discussion about the impact of stressful life events on patient rehospitalization. In this respect the findings are more in support of Oatley and Perring's (1991) investigation of the factors contributing to symptom chronicity. The test of the findings of Brown et al. (1988) will be more appropriately carried out where the subjects are those patients who have undergone 'symptomatic recovery' through the period of follow-up.

1.4. SOCIAL SUPPORT.

Detailed discussion of each of the six components of 'social support' was made in the relevant sections of the fourth chapter. Adopting Brown's (1989) definition of the term 'social support' as 'a label for something which has many components' the 'something' was defined as 'The feeling and knowledge that a person has of being stable and secure and thus less alone and separate' (from Boyce, 1985; Fromm, 1957/1988).

Through an extensive review of the literature on 'social support' several components of this definition of 'social support' were identified (see chapter two, section 4.4.2.). However, no significant differences between the two groups were found on any of the following 'components': (a) actual support received; (b) availability of attachments (as measured by the 'AVAT' construct of the ISSI); (c) availability of social integration; (d) adequacy of close attachments (as measured by the 'ADAT%' construct of the ISSI); (e) pleasurable social contact; and (f) adequacy of social integration.

Rather, what was most notable about the distributions of components for both groups of patient - whether they were readmitted to hospital within the six months or not - was their congregation toward the lower ends of each of the components' scales. That is, the patients in the sample, almost regardless of outcome, were found to be extremely poorly supported:

(i) They received little 'actual' support - whether 'emotional' or 'material' forms.

(ii) They had significantly fewer available close and more diffuse attachments compared with a community sample (that included both 'anxiety-state' and 'depressed' subjects - Henderson et al., 1981).

(iii) They were characterized by marked social withdrawal, engaging in pleasurable contact with family and friends no more than once or twice per month on average.

(iv) They perceived themselves as lacking in several provisions of interpersonal support: having a poor sense of belonging, having few people available to whom they could confide problems, and unlikely to gain a positive sense of themselves through comparison with others.

(v) One might say as a consequence (given that the 'something' was hypothesized as 'the feeling of being secure and safe through being with others and so less alone and separate') they were uniformly dissatisfied with their close and 'socially integrative' attachments - scoring, on average, no more than 53% on the measures.

Where the aim of the study is a straightforward investigation of the nature of the 'social support' experience of a formerly hospitalized psychiatric population, the results of the many analyses are highly informative, supportive of previous research that has examined or reviewed the question (e.g., Brugha, 1991; Cohen and Sokolovsky, 1978; Froland et al., 1979; Ganster and Victor, 1988; Leavy, 1983; Mueller, 1980; Paykel, 1985; Tolsdorf, 1976; Turner, 1979, 1981). Brugha (1991), for example, concludes his review of support and personal relationships thus: "Perceived numerical and qualitative deficiencies in close personal relationships are now well-established associations of non-psychotic disorders, and. . with certain qualifications, the same conclusion can be drawn in relation to functional psychotic disorders." (p.149).

Where the aim, however, was to identify the sources of support that are predictive of or which associate with a patient's return to hospital the results are notably less informative than expected. It could be suggested that the measures themselves were of less anticipated precision and sensitivity. Judgement on this issue, however, is considered more appropriately reserved until further discussion of the second- and third-wave analyses has been made. For example, whilst *significant* differences between groups were few the differences were nonetheless many: most of which were in the expected direction, with less overall 'social support' observed among readmitted patients. It should be kept in mind that just six of the thirty-eight patients had been readmitted to the hospital's assessment ward at the end of the six-month follow-up period. A much greater number in this group relative to the size of the group of patients still living in the community would have increased the power and reliability of any test of these differences (e.g., Sheridan, 1979).

Several authors (e.g., Barrera, 1986; House and Kahn, 1985; Reis, 1984) have emphasised the critical importance of the simple existence of personal relationships for well-being. House and Kahn (1985), for instance, make the rather obvious observation that without the <u>means</u> by which support can be conferred there can be no support: "The existence or quantity of social relationships is a <u>necessary condition</u> for, and hence partial determinant of, both the network structure of those relationships and their functional content or qualities" (p.85). That the patients in the sample are characterized by uniformly low or poor rates across the entire spectrum of support components is in accord with the findings obtained regarding the support component 'mere existence' or 'availability' of these "contents or qualities". Thus, the significantly low levels, (a) of availability of close attachments, and (b) of 'social integration' observed among all patients in the sample - regardless of outcome status - can be viewed as a handicap against the receipt of the 'existentially-securing' resources (e.g., Thoits, 1985) considered so fundamental to emotional well-being (e.g., Cobb, 1976; Barrera, 1981; Cohen and Wills, 1985; Gottlieb, 1981; Reis, 1984; Rook, 1985; Parry, 1988; Weiss, 1974).

Weiss (1974), in this respect, contends that personal relationships are of critical importance for emotional health and well-being for the following reasons. The more psychologically healthy person will be s/he who is able to preempt the conditions of, (a) emotional loneliness, and (b) social loneliness. The former condition is preempted where there is, in the individual's life, someone with whom s/he can confide intimate feeling and with whom there exists a bond of mutual dependence grounded in a feeling of security and a sense of permanence about this bond (Weiss, 1974). In chapter one, empirical research was presented that demonstrated the buffering and main effects of this form of close, confiding relationship on emotional well-being, mainly depression (e.g., Brown and Harris, 1978; Brown et al., 1986, 1988; Roy, 1978, 1981b; Leavy, 1983; Surtees, 1980).

'Social loneliness', on the other hand, is preempted where the individual is known to a number of other, non close-attachment individuals in relationships that are characterized more by friendship than by mere acquaintance. Other terms used in this context are 'social integration' (e.g., Durkheim, 1897/1951; Henderson et al., 1981; Rook, 1985) or 'social embeddedness' (e.g., Barrera, 1986): conditions, where they are absent, that help give rise to 'social loneliness' or, where present, to 'a psychological sense of community' (Sarason, 1974). In chapter one, evidence from empirical investigations of these hypotheses was presented that was clear in its support - particularly with reference to chronically-disabled psychiatric populations (e.g., Froland et al., 1979; Brugha, 1991; Grusky, Tierney, Manderscheid and Grusky, 1985; Harris, Bergman and Bachrach, 1986; Sultan and Johnson, 1985; Turner, 1979, 1981).

Patients in the current sample - regardless of outcome - were markedly deficient in both these basic types of 'social support': the mere 'existence' or 'quantity' features of support from which true helping can be sought. On a general, 'exploratory' level, this deficiency is not surprising - indeed was quite expected: for example, Isele, Merz, Malzachen and Augst (1985) in their review of the literature on social functioning and psychiatric disorders make the point that major deficits in social role performance are "an integral part of their clinical condition".

However, the central question that is addressed by this study seeks to examine the sources of support, if any, among recently discharged 'brief stay' psychiatric patients that associate more strongly with hospital readmission or, with its 'necessary condition' (Caton et al., 1985) - symptomatic deterioration. In this respect, with the outcome as readmission, one major finding did emerge: patients who returned to hospital within the six month follow-up period were significantly less likely to have a close attachment relation *of any kind* in their life (neither close attachment partner nor close attachment figure) compared with patients still living in their homes in the community. As a result, the functional provisions that such relations offer were slightly fewer in number among the readmitted group as defined by the four support components measured by the ISEL (Cohen et al., 1985). For example, differences were found between the two groups on these support provisions such that non-readmitted patients perceived greater levels of (a) 'tangible support', (b) 'appraisal support' - the perceived availability of someone to confide in and with whom to share problems, and (c) 'belonging support' - the perceived availability of companionship. Both groups scored particularly poorly on the fourth 'provision' - the 'likelihood of making a positive comparison when comparing themselves with others'. That is, the sample as a whole was characterized by deficiencies in the ability to make a positive 'social comparison' (e.g., Festinger, 1954). It is notable that previous research has uncovered a strong relationship between the ability to compare oneself favourably with others and the appraisal of and response to stressful situations (e.g., Goethals, 1986; Suls and Miller, 1977; Taylor, 1985). The role that such 'social comparison' processes play in the community adjustment of routinely discharged psychiatric patients will be explored more fully in the third section of this general discussion where the subject will be the regression analyses carried out in chapter six.

Bowlby (e.g., 1982; 1988a), among many others, in emphasising the critical importance of close attachment relations in personality development, asserts that, “intimate emotional bonds between individuals are of primary status and biological function, the making and maintaining of which are postulated to be controlled by a cybernetic system situated within the central nervous system, utilizing working models of self and attachment figure in relationship with each other" (1988a, p.120). A principal feature of intimate relationships throughout life is, he continues (Bowlby, 1988a) their “emotionally mediated communication". For these reasons, many have become aware that a person's mental (or emotional) state is “deeply influenced by whether his or her intimate personal relationships are warm and harmonious or tense, angry, anxious, emotionally remote, or, possibly, non-existent" (Bowlby, 1988b). With this rich, conceptual framework in mind, the results of the current analysis almost require little further explanation. Thus, amongst this highly-filtered sample (Goldberg and Huxley, 1980) - former patients of a “brief stay' psychiatric ward - only fifteen of the thirty-eight patients were found to be involved in an on-going, close attachment relationship with a member of the opposite sex: a feature that could conceivably be another “integral part of their clinical condition" (Isele et al., 1985). However, of the six patients who were readmitted, the attachment relations (of any kind) of four of them were “non-existent" - where there was no attachment partner (husband, wife or long-term partner) and no attachment figure (no best friend, sibling, or the like). If this factor has a critical role to play in patient rehospitalization it would suggest that the five patients (from thirty-two) who had not been readmitted by the six-month follow-up period are at a particular high risk of eventual readmission.** This is not to suggest that not being in a close attachment relationship of any kind for the patients was especially likely to bring about hospital readmission, merely that a strong association between the two was found. Thus, former patients of the ‘brief stay' ward who know no ‘attachment persons' of any kind on whom they can depend for emotional and material support are at greater risk of subsequent return to the hospital under conditions of life adversity.

Of particular interest to this discussion is the study by Brewin, MacCarthy, and Furnham (1989) which examined the hypothesis that individuals' perceptions and use of the social support available to them when negative outcomes occur are influenced by their cognitive appraisal of these outcomes. These authors found that social withdrawal (among college students) following a stressful experience was related to appraisals involving low consensus, global attributions, and blame directed at personal inadequacy. Brewin et al. (1989) propose that where these negative outcomes are considered to be due to the person's own inadequacy, or to be

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** - **NOTE:**

As of 14 02 92: of a further eight patients who were subsequently readmitted to the ward by **12 months** following original discharge (giving a 12-month recidivism rate of around 40%) **four** of these patients had no attachment relation of any kind - neither attachment *partner* nor attachment *figure*.

unlikely to have been experienced by others, that such a person will (a) "probably experience shame or guilt"; and (b) when experiencing such "unpleasant emotions . . will . . either . . keep the information to themselves or . . share it *only with trusted confidants, where these are available*" (p.368; own italics). The obvious point to make here is that where no trusted confidants are available - which they were not, by and large, among readmitted patients - the only alternative would appear to be to keep such information (feelings of inadequacy, guilt and shame) to themselves. Withdrawing from the contact of others, in this way, on the basis of such feelings is likely to take its toll on the person concerned. Brewin et al. (1989) found that such persons continued to seek information and emotional support from **close, trusted confidants**: only did such appraisal inhibit social mixing (the integration/companionship components of support).

Drawing on these findings in the interpretation of the current ones, it would follow that patients in the sample, engaging in little contact with other people (neither friends nor family: being poorly 'socially integrated'), would rely on the support of their close and trusted ones to see themselves through the extreme life adversity in which they found themselves. Where no trusted confidant was available in whom such feelings could be confided the patient was then at particular risk of getting readmitted to the hospital. Extended discussion of this potentially informative paradigm linking social withdrawal and psychological distress with certain types of feeling and social support will continue in the third section of the general discussion.

Recent work by Sarason et al. (1991) which has examined the relationship between perceived support and 'working models' of self and others appears supportive of these conclusions. Briefly, they found that individuals who perceive *high levels of support* to be available to them if needed and who are satisfied with this support also perceive themselves to have many positive and few negative attributes. Individuals, on the other hand, who perceive *low levels of support* - characterizing, in effect, the patients in this study - are more likely to be experiencing feelings of personal inadequacy, anxiety, and social rejection. Sarason et al. (1991) propose that "the association between self-perceptions and perceived social support makes intuitive sense because individuals who do not feel good about themselves have little reason to believe that others are going to take an interest in them" (p.284). It is little surprise, then, that such uniformly low levels of perceived support were found among the patients currently under investigation. In particular, however, the lowest levels of perceived support (approaching significance on the 'belonging' and 'appraisal' components; reaching significance on the 'tangible') were among the readmitted group of patients. In their argument, Sarason et al. (1991) conclude that "not only are these individuals plagued by feelings of personal inadequacy, they are also forced to face life's challenges without the perceived support and encouragement of others".

These conditions that associate with low levels of perceived support appear to be fundamental ones in the lives of the patients routinely discharged from the 'brief stay' psychiatric ward. To them should be added the state of "self-imposed isolation" (Brewin et al., 1989): a process of self-stigmatization in the absence of actual, direct (but nevertheless 'perceived') rejection by 'other people' - i.e., by "society" (p.368). In this way, the withdrawal that takes place as a consequence of the patient's feelings of shame, guilt, lack of support, adverse life circumstances and felt inadequacy can be considered an act of <u>defense</u> against "negative reactions by others that may never materialize, or that may materialize far less often than they envisage." Such elements of defense or retreat have been found among alcoholic samples (e.g., Cahalan, 1970) where the intention is the avoidance of critical attitudes that allow the alcoholic, in turn, to retain or regain a more **positive** (less negative) **current sense of themselves**: a construct on which many researchers have begun to find agreement in its contemporary definition 'working model of self' (e.g., Bowlby, 1973, 1980, 1982, 1988; Sarason et al., 1991; Sroufe and Fleeson, 1986). The point most worthy of note is that **the person's actions with others are influenced by the person's current self-perceptions**: his or her working models of self and of others which influence the "development, functioning and perceptions of relationships in adulthood" (Sarason et al., 1991). Where this 'working model' consists of perceptions of one's <u>lack</u> of supportive provisions in relationships - which Sarason et al. (1991) found to be accompanied by feelings of anxiety, personal inadequacy and social rejection - together with the 'powerful emotions' (Brewin et al., 1989) guilt and shame, and the knowledge that one has few people in whom to confide one's feelings *then it is hardly surprising to find the comparatively high levels of social isolation and psychological distress among this sample.* Social withdrawal may be an attempt to avoid critical attitudes and the feelings that follow interaction with other people considered better able "to cope with the basic requirements presented by life" (Smail, 1984; p.7). A logical step to take, given the considerable life duress under which such people find themselves, would be to return to hospital where the help and treatment provided offers a valuable "haven of refuge" (Wing, 1990).

Finally in this section, from a practical point of view, the findings that have just been discussed - where there is little presence of close attachments in the lives of the rehospitalized patients - would most constructively be incorporated by relevant ward staff when the decisions about any individual's prospective discharge from the ward are being considered. Detailed discussion of this issue was made in the fourth chapter (section four). Where the patient is considered better placed back in his/her home from whence admitted routine follow-up, where appropriate, of patients known to be on their own, without anyone in whom to confide, would seem most appropriate. Further suggestions for the on-going treatment and rehabilitation of newly discharged psychiatric patients adopting knowledge from the 'social support-life stress-mental health' domain will be made a little later in the chapter.

1.5. 'POWERFUL EMOTION' - SHAME, GUILT, SELF-BLAME; and EXISTENTIAL ISOLATION.

There was insufficient data about the construed measures of shame and guilt to enable any reliable analysis of these constructs. A more appropriate discussion of these experiences will be provided in the second and third major sections of this general discussion. Appropriate discussion of the results of the analysis of the patients' ‘consensus judgements' and ‘self-blame' is considered adequately met in the relevant section of the fourth chapter (section five). These analyses uncovered few significant differences between the two groups. Where differences were observed, they were in the expected direction: readmitted patients being consistently more ashamed, guilty and self-blaming of (i) their feelings, (ii) their current condition and (iii) the problems they feel they have caused others compared with the group of patients still living at home. In each, the power of the test of each datum is reduced quite substantially by the markedly small number of subjects in the readmitted group.

2. FACTORS THAT ASSOCIATE WITH OUTCOME “SEVERITY OF SYMPTOMS OF PSYCHOLOGICAL DISTRESS": THE RESULTS OF THE SECOND WAVE OF ANALYSES.

The main purpose of this section will be to address the second question adumbrated in the opening summary, namely, “In ‘postponing' or ‘precipitating' rehospitalization: what sources of stress and support associate with *symptomatic* recovery or relapse?" - a ‘necessary condition' for rehospitalization (Caton et al., 1985).

2.1. PSYCHIATRIC INDICATORS.

Whilst few significant differences between groups were observed - between symptomatically ‘same', ‘better' and ‘worse' groups - those differences that did emerge were in the expected direction. Patients whose symptoms of psychological distress had substantially recovered by follow-up were found to have, on average, the lowest number of years previous contact with psychiatric care, the lowest number of previous in-patient admissions, and the significantly lengthiest average tenure in the community between these admissions. As expected, the distributions of psychiatric indicators among those patients whose symptoms of distress had grown significantly more severe through follow-up (the ‘worse' group) were the exact reverse.

This offers further support, then, for the widely-proposed and empirically-substantiated “past drives the present" phenomenon (e.g., Goering et al., 1984; Strauss and Carpenter, 1984, among others) such that the more often someone is taken into the care of a psychiatric hospital when their experience of distress is severe, the more likely that they will return to receive this care when the appropriate experiential conditions reemerge. Somewhat detailed discussion of some of the possible reasons for this effect has already been made. The remainder of the discussion will centre upon the features of the patients' social, interpersonal and emotional experience which might reasonably lead them (a) to view themselves as being somewhat different from other people and, as a consequence, (b) to become more socially-isolated (Brewin et al., 1989; Bushard, 1957; Sarason et al., 1991). This often “self-imposed isolation" or “self-stigmatization" (Brewin et al., 1989) conceivably 'interacts' with - and may be a consequence of - certain types of emotional experience, stressful living conditions and deficient, inadequate, or inappropriate 'social support' and might thus render less tolerable these conditions, more severe their experience of psychological distress and more likely a return to the hospital for basic help and support.

2.2. SOCIAL DEMOGRAPHIC INDICATORS.

No notable patterns in the distributions of these sources were discernible other than the fact that six of the eight patients whose symptoms of distress recovered during follow-up were female. Whether or not there is any significance to this observation will be uncovered in the remainder of the discussion.

2.3. EXPERIENCES OF SPECIFIC TYPES OF PSYCHOLOGICAL DISTRESS.

That no significant differences were found between the groups in their experience of specific types of psychological distress at discharge provides support for the results of previous research which has found no relation between the initial measurement of *specific* symptoms and likelihood of rehospitalization (e.g., Caton et al., 1985; Goldstein and Caton, 1983). However, this is not to suggest that there is no association between prior experience of global distress and any later assessment: indeed, the consistently most significant predictor of follow-up global distress was previous global distress - a finding that receives wide support elsewhere (e.g., Clum, 1978; Depue and Monroe, 1986; Mintz, 1976; Thoits, 1982; Williams, 1981).

Rather, what appears to be of critical importance for the patient's ability to tolerate his or her symptomatic experience is whether or not these comparatively undifferentiated symptoms of distress (at discharge) deteriorate to the degree that there emerges an experience of paranoic and psychotic distress. Patients who had become significantly more severely distressed following discharge could be distinguished from both 'same' and 'better' groups of patient by their significantly more pronounced experience of symptoms of a paranoic and psychotic nature. This particular finding provides support for the 'hierarchical classification of personal illness' proposed by Foulds (1964, 65). In this system four classes of personal illness are proposed, ordered by increasing degrees of adverse change in the person. Briefly, they are, (a) dysthmic states: denoting *disturbance*; (b) neurotic symptoms: denoting *dissonance*; (c) integrated delusions: denoting *distortion*; and (d) delusions of disintegration: denoting *disintegration.* The latter two classes consist of paranoid, persecutory forms of thought and predominantly psychotic forms of thought: forms solely characteristic of those patients who were readmitted to the ward and of those whose symptoms underwent marked deterioration through the course of the six month tenure in the community. As the Foulds model predicts that a person with symptoms at any class level will necessarily have symptoms at all the lower levels, the theoretical classification receives greatest support in this respect from the current findings. For this would account for the non-significant differences between the 'worse' and 'same' groups at the lower classes of symptom - the neurotic symptoms and dysthmic states: both groups sharing such experiences but diverging on the more severe symptoms found in the class further up the hierarchy. The group of patients whose symptoms had sufficiently recovered - relative to the other two groups - would appear to support a conception that views them as having "moved furthest down the hierarchy of classes" (Foulds and Bedford, 1975), experiencing no more than basic 'dysthmic states'.

The practical relevance of the findings received considerable attention in the second section of the fifth chapter. The most obvious practical suggestion would be to advise the staff involved in both the discharge decision-making process and in providing care in the community of the particularly heightened risk of rehospitalization for those patients whose symptom experience is characterized by or involves elements of such self-destructive modes of thought. To these forms of thought should be added the four attitudes measured by the Beck Depression Inventory (Beck et al., 1979) which significantly distinguished the 'deteriorated' group from the others. These were, self-condemnation for their condition; feeling suicidal (a critical factor in rehospitalization); having greater difficulty making decisions and finding work more of an effort. In terms of a 'clinical picture', the characteristic experience of the deteriorated patient appears to be one of self- and other-alienation: not 'merely' the experience of anxiety, somatic states, sensitivity, obsessive behaviour and social withdrawal but marked self-destructive ways of thinking about themselves and marked fear of other people and of their own loss of 'personhood' or sense of themselves.

At a later stage in this discussion some of the reasons for these patients' extreme sense of alienation will be examined. Whilst no attempt will be made to 'condone' the experiences of such patients, nevertheless, it will be seen that such alienation and loss of, one might say, "personhood" (Foulds, 1964, 1965) are experiences whose conditions can be understood, indeed are experiences themselves, which, in their own way, can also be understood as the reasonable consequence of such conditions. This discussion will, then, reiterate Smail's (1987) position, one arrived at through his many years' clinical experience which states that, "feeling and acting are far from being matters of will, but are, as it were, held in place by the situation in which people find themselves. On the other hand, this does not mean that we are free to do what we like or to feel what we want or think we ought to feel. We act and feel rationally according to our circumstances, and indeed our interests. To say that we act rationally is not to say that we act necessarily correctly or sensibly, but simply that we have reasons for what we do which follow from our experience of the world and our bodily relation to it" (Smail, 1987, p.75). These will be explored a little later in the discussion.

2.4. STRESSFUL LIFE EVENTS.

The distribution of stressful life events across the three groups was in the expected direction - the most severely psychologically distressed at follow-up were those who experienced the greatest 'objective' life adversity, and so on. There was, then, a moderate to strong association between psychological symptoms and life adversity with patients whose symptoms had 'improved' by follow-up evidencing the most significant decrease in the objective stressfulness of their life circumstances. This accords with previous research : e.g., Paykel and Dowlatshahi (1988) in their review of life events and mental disorder conclude that "those events which are more generally stressful are also more likely to produce disorder." (p. 257).

Although the comparisons between initial and follow-up assessments of life events were evidently skewed toward uncovering such differences (where the first assessment covers a 12 month period preceding first admission whereas the second covers just the six months following discharge) nonetheless the size of the fall in objective severity for the 'better' group was the most marked and significant. This simple distribution of events' severity across the three groups lends further support to the view that the experience of psychological distress is necessarily conditioned by the experience of life adversity (e.g., Brown and Harris, 1989, pp.439-440; Caton et al., 1985; Mandler, 1983; Smail, 1984; 1987) and that patients who experience negative events prior to previous admission and discharge are more likely to experience new negative events (which often reflect or produce chronic stressors) during the period following treatment (Moos, 1990).

Some of the reasons for this difference were discussed (and are considered adequately met) in the relevant section of the fifth chapter. What was most noticeable about this finding was the ensuing absence of significant differences among the groups in their experience of particular types of life event. However, the one category of event which was able to distinguish among the groups was that of "chronic events": that is, events which persist for at least one month or more. Thus, patients whose symptoms had significantly improved following discharge were found to have experienced fewer objectively severe events that were less longer-lasting (or 'on-going') compared with the other two groups. These two findings, taken together, are similar to the types of life events that Brown et al. (1988) found among 'recovered' chronically-depressed women. These authors also identified one other type of event that associated with recovery (and referred to earlier in the discussion), namely, the experience of a '*fresh start*' of some kind: any event that gave the woman cause to feel more hopeful about the future. Thus, where the woman experienced a reduction in any on-going difficulty and, moreover, where she had made a 'fresh start' of some kind the likelihood of recovery taking place in her experience of depressive symptoms was significantly increased. What the current findings suggest is that patients whose symptoms improved through the six-month 'tenure' in the community experienced similar reductions in their on-going difficulties - in direct opposition to symptomatically 'worse' patients whose chronic difficulties continued without apparent 'let-up'. That 'recovered' patients also made fresh starts of some kind or another (leading them to feel more hopeful about the future) is suggested by the significant drop in the total severity of the events encountered from pre-admission through post-discharge follow-up. The following informal analysis of these patients' life events (from extensive notes taken during interview) will seek to identify the existence of 'fresh starts' - that is, of events which brought hope to these 'recovered' patients.

Such ‘starts' were markedly absent from the lives of patients who were readmitted to the hospital.

Symptomatically ‘recovered' patients': fresh starts.

Among the eight patients whose symptoms had significantly improved by follow-up, six had made or were making a fresh start of some kind. However, for some patients these ‘starts' represented not just something which gave them ‘cause for hope of a better future' but were events whose consequences might also yield equal measure of uncertainty, threat and disappointment. The contextual details of these events and difficulties can be found in appendix C.

Many patients had made a ‘fresh start'. The most visible of these was made by patient ‘Joan'. She told me she had ‘come to terms' with the death of her husband - an alcoholic who would regularly return home from work drunk and violent toward Joan. His death, she said, had meant that an end had been put to this violent, ceaselessly quarrelsome period in her life. As a result, her daughters, who had been estranged from their father, have begun to spend more time with Joan, talking about their feelings toward their father who had been so immensely feared and hated. Other members of her family had also resumed contact giving Joan a sense of having ‘come back to herself'. Added to this period of ‘conflict-resolution' and coming to terms with a new life without the guaranteed fear and violence was a six-week vacation in Canada! Whilst over there, Joan had made some plans (a) to continue to see her daughters on a regular basis, even to stay with one of them from time to time which was a good, secure promise of respite from being on her own (the offer having been made before she left Scotland), and (b) to devote more time to her ‘flower-arranging' hobby, a talent that others had noticed and encouraged. At time of interview, Joan's financial status was also much more secure than it had ever been thanks to the insurance money she had inherited on her husband's death.

A ‘fresh start' of another kind was made by patient ‘Alison', one which overlaps with the other factor identified by Brown et al. (1988) - ‘the reduction of a persistent difficulty'. At time of interview she was about to move into a flat of her own. This had been arranged by the social work department. Previously she had left home “in order to escape from" the people she knows - particularly her parents with whom she has been in consistent conflict ever since she was a child, at school, where she had been the victim of cruel verbal taunts from other children about her English accent (corroborated by her father who said that he believed his children to be “ashamed of their nationality"). Several underlying tensions between the three - mother, father and daughter - remain unresolved. The impending move to a place of her own, where she will “be able to invite round whoever I want", was something that gave Alison both cause for some hope (for this was a ‘fresh start' of a kind) yet too some cause for concern - “I'm a bit panicky about it all. The last time I left home I went to the Women's Aid and stayed there for quite a bit. But I ended up in Gartnavel after getting upset". In this respect, it was fortunate that it was to a sheltered housing complex run by the local social work department that

Alison was headed. There she would receive important back-up should this be needed.

Among the other 'fresh starts' made by the other four patients was a new job for patient 'Scott' (aged 22), one which gave him "some money in (his) pocket" and a "sense of self-respect" following the break-up with his girlfriend, loss of his former job and hospital admission. In hospital he had "learnt a lesson - that I just can't take things for granted". Whilst there he had spoken to two other patients, "talking about things that I'd been needing to for a while; needing some advice about how to get over things. The experience of being there. . seeing that others have problems much worse than you. . . I've got a sense of purpose again". Two other patients had been on long vacations to the United States (patients 'Elizabeth II' and 'Clare'). Another, a young male diagnosed as schizophrenic (patient 'Derek'), had begun to get out of the house much more, going along to a Drop-In centre twice per week and doing a couple of hours gardening per week in the hospital's garden. His parents continued to be rather critical of him (e.g., "When are you going to get a job?!") but, at the request of Derek's junior house officer, the family had become less "emotionally expressive" toward their son. At the drop-in centre, Derek has befriended two older people, one of whom is paralyzed from the waist down and who Derek takes for walks in the local neighbourhood. He feels more hopeful about things, where he's now considering "a career in gardening" and grateful to know these new people and also to have retained other interests such as bird-watching and weight-training.

The full text of these events can be found in appendix C. In summary, there was evidence for the presence of 'fresh starts' among six of the eight 'symptomatically better' patients. This contrasts sharply with the one 'fresh start' observed among patients who were readmitted to the ward within the six month study period. It was a cruel irony that such a 'start' had, for that patient, become a 'plan that had fallen through' by the time of follow-up and suggests an unfortunate 'flip-side' to such 'starts'. In this respect, certain patients who had made 'fresh starts' were at particular risk of disappointment. Patients like 'Alison', for instance, about to move into a place of her own; and Clare, who had resigned from her nursing post and who had moved into new accommodation to get away from the conflicts she had experienced in each but who, nonetheless, described her most worrying problems to me as (a) finding a new job, (b) financial difficulties, (c) the lack of close friendship and (d) her feelings of (then mild) depression - fearing she'll always feel the way she does. For these reasons, it would be advisable to maintain the follow-up or 'continuing care' of all patients routinely discharged from the ward. Such follow-up need not be particularly labour- nor time-intensive but would require that someone, a CPN or social worker, 'look in' on the patient to make sure that 'everything's all right' (e.g., Kiesler, 1985).

These exploratory findings, subject to less rigorous examination than those which form chapters four through six, should not be regarded as conclusive: such was the informal nature of the assessment of these on-going difficulties and fresh starts. Instead, they merely complement the findings of the formal analysis which identified a relationship between the severity of symptoms of distress and the number and severity of chronic life events. The nature of this relationship is such that patients whose symptoms had undergone *improvement* following discharge were found to have experienced *fewest* chronic events following discharge; patients whose symptoms had markedly *deteriorated* following discharge experienced *most* chronic events.

2.5. 'SOCIAL SUPPORT'.

Extensive discussion of these results was made in the appropriate sections of the fifth chapter. The central findings supported the views referred to in the previous discussion (section 1.4) of a relationship between, *on the one hand*,

(a) perceived support, in particular, perceptions of '*a sense of belonging*' and '*the means by which a positive sense of oneself can be engendered through comparison with others*' - from the ISEL (Cohen et al., 1985),

(b) level of '*social integration*' - from the ISSI (Henderson et al., 1981),

(c) satisfaction with the degree to which one is '*socially integrated*',

(d) withdrawal from others - measured indirectly by level of contact with friends and family as well as directly by frequency of time spent alone,

and, *on the other*,

(i) course of psychological distress (Brewin et al., 1989; Sarason et al., 1991).

Patients whose symptoms of psychological distress had **improved** during the course of tenure in the community could be distinguished from the 'same' and, more substantially, from the 'worse' group in being significantly more likely to have a stronger 'sense of belonging', more likely to 'gain a good sense of themselves through comparison with others', less socially withdrawn, more involved in pleasurable, 'social round' contact after discharge both with friends and with family (compared with 'worse' patients) and in being more satisfied with the greater availability of other people to turn to for various material and emotional resources.

Although there was no *significant* effect of availability of close attachments as one might have expected, nonetheless both 'same' and 'better' groups of patients were characterized by greater levels of availability of this form of support. Indeed, whereas the 'same' group had experienced a slight improvement in close attachment support and the 'better' group no change, the 'worse' group had experienced a decrease during the course of tenure in the community.

Given the uniformly low levels of satisfaction with close attachments among all patients it could be that such attachments are characterized more by "deleterious effects. . that are conflictual, insecure, or otherwise not sustaining" (Coyne and Downey, 1991). Thus, more noxious features of these relationships may be having an impact on the psychological distress experienced. Previous research has demonstrated that the more negative features of relationships correlate more strongly than positive features with measures of both perceived support and psychological distress (Coyne and Bolger, 1990; Fiore et al., 1983; Pagel et al., 1987; Rook, 1984). Such “deleterious effects" need not necessarily be experienced in a uniform manner across the entire sample. Where no formal statements can currently be made on what might well be a critical feature of such close relationships (since no formal measures were obtained), future research would do well to include measures of these features.

It seems reasonable to suggest that greater interpersonal conflict or less security in the close relationships of routinely discharged psychiatric patients will be related to the rate of recovery or deterioration of symptoms of distress. In this respect, the group of patients whose symptoms of distress improved after discharge might well be involved in close relationships characterized by these negative features, but their involvements with other people (their level of ‘social integration') and the satisfaction that these involvements provide could conceivably provide adequate compensation. This, of course, would imply a test of the proposition made by Brewin et al. (1989). This claims that people who experience negative life events and who, engaging in various forms of appraisal intended to make sense of their occurrence, blame themselves for such adversity might well continue to seek support from close attachments but will withdraw from other people in general. However, such withdrawal was only found when the individual blamed him or herself for the event and when s/he thought the event was something outwith the experience of others (which, the authors conjecture, could lead to “shame or guilt. . . unpleasant emotions", p.368; elsewhere described as “powerful emotions", p.354, and “intense feelings", p.369). The current result, whereby ‘symptomatically improved' patients' level of ‘social integration' and satisfaction with being ‘socially integrated' was greater than both ‘same' and ‘worse' groups suggests the absence or weaker presence of such self-blame, shame, guilt and adjudged low consensus of their stressful and distressing experience (for otherwise they would be expected to withdraw from or experience dissatisfaction in their non-intimate, diffuse social contact). It is toward a discussion of these “powerful emotions" and appraisals that attention will now turn.

2.6. 'POWERFUL EMOTION' - SHAME, GUILT, SELF-BLAME; and CONSENSUS JUDGEMENTS.

The results of the analyses of these “powerful emotions" and forms of cognitive appraisal revealed few significant differences but differences nonetheless - most of which were in the expected direction. Patients whose symptoms of distress had become significantly more severe following discharge - the ‘worse' group - were, as expected, more ashamed than those patients whose symptoms had undergone recovery (i) on the whole, and (ii) were significantly more ashamed about their ‘bad' thoughts and feelings and about being in mental hospital. This symptomatically ‘worse' group also felt more (though not significantly) guilty and blamed themselves more about their thoughts, feelings, being or having been in a psychiatric hospital and about having caused other people problems compared with the 'better' group. However, there were few differences between the groups in their judgements of the consensus of their (largely negative) experiences. By and large, the 'worse' group compared with the 'better' had a lower consensus about their experiences (i.e., thinking that these experiences were <u>less</u> like those of other people). However, these differences were less marked than those found for the shame, guilt, and self-blame experiences. Only one type of consensus judgement was found to most noticeably distinguish between the groups: the consensus about the problems the patient felt s/he'd caused others whereby the 'worse' group believed that most other people <u>hadn't</u> caused the kinds of problems they felt <u>they</u> had caused for others whom they knew.

Taken together, these findings offer moderate support for the hypothesis suggested by Brewin et al. (1989) which has been referred to throughout this discussion. This proposes that patients (a) who are engaged in more frequent pleasurable contact with both family and friends, (b) who have fewer disruptive life events with which to contend and (c) who enjoy a comparatively high level of perceived support (particularly 'sense of belonging' and 'likelihood of making a positive assessment of themselves in comparison with other people') will not only be less psychologically distressed but also less socially withdrawn. Under conditions the exact reverse of this, the authors go on to suggest that an individual will engage in more blame of him or herself for these current negative experiences. Where the individual has a much poorer understanding of the commonality of these experiences, such individuals will be <u>more likely</u> to feel strong shame and guilt. The current findings offer moderate to good support for this hypothesis whereby heightened symptoms of distress and greater social withdrawal were found among patients whose life conditions were the mirror reverse of such symptomatically 'improved' patients - where there was (i) significantly less change through community tenure in the degree of life adversity, (ii) marginally less availability of support, (iii) significantly less perceived support, (iv) greater previous contact with psychiatric services, (v) significantly less time spent in the community between admissions, (vi) significantly less change through community tenure in satisfaction with more diffuse relations ('social integration'), and (vii) greater levels of guilt, self-blame and a significantly more severe experience of shame.

It is at this stage of the discussion that a resume should be made of some of the points raised in the earlier discussion about the factors which might contribute to the "past driving the present" phenomenon (e.g., Avison and Speechley, 1987; Kiesler, 1982; Mendel and Rapport, 1977), one that is intimately associated with the related phenomenon "the revolving-door syndrome" (Goldman et al., 1980). It will be recalled that patients who are taken into the care of a psychiatric hospital when their experience of distress is severe will be more likely to return there to receive this care when the appropriate experiential conditions reemerge. And so, the more and more a patient has been in hospital as a psychiatric patient, the more likely this patient will go back again and again for treatment. <u>Support for this phenomenon was found.</u>

It was then suggested that some features of the patients' social, interpersonal and emotional experience might reasonably lead them to view themselves as being somewhat different from other people and, as a consequence, they would become more socially-isolated (Brewin et al., 1989; Bushard, 1957; Sarason et al., 1991). This often “self-imposed isolation" or “self-stigmatization" (Brewin et al., 1989) conceivably interacts with certain types of emotional experience, stressful living conditions and deficient, inadequate, or inappropriate ‘social support' to render less tolerable these conditions and more severe an experience of psychological distress. Empirical support for this proposition would also appear to have been found. That is, patients (a) who were undergoing continued marked chronic life adversity, (b) who had few close and more diffuse attachments (the ‘integration' component), (c) who perceived little availability or had little actual experience of interpersonal support (particularly ‘belonging' and ‘esteem-enhancing' forms of support), (d) who had a lower, average, consensus of their negative experiences (their feelings and thoughts, their ‘past', being in psychiatric hospital and the fact of having caused other people problems) were found to be (i) significantly more psychologically distressed, (ii) significantly more isolated from the contact of others and (iii) significantly more ashamed about these negative experiences compared with the patients whose symptoms of distress had significantly *improved* following discharge and who were less socially isolated.

In the discussion that follows, links will be forged between these findings and that which has been observed time and again within this specific research domain, namely, the “past driving the present" phenomenon. The proposed explanation of this phenomenon is based upon the idea that those patients who return again and again to the psychiatric hospital for basic care and asylum have, to large extent, become “institutionalized" in their mode of construction of their ‘problems' or ‘illness' and perhaps too of themselves.

In the earlier discussion, reference was made to the concept of the ‘working model of self' (Bowlby, 1973, 1980, 1982, 1988). This working model is similar if not identical to various models that have been hypothesized to encompass the notion of **the current view that the person has of him or herself**, views which emerge both through interaction with others and with one's self (e.g., Jones, 1990). The ‘working models' or ‘self-perceptions' conceived by Bowlby (e.g., 1988) are said to be ‘built' by a child during the first few years of his life and are based on his experience of the mother and of her ways of communicating and behaving towards him. Complementary models of himself in interaction with each parent and with others are gradually constructed (which come to operate at an unconscious level) and become established as influential cognitive structures (Main, Kaplan, and Cassidy, 1985). The models then help to “govern how (the child) feels toward each parent and about himself, how he expects each of them to treat him, and how he plans his own behaviour toward them" (Bowlby, 1988, p.130). These models continue to influence the “development, functioning and perception of relationships in adulthood" (Sarason et al., 1991).

Given that these ‘working models of self' have been posited as having a central, determining “influence" on or as being an important “guide" to current functioning and perceptions, the question ‘begged' by the findings of this study must be "what is the nature of the working model of self held by the psychiatric patient (particularly those who were readmitted or whose distress became more severe during the six months following discharge)?". This 'working model', as it can be seen, is not only a stable and inherent aspect of the person but also "guides interpretations of social interactions and interpretations about oneself and others" (Bowlby, 1980; Sarason et al., 1991).

A little earlier in the discussion a suggestion was made about the likely content of the patient's 'working model of self'. This model of self was thought likely to consist of perceptions of differentness, incompetence, helplessness, and inadequacy. In the course of the following discussion, each of these characteristics will receive attention. In so doing, it is considered likely that a richer understanding will emerge of the factors which help precipitate or postpone the formerly-hospitalized psychiatric patient's return to the hospital - an address of which remains the central aim of this investigation. In the course of this examination, refererence will be made both to empirical findings and to theoretical knowledge from the domain.

In his rehabilitation work with mentally unstable army recruits, Bushard (1957) demonstrated that withdrawal from duties, and "any implication that the problem stems from remote or imponderable situations, is due to disease or is based upon considerations which are not immediate and amenable to mastery" (Bushard, 1957; cited by Goffman, 1961, p.311) can bring about isolation on the part of the sick person and "increasing confirmation of his being different". The social isolation of the patients in the sample has been demonstrated. In the following discussion it will be argued that each of the conditions leading to 'isolation' and the condition of 'being confirmed as different from others' can be seen to apply in the lives of formerly hospitalized psychiatric patients.

To begin with, the evidence suggests that the psychiatric patient's 'working model of self' consists of cognitions of self as "being different". Recent research, for instance, has identified a tendency among depressed persons to rate themselves as being dissimilar to others - particularly in an unfavourable way (Brewin and Furnham, 1986; Coates and Peterson, 1982; Furnham and Brewin, 1988; MacCarthy and Furnham, 1986; Tabachnik, Crocker, and Alloy, 1983). In their investigation of psychiatric patients' conceptions of psychological adjustment in the normal population, MacCarthy and Furnham (1986), for example, found an assumption among psychiatric patients of their differentness from and even opposition to "the 'ordinary' person".

In more objective terms of "uniqueness" or "differentness" the psychiatric patient can be seen to be well-justified in his or her view of 'being different' from others. Reference has been made throughout the results sections to the high degree of specificity of the sample being investigated - former patients of the acute-assessment ward of a psychiatric hospital (e.g., Brugha, 1991). In their informative analysis of the pathways that lead to a psychiatric referral, Goldberg and Huxley (1980) demonstrate that only a small minority of persons suffering from various forms of psychiatric or psychological disorder in the community are seen by psychiatrists (where they have had to be 'filtered through' at least four referral 'gateways' to reach the care of a psychiatrist). The average annual first admission rate to psychiatric beds per 1000 population at risk in the fourteen health regions of England is just 1.2 (DHSS, 1977). Thus, when the psychiatric patient becomes conscious of having been 'a hospitalized psychiatric patient' s/he will see that their condition is indeed confined to a very small minority: such knowledge might reasonably lead him or her to "feel more different", indeed to feel "worse" than the ordinary person. In response to the question that could be posed at this point in the discussion, namely, "Why should such knowledge lead the patient to feel **worse** than the 'ordinary' person?", as if it were not rather self-evident, a brief account of why this might be so will be made, one that draws upon the work of Smail (1984). In this account, the role played by considerations of 'normality' will be seen to underpin the basis of this perception.

Smail (1984) proposes that there exist conceptions - one might say, "shared" 'working models' - of what it is to be 'normal'. Such conceptions converge on the view that, in the final analysis, any person ought to be able to cope with the most fundamental requirements of daily living: 'to be able to get on with things'. He writes,

> "Looking at the world around them, few people can escape getting a fairly clear impression of what it is to 'fit in' to our society, what it is to be normal, competent and stable. Even if we cannot all achieve the *ideals* of confidence, attractiveness, power and success, at least we can expect to be *normal* For example, if you are a man, this might mean being able to perform your job satisfactorily and reasonably successfully, at the same time getting on all right with your fellow workers, providing at least adequately for your family, enjoying a satisfactory social life, being a good sexual partner, being able to stand up effectively to unfair opposition, and so on. . . The *norms* for how we should be are all around us, everywhere, all the time: we learn them from our parents and at school, see them apparently exemplified by our friends and neighbours, imbibe them from the television, have them, as I have said, enshrined in our institutions. Though fame and stardom and brilliant success may clearly not be achievable, *anyone ought to be able to cope with the basic requirements presented by life*" (Smail, 1984, pp. 6-7, current author's italics).

The psychological consequences of considering oneself not to be normal but, instead, to be essentially different from others have, one can reasonably firmly suggest, been demonstrated by the findings of the current study. That is, it can be argued that there will be greater likelihood of chronic, disruptive life difficulties; a marked lack of receptive support from a smaller network of others (predicated by withdrawal from others); a severe experience of psychological distress that can lead to psychotic, disintegrated forms of thought; and the experience of guilt, self-blame, a low consensus concerning the extent to which other people cause problems to their close ones, and marked *shame* about one's negative experiences - particularly where the person has had the lengthiest previous contact with the psychiatric services. Smail describes these 'consequences' thus:

"If you *cannot* cope with these basic requirements, you are likely to conclude that there is something the matter with you - you are not *normal.* Unless you have a lot of courage and a strong belief in yourself, you are not likely to conclude that it is the norms themselves which are wrong. If you do conclude that you are not normal, you are likely to feel anxiety and shame, and you are likely to keep the extent of your abnormality a closely guarded secret. It is of course likely that you are not the only one nursing a secret fear that you do not come up to the standards 'set' by our society, **but because other people too keep their shame to themselves, it becomes impossible to share the experience of 'inadequacy'**, and it looks as though just about everyone is normal except you" (Smail, 1984, p.7).

The subtle development of 'working models' of self in patients that include perceptions of 'being different from others' - perceptions that develop from the implication that their problematic experience stems from "remote or imponderable situations, (or) is due to disease. . " (Bushard, 1957) - can, in one valid sense at least, be seen to be contributed to by the prevailing orthodox methods of medical psychiatry. In these methods, emphasis is laid on the accurate identification of illnesses or 'disease entities' (Smail, 1984, p. 125) so that instituted methods of treating such entities can be applied almost automatically. Smail (1984) argues that whilst it is undoubtedly possible to "'discover' systematic similarities and differences in the way people cope with distress, and (that) it is therefore *plausible* to treat the revealed regularities as 'syndromes' resembling those more fruitfully identified in other fields of medicine. . It is, however, frequently overlooked that the reliable identification of such 'behavioural' syndromes does not *necessarily* imply the presence of actual disease." (pp. 125-6). However, in practice, proper qualifications of this kind are seldom passed on to the patient, leading them, in many but not all cases, to equate their real, subjective distress with 'disease' *alone*. Other equations do exist.

This point is not to dismiss the sometimes essential role that can be played by the ingestion of medication in relieving the patient of their more painful experience of the world through their bodily engagement with it. It is undoubtedly the case that physical treatments of the person do 'work' in that they provide temporary and even consistent relief of symptoms of psychological distress. Medication, however, *may itself* be a stressing agent such that it tampers with the meaning of subjectively experienced distress, obscuring its connections with the conditions which brought the experience into being - helping to make these conditions more 'remote'. On this subject, Smail (1984) writes, "It is also true, however, that many patients experience psychotropic medication as in itself a further source of confusion and discomfort, since it may alter their perception of the world in an idiosyncratic way, so that their experience seems to bear no relation to the meaning of the actual events of their world." (ch. 7, p. 126).

One effect on the patient's 'working model' of self - a 'self' in considerable distress - of the ingestion of neuroleptics for the relief of 'symptoms' of distress *without then attempting to examine its sources and meaning to the patient* - "the process of regression" (Jackson and Cawley, 1992) - might well be to "make one care less, not more, about the *circumstances* of one's life (which are in any case often extremely resistant to easy alteration) and hence to encourage an ***attitude which is even less likely than before to confront them***" (Smail, 1984, p.126, current author's italics). That is, a patient's distressing circumstances could very well, though not always but certainly possibly, come to be viewed as less "immediate or amenable to mastery" (Bushard, 1957). This is a view implicit in the scenario outlined by Hoult (1986), among others, of the environmental conditions that contribute to symptomatic relapse and readmission. He criticizes the use of medication to deal with the patient's psychopathology *without then dealing with* the "underlying interpersonal stresses which have precipitated such symptoms" (Hoult, 1986, p.137).

Using neuroleptic medication to treat ("normalising" - Jackson and Cawley, 1992) someone's painful subjective experience without also acting in other ways to explore the reasons for and meaning of that person's distressing experience - their "regression" - may, according to Jackson and Cawley (1992), "run into difficulties". For example, in his review of recent developments in expressed emotion (EE) (Brown et al., 1962; Brown, Birley and Wing, 1972) and schizophrenia, Kavanagh (1992) concludes that the evidence for the effectiveness of a regular intake of neuroleptics in moderating the distressing effect of expressed emotion is inconclusive. Vaughn and Leff (1976) and Vaughn, Snyder, Jones et al. (1984) found that neuroleptic intake reduced the predictive effect of EE. Leff and Vaughn (1981), Moline, Singh, Morris et al. (1985), Nuechterlein, Snyder and Dawson (1986), and Karno, Jenkins, de la Selva et al. (1987) did not. (One plausible reason for such inconclusive evidence is suggested by Smail (1984) above. That is, neuroleptic medication on its own may itself be discomforting and confusing - when there is no joint attempt to explore the person's reasons for and understanding of their distressing experience.)

For example, Nuechterlein et al. (1986), eliminating the effects of compliance by giving regular neuroleptic injections to subjects themselves, found that 40% of high-EE subjects relapsed within a nine-month period compared with none among low-EE subjects *despite receiving medication.* Citing this research, Kavanagh (1992) suggests that, "clinicians cannot rely on medication *alone* to protect the patient from the impact of a stressful interpersonal environment, although it remains an important factor in reducing relapse (Davis, 1975)" (own italics). "The optimum treatment strategy," he continues, "appears to be a combination of medication with a social intervention (Goldstein & Kopeikin, 1981); this may often allow medication doses to be reduced (Falloon et al., 1985)" (Kavanagh, 1992, p. 605).

Perhaps the best summary of these points is made by Jackson and Cawley (1992) in their paper reporting the psychodynamic and psychotherapeutic treatment of severely disturbed patients on an acute psychiatric ward. They call for the growth of "therapeutic milieux" for in-patients of acute psychiatric wards where "individual, group and family psychotherapy and behavioural methods can be employed in treatment plans suited to the individual". They continue, "In such milieux, medication is regarded, at least in the first instance, as an often indispensable agent for reducing anxiety and thought disorder to a level where more rational 'secondary process' thinking can be sufficiently restored *to allow contact and exploratory communication with the patients.*" (Jackson and Cawley, 1992, p.42). Without this 'exploratory communication' or 'social intervention' it becomes more likely that a patient will solely equate their problematic experience with 'disease' and with the need to take medication. If the qualified expert time and again, through the course of repeat readmissions, does not attend to the 'actual events' of the patient's world, we cannot be surprised that through time the patient learns to do likewise, bringing him or her back to the door of the acute admission ward, confused and in disarray.

The feeling of shame might be expected given the perception of being different from, that is, less 'adequate' than others (Brewin and Furnham, 1986; Coates and Peterson, 1982; Furnham and Brewin, 1988; MacCarthy and Furnham, 1986; Tabachnik, Crocker, and Alloy, 1983). It might also be reasonably expected where the patient is not informed about his or her diagnostic classification (not one of the patients interviewed knew what their 'condition' was), an implicit, though not necessary, admission on the part of the psychiatrist administering treatment of the shamefulness of such categorization: it is something about which the patient is to remain ignorant.

Thus, in sum, one can conclude that the patient's typical 'working model of self' might reasonably include (a) perceptions of being less able than others to cope with the basic requirements of existence; (b) perceptions of inadequacy (if one accepts Smail's conclusions and the empirical work of Sarason et al. (1991) whereby individuals who are characterized by low perceived support are more likely to experience feelings of personal inadequacy, anxiety and social rejection); (c) perceptions of dependency and powerlessness about their feelings of distress - "based on considerations which are not immediate and amenable to mastery" (Bushard, 1957); and, by logical extension, (d) feelings of guilt and shame. That is, such self-perceptions or 'working models' might encourage a feeling of shame. Tangney (1990), for instance, in examining the nature of this feeling writes,

> "Shame involves less of a focus on specific behaviours and more of a focus on the entire self. The entire self is painfully scrutinized and evaluated. Thus, the shame experience involves a considerable shift in self-perception - often accompanied by a sense of exposure; by a sense of shrinking, of being small; and by a sense of worthlessness and powerlessness. The person in the midst of a shame experience is most likely to want, generally, to hide from others and, more specifically, to remove him or herself from the interpersonal situation(s) that gave rise to this experience" (Tangney, 1990, p.103).

On the same subject, Merrel-Lynd (1961/1968) writes,

> "Shame, while touched off by a specific, often outwardly trivial, occurrence initially felt as revealing one's own inadequacies, may also confront one with unrecognized desires of one's own and *the inadequacy of society in giving expression to these desires.* There is a natural tendency to *seek cover* from such experiences since the culture has little

place for revelations of the inmost self" (p.221, current author's italics).

The consequences of the experience of shame - "hiding", "removing oneself" or "seeking cover" from other people is highly characteristic of patients in the sample, particularly those who were readmitted to hospital within the study period or whose symptoms of distress had become significantly more severe by follow-up. Indeed, the findings of the study - with respect to the comparisons of 'better' and 'worse' groups of patients' experiences (particularly of shame) - would strongly appear to support these conceptions about the nature of the 'working models' held by patients in the sample. However, as no specific measure of these 'working models of self' was obtained, indeed as this whole issue was not specifically addressed by the current study, the interpretations of the findings that have been made can only, necessarily, remain suggestive until put to the specific test. Future research would usefully incorporate measuring instruments intended to obtain measures of such 'working models' (Bowlby, 1980, 1988). In this respect, the use of the 'Repertory-Grid' technique might prove most fruitful (e.g., Kelly, 1959; Pervin, 1984). That is, through the use of this technique (e.g., Button, 1985) exploration of patients' ways of construing themselves, close others and general 'Others' (Cooley, 1902) is made possible. This kind of exploration might reveal significant ways of thinking or of feeling which are fundamental to the patient's experience of differentness, inadequacy and dependency. Such information would then be of use to professional and 'lay' carers - incorporated into modes of communicating and supporting intended to rekindle the former patient's perceptions of control and agency with respect to his or her experiences of psychological distress, shame, inadequacy and dependency.

In addition, future research could adopt for use more sensitive and precise measuring instruments of these "powerful emotions" than those currently used such as, for example, the "Self-Conscious Affect and Attribution Inventory" recently developed by Tangney (1990) which has been found to possess adequate reliability and validity. The purpose of such research would be the specific examination of the patient's 'working models of self' - their 'self-perceptions' - and of their 'working models of others', models which, it is argued, might conceivably play a central role in the patient's responsivity to his or her stressful life circumstances and in his or her responsivity to the (re-)emergence of symptoms of psychological distress. Both these factors were found to make a significant contribution to the likelihood of readmission and to the course of psychological distress.

3. THE THIRD-WAVE ANALYSIS: THE REGRESSION ANALYSES.

3.1. THE FIRST REGRESSION ANALYSIS.

Detailed discussion of the results of the two regression analyses has already been made in the sixth chapter. The first of the two regression analyses - the regression of time 1 variables on time 2 psychological distress - found the best predictors of psychological distress experienced six months after discharge to be, in descending order of predictive value, (a) the discharge assessments of psychological distress and (b) objective life stress, as expected, followed by (c) the 'social support' *structural* components 'availability of social integration' and 'availability of close attachments', (d) the variables 'actual amount of pleasurable social contact with friends and family' during the three months preceding recent admission and (e) the *functional* components 'perceived esteem through others' and 'perceived sense of belonging'. These variables working together accounted for sixty-nine per cent of the variance in follow-up psychological distress. It was unfortunate that measures of the "powerful emotions" and "cognitive appraisals" were not obtained for all thirty-eight subjects of the investigation thus precluding their effective inclusion in the regression equation.

The contribution of prior distress and life adversity to subsequent symptoms of distress was as expected - a relationship that has been well documented (e.g., Clum, 1978; Mintz et al., 1976; Depue and Monroe, 1985; Lin et al, 1979; Kessler et al, 1985; Thoits, 1982). The contribution of the patient's experience of 'social support' to improving the prediction of later symptoms of psychological distress is, however, also remarkably influential - particularly those structural indices of support, 'social integration availability' and 'close attachment availability'. That is, the "mere existence" of social relationships (House and Kahn, 1985) contributes substantially to the variance in psychological distress at some later point (six months) in time.

The finding offers validation of Gottlieb's (1985) observation that "the primary social context in which individuals are embedded has a critical direct and indirect impact on their health and well-being" (p.305). This finding would also suggest some self-evident confirmation of the current definition of support where it was defined as 'being with people makes the person feel more secure and safer, and so less alone and separate', where the presence of basic attachments to others, whether in close or more diffuse contact, contributes to a person's sense of well-being (and a lack of such attachments, by and large, to a feeling of psychological distress). The finding also provides support for the views of Rook (1985) who in reviewing three areas of 'social bonds' research drew two related conclusions. First, from 'loneliness' research, she identified the importance of pleasurable companionship and intimacy for mental health, thus reiterating the ideas of Ainsworth (1972), Bowlby (1982; 1988), Henderson et al. (1981) and Weiss (1974). The current finding suggests the more appropriate relation between intimacy's opposite, loneliness, and the experience of psychological distress. Secondly, she identified a relation between being 'socially integrated' - i.e., "being *embedded* in a web of interpersonal influence" - and the promotion of healthy behaviour, where the absence of strong interpersonal connections "contributes to despair, and, in extreme cases, to suicide". The relative predictive influence of the 'social integration' component of the 'social support' conception is, then, quite substantial, a finding that has already received quite considerable discussion (chapter six, step six).

It is from these basic attachments that the functional, more qualitative components of support are drawn, functions or provisions (Cohen et al., 1985) which, nonetheless, make a moderate independent contribution to the experience of distress. Thus, the predictive contributions made by support components 'perceived sense of belonging', 'perceived tangible assistance', 'perceived esteem through others' and 'actual contact with friends and family', although less pronounced, are yet significant, moderately large and independent of the basic attachment relations. These provisions correlate moderately highly with the 'social integration' component suggesting that it is through such relations, rather than through 'close attachment' relations that the patients in the sample gain such provisions. More notably, the very high correlation between 'close attachments' and 'perceived availability of people with whom to confide and share problems' (r=.751; p<.001; 1-tailed) provides strong support for the conclusions made by Brewin et al. (1989) that negative experience may lead persons to withdraw more from *others in general* (the 'social integration' component, where the correlation with 'problem appraisal' was low) but this will have little to no effect on support-seeking to improve understanding of problems from *close attachments*, where they are available.

Finally, the comparatively moderate but significant independent contribution of the psychiatric history variables to variance in later distress (added to an equation that contained the four best predictors - prior distress, life stress, attachment availability and perceived support) supports the claims made earlier in the discussion about the relative importance of such experience in providing explanations of how "psychologically well" (Henderson, 1988) a person is likely to be at some later point. This contribution might not be as marked as expected yet it is moderate (comparing on a level with 'perceived support'), significant and independent of the other factors working together. Taken together, the findings of the first regression analysis strongly suggest the validity of the points raised earlier in the discussion (and throughout the three results chapters) concerning the contribution made by on-going psychological distress that has been left unresolved save for the relief provided by medication - to the experience of distress at any later date. Such distress, together with measures taken when patients were about to get discharged from the hospital of (a) prior exposure to objectively stressful life events and difficulties, (b) inadequate and less available close and general attachment support that provides little opportunity for feeling good about oneself, feeling that one 'belongs', or for the appraisal of problems, (c) little contact with friends or family and (d) greater previous contact with psychiatric care, *working together* make a large and significant contribution to the experience of distress at a point six months later, following the patient's resumption of 'ordinary living' back home.

From a practical point of view, the findings would suggest that careful attention be accorded those fundamental 'structural', 'availability' components of the patient's existence whilst the patient is in hospital and after s/he has been discharged back home. Discussion of these points has already been made (chapters four and five). Briefly, where patients are known to have especially few outside contacts - where they have no close and few general attachments - such patients, rather than those known to possess such relations, might benefit most from a gradual release back to their homes in the community, continuing their contact with the hospital ward through the provision of 'day-care' facilities. Alternatively, such patients might, with the help of appropriate carers in the community (e.g., a CPN or social worker) be encouraged to re-forge links with known friends (but with whom contact has been lost through the patient's mental difficulties). Most friendships that exist in this state of limbo need not necessarily 'be given up for dead': the reasons for the break or simple loss of contact can, in most instances, be resolved, particularly where there is someone who can act as an arbiter or 'enabler' (e.g., a 'care manager').

Where suggestions are being made for the more appropriate treatment of such formerly-hospitalized patients, it might well be that, where it applies, basic integrated or directive family therapeutic techniques will most likely bear fruit (e.g., Epstein and Bishop, 1981). However, rather than spend time arguing about the relative efficacy of one 'method' over another it would be much easier to suggest the simple encouragement of interpersonal contact between the former patient and those people he or she already knows or who might be more likely to re-establish the patient's sense of self-worth and self-love - when the patient truly wishes such contact. This, of course, will entail further examination of the on-going difficulties and major worries with which the patient is faced.

It would, perhaps, be sufficient simply to advocate that such problems be treated with the due respect, acceptance, understanding and seriousness the lack of which has most probably been the single-most important contributor to the patient's current psychological disarray. That is, it is almost certainly for the continued *lack* of (i) being truly respected, (ii) being listened to seriously, (iii) being accepted and understood by others (Miller, 1990, ch.3) that there arise the 'meta' feelings (and, if possessing insight thereof, then the *knowledge* too) (Honess, 1986) that one's subjective experience is being disconfirmed. That is, the reality of a person's communicated feelings and ideas - his or her subjective experience - may not be confirmed by other people. For example, a distressed person's account of the presence of various 'symptoms' of malaise may be considered to be exaggerated and untrue by a relative (breeding resentment). Or, a young child's genuine interest in a particular subject at school may be ignored by a parent or, for example, in the case of an interest in sex or religious education, be met with disapproval and angry reproof. Such "**disconfirmation**" (Buber, 1957b; Laing, 1967), when repeated and unchallenged, will eventually give rise to a 'false sense of self' (e.g., Yardley and Honess, 1987; Miller, 1990) through which many psychological problems come to be felt.

The 'false self' is described by Miller (1990) as the feelings and beliefs that are not one's own but which are held nonetheless: they are imbibed from the 'other' through being sensitive to the other's feelings and behaviour. They are learned and internalized to ensure the continued interest, approval and so-called love of the other, thus averting the withdrawal of these life-sustaining functions. In one of the examples given, the young child might retain two attitudes. S/he might continue to like the school subject. But, towards his or her parent he or she would have to minimize, make a secret of, even disregard, his or her liking for it in order to avoid the parent's displeasure and ensure his or her continued acceptance, approval and 'love'.

Disconfirmation of the experienced self, as Bowlby (e.g., 1988) and many others have correctly identified, can begin as early as the first five to six years of life when it is particularly influential in shaping the developing child's sense of identity (Miller, 1990). Such disconfirmation can continue, when not acknowledged, to influence the fundamental attitudes of the person toward others *as well as* his or her sensitivity to such disconfirmation throughout adulthood (e.g., Bowlby, 1973; 1982; 1988; Buber, 1957b; Denzin, 1987; Laing, 1967; Miller, 1990; Mair, 1989; Ramanyshyn, 1987).

With respect to former patients, proper treatment would not be to continue to reinforce the patient's suffering by failing to recognize that their problems *are*such because the person *considers* them as such (indeed, their 'annihilation' - such is the consequence of continuously not taking someone seriously, but, instead, of confirming the patient's 'false self' - Miller, 1990). Instead, the suggestion would be not to view people as "belonging to illness categories, but (instead) as individuals who have problems . . . (in so doing) we are irrevocably led to the position of asking people what their trouble is" (Bannister and Fransella, 1986, p.134).

This is a view shared by many whose interest is a genuine exploration and resolution of the problems "presented by life" (e.g., Bannister, 1970, 1975, 1985; Button, 1985; Kelly, 1955; Mair, 1989; McKechnie, 1989; MacMillan, 1989; Miller, 1990; Moss, 1990; Salmon, 1990; Smail, 1978, 1984, 1987; Wright, 1970). The basic requirement in therapy, treatment or "continuing care" (Lavender and Holloway, 1988) is this simple 'resource' or attitude enshrined in the words of the chief medium (as, perhaps, he would have expressed it) of the Theory of Personal Constructs, George Kelly: "**If you don't know what is going on in a person's mind, ask him; he may tell you**" (Kelly, 1958b, p. 330). In doing so, it would be of most therapeutic value if the person doing the listening has, among other qualities, a genuine feeling of interest in the person doing the talking, has respect for their ways of construing themselves and others, takes these problems - and the person whose problems they are - seriously, offers no initial judgement on such constructions and feelings but, instead, confirms their validity - their real-ness for the person, acknowledges the centrality of such problems in their life and is cognizant of the evolutionary nature of the person whereby he or she exists at a particular moment in time in a particular place in a particular society in a particular culture that prizes certain values whilst derogating others (see Smail, 1990). Any attempt to involve the person in therapeutic regimes such as those described by, say, Gottlieb (1985), Berkowitz, Kuipers, Eberlein-Frief and Leff (1981), Dunkell-Schetter and Wortman, (1981) or Caplan (1974) - regimes intended to "weave the patient into a social fabric composed of professionals and lay persons capable of sustaining effective functioning in the community" (Gottlieb, 1985) - must, primarily, quite simply, take seriously the person to be "weaved" - their predicament, their perspective, their self.

3.2. THE SECOND REGRESSION ANALYSIS.

The first, longitudinal regression analysis regressed measures of the independents that included measures of both current as well as recalled support and life events prior to the hospital admission from which the patient was about to be discharged on follow-up psychological distress. The second, cross-sectional analysis regressed measures of all the independents that covered the six month period after discharge on a measure of distress that could more appropriately be considered the consequence of this combination of life event, psychiatric and support experience. The results have been examined in considerable detail in the second main section of the sixth chapter. The remainder of the current discussion will examine more closely the meaning of this analysis within a broader perspective that encompasses the central points that have been made thus far about the proposed influence of 'working models of self', of the "past driving the present" phenomenon, and of "powerful emotion" attending in particular to the critical, joint influence of the support experiences 'perceived likelihood of making a positive comparison when comparing oneself with others' and 'actual emotional support received'.

The support component 'perceived likelihood of making a positive comparison when comparing oneself with others' made the largest and most significant independent contribution to the variance in psychological distress controlling for the all other independents in the equation. Perhaps this is less surprising than it might seem. In his appraisal of the accomplishments of support groups - such as 'family support programs' (Gartner and Reissman, 1977) - Gottlieb (1985) concludes that such groups (a) enable alteration of the person's social network to include people who face similar difficulties, challenges or situationally-specific crises; and (b) bring into being *a process of social comparison* that facilitates the expression of fearful feelings, offers validation for new social identities (Dunkell-Schetter and Wortman, 1981; Hirsch, 1981; own italics), and reduces the likelihood of vulnerability to any present or subsequent stressful life conditions. Drawing on the views expressed by Epley (1974), Gottlieb proposes that this "process of social comparison lies at the heart of social support's stress-mediating role, and is chiefly responsible for producing its salutary effects on cognitive, affective, behavioural and physiological functioning" (Gottlieb, 1985, p.309). The current findings provide strong support for this view such that patients suffer *poor* comparison that would appear subsequently to *preclude* or *hinder* the expression of fearful feelings, *withdraws* validation of identity and*increases* the likelihood of vulnerability to any present or subsequent stressful life conditions.

That comparison with others contributes so strongly to experienced distress provides confirmation, in turn, of the view that 'social support' in any of its manifestations provides important "messages about the self" (e.g., Brewin et al., 1989; Brown and Harris, 1978; Dunkel-Schetter, Folkman, and Lazarus, 1987; Folkman, 1984; Gottlieb, 1985; Jones, 1983; Jones et al., 1985; Parry, 1988). That is, the purpose of such comparison with others is self-relevant (e.g., Jones, 1990): its purpose is to enable the person to come away from this comparison with a good, positive sense of oneself - reflected in a satisfactory level of 'self-esteem'. Where there is *little* likelihood of such a positive comparison - a likelihood experienced by most of the sample where even the 'symptomatically better' patients' average experience of this component was at the mid-point of the scale -

there is every likelihood that the person will come away from such comparison feeling ‘bad' or ‘negative' about themselves. This is precisely the condition within a person's experience that renders more likely (a) a poor (coping) response to the stressful events in their life (e.g., Folkman, Lazarus, Dunkel-Schetter, DeLongis and Gruen, 1986), (b) the experience of self-derogation for being unable, for example, to form the types of relation that proffer the appropriate forms of support (e.g., Cohen and McKay, 1984; Cutrona, 1982), (c) withdrawal from others in order to preserve what estimation of oneself remains - withdrawal from criticism and admission of one's relative powerlessness and failure to “cope with the basic requirements presented by life" (Smail, 1984), and, as a consequence, (d) the experience of emotional distress (Folkman, 1984; Folkman and Lazarus, 1980).

At the heart of this process is the estimation of self that one ‘perceives' through comparison with others. Indeed, the current finding could be seen to provide support for the conception of the ‘social' part of self made by James (1890, 1892/1976) and of those conceptions proposed by the ‘symbolic interactionists' - Cooley (1902/1976) and Mead (1934, 1956/1976). In each, there is specific reference to the importance of the presence of others in contributing to one's self- view, conception or estimation. According to Cooley (1902/1976), for example, “A self-idea . . seems to have three principle elements: the imagination of our appearance to the other person; the imagination of his judgement of that appearance, and some sort of self-feeling. We can expect to know what the self is only by experiencing it. There can be no final test of self except the way we feel".

William James (1890, 1892/1976) in particular, proposed that in order to understand the person's conceptions of “Me" one must consider both the feelings and emotions about the self (self-appreciations) and the actions which they prompt (self-seeking and self-preservation). Considered in this way, the very large contribution to follow-up experience of psychological distress made by the perceived ‘social comparison' component suggests the excruciatingly negative ‘appreciation' of self held by patients that understandably relates to their ‘self-seeking' and ‘self-preserving' actions whereby withdrawal ensues from the contact of others. The inevitable consequence of this withdrawal, particularly where it is accompanied by feelings of shame (defined earlier by Tangney (1990) as “the painful scrutiny and evaluation of the entire self"), is the further psychic deterioration of the patient manifest in various symptoms of psychological distress.

The finding also provides support for the claims made earlier in the discussion of the patient's likely ‘working model of self', particularly with respect to the feeling of ‘being different from others'. That is, the result would imply that patients ‘come away' from a comparison of their self with others with the feeling of being <u>less able than others</u>, (a) ‘to make changes in their lives'; (b) ‘to feel satisfied with their life'; (c) ‘to solve the problems of others'; and (d) ‘to do things well' (items from the ISEL). This considered ‘differentness' from others entails feelings and considerations of one's self as being less capable, less competent, less adequate

(Brewin et al., 1989; Sarason et al., 1991) and would suggest "a sense of shrinking, of being small; and a sense of worthlessness and powerlessness" (Tangney, 1990).

The central, highly significant contribution of this variable to subsequent symptoms of distress supports, too, the validity of the arguments made previously concerning the nature of the phenomenon known as "the past driving the present". The finding also provides a linkage into the processes whereby the perception of 'being different' translates into feeling "psychologically unwell" (Henderson, 1988): i.e., into the presence of symptoms that denote underlying psychological distress. Thus, if one were to assume that the patient is quite justified in feeling that he or she is 'different from others' such a perception would have fairly self-evident consequences for the nature of the comparisons he or she makes of him or herself with others. One might reasonably contend that, where the process of comparison "lies at the heart of social support's stress-mediating role" - which the current finding strongly supports - and where that comparison process for the patient is hinged on the feeling of 'being different' (i.e., less able, less competent, less mentally stable, and such like) there is every likelihood that the person will come away with a 'bad' or 'negative' self-feeling. This 'bad' or 'negative' self-feeling contributes to the emergence of symptoms of distress of ever-increasing severity where that comparison process offers no hope for the expression of fears, validation of selves, or reduction in vulnerabilities to life stressors.

At the 'true' heart of the process, however, would not be the act of comparing oneself - although its intermediary role between the person's 'working model of self' and the development, maintenance or worsening of psychological distress cannot be in question. Rather, what would appear to be the 'true heart' of the process is the person's current perception of him or herself: that is, his or her current 'working model of self'. For the patient's 'differentness', founded upon experiences of a particular kind and of a particular value that are commonly held to be something to be ashamed of, will bring him or her, in turn, to de-value him or herself, view him or herself as 'lesser' in many ways and so 'less likely to gain a positive sense of self through comparison with others'. That is, it is being suggested that at the heart of the entire "revolving-door syndrome" (Goldman et al., 1980) is the patient's 'working model of self' (Bowlby, 1988), what Kelly (1955, 1969) construes as the person's "core constructs" concerning self. In this way, it could be suggested that some of the patient's core constructs of self are 'different-alike'; 'mentally well-unwell'; 'competent-incompetent'; 'worthy-unworthy'; 'shameful-acceptable'.

In the absence of formal measures of such constructs or working models any discussion would merely be conjectural. Future research would fruitfully incorporate measuring instruments such as the "Repertory Grid" in order to elicit or obtain a measure of the patient's current 'model of self'. Such a model might provide further insights into the nature of the process whereby past experiences of a particular kind (e.g., the patient's previous experience as an in-patient in the hospital) come to influence current attitudes toward the self, current vulnerability to life stressors, current level and adequacy of social support that the patient considers s/he needs and which s/he actually receives in crises, and the nature of the comparison with other people which is so evidently critical for psychological well-being. In sum, that the variable 'likelihood of a positive comparison when comparing oneself with others' makes such a large contribution to the experience of distress provides support for the widely-documented evidence for the centrality of estimations of self in feelings of distress (e.g., Beck, 1967; Brown and Harris, 1978; Brown et al., 1986; Coopersmith, 1967; Ingham et al., 1986; Luck and Heiss, 1972; McCord and McCord, 1960; Rosenberg, 1962; Wilson and Krane, 1980).

The second best contributor to variance in psychological distress after 'life events' (whose independent contribution was greatly reduced when controlling for the 'support' variables) was the variable 'actual received emotional support'. The nature of influence of this form of support was given considerable discussion in the second section of the sixth chapter. The "suppressant" role of this component has already been discussed: that is, the 'actual support' (or 'enacted') variable correlates poorly with psychological distress but shares significant amounts of variance with practically all other variables in the equation, particularly perceived support, attachment support, and actual, pleasurable contact with family and friends.

This finding receives support in the literature from Lakey and Cassaday (1990). Although they found marginally less variance in common between the perceived and enacted support variables than was currently found, nonetheless their discovery of a strong relationship between perceived support and psychological distress and a weak one between enacted support and psychological distress is replicated amongst this sample of psychiatric patients. The authors concluded that their studies "support the hypothesis that perceived social support operates in part as a cognitive personality variable that influences how supportive transactions with others will be interpreted and remembered" (Lakey and Cassaday, 1990; p.341).

They found an association between low perceived support and a bias toward perceiving supportive attempts as unhelpful and toward recalling fewer instances of helpful supportive behaviour (which might, however, have reflected actual less received support). The authors continue, "In the same way that negative beliefs about the self may lead to distress by negatively biasing information processing, persons with low perceived support may be more distressed because of negative biases in evaluating and remembering the support that they do receive. Of course, this does not mean that enacted support does not play a role in the link between perceived support and disorder. . . Instead, enacted support may operate indirectly by contributing to the perception of support availability or by influencing coping behaviour (Lakey and Heller, 1988)" (p.341). The current finding suggests that enacted support makes both a direct contribution to distress (noting its significant independent contribution to variance in distress) and an indirect one via its contribution to the variance in attachment support, actual pleasurable contact support, and, most notably, in 'perceived support'. In this respect, the finding would appear similar to that of Pearlin et al. (1981) whereby emotional support was found to mitigate depression *indirectly* through its effects on self-esteem and mastery. The major effect of emotional support appears to be a 'mitigatory' one, exerted 'indirectly' through its contribution to the experience of various forms of appraisal of self (e.g., self-esteem) and of others (e.g., 'perceived sense of belonging').

On a practical level, the current result strongly advises for the provision of emotional-based forms of support for patients currently on the ward and currently making the transition to living back home following what will have been a most traumatic period in their lives. Such support would be best provided *where* it is needed (Cohen and Wills, 1985) and *when* it is needed (e.g., Alloway and Bebbington, 1987; Brown et al., 1986). The current measuring instrument (the ISSB) for providing measures of 'enacted' or 'actual received' support demonstrated the moderate direct and strong indirect contribution of actions, words, or deeds (e.g., Brugha, 1984b, 1991; Gottlieb, 1985b; Thoits, 1982) to feelings of well-being. Thus, the basic provision of 'care in the community' that was advocated a little earlier in the discussion - that one listen attentively, respect the speaker, attempt to understand his or her way of construing their world and offer words that confirm these feelings and this current self - would also appear to attract support in this respect.

On this subject, Gottlieb (1985b) makes the important point, crucial to an interpretation of this current finding, that "it is the words or deeds we exchange that matter most to me, not the sense of reliable alliance with others or the psychological promise of support. In the coping process, it is the behavioural manifestation of support expressed by my close associates - its materialization in interpersonal transactions - that has greatest significance for the course and outcomes of my ordeal" (p.361). For it is such manifestations of support that provide the person with the 'perception', that is, with the subjective feeling that he or she has 'a sense of belonging', 'the perceived likelihood of making a positive comparison when comparing oneself with others', and so on. In such **actions**, one can infer that one is supported, this contributing to a 'perception' of support and a 'perception' of satisfaction with support: actions and perceptions which translate into emotional states either of well-being or distress (Thoits, 1982).

This view is one shared by Folkman (1984) who posits a 'bi-directional relationship' between the person and the environment, somewhat similar in essence to Bandura's (1977) conception of 'reciprocal determinism'. These perceptions or appraisals of support and of self partly depend upon the actual experience of being supported by others where such actual words, acts, and deeds appear to satisfy the 'basic' essence of 'man's life' (Buber, 1957b; Laing, 1967), "the wish of every man to be confirmed as what he is, by men; and the innate capacity in man to confirm his fellow men in this way". This may appear somewhat grand, but, nonetheless, the current findings of the second (cross-sectional) regression analysis provide good evidence for this conception of **true support** - a conception that meets with increasing agreement by many researching the construct (e.g., Gottlieb, 1985; Rook, 1985; Thoits, 1985; Walker et al., 1977). Moreover, it is 'emotional' forms of support that have been demonstrated time and again as being the most common kind of support that is **sought** by people during life crises (e.g., Brewin et al., 1989; Dakoff and Taylor, 1990; Dunkel-Schetter, 1984; Gore, 1985; Parry, 1988).

In the final part of the discussion perhaps what can be considered the major criticism of the study will be briefly re-examined: the emphasis on the patients' mainly subjective accounts of the study's variables - psychological distress, 'social support', 'powerful emotion', 'cognitive appraisal' and 'life events and difficulties'. This criticism has been examined and, in the current author's mind, adequately dealt with in the relevant chapters (chapter two, sections 1.4. and 1.5.; chapter three, section 3.3.1.).

Criticism about excessive over-reliance on people's subjective, 'self-reports' of the contents of their consciousness usually centres upon their proposed unreliability - forgetting events, for example, or up-grading or down-grading reports of consciousness in tune to the subtle 'demand characteristics' inherent in the situation and in the person to whom the subject is 'self-reporting' (Aranson et al., 1990). However, there are two, perhaps three responses that can reasonably be made to such criticism. The first is to acknowledge that such sources of error or bias do exist (and perhaps they always will, such is human nature) and that they are, therefore, possible where adequate control is missing from the experimental design. Such sources of bias are, however, one of the difficulties that one must face where one wishes to investigate a subject that is inherently grounded in subjectivity: the mental life of the formerly-discharged psychiatric patient. Brugha (1991), in his recent review of social support and personal relationships, concludes thus, "Of all the standards required of good empirical research, studies of personal relationships and psychiatric disorders are particularly vulnerable to problems of interpretation, arising from the effects of errors in the data, and also from effects of bias" (Brugha, 1991, p.124).

The second response is to state that verbal measures which are direct rather than indirect are more likely to be a representative measure of the contents of consciousness - that is, they will be valid (Sheridan, 1979). A question is asked - the reply to which demands little reflection on the subject's part of the causes of the content enquired about. Questions of this type were asked of subjects - questions which demanded a straightforward criterional response. However, a criticism of such 'social support' questionnaires will be ventured at this point. Although such measures that were used had been found to possess demonstrable levels of scientific reliability and validity (chapter two, section 4.8.) the responses to many of the items on the ISEL (Cohen et al., 1985) were more correctly a function of the specific period in time and the specific context in which the measurement was being taken. Thus, many items would very well have been responded to in the affirmative if they applied to say, 'weekdays' but not if applying to 'weekends' when less support might have been available. This would imply the need for more detailed coding of information such that a measure of qualifications of this kind could be handled. An improvement of this kind would add both to the quality of the information obtained and to the quality of explanation made.

The third response to criticism of this kind is provided by the result of the 'consistency' test of patients' responses to all items from all the questionnaires - psychological distress, 'social support', 'powerful emotion', 'cognitive appraisal' and 'life events and difficulties'. That is, the test of such criticism - namely, that one's data are of a dubious quality grounded more in the shifting, muddied and untrustworthy perceptions of the psychiatric patient than in any kind of 'objective reality' - would be to subject such information to a sensitive test of its validity. That is, "Were the patients consistent in their responding to items of an identical kind that were spread unevenly across a number of different questionnaires?" - in which case we will have more confidence in the essential validity and quality of the data at our disposal. Or, "Were patients inconsistent: responding in "bad faith" (Mair, 1989) or simply dishonestly?" - in which case we must entertain doubts as to the validity of any information obtained. The result of this analysis was quite categorical: patients were highly consistent in their responses to items from the questionnaires. Some credit for this can be attributed to the design of the project which requred patients to sit in on lengthy interviews with the author - 'interviews' which would have been greatly reduced had patients simply been asked to fill-in the questionnaires themselves, in their own time. However, such a method, as argued in the third chapter, has its equal, indeed unequal - for there are many - number of pitfalls. The method of investigation was considered the best available. The result of the 'consistency test' does not, yet, guarantee that the patient will not have consistently lied or acted in 'bad faith'. It does, however (as argued in chapter three), make this possibility highly unlikely.

3.3. CONCLUSIONS.

Finally, a point should be made about the reliance on subjective reports of feelings, support and so on which makes it clear that such information, where it is valid and consistent (which it was) is considered essential in helping to improve understanding of the reasons why many patients consistently return to hospital within a year to eighteen months of getting discharged: that is, of the reasons for the discharge "revolving-door syndrome" (Goldman et al., 1980). Whether someone is able to correctly perceive the totality of their experience of the world at any one time and provide a true representation of this 'objective reality' or not does not matter, or rather, it is almost to miss the point. One of the fundamental defining characteristics of the person who has become psychologically disturbed is that he or she *appears to have* lost some of his or her ability to see things in proper perspective - hence the severe experiences of anxiety, depression, obsessional-ruminative behaviour, paranoic and psychotic thinking all of which severely impair the ability to get on with things - "to cope with the basic requirements presented by life" (Smail, 1984). In these circumstances, it becomes quite essential that one obtain an accurate measure of the patient's own perceptions: of feelings, symptoms and social support. The patient's troubles are his own. If one is to improve an understanding of these troubles it would help to listen to him and to record what he has to say - *provided he takes us seriously.* <u>The result of the consistency test proves that he did</u>. These 'perceptions' - the patient's subjective accounts of the details of their emotional experience, daily life experience, and social support experience - are the essence, for it is such perceptions which influenced, influence and will continue to influence his or her actions in the world - one of which is the attempt at killing oneself or the return through the doors of the acute assessment ward for help. It is this that matters, above all else.

It would be fitting, in this respect, to conclude with the words of Don Bannister and Fay Fransella who make the essential point that our experience and interpretation of our experience is uniquely our own. They write,

> "It could be argued that the fundamental mystery of human psychology is covered by the question 'Why is it that two people in exactly the same situation behave in different ways?' The answer is of course that they are not in the 'same' situation. Each of us sees our situation through the 'goggles' of our personal construct system. We differ from others in how we perceive and interpret a situation, what we consider important about it, what we consider its implications, the degree to which it is clear or obscure, threatening or promising, sought after or forced upon us. The situation of the two people who are behaving differently is only 'the same' from the point of view of a third person looking at it through <u>their own</u> personal construct goggles. Among the many implications of this statement is that when people are said to be similar, it is not necessarily because they have had the same experiences, but because they have placed the ***same interpretations*** on the experiences they have had. In the final analysis, none of us is likely to be a carbon copy of another. Each of us lives in what is ultimately a unique world, because it is uniquely interpreted and thereby uniquely experienced." (Bannister, 1986, p.10).

A final point will be made concerning an issue that is related to the quotation made above. It is one made by another clinically-based philosopher of human nature, David Smail (1987) and it is this. Can it be contended that the experiences of the patients in the sample are far from 'mad' or illogical or irrational (as proposed throughout this thesis) but that they are actually characteristic of and supportive of Smail's (1987) view that "feeling and acting are far from being matters of will, but are, as it were, held in place by the situation in which people find themselves. On the other hand, this does not mean that we are free to do what we like or to feel what we want or think we ought to feel. We act and feel rationally according to our circumstances, and indeed our interests. To say that we act rationally is not to say that we act necessarily correctly or sensibly, but simply that we have reasons for what we do which follow from our experience of the world and our bodily relation to it"? (Smail, 1987, p.75).

Judgement on this issue might best be considered <u>open</u>. However, the current author has an informed view. In other words, *I* have a view. This 'view' is one based on the many results of the many analyses of the scientifically-controlled, empirically-obtained information. It is a view based, also, on my many reflections on these results. And it is a view 'informed' by my many reflections that followed my conversations with each patient. Thus, concerning the essentially *rational* nature of the people with whom I conversed such that, “according to (their) circumstances and their interests . . . each person has reasons for what he does which *follow from* his experience of the world and his bodily relation to it", it is my informed view that such a contention would appear to be confirmed. That is, such a *premise* has found *support*.

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Appendix: A.

BECK DEPRESSION INVENTORY

In the course of the next five to ten minutes I shall ask you several questions about how you have been feeling over the past week. For each question there will be several options to choose from in answering the question. What I'd like you to do is to point to the item - which I'll present to you - which sums up how you've been feeling, or what you've been thinking about yourself **OVER THE PAST WEEK.**

A. MOOD
0 I do not feel sad
1 I feel sad
2 I am sad all the time and I can't snap out of it
3 I am so sad or unhappy that I can't stand it

B. PESSIMISM
0 I am not particularly discouraged about the future
1 I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel that the future is hopeless and that things can't improve

C. SENSE OF FAILURE
0 I do not feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life all I can see is a lot of failures
3 I feel I am a complete failure as a person (parent, husband, wife)

D. LACK OF SATISFACTION
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to
2 I don't get real satisfaction out of anything anymore
3 I am dissatisfied or bored with everything

E. GUILTY FEELING
0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

F. SENSE OF PUNISHMENT
0 I don't feel I am being punished
1 I feel I may be punished.
2 I expect to be punished
3 I feel I am being punished

G. SELF HATE
0 I don't feel disappointed in myself
1 I am disappointed in myself
2 I am disgusted with myself
3 I hate myself

H. SELF ACCUSATIONS
0 I don't feel I am any worse than anybody else
1 I am critical of myself for my weaknesses or mistakes
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

I. SELF-PUNITIVE WISHES
0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself but I would not carry them out
2 I would like to kill myself
3 I would kill myself if I had the chance.

J. CRYING SPELLS
0 I don't cry any more than usual
1 I cry more now than I used to
2 I cry all the time now.

3 I used to be able to cry but now I can't cry at all even though I want to

K. IRRITABILITY
0 I am no more irritated now than ever I am
1 I get annoyed or irritated more easily than I used to
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

L. SOCIAL WITHDRAWAL
0 I have not lost interest in other people
1 I am less interested in other people now than I used to be
2 I have lost most of my interest in other people.
3 I have lost all my interest in other people.

M. INDECISIVENESS
0 I make decisions about as well as ever
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all any more

N. BODY IMAGE
0 I don't feel I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel that there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

O. WORK INHIBITION
0 I can work about as well as before
1 It takes extra effort to get started at doing something
2 I have to push myself very hard to do anything
3 I can't do any work at all

P. SLEEP DISTURBANCE
0 I can sleep as well as usual
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
3 I wake up several hours earlier than I used to and cannot get back to sleep.

Q. FATIGUABILITY
0 I don't get more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I get too tired doing anything

R. LOSS OF APPETITE
0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all any more

S. WEIGHT LOSS
0 I haven't lost much weight, if any, lately
1 I have lost more than 5 lb.
2 I have lost more than 10 lb.
3 I have lost more than 15 lb.

T. SOMATIC PREOCCUPATION
0 I am no more concerned about my health than usual
1 I am concerned about aches and pains **or** upset stomach **or** constipation **or** other unpleasant feelings in my body
2 I am so concerned with how I feel or with what I feel that it's hard to think of much else
3 I am completely absorbed in what I feel

U. LOSS OF LIBIDO
0 I have not noticed any recent change in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely.

The General Health Questionnaire - 30

We should like to know if you have had any medical complaints, and how your health has been in general, over the past week including today. Please answer all the questions by answering which you think most nearly applies to you.
Remember that we want to know about your present and most recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

HAVE YOU RECENTLY
(OVER THE PAST WEEK):

1. been able to concentrate on whatever you're doing?
2. lost much sleep over worry?
3. been having restless, disturbed nights?
4. been managing to keep yourself busy and occupied?
5. been getting out of the house as much as usual?
6. been managing as well as most people would in your shoes?
7. felt on the whole you were doing things well?
8. been satisfied with the way you've carried out your task?
9. been able to feel warmth and affection for those near to you?
10. been finding it easy to get on with other people?
11. spent much time chatting with people?
12. felt that you are playing a useful part in things?
13. felt capable of making decisions about things?
14. felt constantly under strain?
15. felt you couldn't overcome your difficulties?
16. been finding life a struggle all the time?
17. been able to enjoy your normal day-to-day activities?
18. been taking things hard?
19. been getting scared or panicky for no reason?
20. been able to face up to your problems?
21. found everything getting on top of you?
22. been feeling unhappy and depressed?
23. been losing confidence in yourself?
24. been thinking of yourself as a worthless person?
25. felt that life is entirely hopeless?
26. been feeling hopeful about your own future?
27. been feeling reasonably happy, all things considered?
28. been feeling nervous and strung-up all the time?
29. felt that life isn't worth living?
30. found at times you couldn't do anything because your nerves were too bad?

CODINGS:

Not at all	**No more than usual**	**Rather more than usual**	**Much more than usual**

Symptom CheckList-90

INSTRUCTIONS

In the next 10 minutes or so, I'll go through a list of problems and complaints that people sometimes have. What I'd like you to do is tell me whether or not you have experienced or felt any of the things which I will ask you.

I'll ask you how much each of these problems have bothered or distressed you **over the past week.**

When I go through each problem, I'll also ask you to tell me how badly you have been bothered by each of these problems. To do this, I'll ask you to tell me if you've felt the problem:

0. not at all; 1. a little bit; 2. moderately; 3. quite a bit, or, 4. extremely.

HOW MUCH WERE YOU BOTHERED BY:

1. Headaches
2. Nervousness or shakiness inside
3. Unwanted thoughts, words, or ideas that won't leave your mind.
4. Faintness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. The idea that someone else can control your thoughts.
8. Feeling others are to blame for most of your troubles
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in heart or chest
13. Feeling afraid in open spaces or on the streets
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Hearing voices that other people do not hear
17. Trembling
18. Feeling that most people cannot be trusted
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. Feeling of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Feeling afraid to go out of your house alone
26. Blaming yourself for things
27. Pains in lower back
28. Feeling blocked in getting things done
29. Feeling lonely
30. Feeling blue
31. Worrying too much about things
32. Feeling no interest in things
33. Feeling fearful
34. Your feelings being easily hurt
35. Other people being aware of your private thoughts
36. Feeling others do not understand you or are not sympathetic.
37. Feeling that people are unfriendly or dislike you
38. Having to do things very slowly to ensure correctness
39. Heart pounding or racing
40. Nausea or upset stomach

41. Feeling inferior to others
42. Soreness of your muscles
43. Feeling that you are watched or talked about by others
44. Trouble falling asleep
45. Having to check and doublecheck what you do
46. Difficulty making decisions
47. Feeling afraid to travel on buses, subways, or trains
48. Trouble getting your breath
49. Hot or cold spells
50. Having to avoid certain places, things, or activities because they frighten you
51. Your mind going blank
52. Numbness or tingling in parts of your body
53. A lump in your throat
54. Feeling hopeless about the future
55. Trouble concentrating
56. Feeling weak in parts of your body
57. Feeling tense or keyed up
58. Heavy feeling in your arms or legs
59. Thoughts of death or dying
60. Overeating
61. Feeling uneasy when others are watching or talking about you
62. Having thoughts that are not your own
63. Having urges to beat, harm, or injure someone
64. Awakening in the early morning
65. Having to repeat the same actions such as touching, counting, or washing
66. Sleep that is restless or disturbed
67. Having urges to break or smash things
68. Having ideas or beliefs that others do not share
69. Feeling very self-conscious with others
70. Feeling uneasy in crowds such as shopping or at a movie
71. Feeling everything is an effort
72. Spells of terror or panic
73. Feeling uncomfortable about eating or drinking in public
74. Getting into frequent arguments
75. Feeling nervous when you are alone
76. Others not giving you proper credit for your achievements
77. Feeling lonely even when you are with other people
78. Feeling so restless you couldn't sit still
79. Feelings of worthlessness
80. Feeling that familiar things are strange or unreal
81. Shouting or throwing things
82. Feeling afraid you'll faint in public
83. Feeling that people will take advantage of you if you let them
84. Having thouths about sex that bother you a lot
85. The idea that you should be punished for your sins
86. Feeling pushed to get things done
87. The idea that something serious is wrong with your body
88. Never feeling close to another person
89. Feelings of guilt
90. The idea that something is wrong with your mind

THE INTERPERSONAL SUPPORT EVALUATION LIST

INSTRUCTIONS

This scale will ask you a number of questions about what you **think** and **feel** about the contacts and relationships you have with other people.

These feelings may be about contacts you have with friends, family members, or anyone who has been a part of your life over the past six months, before your admission to hospital.

I'll ask you to answer either TRUE or FALSE to a number of statements about the sorts of things may have happened to you before you came into hospital.

Sometimes what I say might not really be TRUE or FALSE for you. Try to tell me whether it is PROBABLY TRUE or PROBABLY FALSE.

1. There is at least one person I know whose advice I really trust.
2. I don't often get invited to do things with others.
3. If I were sick and needed someone to drive me to the doctor, I would have a hard time finding someone.
4. Most of the people I know are more successful at making changes in their lives than I am.
5. I am more satisfied with my life than most people are with theirs.
6. When I need suggestions for how to deal with a personal problem I know there is someone I can turn to.
7. There is someone who I feel comfortable going to for advice about sexual problems.
8. Most people I know don't enjoy the same things I do.
9. If I had to go out of town for a few weeks, someone I know would look after the home.
10. If I needed some help in moving to a new home, I'd have a hard time in finding someone to help me.
11. If I was stranded 10 miles out of town, there is someone I could call tocome get me.
12. There is someone I can turn to for advice about handling hassles over household responsibilities.
13. No one I know would throw a birthday party for me.
14. I am closer to my friends than most other people are.
15. There is really no-one I can trust to give me good financial advice.
16. Most of my friends are more interesting than I am.
17. If for some reason I were put in jail, there is someone I could call who would bail me out.
18. There is no one I could call on if I needed to borrow a car for a few hours.
19. I regularly meet or talk with members of my family or friends.
20. I feel that I'm on the fringe in my circle of friends.
21. I feel that there is no one with whom I can share my most private worries and fears.
22. In general, people don't have much confidence in me.
23. I have someone who takes pride in my accomplishments.
24. If I decide on a Friday afternoon that I'd like to see a movie that evening I'd find someone to go with me.
25. If a family crisis arose, few of my friends would be able to give me good advice about handling it.
26. I think that my friends feel that I'm not very good at helping them solve problems.
27. If I were sick, the there would be almost no one to help me with my daily chores.
28. If I needed a quick emergency loan of of around £50, there is someone I could get it from.
29. I am able to do things as well as most other people.
30. If I wanted to have lunch with someone, I could easily find someone to join me.
31. There are several different people with whom I enjoy spending time.
32. There is really no-one who can give me information about how I'mhandling my problems.
3. I have a hard time keeping pace with my friends.
34. There is someone I could turn to for advice about changing my job or finding a new one.
35. Most people I know think highly of me.
36. If I needed a ride to the hospital day-centre very early in the morning I'd have a hard time trying to find someone to take me.
37. If I wanted to get out of town for the day (eg. to the coast, the hills) I'd have a hard time tring to find someone to go with me.
38. If I had to mail an important letter at the post office by 5.00pm and couldn't make it, there is someone who could do it for me.
39. There are very few people I trust to help solve my problems.
40. When I feel lonely, there are several people I could call and talk to.

THE INVENTORY OF SOCIALLY SUPPORTIVE BEHAVIOURS

The following set of questions are designed to assess the number of times in the six months before your admission to hospital that you were helped by people. This help can be of all kinds.
It is important that you think of **anyone** at all who did anything for you in those six months, anything, that is, you might call **helpful**.
This might include members of your family, friends, people you know in your neighbourhood, **or even** members of the health services, such as doctors, nurses, health visitors.

Was there anyone at all in the past six months who: (Yes or No).

1. Looked after a family member when you were away
2. Was right there with you (physically) in a stressful situation.
3. Provided you with a place where you could get away for a while.
4. Watched after your possessions when you were away (pets, plants, home, etc.).
5. Told you what she/he did in a situation that was similar to yours.
6. Did some activity together to help you take your mind off things.
7. Talked with you about some interests of yours.
8. Let you know that you did something well.
9. Went with you to someone who could take action.
10. Told you that you are OK just the way you are.
11. Told you that she/he would keep the things that you talk about private - just between the two of you.
12. Assisted you in setting a goal for yourself.
13. Made it clear what was expected of you.
14. Expressed respect for some personal quality of yours.
15. Gave you some information on how to do something.
16. Suggested some action you should take.
17. Gave you over £10.
18. Comforted you by showing some physical affection.
19. Gave you some information to help you understand a situation you were in.
20. Provided you with some transportation: a car, van, etc.
21. Checked back with you to see if you followed the advice you were given.
22. Gave you under £10.
23. Helped you understand why you didn't do something well.
24. Listened to you talk about your private feelings.
25. Loaned or gave you something (eg. a box of matches, a tool) that you needed at the time.
26. Agreed that what you wanted to do was right.
27. Said things that made your situation clearer and easier to understand.
28. Told you how she/he felt in a situation similar to yours.
29. Let you know that he/she will always be around if you need assistance.
30. Expressed interest and concern in your well-being / health.
31. Told you that he/she feels very close to you.
32. Told you who you should see for assistance.
33. Told you what to expect in a situation that was about to happen.
34. Loaned you over £10.
35. Taught you how to do something.
36. Gave you feedback on how you were doing without saying it was good or bad.
37. Joked and kidded to try to cheer you up.
38. Provided you with a place to stay.
39. Gave you a hand to help you to do something that you needed to get done.
40. Loaned you under £10.

THE SOCIAL RELATIONSHIPS AND ACTIVITIES QUESTIONNAIRE.

On the average, how often have you done each of these things in the past three months (prior to admission to hospital):

1. Visiting with friends.
2. Visiting with relatives.
3. Going to the movies.
4. Going to watch sports events.
5. Going to concerts, plays, etc..
6. Going to fairs, museums, exhibits, etc..
7. Attending meetings, etc..
8. Going to church.
9. Going on pleasure drives in the country, picnics, etc..
10. Going to classes (eg. evening classes), lectures, etc.

CODINGS:

1 = didn't do this at all in the past 3 months;
2 = once or twice in the past 3 months;
3 = about once per month;
4 = about once or twice per month;
5 = about once per week;
6 = more than once per week.

About how many hours in an average day or an average week do you spend:

1. Watching television, including videos on t.v. (total time).
2. Listening to the radio (total time)
3. Listening to the news on radio or watching the news on television
4. Reading newspapers
5. Reading magazines or books.

How much satisfaction do you get from each of these things?

CODINGS:

1. "NONE" . . . 5. "A GREAT DEAL"

THE INTERVIEW SCHEDULE for SOCIAL INTERACTION

First, I want to get some idea of the people around you in your life. This includes those that are closest to you - your family, friends and neighbours - all the people you may meet from day to day. These first questions will be about people you know a little, but who are not close friends.

1. Now let's consider people you exchange a word or two with; that is, someone serving you in a shop or office, but whom you normally don't see apart from at their work. Most days, how many people like this do you see?

None	1
1-2	2
3-5	3
6-10	4
11-15	5
More than 15	6

2. Would you like more or less of this, or is it about right?

Less	1
About right	2
More	3

I shall be asking this sort of question throughout this section - ie. would you want more, or less of this, or is it about right.

3. On most days, how many people do you see whom you know just a little, to smile or wave to, or to say good morning to? People you do not know well - you may know their names - but you greet each other when you pass by.

None	1
1-2	2
3-5	3
6-10	4
11-15	5
More than 15	6

4. Is this about right for you, or do you wish you saw more or fewer such people?

Less	1
About right	2
More	3

5. These days, how many people with similar interests to you do you have contact with?

None	1
1-2	2
3-5	3
6-10	4
11-15	5
More than 15	6

6. Would you like more or less of this or is it about right?

Less	1
About right	2
Depends on the situation	3
More	4

7. On your job do you usually work with others or alone?

Not employed (Go to Q.10)	0
With others	1
Depends on the situation	2
Alone	3

8. How often do you go out with people at work?

Never	0
Once per year	1
A few times per year	2
Monthly	3
Weekly or more	4
Not Applic.	9

9. Would you like to go out together more or less than you do, or is this about right?

Less	1
About right	2
Depends on the situation	3
More	4
N.A.	9

10. In an ordinary week, how many people whom you know would you say you have contact with?

None	1
6-10	4
1-2	2
11-15	5
3-5	3
More than 15	6

11. Would you like more or less of this or is it about right for you?

Less	1
About right	2
Depends on the situation	3
More	4

12. At present, do you wish there were more, or less, or are there about the right number of people in your day-to-day life?

Less	1
About right	2
Depends on the situation	3
More	4

13. I have been talking about people you may know a little but may not call them allclose friends. At this time last year, would you have said there were more such people in your life than now, fewer than now, or about the same number as now?

Fewer last year, more	1
Same	2
Depends on the situation	3
More last year, fewer now	4

Now I'd like you to think about people you are close to who live in or near this town (town). Close friends who are near enough physically so you can see them whenever you wish.

14. How many friends do you have who could come to your home at any time and take things as they find them - they wouldn't be embarrassed if the house were untidy or if you were in the middle of a meal.

None	1
1-2	2
3-5	3
6-10	4
11-15	5
More than 15	6

15. Would you prefer more or less of this or is it about right for you?

Less	1
About right	2
Depends on the situation	3
More	4

16. How many friends do you have whom you could visit at any time, without waiting for an invitation. You could arrive without being expected but still be sure you'd be welcome.

None	1
1-2	2
3-5	3
6-10	4
11-15	5
More than 15	6

17. Would you like to have more or fewer friends like this, or is it about right for you?

Less	1
About right	2
Depends on the situation ...	3
More	4

18. Overall would you say you belong to a close circle of friends - a group of people who all keep in close touch with each other - or not?

Yes	1
Qualified response	2
No	3

19. Would you like more or less of this or is it about right for you? (persons, duration or frequency)

Less	1
About right	2
Depends on the situation ...	3
More	4

20. People differ in how much they need friendship. Would you say you are the sort of person who can manage without friends or not?

Can't manage without friends (Go to Q.21)	1
Depends on the situation	2
Can manage without friends	3

A. Do you prefer to do without friends or would you prefer to have them?

Do without	1
Have them	2
Not applic.	3

Now please think about all the people in your life who live in or near (this town). This includes the people you live with, your family, and your friends.

21. Among your family and friends, How many people are there who are immediately available to you whom you can talk with frankly, without having to watch what you say?

None (Go to Q.21 D)	1
1-2	2
3-5	3
6-10	4
11-15	5
More than 15	6

A. Would you like to have more or less people like this or is it about right for you?

Less	1
About right	2
Depends on the situation	3
More	4
Not applic.	9

B. With the one (those) you have, would you like to feel more free to be frank or is it about right?

About right	2

Depends on the situation ...	3
More free	4
Not applic.	9

C. Who is this mainly? (Fill in one only on the Attachment Table)
(Go to Q.22)

D. Do you wish there were someone or not?

Yes	1
Don't Know	2
No	3
Not applic.	9

22. If something unpleasant or irritating hapens and you get upset or angry about it, Do you have someone you can go to who isn't involved and tell them just how you feel, or not?

Yes	1
Depends on situation	2
No	3

(Code 0 for number, and go to Q.22 C)

22. A How many people like this are there?

Number .... ______

22. B. Do you wish you had more or fewer people like this or is this about right?

Fewer	1
About right	2
Depends on situation...................	3
More	4
Not applic....................................	5

(Go to Q.23)

(If no one)

C. Is there no one you can go to in that situation or do you prefer to keep such things to yourself?

No one...	1
Depends on situation	2
Keep things to yourself..................	3
Not applic......................................	4

23. These last questions were about close friends and people you know really well. At this time last year, did you have more or fewer people or about the same number?

Fewer last year, more now.............	1
Same.................................	2
Depends on the situation	3
More last year, fewer now...........	4

24. And would you say that the quality of friendships you had a year ago was as good, less good, or better?

Less good a year ago	1
Same (Go to Q.25)...........................	2
Depends on the situation	3
Better a year ago	4

A. What would you say is the main reason for this?

REPLY:

25. Now I want you to think about exerybody in this town to whom you are close. Considering those you live with, your family and friends, who above all would you say you are closest to, fondest of, most attached to.
Who would be next? Anyone else? (Fill in on Attachment Table)

26. Would you say you have a single lasting relationship, someone you intend to go on sharing your life with, or not?

No one (Go to Q.26 C) _____
Yes _____

A. Who is this? (Fill in on A.T.)

B. Do you wish you felt more certain of this or not?

Yes...	1
No...	2
Not applic..................................	3

(Go to Q.27)

(I no one)

C. Do you wish there were someone or do you prefer to be unattached right now?

Wishes there was someone..........	3
Don't know.................................	2
Prefers to be unattached.............	1
N.A..	9

27. Is there anyone very important to you whom you are no longer in close touch with?

No. (Go to Q.28) _____
Yes _____

A. Who is it (Fill in on A.T.)

B. Why don't you see him / her any more?

Died...	1
Moved away	2
Conflict	3
Other (specify)..........................	4
N.A...	9

27.

C. When did this occur?

Months ago ____
Years ago _______

(If died)

D. Would you say you still think about this person?

Not at all	1
A little......................................	2
Most days..................................	3
All the time.................................	4
N.A.	9

28. May I ask if anyone (or anyone else) close to you has died in the last few years?

No (Go to Q.29) ___________
Yes ___________

A. Who was it?

B. When was that?

Months ago _____
Years ago ______________

C. Would you say you still think about this person?

Not at all	1
A little	2
Most days	3
All the time	4
N.A	9

29. Now I would like to ask if there is anyone who lives in or near this town who knows you very well as a person. (This includes friends as well as family members)

No one (Go to Q.29 E)	1
Yes (qualified)	.2
Yes	3

A. Who is this?

29.

B. Would you say _________________ really knows you very well indeed?

Yes	1
No	2
N.A.	9

C. Do you wish ______________ did not know you quite so well, knew you better, or is it about right?

Less	1
About right	2
Depends on situation	3
Better	4
Not applic	9

D. Would you like to have someone else like this or not?

Yes	1
Don't know	2
Depends on situation	3
No	4
N.A	9

(Go to Q.30)

(If no one)

E. Do you wish there was someone or not?

Yes	1
Don't know	2
No	3
N.A	9

30. Is there any particular person you feel you can lean on?

No one (Go to Q.30D)	1
Yes, but don't need anyone	2
Yes	3

A. What is his / her name?

30.

B. Would you like to be able to lean more or less on _________?

Less	1
About right	2
Depends on situation	3
Better	4
Not applic	9

C. Would you like to have someone else like this or is he / she enough?

Yes	1
Don't know	2
Enough	3
N.A	9

(go to Q.31)

(If no one)

D. Is it that you have no need for such a person or do you wish there were someone?

Wish there were	1
Don't know	2
No need	3
N.A.	9

31. Do you feel there is one particular person who feels very close to you?

A. Who is this mainly? (Fill in on A.T.)

B. Would you like ___________ to feel closer, or not so close to you, or is it about righth the way it is?

Closer	1
About right	2
Depends on the situation	3
Not so close	4
N. A.	9

C. Would you like to have more or fewer people like this or is it about right?

Less	1
About right	2
More	3
Not applic.	9

31.
(Go to Q.32)

(If no one)

D. Do you wish there were someone or not?

Yes	1
Don't know	2
Enough	3
N.A.	9

32. When you are happy, is there any particular person you can share it with - someone you feel sure will feel happy simply because you are?

No one (Go to Q.32D)	.0
Yes	1

A. Who is this mainly?

B. Would you like to feel this more with ____________ or is it about right?

About right	1
More	2
N.A.	9

C. Would you like to have someone else like this or is this enough?

Yes	1
Don't know	2
Enough	3
N.A.	9

(Go to Q.33)

(If no one)

D. Do you wish there were someone or not?

Yes	1
Don't know	2
No	3
N.A.	9

33. At present, do you have someone you can share your most private feelings with (confide in) or not?

No one (Go to Q.33D)	0
Yes	1

A. Who is this mainly?
B. Do you wish you could share more with ____________ or is it about right?

About right	1
Depends on situation	2
More	3
Not applic	9

C. Would you like to have someone else like this as well, would you prefer not to use a confidant, or is it just about right for you the way it is?

Prefers no confidant	1
About right	2
Depends on situation	3
Like someone else as well	4
Not applic	9

(Go to Q.34)

(If no one)
D. Would you like to have someone like this or would you prefer to keep your feelings to yourself?

Keep things to self	1
Like someone	2
N.A.	3

34. Are there ever times when you are comforted by being held in someone's arms or not?

No (Go to Q.34C)	0
Yes	1

A. By whom mainly? (Fill in on A.T.)

B. Is there anyone you'd like to comfort you more in this way or is it all right the way it is?

All right as it is	2
Yes	1
N.A.	9

34.
C. Is this because there's no one to hold you, or because you prefer not to be comforted in this way?

No one	2
P{refer it that way	3
N.A.	4

35. Now, I have been talking about those persons (the person) Who are (is) closest to you. At this time last year, would you say that you and ________________ were closer, less close, or about the same?

(Code these on the A. T. Ask about each of the first 4 people mentioned regardless of the Q. which elicited the information)
(If response is not "about the same" *for all 4 people, ask Q.35A)*

A. What would you say are the main reasons for the change?

REPLY:

36. Recently, have you been having any unpleasentness, or rows with anyone close to you?

No (Go to Q.37) ____
Yes ____________________

A. Who is this? (A.T.: up to 3 names)

(For each person)
B. Would you desribe this unpleasentness or row as mild, moderate, or severe? (Code on A.T.)

37. How many people are there for whose care you are needed? Persons who are solely dependent on you in their day-to-day life?

Number ________________

38. Would you like to have more or less of this in your life or is this about right

Less	1
About right	2
Depends on situation	3
More	4

39. Still thinking of people in or near this town, you family and everyone else - how many people are htere who depend on you *particularly* for help, or guidance, or advice in day-to-day life?

Number _______

40. Would you like to have more or less of this in your life, or os it about right?

Less	1
About right	2
Depends on situation	3
More	4

(If respondent lives alone, Go to Q.42)

41. Do you think those at home really appreciate what you do for them or not?

Yes	1
Not really	2
Depends on sitn.	3
Not at all	4
N.A	9

A. Would you like any of them to show appreciation more, or less, or is it about right?

Less	1
About right	2
Depends on situation	3
More	4
N.A	9

42. Are there any othe people outside your home who really appreciate what you are doing for them?

No (Go to Q.43) 0
Yes ____________

A. How many? No. ______

43. Would you like more of this, less of this, or is it about right?

Less	1
About right	2
Depends on situation	3
More	4

44. Do people tell you that you are good at doing some things or not? Being praised for something you're good at, in the home, at work or elsewhere.

No. (Go to Q.45)	.0
Yes _________________	

A. How many? Number _______________

45. Would you like more of this, or less, or is it about right?

Less	1
About right	2
Depends on situation	3
More	4

46. Are there people around from whom you can easily ask small favours? Such as people you know well enough to borrow tools or things for cooking.

No. (Go to Q.47)	0
Yes ___	

A. How many? Number __________________

47. Would you like more of this, or less, or is it about right?

Less	1
About right	2
Depends on situation	3
More	4

48. Apart from those at home, are there people in this town to whom you can turn in times of difficulties?

No. (Go to Q.49)	0
Yes _____	

A. How many? Number ____________

49. Do you wish you had more of such help available or is it about right?

About right	1
Depends on situation	2
More	3

50. When things are difficult, do you find it more helpful to be with someone or to be by yourself?

Be with someone	1
Depends on situation	2
Be by self	3

51. How many people whom you have to see regularly do you dislike?

Number _______________

52. Recently, have some things been unpleasant for you with any people outside your home?

No	2
Yes	1

THE LIST OF RECENT EXPERIENCES

Additional information about the **Month**, **Year**, **Duration** and a brief **Description** of each event is recorded.

DISTRESS WEIGHTS

A. Illness, Injury, Accident.

1. You had a serious accident
2. You had a serious illness or injury
3. Sudden serious illness or injury of someone close to you
4. You have had a spouse with a long and serious illness
5. You have had a child with a long and serious illness
6. You have had a parent with a long and serious illness
7. You had a minor illness or injury
8. You underwent change of life
9. You were personally involved in a natural disaster

B. Bereavement.

10. Your child died
11. Your husband (or wife) died
12. Death of close family member / friend

C. Pregnancy or Childbirth.

13. You became pregnant (unwanted / unwanted)
14. Self (or wife) had baby
15. You (or wife) had an abortion or miscarriage
16. You (or wife) had a still-birth
17. You adopted a child.

D. Changes in relationships.

18. You became engaged or started a new relationship
19. You were married
20. You got together again after separation due to marital difficulties
21. There was marked improvement in your relationship with husband or wife
22. There was improvement in the way you get on with someone else
23. There were increasing serious arguments with your husband (or wife)
24. There were increasing serious arguments with with someone else who lives at home
25. There were serious problems with a close friend, relative or neighbour not living at home
26. You started an extra-marital affair
27. Your husband (or wife) started an affair
28. The behaviour of one of your parents has been a problem to you
29. The behaviour of your spouse has been a problem to you
30. The behaviour of one of your children has been a problem to you
31. You ended an engagement
32. You had sexual difficulties

E. Separation.

33. You broke off a steady relationship
34. You were separated from husband or wife
35. You were divorced
36. Your child was engaged or married (with or without approval).
37. Your child left home for reason other than marriage
38. You were separated from someone else close to you

F. Changes in living conditions.

DISTRESS WEIGHTS

39. You had holidays for a week or more
40. You moved to (this town) from overseas
41. You moved to (this town) from within Scotland
42. You moved house within (this town)
43. A new person came to live in your household

G. Studying or school.

44. You started a new course or school
45. You changed to different course or school or college
46. You dropped out of course or school or college
47. You completed a course or finished at school or college
48. You were studying for examinations
49. You failed an important examination

H. Work situation.

50. You were unemployed or seeking work
51. There was a continuing threat of your being laid off or made redundant
52. You were downgraded or demoted at work
53. You started a completely different type of job
54. You were sacked or laid off
55. Your own business failed
56. There was a big change in the people, duties, hours, or responsibilities at your work
57. You were required to work very long hours
58. You were required to do very tedious or boring work over a long period of time
59. You were required to do work over a long period which you found very difficult
60. You were promoted
61. There was trouble or arguments with people at work or other difficulties
62. You retired or resigned.

I. Financial situation.

63. You have had continuous financial worry
64. You had a major financial crisis
65. You had minor financial problems
66. Something you valued had been stolen or lost
67. You became much better off financially

J. Legal difficulties.

68. You had minor difficulties with police
69. You had problems with police leading to court appearance
70. You had jail or prison sentence
71. You had a civilian suit (eg. divorce, custody, debt)

K. Disappointments.

72. Have there been any serious disappointments for you *in the last twelve months?*
eg. You might have been **expecting** something that didn't happen,
or which didn't turn out the way you wanted, or expected?

L. Continuous worry or stress

73. Have you had any other major trouble or worry
which you have had to bear for some months or more?

MEASURE OF TRUST, SHAME, GUILT, AND BLAME.

(CODINGS: 0 'not at all'; 1 'a little bit'; 2 'moderately'; 3 'quite a bit', and, 4 'extremely'.)

A. SHAME.

Do you feel ashamed of:
1. The (odd / bad) feelings you have?
2. The (odd / bad) thoughts you have?
3. the (odd / bad) things you've done?
4. being in a mental hospital?
5. the problems you feel you might cause others around you?

B. GUILT.

Do you feel guilty about:
1. The (odd / bad) feelings you have?
2. The (odd / bad) thoughts you have?
3. the (odd / bad) things you've done?
4. being in a mental hospital?
5. the problems you feel you might cause others around you?

C. BLAME.

Do you blame yourself mostly for:
1. The (odd / bad) feelings you have?
2. The (odd / bad) thoughts you have?
3. the (odd / bad) things you've done?
4. being in a mental hospital?
5. the problems you might cause others around you?

D. CONSENSUS.

Do you think that most other people: just haven't experienced	1. The (odd / bad) feelings you have?
Do you think that most other people: just haven't experienced	2. The (odd / bad) thoughts you have?
Do you think that most other people: just haven't experienced	3. the (odd / bad) things you've done?
Do you think that most other people: just haven't experienced	4. being in a mental hospital?
Do you think that most other people: just haven't experienced	5. the problems you might cause others around you?

E. ISOLATION.

1. Do you feel you have anyone whom you can share your most worrying problems with?

1. YES 2. NO

2. Do you feel that the problems you have are <u>not</u> the sorts of things that happen to <u>other</u> people?

1. YES 2. NO

3. Do you feel that the sorts of problems you have and the sorts of things that happen to you:

1. others just wouldn't understand? 1. YES 2. NO
2. others just wouldn't be able to help you with? 1. YES 2. NO
3. others might make you feel uncomfortable if you were to try to get them to understand? 1. YES 2 NO

4. Is there anyone you <u>wish you could</u> share your deepest worries with? 1. YES 2. NO

MEDICAL RECORDS.

Patient:

1. Date of ADMISSION :

2. Date of DISCHARGE:

Address:

3. Length of current in-patient admission :
4. Occupation:
5. Marital Status:
6. Age:
7. Sex:
8. Religion:
9. Patient status:

Next of Kin:

10. Primary Diagnosis:
11. Secondary Diagnosis:
12. Former Diagnoses:

Family History:

12. Siblings:
13. Accommodation:
14. Number previous psychiatric in-patient admissions:

(If 1st admission, please note)

15. Average length stay of in-patient admissions:
16. Average length of tenure in the community between admissions:
17. Length of most recent period in the community between admissions:
18. Seen as an OUT-patient:
19. Seen as a DAY-patient:

20. Family doctor.
21. Hospital Consultant.

22. ADMISSION Notes:

23. OTHER INFORMATION:

Appendix: B.

THE 30 CATEGORIES FOR THE TEST OF CONSISTENCY OF SUBJECTS' SELF-REPORTS.

1. HOPELESSNESS: BECK 2, SCL 54, GHQ 26.
2. DISTURBED SLEEP: BECK 16, SCL66, GHQ 3.
3. SLEEP DIFFICULTIES: BECK 16, SCL 64, GHQ 2.
4. APPETITE: BECK 18, SCL 19.
5. CONCENTRATION: SCL 55, GHQ 1.
6. DIFFICULTY/DECISIONS: BECK 13, SCL 46, GHQ 13.
7. WORTHLESSNESS: BECK 3, SCL 79, GHQ 24.
8. SUICIDE: BECK 9, SCL 15.
9. MOOD: BECK 1, SCL 30, GHQ 22.
10. GENERAL SATISFACTION: GHQ 7, 8, 27.
11. MANAGING: GHQ 6, ISEL 29.
12. GENERAL STRAIN: GHQ 14, 16, 21.
13. EXTRA EFFORT: BECK 15, SCL 71.
14. TIRED: BECK 17, SCL 14.
15. IRRITATED: BECK 11, SCL 11.
16. LIBIDO: BECK 21, SCL 5.
17. SCARED/NO REASON: SCL 23, GHQ 19.
18. ANXIETY: SCL 33, SCL 57.
19. SOMATIC: BECK 20, SCL 87.
20. GUILT: BECK 5, SCL 89.
21. MEETING FAMILY/FRIENDS: SRAQ 1, 2, ISEL 19.
22. SHARE PRIVATE FEELINGS: ISEL 1, ISEL 21.
23. PRAISE: SCL 76, ISSB 8, ISSI 44.
24. INFORMATIONAL SUPPORT: ISSB 19, ISSB 27.
25. BELONGING: ISEL 24, ISEL 30.
26. TRANSPORT: ISEL 18, ISSB 22.
27. LOOK AFTER POSSESSIONS: ISEL 9, ISSB 4.
28. PHYSICAL COMFORT: ISSI 34, ISSB 18.
29. PRIVATE FEELINGS: ISSI 33, ISSB 24.
30. SMALL FAVOUR: ISSI 46, ISSB 25.

Appendix: C.

A. PATIENTS WHOSE SYMPTOMS HAD '*IMPROVED*' AT FOLLOW-UP.

LIFE EVENTS: 1. Margaret. Interviewed: 4-5 June 90.
Margaret is a 61 year-old married woman admitted on 03 05 90. She has been admitted on 4 previous occasions: twice in 1963, in 1975, and in March 1980. The primary diagnosis on this occasion was of a paranoid episode in a recurrent schizophrenic illness. She has received previous diagnoses of paranoid psychosis, schizophrenic illness, depressive illness, and recurrent endogenous depression.

Both her parents are now dead neither of whom were identified as having suffered from any form of psychiatric illness, alcoholism, or epilepsy.

Her husband was employed as a shop assistant in Lewis'. Margaret herself is described as a highly strung, keyed-up, overly suspicious woman. A sensitive woman, she has, over the years, moved from job to job because of imagined slights and frank ideas of reference. She left school aged 15 and worked as a secretary with various companies, businesses and academic institutions.

RECENT EVENTS.
The event which precipitated Margaret's current admission to hospital was itself the culmination of a number of circumstances. The event itself was the arrival at the door of Margaret's house of the senior admissions consultant and two nurses from the hospital: Margaret was both surprised and felt let down by her family, feeling they had "ganged up on me behind my back. . . The doctor had called earlier, the family were a wee bit worried about me." She says she was hurt and taken aback by the arrival at the front door of the ambulance. She feels that her husband is a "bit of a dark horse: he doesn't say his true feelings, won't say it right out".

The circumstances surrounding this event help to explain how this all came about. Margaret had become increasingly tired about the house, morose, thinking about her parents and how things have turned out through the years. She had been having restless, disturbed nights "for a good while back" and hadn't been able to participate in nor enjoy her normal day-to-day activities such as reading, knitting and so on: "I felt I'd lost strength: it had been taken out of me. I was disappointed in myself; have been feeling less confident for years. What's the point? What's the use?"

She had also been pondering over several other features of her life, most notable of which are the following:

(a) Her relationship with her husband Denis: he has had heart trouble recently, "doing so much about the house, wearing himself out". Apparently he "just gave up doing everything". His heart condition has been an on-going problem for around three years now. She feels there is so much more they could be doing together, maybe doing something special now that they are both retired. And yet, they're not.

(b) Religion. Almost everyone else about her feels that Margaret has been getting "too religious" recently. She told me she thought her husband was "deceitful in saying I was too religious". He had himself been going to church much more often - to accompany Margaret, although Margaret doesn't consider him particularly religious. She did not care to discuss what it meant for others to say that she was becoming more religious.

(c) Her daughter's marriage, particularly the birth of her physically-handicapped son. She found this "a wee bit disappointing": and moreso the subsequent break-up of her daughter's marriage. She told me that a lot of her time lately has been spent "thinking about the past, thinking about how things used to be, thinking about mum and dad, the times we had, things not done, (the fact) we don't bother the same".

Margaret was admitted under Section 24, Mental Health Act (Scotland).

FOLLOW-UP: 15 NOVEMBER 1990.
Margaret was noticeably more relaxed when I saw her in her home. She and her husband Dennis live in a comfortable, two-bedroomed house situated in a secluded drive in the Bearsden area of Glasgow. Her husband was in town - on account of my visit, letting us "get on with it".

Margaret had had a restive, relatively non-eventful previous six months following hospital discharge. She had been arguing much less with Dennis about "niggly things" - such as religion and church-going. Her daughter came round to visit her more frequently with her handicapped son (i.e., Margaret's grandson). Margaret appears to have "got over" the obsessive rumination about her grandson - where previously she had wondered how things would have been if this child had just been "normal". She and Dennis had been on two holidays during this six-month period: one of which was in Blackpool with the little boy. Margaret told me that she had come to terms much more with this 'problem' - saying that she found "the wee boy" quite "lovely". This was a relief: for it had been occupying her thoughts for some considerable time (several months) (i.e., that things weren't quite perfect).

Margaret was seen by the hospital consultant's junior house officer on two occasions since leaving hospital. She is also seen by a CPN on a regular, six-weekly basis. She receives medication on prescription - tablets that are renewed each month. The CPN "just calls in to see how I am: she's not here usually for more than 10 minutes. I've got Dennis around all the time, so I'm all right that way!".

Margaret looked much more relaxed: it was clear that she had been living a quiet, socially-secluded existence since leaving hospital. However, such a life would appear to be of optimal benefit to Margaret's health, where what contact there is with other people is limited to members of her immediate family or to those professionals responsible for her welfare after leaving hospital. The regular contact appears to be of great benefit here, where Margaret knew that someone would be there if needed.

LIFE EVENTS: 2. Joan interviewed on 28 May 90.

Joan is a 41 year-old recently widowed woman admitted to the ward on 17 05 90 with alcohol dependence primary to depression. Both she and her husband had been admitted to Vale of Leven hospital on the same day in March of this year. An alcoholic, he died whilst in hospital. Joan, herself suffering from acute pancreatitis, took her own discharge against medical advice to attend the funeral. She has been drinking a bottle of vodka per day for 7 weeks since her husband's death. For the past 10 years she has been on a half bottle per day.

She lost her last job as a manager in a bakers in Bearsden over two years ago. She had been married for 22 years with two daughters, aged 21 and 19, both of whom had been living away from home until very recently.

She was recently discharged from the Vale of Leven hospital on 14 05 90. Her only previous admission to ward 2 was on 14 07 90 for 19 days.

RECENT EVENTS

Joan has had the acute pancreatitis to put up with recently. She has also had chronic bronchitis for over two years. Whilst in hospital recently her husband died. She told me she's still in a period of shock, with the need to reassess the course of her life ahead. She has gone to live with her daughter. A holiday has been planned together with the redecorating of her home.

Her husband would abuse Joan when drunk, something she found hard to talk about but which obviously exerts a tremendous influence on the manner of her reaction to his death where there are a mixture of feelings. She describes them as having frequent arguments throughout the past 12-18 months.

Joan's other major worry has been the state of her finances where she currently carries a debt of around £2 500. She doesn't quite know how she will be able to pay this off.

FOLLOW-UP: 28 NOVEMBER 1990.

Joan lives in a fashionably-decorated two-bedroomed flat near the Council offices near the centre of Dumbarton town. She lives with her dog: one that made me very welcome when I arrived! On arrival, she prepared me a hearty lunch of sandwiches, biscuits and coffee - no expense spared. Many examples of Joan's flower-making were to be seen around the house: evidence that she had been filling her time in a most industrious and potentially-lucrative way. She told me that most were for other people: friends and members of her family - with whom she has resumed close contact. Indeed, when I contacted Joan originally, by phone, it was her brother who answered. He told me that Joan was much better now that she was "back in the fold". She spends part of the time at her brother's (the one she is closest to) and with her two daughters with whom she has become more strongly attached following the death of her much loathed husband (from alcohol consumption). Joan told me that she had begun to drink increasing amounts the more "things got out of hand" with her husband: in his treatment of herself and of their children. His death has, through time, come to mean much better things than she had originally thought. She gets on with her daughters (who had "boycotted" their parents during the preceding months); she has money now to provide her with comfort; she no longer has to suffer the constant anxiety about what would happen next: what form of abuse would follow her husband's return home of an evening; she now enjoys the peace and quiet and being able to spend some time on her own with her thoughts.

Added to this period of 'conflict-resolution' and coming to terms with a new life without the guaranteed fear and violence was a six-week vacation in Canada! Whilst over there, Joan had made some plans (a) to continue to see her daughters on a regular basis, even to stay with one of them from time to time and (b) to devote more time to her 'flower-arranging' hobby, a talent that others had noticed and encouraged. At time of interview, Joan's financial status was also much more secure than it had ever been thanks to the money she had secured from the receipt of money form her husband's life assurance policy. This helped pay off her debts and much more: she is "financially secure" now with "no worries on that side at all". This is a most important change in Joan's life - where previously it can be seen to be one of the motivating causes that underpinned her severe drinking habit. With the "heat off" she was clearly able to live a less intense life, one previously lived "on the edge".

LIFE EVENTS: 3. Scott interviewed on 24 07 90.

Scott was an emergency admission to the ward on 19 07 90 following an overdose of paracetamol. He has been off work recently and received anti-depressants unsuccessfully on account of depression relating to the split-up with his girlfriend 6 weeks earlier. She worked at the same place he did and he's therefore given up his job as well. He's in financial problems on account of his flat.

He was recently rejected by his father - with whom he'd tried to effect greater contact - and with little contact with his brother this was reflected in his current sense of rejection. He's stopped going out with friends and has lost hobbies and

interests. During the last 6-8 months he's been going out with his girlfriend and working as a caretaker in an Old People's Home. As a result, he now finds he has no girlfriend, no work, no interests whatsoever, and very little to do.
His sleep and appetite are poor; he remains depressed and is vaguely sorry he was not successful in the suicide attempt. He's told his aunt and uncle that he's desperate for his girlfriend to come back to him.
Scott's mother and father abandoned him when he was 8. He lived in a succession of Children's Homes - Orchardton, Blairvadach. He was taken in by his paternal uncle and aunt. He seldom sees his brother Frank who stays with his mother and step-father in Barassie.

RECENT EVENTS

He had felt very low for a long time recently - since February 90 - feeling there was no light at the end of the tunnel, that things wouldn't get better. He wasn't going out, only wanted fluids, wasn't sleeping at night. In March his mood suffered a change. He'd return home from work and only want to sleep. He hated being on his own, always had to be in company. He underwent a weight-loss. Beforehand, he would have discussed these sorts of things with others, at this period, however, he felt that he couldn't. For a short period he would be up, then, just as quickly, he'd be back down again ("I felt so alone").
In May 90 he broke up with his girlfriend. They had met one another in July 89. At this point his moods began to change. When he went to see his father - who he'd been out of contact with for several years - he went "really downhill then". Scott and his girlfriend looked at homes, finding one apparently to settle down in. It was when Scott called his father back, expecting him to be as amiable and receptive as he was on his first contact with him the fortnight before, and found that any promise he had made to keep in close touch had been broken that Scott himself felt completely broken. He felt let down, lost in the world, and angry that his stepmother should be the one who was keeping them apart.
This, he said, brought back all the past: he felt totally rejected. He saw friends very occasionally then, those he had drawn away from since starting the relationship.
His closest male friend left Glasgow recently, moving to London to live: he went "even further downhill " at this. He gave up his job at the Old Folk's Home and feels that it's unlikely he'll return given the fragile circumstances there at the moment.
He has very bad debts. In June-July 90 he received letters from the Council warning him that he had accumulated significant arrears over the past few months. He has been threatened with eviction recently. He's currently relying on State benefit: "Problems are just piling one on top of the other."

FOLLOW-UP: 15 DECEMBER 1990.

Scott lives in the top one-bedroomed, flat of a 15-storey block of flats near Bonhill, Dumbarton. It is sparsely decorated, with a settee, tv and modest hi-fi in the main living room. We drank from a mug of tea - prepared in a kitchen with evident wet-rot - throughout the course of the interview. The flat was provided Scott by the local Social Work department. It is a potentially isolating place - particularly in someone like Scott's case.
Scott told me that he had yet to recover completely from the break-up of his relationship with his girlfriend. However, throughout this harsh period, he had been thankful for the continued help and encouragement he'd received from one of the hospital's consultant's. He had "kept me going". Much of the interview was on the subject of his feelings toward his ex-girlfriend. He does miss her still - and is somewhat peeved at being unable to return to his work at the Old Folks' Home since this girlfriend also works there. He finds it "unthinkable" to return there to work under these circumstances: clearly Scott remains emotionally-attached to this person.
On the brighter side he has recently started working - as a security guard at a local factory. He works on a shift basis - which means being away from friends at times (he must work one weekend in three). However, this is offset by the benefits he now enjoys: quite clearly, for his general pallor had much improved; where before he was gaunt and tense of face he was, at interview, more relaxed, cheerful, smiling and laughing on occasion. He now had "money in my pocket" and could go out with his friends and not be quite so conscious of the price of everything and so "Can I afford to do that or go there - you know?". He felt a "sense of self-respect" again, not having to penny-pinch, actually doing something he considered valuable with his days.

In hospital he had "learnt a lesson - that I just can't take things for granted". Whilst there he had spoken to two other patients, "talking about things that I'd been needing to for a while; needing some advice about how to get over things. The experience of being there. . seeing that others have problems much worse than you. . . I've got a sense of purpose again".

Scott felt rather good about himself at interview. He felt he'd had to put up with a lot of seriously upsetting events: the break-up of his relationship with his girlfriend; financial worries such as the threat of eviction from this flat (he had come to an agreement with the council through the intervention of the SW dept. on payment of arrears); the disappointment of being turned away by his father and step-mother (he had been back in touch with his father. He had agreed to see Scott and to continue to see him on a regular basis. However, his wife - Scott's stepmother - apparently continued to show no interest in him, seeing him as a relic of her husband's past - one she had no wish to be drawn toward. This interest - on his father's part - came about following Scott's admission to the psychiatric hospital. It was as though such an event was needed to startle him into taking Scott's plea for recognition seriously); and, of course, there was Scott's eventual admission to hospital to contend with: an admission that had "taught me a few lessons about things".

LIFE EVENTS: 4. Clare interviewed on 09 05 90.

Clare is a 24 year-old single woman admitted to the ward with a diagnosis of depression with a secondary eating dissorder (bulimia nervosa). She has been admitted to the ward on three previous occasions in 1988 and 89. Throughout the last year she has been seen on a regular basis by a clinical psychologist.

RECENT EVENTS

In January 90 she phoned the ward doctor to say she was going to kill herself. She was reluctant to come in. She is regarded as suffering from a depressive illness, currently not sleeping well, with early morning wakening, lying in bed for most of the day. The current recent relapse was on 30 March 90 when she described herself as very fed up.

She works as an enrolled nurse in the gynaecology ward at the Western Royal Infirmary. Both her parents died in their 40s. Clare spent much of her earlier years in an orphanage. She has 4 sisters and 2 brothers.

On the Thursday of one of her regular appointments with the clinical psychologist she discovered she'd be absent for four weeks. This completely threw Clare into a black mood of depression, thinking that she wouldn't be able to cope.

Clare's flatmate had a baby recently. She described the situation there as intolerable. The baby cries all day. Her flatmate spends a lot of time in the flat, she doesn't work and "is depressed right now". She has problems with money finding it hard to pay the rent, hard to make ends meet. Her family "are around all the time, I just don't like them being around all the time, they'll just appear and take over as if it were there own place. They're round several days a week, if it's not her father, it's her sister and sister's boyfriend just taking over. Carla gets depressed right now because her mum has cancer and her dad's drinking pretty bad. They've split up. And I get jealous, I suppose, with Carla and her baby: I'd been jealous when she was pregnant and now she's got the baby she has something and I don't. We've been getting on terrible."

Clare then gets angry and upset that she can't express this anger. "I can't tell them how I feel, because that'd be too upsetting for me. I'm scared to tell anyone I'm angry in case they walk away from me. I feel I'd get into trouble if I express any anger, feel I'd lose someone's friendship." At the Children's Home there had been no real emotional support. "I'd get so angry and upset there, and mixed up. I had to obey others all the time, and I'd never say anything back in return. I was late for mealtimes on two or three occasions and was slapped **hard** as a result. At school I'd always keep everything in, I wouldn't get angry, until I'd snap! It's the same when I'm in hospital right now: I get angry for no reason. I'd like to smash things up but I'm scared to, just too scared to. On the ward I feel that if anyone's being let down (Clare hadn't felt able to participate in some of the ward's activities) it's me!! I feel that others disregard what I say."

The suicide attempt had "not just been a cry for help, I just wanted to die! At my death I still think my parents would say 'Go Back!!' at the Pearly Gates, they wouldn't want me in with them in Heaven."

Clare has had great difficulties at her work recently. She has been off sick so often she wonders that she might not be likely to lose it eventually. Indeed, a senior staff nurse recently became aware of the amount of sick leave she'd had over the past two years and promptly threatened Clare with dismissal should it continue at such volume. She hates her job "although it's safe". Though she still loves nursing, she feels she's getting nothing out of it anymore, she has no time for the patients. She thinks others are better than she is at nursing. And when they do praise her for anything she thinks that they're just trying to make her feel good.

Last summer she got more insight into the patients' condition. Now she feels that she doesn't really care about them anymore. She's "fed up caring for other people, she wants them to get out of bed, me to get in". She "hates the fact they've got cancer, they've got something that I haven't. Others wouldn't hate you for wanting to die then, I'd have something that people would pity me for. Their illness is the cause of their death, they don't have to feel too guilty. I feel guilty because it upsets me that others hate me for having what I've got, they don't understand me for it, call me "a silly little bitch".

Another incident serving to reinforce these depressive attributions was the recent hit-and-run: a car had run into Clare's recently and sped off. As a result Clare finds herself having paid money she had put by for bills to the solicitors dealing with her case (the other insurance company are refusing to deal with her claim). This has been a lot of hassle and very upsetting, leaving her feeling, again, that she has no real control over things around her, that she would be better off just giving up.

FOLLOW-UP: 23 OCTOBER 1990.

Clare had recently come back from a three month holiday in San Francisco where she stayed with one of her aunts on her mother's side of the family (both her parents died when she was a child). She was much less apparently depressed compared with how she had been at our first interview on the ward.

The holiday had been a welcome respite from the difficulties written about following the first interview. Before leaving for the States - some three months after discharge from the ward - a number of importannt events had taaken place:

1. Clare left her job in a local hospital where she worked as a staff nurse. She felt "relieved" about this - having followed the advice of her "friend" and therapist (from the hospital's psychology department). However, she still had to find alternative employment and was a little anxious at this prospect, particularly where it could impinge on the payment of the basic things in her life: food, rent and her car. Overal though, she expressed great relief at having, at long last, after much "huffing and puffing". left a job which she considered - as did her therapist - made a significant contribution to her gener-

al unhappiness.
2. She left the flat she had been sharing with her friend Carla. Again, she felt "relief" at this - leaving what she saw to be the second most important cause of her unhappiness. The interruptions from Carla's family, the baby's crying and the mixture of feelings such as jealousy and intolerance had "been too much for me to cope with. . it's good to be back and know that I don't have to put up with that stuff any more!!".
She was now living in a house nearer to some other of her friends in Glasgow's Johnson district, sharing with three others in a detached residence beside a main thoroughfare.
Whilst on holiday in the USA she had found out a number of things about her mother and father from her aunt. At first, she had not taken well to this woman - hitherto a relative stranger to Clare. However, the climate, the fact that she was away from all her troubles in Glasgow and through simply being around on a day-to-day basis all helped make relations between the two more tolerable. Clare did not wish to divulge in any detail the things she had found out from her aunt regarding her parents. However, she told me she felt she could understand better "what things must have been like for them then".
Clare has an air of immense fragility. She confides with this psychologist therapist on a weekly basis, meetings which would appear to contribute to her immensely reflective character. She knows she is fragile, and knows something about some of the reasons why this might be so. However, it's clear that she is still very much in the dark about why she feels the way she does nevertheless at follow-up she demonstrated considerably more self-knowledge than she had appeared to have the first time we met. To this end, where she considers the cause of her unhappiness to be in these three areas mentioned - her job, her home, her childhood - the fact that she has made some evident progress in these areas, reflected in concrete decisions to attempt to effect some change or transformation she was much less psychologically distressed and much more "in control".
It should be noted that the therapist with whom Clare enjoyed close, regular contact recently left her post in Glasgow to resume another in the South of England. Clare expressed some anxiety about this, saying that she would continue to keep in contact - by letter. She would <u>not</u> however be seeing anyone else from that department. It seemed that she was avoiding the inevitable feelings of loss and disappointment that would be expected given Clare's depressive, parentless condition.

LIFE EVENTS: 5. Elizabeth interviewed on 24 04 90.
Elizabeth was admitted to the ward on 12 12 90. She was diagnosed as suffering a relapse of a depressive illness which has bedevilled her on occasion in the past.

ADMISSION NOTES
On admission she was preoccupied by the sense of grief which resulted from her mother being taken into long-term care, a sense of utter hopelessness and pointlessness as far as the future is concerned and the wish that she were dead. She is actively contemplating suicide at this moment in time. She is aware that she is ill and feels that she will never become well again. There was no evidence of cognitive impairment. The impression was of the recurrence of a depressive illness, possibly an abnormal adjustment reaction.

On 15 01 90 her mother died. A week later she had grown tearful and very gloomy, with a sense of there being no future without her mother. She is unwilling to show her emotions to her friends and family as she feels she has to 'keep face'. She avoids visiting her mother's house. On 05 02 90 she refuses medication over the week. She still has suicidal thoughts but has no plans to carry them out.
An aunt then visited who wasn't very understanding about her illness. She cries everywhere and feels embarrased about it. "I can't see any way of getting my life together, I've lost all my resources. I'm becoming a burden on people". She has a very poor self-image and is experiencing depersonalization. "It's an unreal world, I'm not in contact with people." This feeling is emphasised when she's outside.
Elizabeth then underwent a series of sessions of ECT starting 14 03 90.
On 04 04 90 her mood had improved and she had started to improve and become quite humorous: "I can't see any improvement but I suppose it's hard when I'm so involved with my feelings. I guess other people will see it before I do."

The single most consuming event in Elizabeth's life immediately preceding admission was the illness and sudden deterioration of her mother from a heart attack. There is a brother in the family, but he had offered no assistance. She felt very let down by this and hasn't spoken to him since.
After her mother's death no-one came to the funeral; she felt very, very angry for her mother's sake. Her cousins have been some support but not very much. She feels bitter about what happened, feels that her help was in no way reciprocated by the others in the family and so feels badly let down as a result.
Phone calls have been another especial irritant. These have been frequent and the line has either been very bad or she was unable to concentrate on what was being said.
Her mother had not settled down in the Nursing Home and yet she didn't want to come home to Elizabeth. Elizabeth had been looking after her mother for years, having sacrificed her job to do so.

She was very upset by the change in circumstances and too by the impending role changes that would arise through her mother's attack and eventual death. She told me she found it hard to cope with, being on her own from now on, with no-one around to look after, no-one to talk to.

FOLLOW-UP: 02 NOVEMBER 1990.
Elizabeth was noticeably les depressed when I saw her in her comfortable two-bedroom flat in the fashionable Broomhill district of Glasgow. She had good reason to:
1. She had managed to get over some of the worse feelings of loneliness she had felt on returning to her flat following discharge - a flat she had, until then, shared with her elderly mother (Elizabeth is, herself, 64). Although she does "have a wee cry to myself from time to time - I feel I've missed out on so much over the years (looking after her frail mother)" the worst feelings of loneliness and of despair have dispelled. She said, "I want to do some work for other people out there who're in need of help: maybe I could do something for the CAB or some other kind of voluntary work?".
2. The feelings of loneliness and despair have dispelled partly through her increased sense of belonging in her flat, situated in a large tenement. There is a woman who lives in the flat above who has become a close and valued friend. She drops in each day - to see if Elizabeth needs anything, for a cup of tea and a chat and the like. Indeed, during the interview this woman "dropped by" - one of her daily visits.
3. Elizabeth managed to resolve the distribution of her mother's belongings with her brother in Petersborough, England. This required some patience on Elizabeth's part - her brother had shown no interest in their mother when she was alive. However, Elizabeth told me that during a long walk together during her stay in Peterborough she and her brother had managed to come to some kind of agreement and understanding about things: about their mother's belongings, and about her feelings of bitterness and anger toward her brother for his absence throughout the years: years Elizabeth feels have been carried solely by her self.
4. A month's holiday in the USA had been "marvellous - it's such a fascinating place". She had spent the month with relatives in Washington, visiting the White House, and generally marvelling (demonstrating a tremendous sense of being back in touch with her surrounds) at the sights and sounds. It was quite evident that Elizabeth had regained a sense of purpose through this visit: delighting once again in the world about her; delighted to be back amidst people with whom she felt a tremendous kinship and **grateful**: for "what I've put up with; for knowing people like this" and for being looked after: by the friends she knows and by the people in the hospital - the consultant and all staff.

LIFE EVENTS: **6. Alison interviewed on 20-21 March 90.**
Alison is a 25 year-old divorced woman admitted to the ward on 26 01 90 on a 'high' phase of her manic depressive disorder. On admission she was hyperactive and badly agitated, grandiose in her ideas of self and how she'll manage her life. Her only previous admission to the hospital's ward 2 was between March and June 89. She was seen on an O-P basis and Day-basis in 1987 and '88. A secondary diagnosis on this admission was that Alison was a very insecure girl, insipiently paranoid.
Alison's father is the director of a local company, her mother acting as secretary, her brother a trainee surveyor, and whilst Alison worked as a telephonist with the firm, she felt unable to stay there, it becoming too much for her.

Presenting Complaint
Alison attended the O-P clinic with a friend fromWomen's Aid. She'd left home in Feb 89 and had been staying there ever since. She did so "in order to escape from the people she knows". Her father had been getting on her nerves; she wanted out because she felt she was ruining things, "a happy home". In the past she's stayed with W.A. for 5 months. She feels she has paranoid-type feelings towards other people but feels happier in the hospital.
She was diagnosed manic depressive whilst living in South Africa. She was in and out of wards and private hospitals and was constantly drugged up such that she felt she was going mad. She has made numerous suicide atempts.
Aged 5, she was bothered by her English accent in Scottish schools. There was tormenting and taunting. She felt her brother was always the favourite (she was the older of the two). She completed a secretarial course, though she believes her father did not think this good enough for her. She says she can also play her mum and dad against her. She blames the drugs for making her feel worse about things, and herself. She says (March89) she feels tired, fed up with her parents and friends, and she wants a bit of a rest.
She had an ectopic pregnancy in 1983 - which leaves her with continual bowel pains.
She currently has no boyfriend - March 89 - although she says she split up with her boyfriend the day before because, she said, he wasn't very much worthwhile.
She appears to have no insight into her problems. She dislikes the hospital and would rather be back home. She likes getting out with her mother at evenings and weekends. She tends to get very sleepy.
During her time on the ward, she struck up a relationship with one of the male patients. She was actively discouraged from doing so. They had become sexually involved, with Alison fearing she may be pregnant. Throughout the course of the interview, this patient would interrupt, to check on Alison, making sure she was all right.
Her father feels that the children are ashamed of their nationality. They were ridiculed at school which caused some resentment. Alison had "never been a loving child". Aged 17 she had got pregnant and was encouraged to have an abor-

tion. Alison remains angry at the pressure she was put under at the time.

When she was 18, she went to South Africa with her boyfriend. She married him there, but within a brief period was hospitalized with the ectopic pregnancy. After only 18 months the marriage broke down. Mr Walker returned to Glasgow. Alison stayed on in Durban, working for Visionhire. She distinguished herself in the job, becoming the youngest ever shop manager. The promotion at her work exposed her to a high degree of stress, occasioned by the shop accumulating a substantial number of delinquent accounts. The collection of these debts became her responsibility. It was at this time, as the manager of the branch, that she was first given a psychiatric diagnosis. She was admitted to hospital in Durban and teated for manic depression. This was in 1987 (then 22 years old). Her parents went out to Durban and brought her back home (October 87).

In Glasgow she was seen by one of the consultants on the ward. She didn't want the O-P treatment offered. month period she spent in Glasgow before returning to Durban, she spent a lot of time with friends.

She returned to S.A. in January 88 and stayed there until August 88. Around June 88 whilst working as a showroom assistant, helping to sell kitchen equipment, she became unwell again and started acting strangely. She was hospitalized again. Her parents brought her back home to Scotland where she was seen by the consultant.

Back home her behaviour was frequently quite disruptive. She was rejecting both her parents, and particularly abusive towards her mother. She "wished" her mother's death, from a road accident, or slow, lingering cancer.

Her brother was less tolerant than the parents of this behaviour, feeling she was manipulating them. Alison frequently stayed away from home for days on end, staying with friends in the West End of the city.

There remains some doubt about the most appropriate label with which to describe Alison's behaviour. Previously she exhibited pronounced phases of manic behaviour alternating with depressed phases which attracted the diagnosis of bipolar illness. During her recent breakdown, she has been deluded and hallucinated and schizophrenia is being considered as a possible diagnosis.

FOLLOW-UP: 21 AUGUST 1990.

At time of interview Alison was about to move into a flat of her own. This had been arranged by the social work department. Previously she had left home "in order to escape from" the people she knows - particularly her parents with whom she has been in consistent conflict ever since she was a child, at school, where she had been the victim of cruel verbal taunts from other children about her English accent (corroborated by her father who said that he believed his children to be "ashamed of their nationality"). Several underlying tensions between the three - mother, father and daughter - remain unresolved. The impending move to a place of her own, where she will "be able to invite round whoever I want", was something that gave Alison both cause for some hope (for this was a fresh start for her, where, at long last, she would achieve some form of independence form her parents) yet too some cause for concern - "I'm a bit panicky about it all. The last time I left home I went to the Women's Aid and stayed there for quite a bit. But I ended up in Gartnavel after getting upset". In this respect, it was fortunate that it was to a sheltered housing complex 'run' by the local social work department that Alison was headed. There she would receive important back-up should this be needed.

The interview was conducted in a fairly oppressive atmosphere - both Alison's parents were in close proximity, in the open-plan kitchen. As a result, Alison seemed rather ill at ease, unwilling to expand upon any of her statements about her relations with her parents. Each said to me afterward, outwith Alison's hearing where she was in the toilet, that (1) they thought she had become a litle 'strange' again of late: that "she has these turns - she just becomes all strange. . we just don't know what to do.", and (2) they were quite relieved at the prospect of Alison's departure to a Social Work flat - "to a place of her own - we think that's what she really wants. She does seem a bit strange, doesn't she?". When Alison returned from the toilet she was in tears: sad, it seemed, to see us talking about her as if she weren't really there; as though she were someone else. (which Alison confirmed when we spoke in the drive leading to the house as I was about to leave. She grew noticeably stronger when, as I was about to leave, her best friend arrived to go out shopping with her.).

LIFE EVENTS: 7. Derek interviewed on 09 07 90.

Derek is a single, unemployed 22 year-old male admitted to the ward on 30 05 90 with a diagnosis of acute scizophrenia. He had been admitted on one previous occasion in 1988 for a period of 17 days.

RECENT EVENTS

Derek has not worked for three years. He left school at 16 and took on a job as a labourer under the YTS. He then worked on the Community Programme for a year. He told me he would like to have a job, but that he just doesn't have the qualifications at the moment. He worries about not having one, and about not getting one. However, Derek feels "that he's not right on his feet yet to start pushing for a job".

Recently there had been pressure from within the home for him to find something useful to do with his time. His mother in particular has been "on at" him to do something.

Derek has few friends other than those he does weight-training with. Others he knows have got cars and girlfriends, and this makes him quite envious. He regards his most pressing concern to be his difficulty in "pulling the birds". He would rather have someone he was close to, and as he experiences some difficulty in this it has become a worry of some magnitude.

FOLLOW-UP: 29 NOVEMBER 1990.

Derek had begun to get out of the house much more, going along to a Drop-In centre twice per week and doing a couple of hours gardening per week in the hospital's garden. His parents continued to be rather critical of him (e.g., "When are you going to get a job?!") but, at the request of Derek's junior house officer, the family had become less "emotionally expressive" toward their son. At the drop-in centre, Derek had befriended two older people, one of whom is paralyzed from the waist down and who Derek takes for walks in the local neighbourhood. He feels more hopeful about things, where he's now considering "a career in gardening" and grateful to know these new people and also to have retained other interests such as bird-watching and weight-training.

LIFE EVENTS: 8. Carole interviewed on 18-19 06 90.

Carole was first admitted for in-patient care in 1978. She was admitted on one subsequent occasion in 1987. She's been on regular Fluspirilene weekly now for 13 years, in fairly brief contact with day- and out-patient services (receiving ECT on an OP basis in 1988). Her attendances in Day-Care have been brief, seen on one or two occasions each 2 years or so.

She is described as precarious and dependent on high levels of neuroleptic intake for her currently diagnosed schizo-affective illness (formerly diagnosed as psychotic and suffering from a schizophreniform illness). When unwell, Carole becomes absent-minded, careless of appearance, delusional in beliefs about the existence of "daughter Lucy" (she has a real daughter Katy).

Divorced in 1983 she had been separated from her husband Bill since 1979, a marriage lasting 11 years. He had been very patient in her illness, visiting her on a regular basis throughout her difficulties. Bill and Carole's mother - described as a very shrewd woman who frequently takes over in the house whenever deemed necessary - have, according to Carole, never got on. Carole describes them as calling a truce whenever she becomes ill. Bill calls regularly, and would still appear to be dependent on Carole's more decisive and matter-of-fact approach to things.

Carole is decribed as tending to lose insight, becoming deeply involved in complex, bizarre, delusional beliefs involving falsification of her past life and achievements.

She lives with her only daughter Katy, a 17 year-old who recently sat her Highers and who is currently looking for a summer job, apparently without much success.

RECENT EVENTS

Carole and Katy have been arguing a lot over the issue of Carole's continued excessive smoking. Her daughter hasmade it clear that she won't put up with it any longer - clothes smelling of smoke, the effects on her health of passive smoking. Whilst this worry has perhaps been taken out of proportion, nevertheless for Carole, at this moment in time, it represents a source of great worry and distress. She is afraid of having Katy leave her, abandon her alone in the house. Yet too she remains excessively dependent on cigarettes to calm her nerves: she told me she "cracks up" when too long away from a cigarette, her only source of pleasure, "so how can I stop?"

She suffers from what she terms a recurrent flu - believing this to have something to do with yeast. It is unpredictable and "upsets others around" - something she wishes were otherwise. For the 2-3 months preceding admission, her daughter had first to attend the WRI for treatment of her acne (a big problem) and the more troubling concern: requiring hospital treatment for the removal of ovarian cysts (a problem Carole had tried to play down saying "lots of people have this, it's so as they can have children in the future").

Bodily problems had been in evidence over Christmas when she had a bad sore on her nose, something she found uncomfortable and unbearable at the time (rendering her more self-conscious). She also burned her leg on the oven just before coming into hospital.

She has continuous financial worries, with big debts (which have mounted steadily since 1986, exacerbated by the recent necessity of repairs to the house, Carole's smoking costing her around £60 per month. . . indeed, she described this mounting worry to me in a way that indicated she no longer found it a tenable position, nor a manageable one: she "simply must do something about it". She went on to consider the feasibility of stopping smoking). Financial burdens are clearly heavy on Carole's shoulders at present.

Working as a speech therapist until 1984 when she gave it up as a result of numerous doubts about her abilities, she has been receiving sick/invalidity benefit since. However, payments of this have recently ceased.

The event which appears to have had the most far-reaching impact on her current state of well-being has been the current re-appraisal of her marriage to former husband Bill. Carole does not appear to have satisfactorily resolved this period in her life. Her husband had started an affair with another woman, eventually leaving Carole to live with her. Carole continues to experience feelings of inadequacy, of "why wasn't I good enough?", doubts about her own ability to be a wife, and a good wife (and mother to her daughter). She feels disappointment in herself, wishing somehow she were a "tougher cookie". Though having people around her in whom to confide, or simply to have lunch with, either financial restraints or, moreover, the sense that she will be no fun, prevents her from engaging more with others.

Whilst discussing these events with me, she broke down in tears on mention of the "other woman" - and yet the somewhat ironic fact is that she and this woman presently manage to get on quite well. With Bill's recent demotion, he has had

to do much more travelling, something which has curtailed the amount of time she and Bill are able to spend together (Bill would pop in around tea-time / late afternoon most days of the week).
What appears to have acted as 'the last straw' - breaking Carole's back - was the announcement of Bill's intention of marrying this other woman. Carole could barely brimg herself to discuss this, breaking down in tears at this point.
She believed this would mean they'd see each other much less. "I mean, why do they have to get married after all these years?! They've been seeing each other without any problems for years - why should they want to change things now?!"
Carole's self-confidence took another blow just before admission when, at the last moment, she decided she'd "not be up to working as a Voluntary worker in a local playgroup (for her own reasons, which were not discussed: generally, she felt she "simply wasn't up to it; wouldn't be able to handle it"). Her daughter Katy had been disappointed with her, quite badly so. Evidently this criticism allied to that surrounding the issue of smoking served to unhinge Carole somewhat.

FOLLOW-UP: 22 NOVEMBER 1990.
Carole lives with her daughter in a small, comfortably-decorated two-bedroom flat in the Broomhill district of Glasgow. She was less agitated than the first time we met and feeling reasonably well although her "illness", as she described it, is such that she "takes two steps forward and then ten back when things aren't going well. It's not like that for other people: I'm always having to drag myself back to the same place . . only to fall back down again. . it's just like that - back and forth all the time: no real progress!".
During the previous six months, since leaving hospital, she had had "quite a good time of it". Although she continued to worry about her daughter Katy's efforts in seeking to find a job, she had found this much less of a strain. She told me that she worries about her because she feels she might "have passed something on to her: I wouldn't want her to have to go through all that I've been through."
Regarding her ex-husband's remarriage (to Susan), Carol told me that she had begun to get over the worst feelings she had had (and which she described to me in hospital - feelings of surprise, guilt - that she wasn't the 'good wife', and of inadequacy - "maybe I wasn't good enough - obviously not, otherwise we'd still be together!!").
Helping her to 'get over' such feelings has been a friend who lives in the same housing scheme. This woman practices in herbal medicine. Carole has received several aromatic massages from this woman, feeling "quite marvellous! It's such a delight!". She has also spent more of her time with this friend - seeing her for coffees and the like. Carole feels much better for this - knowing there is a good, fairly close friend nearby.
Carole contines to see the consultant from the hospital ward on a fortnightly basis. With this consultant she is able to confide some things, "but very little really - he's such a busy man: I'm just in and out again. But it's a help knowing that he's there when I start to feel down."
Finally, Carole described to me her meeting and maintanance of relations with one of the patients from the ward, a middle-aged man (i.e., of Carole's age, social class, and background - one of the other patients I interviewed, a former air-pilot). She had been on a couple of trips with this man to the Trossachs (in the country) finding it nice to be taken someawhere, to have the feeling of being attractive to someone (although she feels nothing other than platonic attraction to him) and to be able to vent some of her feelings and thoughts concerning her period in hospital. This, in particular, she found most gratifying: "We were talking about (the consultant) - what we thought of him, of how we were treated in hospital, of what we thought about ourselves - our 'ilnesses'. O! It was a lovely, lovely day - but, no, I'm not attracted to (this former patient) - I can't see us getting married or anything like that. But it's nice to have his interest and to get taken places!!".

B. PATIENTS WHO WERE *READMITTED* WITHIN THE 6-MONTHS.

LIFE EVENTS: 1. Thomas interviewed on 14 03 90.
Tommy was transferred to the ward on 11 12 89 from the hospital's alcohol unit to which he'd been admitted on 11 07 89. A 51 year-old unemployed man he was diagnosed as paranoid (alcohol-related) with major depression, evidenced within 4-6 weeks of admission.

RECENT EVENTS
In March 89 he began to feel menaced, feeling that he was being attacked from somewhere. The last time he'd felt this way was in Saigon (he served twice in Vietnam). He had livid spells - these took on the manifestation of dogs: he sees huge dogs, ready to attack. This would cost him about £70 per week in taxis, he felt he couldn't go out on his own. A friend called in a GP. Since leaving the army in 1974 he's worked very long hours, working hard for money to spend on alcohol. For years he has suffered from an anxious disposition.
In 1976/77 whilst in Malaya he suffered badly from depression. He went to see a psychiatrist in Adelaide, Australia. Describing this episode to me, he elaborated on some of the reasons he felt he had for being this way. He had been very close to his mother, the closest perhaps of all his 4 brothers and 3 sisters. When she had been unwell before and leading up to her death he hadn't been around to look after her. He has always felt that he could have done much more, indeed that he should have been there. He feels and has felt over the years increasing guilt and disappointment over this. It's something he has never been able to rid himself of.

He feels there are emotional problems in every member of his family. He doesn't get on at all well with his family. He sees little if anything of them. He lives alone with only one person he says he knows in the neigbourhood.

He has been in bad debt through spending any money he receives on drink - and this includes a £1000 loan for a car. Drinking 5 bottles of vodka per week before admission, he is currently homeless and seeking rehousing. He has firmly held delusions regarding dogs and the police, is paranoid then depressed: with anergia, loss of interest, diurnal variation, and early awakening.

Tommy was working in England throughout the previous year as a lorry driver. There were "enormous changes" in his duties, responsibilities, and hours at his work. His "whole world changed" with "enormous pressure, and very exacting work". He felt that he just couldn't cope with the constant long-distance travelling, the worrying about getting things delivered on time, and eventually he'd simply come home each evening, get a bottle of vodka or other spirit, and drink himself into some state of more relative calm and contentment, drowning the pressure of the day.

The other major concern of his has been his growing sense of inadequacy. He told me he feels very self-conscious about his height, his physical presence in the world. He feels that he's "just a small man", that all his life he's had "to put up with people's poor reactions to my height" (though a small man, he is not strikingly so). He feels very sensitive about this, feels that people always disregard what he has to say, and feels bitter "that this should be the case". He has regarded himself in this way for many, many years, thinking himself more and more insignificant, believing that others will always react to him in this belittling way.

When he feels lonely, he turns to the bottle. He told me he becomes "more erudite when I'm drunk; alcohol unlocks me, like a key, into a new way of seeing things". Otherwise, he is obsessed by the imagined slights he receives from people whenever he expresses something of himself.

FOLLOW-UP: 24 OCTOBER 1990.

When I saw Tommy again, in the ward, he was most noticeably dejected - as though he had failed in something. This came across through the course of the interview.

When I spoke with Tommy at discharge he had described to me his anxiety about leaving the ward and having to return to the flat in which he lived prior to admission. He described this flat as being one of the sources of his troubles. Thomas, then, was already disappointed at discharge when he was informed by the hospital's resident Social Worker that the efforts to secure him new accommodation had been unsuccessful. On discharge he returned to the flat from whence admitted almost one year previously. This flat Thomas described as "damp and filthy" - a place that had poor associations in his memory: a place to which he would return exhausted from a long day's work and where he would sit on his own and drink himself into a stupor that was both sedating as well as "unlocking his mind into a new way of seeing things". The prospect of returning there had, at the initial assessment, filled Thomas with immense perturbation and dismay. That he went back to live there following discharge after continued pressure on the social work department (on Thomas' as well as the ward manager's part) to find him alternative accommodation was an evident source of immense stress to Tommy. That he was back in the hospital ward - following a period of just four months back home (following, in turn, a period of 12 months' stay on the ward!) - was, for Tommy, "a big relief . . I simply could not face going back to that place."

Through the course of interview it became clear that the other residents in the flat - with whom he has to share a toilet - are also a source of trouble for Tommy, making unsociable noise at "all hours". Incidentally, throughout the four months 'post-discharge' Tommy was still a twice-per-week member of the ward, "being seen" as an out-patient. However, he said this had been of no help: "because nobody talks to me. I just come in, say 'hello', then read my paper, sit around, then leave again, saying 'goodbye'". From what I knew of Tommy, this non-responsiveness might have been the result, in part, of his "manner" toward other people. He is a highly suspicious man, unwilling to talk with others on the ward because, as he said on our first meeting, he doesn't see himself as having anything in common with the others. (Tommy was known as the 'one with the Guardian newspaper' tucked under his arm, a bit of an intellectual but, unfortunately, with no evidence for this belief. In other words, there was an element of "stand-offishness" on Tommy's part which was the result of this semi-delusional belief of intellectual grandiosity. As a result, "others keep their distance from me".) Unfortunately, this would also appear to have included the professional staff on the ward.

The second major worry in Tommy's life was confirmed, in a sense, during his four months out of hospital. He was unable to find a job. This, he said at discharge, was one of the greatest difficulties facing him: what would potential employers make of someone like him who would have to explain where he had been during the previous year. That he had not found any form of employment by this four-month period was, for Tommy, some confirmation of thios otherwise "paranoid" suspicion of being 'set apart' by others. At the follow-up interview he expressed great dismay that he had been unable to find anything. As a result, he would simply squander his days - in Bookies, in his flat, doing nothing, in Tommy's view of things, of any use or value to anyone. In course of time, Tommy became "extremely anxious" where "the whole thing just started all over".

LIFE EVENTS: 2. Patricia interviewed on 05 and 07 02 90.

Patricia is a 48 year-old married woman admitted to the ward on 30 01 90 with an episode of extreme distress in her manic depressive illness. First admitted to the ward in 1970, aged 28, she has been in and out of the hospital on many occasions ever since that first presentation of alcoholism. She has been on anti-depressants and valium since that first admission.

RECENT EVENTS

Patricia's is a long-standing illness. It is, she told me, whenever she gets more irritable than usual that she becomes aware of something not quite right, aware that she might be heading for another episode. This was what happened in this instance.

Last January a good friend of hers died. Her husband has been diagnosed schizophrenic and continues to receive medication. Other difficulties have been financial, where Pat has had continuous worries, wondering whether ends will meet, indeed, as she said, worrying about every little thing.

FOLLOW-UP: 22 MARCH 1990.

Patricia was most distinguishable from the last time I saw her in her appearance of confidence: she had, what seemed, absolutely none.

During the previous two months she had been in receipt of care from the Community Psychiatric Nurse (CPN). She had been seen on three occasions. The last time she had been seen, the CPN had said that she thought Pat was going to "go high". In Pat's mind this expression - "going high" - is associated with "things getting out of control". Pat is officially described as being a "manic-depressive" (the last time I'd seen Pat, at discharge, she had inquired, in a rhetorical sense, "what can I do Doctor? I just go up some times, then really down. It's a real mystery, isn't it? How can ye explain it?).

As a result of this meeting Pat had begun "to panic". "Thoughts come on. I'm not well. It's just not you. You know? It's something taking me over."

It seems that she simply wound herself into a more and more frenetic state leading, eventually, to readmission to the ward. She described her feelings as having "a fear in me. . I feel I'm not going to get any better." She'd then do things around the house over and over again - for example, doing ironing into the night and early morning; drinking gallons of tea (which she had been warned against by the consultant at discharge); or pacing about the house.

She also stopped going along to Alcoholics Anonymous meetings, feeling that she "didn't belong". One of her friends - a fellow AA client - would continue to call round to visit Pat but, when she was in "this kind of mood she'd know not to press me on things" (usually this friend is instrumental in encouraging Pat to attend the AA meetings).

Another ongoing worry was the payment of bills. A recent announcement had been made that Poll Tax bills were to rise. As a result, Pat would have to make even more sacrifices, although she was "just grateful for what we've got".

LIFE EVENTS: 3. David interviewed on 30 04 90.

David is a 25 year-old unemployed single man admitted to the ward on 20 12 89 from the Orthopaedic surgery because of his strange behaviour. He'd been aggressive, unfriendly, a bit disoriented. He had been admitted to the Western Infirmary following a road-traffic accident. Some of his lability of mood and impaired short-term memory were connected with a drug withdrawal state. He was thought to be undergoing acute paranoid psychosis.

RECENT EVENTS

David described the somewhat bizarre story to me of how he came to find himself firstly, in a police station, on a charge of drug-taking, and then subsequently in the orthopaedic ward of the Western infirmary, with a broken leg. David likes to take hash. In December 89, following a particularly good toke, he'd lain down on a grass football pitch somewhere in East Kilbride. When he awoke, it was to two policemen standing over him. They bundled him in a van, and took him in overnight. The following day, when he'd got back home, and had again smoked for a bit - "To get my head together after what had happened!" - he was knocked down by a car whilst attempting to cross Great Western road. He had walked slowly, not expecting the car to smash into him (as though he were taunting it to do so, like a toreador with the bull). But it had, and he was referred to the Western. This took place in December 89. The police problems he described as on-going. That is, as a 'goth' - a punk with black-dyed hair - he feels that he is singled out for harsh treatment at the hands of the police. They will take him in, or stop him in the street and accuse him of ingesting or peddling drugs. David admitted to smoking hash only, and to drinking!

His 'girlfriend' had a baby in November 89. She left him to live in Brighton soon after. He's not sure where she lives right now. He had wanted to be able to look after the child, and his wife. He had taken up a course at Glasgow College of Commerce, but had dropped out last February and gone to Brighton instead. There, he took on a job in a hotel but was sacked for being off sick too much with the flu (something which indicates that he might have ingested substances other than hashish, such as heroin). His girlfriend had asked him to try to "get around £1000 together" to help out with raising the child. David was unable to manage this, and returned to Glasgow very disappointed. He felt he'd let his girlfriend down, and himself (though he expressed more concern about letting her down).

He is currently unemployed and, at time of interview, homeless. (On discharge he had been set up with a small bed-sit by the Social Work department).

Though he describes himself as having a lot of friends, these were, however, on closer inspection, only drinking buddies, people he knows only in the pub, and nowhere else. He would rather be with his girlfriend, and was quite shy and reticent when he described his feelings for her - which are very tangible. He misses her being around quite badly. In Glasgow, he has only one brother who lives on the South Side but who he doesn't see.

FOLLOW-UP: 25 SEPTEMBER 1990.
At follow-up interview, David had lost much of his verve, reassurance and self-confidence. David was discharge to Social Work accommodation. However, whilst there hae had made an evident nuisance of himself: annoying residents with his guitar-strumming, often into the small hours, and attacking the Social Worker to whom he had to report on two occasions each week. Charges were being pressed against David as a consequence.
David did not find any employment following discharge. Instead, he'd simply roam the stressts and pubs in the West End of Glasgow (where one evening I saw him looking around the floors of the pub, evidently for some money). The major precipitating incident that led to his second hospital admission was the attack, through, it appears, sheer frustration which was followed by removal from this flat. David was unlikely to get a job given his general demeanour: aggressive-appearing, in leather jacket, tattered jeans and with spiky, dyed-black hair. In turn, David continued to be singled out by police - for loitering and being a public nuisance.
David described to me how he likes to be termed "crazy: I'm happy at this; it makes me feel good.". He was critical of the "doctors" on theward, suggesting that they would do better to "look into people's lives with greater understanding, finding out about their history, listening to what I've got to say. And I wish the nurses were less prodding than they are. I don't feel I get helped at all." At follow-up he was not taking the medication which he is prescribed on a weekly basis.

LIFE EVENTS: 4. Sarah interviewed on 05 03 90.
Sarah is a 59 year-old schizophrenic woman admitted to the ward on 06 02 90 with an acute episode in her chronic illness. She has been admitted on many occasions down the years, since 1980.
Never employed, she left school at 14 and lived with her mother until her death 10 years ago. Since then she has been socially isolated - she has no friends, no regular contacts, and the only person she sees on a regular basis is the home-help, since April 89. The CPN also makes quite regular visits.
She has a medical history of hypertension, experiencing hallucinations, delusions and the like: "a regular patient".

RECENT EVENTS
Sarah was referred to the ward by the CPN and SW department. She had started a fire in the flat last week. She feels tired and has had very poor appetite for the 2 weeks prior to admission. She has no other complaints.
Her only worry before coming back into hospital - she has come to regard the ward as a home-from-home - has been the constant tiredness: she couldn't do much around the house. She had terrible headaches that wouldn't go away, and as a result she became very worried about her symptoms leading to high blood pressure.
These were the only problems she felt she had: the worry concerning whether or not she would be able to get over her current difficulties, ie. the proliferation of symptoms.

FOLLOW-UP: 09 MAY 1990.
Of the many patients I saw on the ward, Sarah, together with Elizabeth (whose events will shortly be described) could be described as being insane. That is, she had lost all orientation with the world, responding, instead, to 'voices' inside her head: 'voices' that threatened her entire existence - her life.
An old woman living in the high-rise block of flats, she had felt herself "in the grip" of an evil spirit - a "grip" that held her attention for periods during the follow-up assessment (conducted in the hospital). This spirit also "told" this woman that she was evil and that she "couldn't be trusted". This spirit "told" her to do away with herself.
It was an extremely disturbing interview. At one stage I had to ask Sarah to "speak" to her 'voice' to tell it to go away (otherwise the interview would have been impossible). Fortunately, this helped: the transformation in her face and entire being was quite incredible. Instead of staring into a void, somewhere at the end of her nose between her body and mine, with a glazed expression, her body taut and her attention quite fixated, she would look at me as a real person, not as someone who might as well have landed from another planet. Contact, in other words, was resumed when she followed this advice - to "speak away" the evil voice.
Sarah had been living on her own again. Her usual Home-Help had not been available. Instead she had to be seen by two separate people. Apparently this had been rather upsetting for Sarah. One of the Home-Helps alerted the CPN - who also calls in regularly on Sarah, about once per fortnight (Carol - something of a friend for Sarah) - when she saw Sarah making faces at herself in a mirror. She had also been acting strangely about the flat - situated at the top of a 10-storey block.
Sarah is well-known to the ward. She has been admitted on so many occasions that she is seen by many staff as a somewhat permanent member of the ward.
Sarah told me that she is on her own for much of the time. She had been missing Mary - the other Home-Help who was, unfortunately, ill during Sarah's few months back home following discharge. She would try to fill her time by hoovering the carpets (where unnecessary), by listening to the radio and by trying to sleep. The meaninglessness of each of these activities appears to have destabilized Sarah. This together with the over-stimulation consequent on having to receive two new strangers (the Home-Helps) into her house.

LIFE EVENTS: 5. John interviewed on 29 05 90

John is a 22 year-old single, unemployed man admitted to the ward on 08 05 90 for a period of 27 days with a diagnosis of suffering from a psychotic illness. Secondary diagnoses focussed upon his paranoid ideation, and mood disorder. He has had a long hiistory of truancy from list "d" schools. He has been guilty of fireraising and antisocial behaviour at school and since leaving school. On medication for several years now, he views the ingestion of these as a source of his problems. He has previously been described as a "delinquent: an unhappy boy in a state of mental conflict". His father works as a long-distance lorry driver, his mother a housewife who dotes on her youngest son. He has two brothers and one sister - Robert, 30, Thomas, 31, and Francine, 33. He has a history of drug abuse - amphetamines, cannabis, LSD, stealing his family's belongings to stoke the habit.

He has also been described as suffering identity-conflict, especially in his feelings toward his father. Too often indulged in the past, and now, therefore, few coping resources to fall back on. He refuses medication (and has done so on several occasions in the past): his suicide attempt was described as a cry for help to draw attention to his plight at home in an ever more critical atmosphere. Over-protected as a child - born 8 years after his nearest sibling Robert - he is very close to his mother. Standards of behaviour expected differ across parents. His father's addiction to alcohol is a problem for John. He has few close friends: "Cardross was magic", a list 'D' school which afforded small classes/groups which afforded individual attention - "His problems are related to his family environment" (Social Worker in 1982).

On 4th May 90, 4 days preceding his admission to the ward, John continued to refuse medication. With increasing paranoid ideation, the Health Services (through the Registrar) stated they were unable to offer any further follow-up assistance since John refused to comply with advice.

This is John's second admission, his first in 1988 was for three months.

RECENT EVENTS

The focus of John's problems is upon the family, his relationship with his father, mother, and especially his brother. His sister lives in Wiltshire. Recently she asked John to come and live with her: "she's nice, talks polite to me, a good sister." It seems that she may be coming to live once more in Scotland.

John described to me some of the difficulties he faces living with his family: "In the middle of a good film my mother'll put on some other tape: it drives me fuckin' crazy!!" He feels that he's being wound up. . . by his mother, father, brother. For example, when John is on medication he finds that he sweats a lot. As a result he has to take baths each day. He then gets criticised by his father for doing so, especially for wasting too much.

When he sits in his own room listening to tapes or even when he's in the bath on his own he finds that others in the family "are checking up on him". . .saying things like, "You in there John?" Though this 'winds him up', the behaviour of the family is quite valid given that on several occasions John has attempted suicide whilst on his own.

His mother, he believes picks up new problems for him every day. He believes "she has a right to fling me out, but not so my dad!!" He had stolen his mother's jewellery for speed. . . buying £62 worth - 312 grammes of speed - on top of his medication. John was kicked out of the house following this theft.

John's brothers regularly beat him up. He feels his mother doesn't really care. The Social Worker had come round for a home visit. John told her he "knew I shouldn't have done it", and has agreed to pay back the money owed to his father over a 6 month period.

'Speed' - the substance - makes John feel "normal again, like a nineteen year-old, seeing girls". Other friends might smoke hash; John speeds because, he says, "It gives me thrills". He was on 'acid' for an entire year, taking some every day, constantly. To feed his habit he would have to steal.

Recently, John chased his brother and his dad around the house brandishing a knife - his father had belted him for 'bumping school'. John says his father is an alcoholic. He had recently lost out on a redundancy payment of £30 000 (surely somewhat exaggerated?!) through driving whilst drunk and being reported. He is seldom in the house - only about 2/3 days per week - and when drunk he bullies John. Otherwise "he just sits and reads the paper and says 'don't do this; don't do that' - he just keeps on going and going and going. . : that's my problem!!" He feels the only way out is to kill his family.

Recently John stopped taking medication (again) because he says it "zombifies him". His brother - whom he describes as another alcoholic who goes out and gets drunk every night - takes "the piss out of me", teasing him when he's on medication: "He has a an attitude problem".

He feels he's in such a zombified state otherwise - something he can't stand to be in.

FOLLOW-UP: 26 JUNE 1990.

John is a young 22 year-old patient who had received a diagnosis of paranoid schizophrenia on his return to hospital and who had overheard this classification. He expressed great concern to me that he was being labelled thus: that "It wasn't fair. They don't understand things at all!! It's not me - it's my family: that's the problem". The account given by John of the difficulties and events which precipitated his successive admissions confirms their source: his family and their modes of interaction and communication. However, there appears to be a basic element of distrust and suspicion among all family members - the foundations of which are suggested by their actions together (see discharge assessment).

John had also been through the experience of homelessness, having been kicked out of his home by his father after he'd admitted to having stolen his mother's jewellery to finance his drug habit. At discharge assessment he told me that his sister, living in Wiltshire, had asked him if he'd like to go and stay with her. Intending to get away from the family (which he saw as his problem; which he said he'd have to kill 'to get out') this plan, however, fell through when his sister announced that she was, instead, coming back to live in Glasgow.

The persistent problems continued - criticism from his father, overconcern on his mother's part, bullying by his older brother - each of which - added to John's unpredictability - eventually helping to bring about John's second admission to the ward.

LIFE EVENTS: 6. Elizabeth interviewed on 09 05 90.

Elizabeth is a 35 year old woman well-known to the psychiatric services having had several admissions to the ward since her first in 1988 when diagnosed schizophrenic. She presentad with auditory hallucinations and lowered mood. Hallucinations told her to harm her in some way and she was afraid she might act on these.

She lives alone and is supposed to be attending D-P care at GRH 2 days per week, working for the WRVS on other week-days.

The voices tell her to kill herself - but don't tell her HOW. She could not rely upon herself NOT to act upon these hallucinations. Concentration was impaired and so Elizabeth was admitted for assessment and review of medication. Elizabeth sees her GP every week for an injection.

Diagnosed as chronic schizophrenic, she has since had episodes of depression, and the current assessment is of an acute psychotic episode in her scizophrenic illness.

RECENT EVENTS

Elizabeth described to me the circumstances surrounding the death of one of her friends recently - a subject she raised at once with me on asking her what kinds of things had upset her recently. This friend died 6 weeks before Elizabeth came into hospital. This friend was very close and is still on her mind.

Elizabeth went to her funeral yet still she felt she couldn't cope with it (the death, the loss, the funeral). She had felt anxious and depressed and felt very bad about not going to see her in hospital. She blames herself for her death - for no clear reason. The friend had died of a viral infection, one she had picked up in Australia.

Elizabeth recently gave up a relationship of one year's standing with a boyfriend Andrew. "He was getting too serious, wanted to marry me. I don't want to get married". Six months ago there had been improvement in their relationship but now she is no longer seeing him. She told me that she won't see him again, and that she's no longer bothered by this.

The other makor trouble or worry that Elizabeth has had to bear for some months or more has been the fear of not being well again, ever. This she dreads. Indeed, there was the impression that this was paramount to all else: the bad feelings and bad thoughts that appear to take over.

FOLLOW-UP: 26 SEPTEMBER 1990.

Elizabeth, a woman diagnosed as suffering from chronic schizophrenia is well-known to the ward (with more than 10 years previous contact), had met with an increase in the availability of other people in general to turn to following hospital discharge. She had resumed voluntary work both with a local charity shop and also with the local Girl Guides group.

At the discharge assessment, Elizabeth had resolved to get once more involved in her formerly active life, (a) as a Girl Guide administrator, and (b) as a Salvation Army volunteer. This she managed, at first, resuming her former activities with enthusiasm. However, within three months of discharge she had become increasingly tense, moody, and depressed. The death of her close friend - now three months in the past - continued to preoccupy her thoughts. The attitude of her parents - who she sees each weekend - continued to rattle her: "They tell me to 'pull myself together'; 'to get on with it' But I just can't. It makes me feel so helpless. It really upsets me." There was evidence in this of an element of 'overstimulation' (e.g., Dohrenwend and Egri, 1981; Wing and Brown, 1970) - through her voluntary activities. And evidence, too, of the element 'overcriticism' (e.g., Vaughn et Leff, 1985) - by her parents, and by <u>herself</u>: (a) where she blamed herself for her (unknown) involvement in her friend's death; and (b) for being unable 'to pull herself together and get on with it'. Whatever the 'cause', the third event which perhaps best predicted Elizabeth's return to hospital was the onset of greatly feared thoughts: 'voices' which 'told' Elizabeth she was 'an evil woman and that she must kill herself' (exactly the judgement and demand made by the other schizophrenic patient Sarah's 'voice'). That is, given the extent of her fears concerning the resumption of thoughts of this kind - expressed at the discharge interview - that they had actually resumed during her time back out of hospital <u>confirmed</u> for her their existence. She was, she told me, "right to fear them. They always come back". She was very helpless seeming - as though there was nothing she could do to effect any kind of change.

She felt she had been 'taken over' by an evil spirit. She told me she felt herself trapped in an evil bubble - unable to escape the damaging thoughts contained therein. These thoughts or "voices" "told her" she was evil and that she must kill herself.

Appendix: D.

GREATER GLASGOW HEALTH BOARD

THE WEST ETHICAL COMMITTEE

FORM OF CONSENT FOR PATIENTS/VOLUNTEERS IN CLINICAL RESEARCH PROJECT

Brief Title of Project

The relationhip between social support and psychological adjustment in the follow-up of acute psychiatric admissions.

Patient's Summary (purpose of study, nature of procedure, discomfort and possible risks in terms of which the patient or volunteer can understand.)

We are trying to study the relationship between the degrees of psychological upset in patients and the amount of support they need in the community after discharge. This will require a series of questions assessing the contact you have with other people, your relationships with those closest to you and how you feel about these. There will be other tests of feelings such as depression and other symptoms which will last about an hour and a half. Some of these questions you will be able to answer yourself on forms provided, all however **can** be answered without having to write down anything yourself.

The questions - in the form of questionnaires - will be repeated with your permission at six months after discharge to assess how well you have done and what help and support you have received in the community.

All information will be confidential.

It is hoped that this study might help you directly as many measures not usually performed will be assessed: measures of your well-being and of the types of contacts you have when you are back in your local neighbourhood. The study is also aimed at helping **us** to develop services to help **all** patients, so that what happens to you can be viewed as something that might happen to many other people discharged from the hospital.

If you don't want to participate in the study or wish to withdraw at any time after commencing you are entirely free to do so without any effect on your care or treatment.

Consent

I, ... of ....

give my consent to the research procedures described above, the nature, purpose and possible consequences of which

have been described to me by ....

Signed .... Date ....

Witness ....

Appendix: E.

FOLLOW-UP INTERVIEW: COVERING LETTER TO PATIENTS.

"Dear ______ ,

I hope this letter finds you in good spirits and in good health.

Do you remember our first meeting at the hospital several months ago, just before you were discharged from Ward 2 at Gartnavel Royal Hospital? I was the Psychologist who interviewed you before your discharge back home. I'm working alongside Drs. X, Y, and Z on ward 2 of the hospital.

On that occasion, I asked you a number of questions about how you were feeling and about the support you have around you when you're back home.

Well, it's important that I see you again very soon for another, final assessment.

WHAT I'D LIKE YOU TO DO:

It's quite important that I see you fairly soon: the interview will take around an hour to two hours depending on what's happened these past few months. Once again, anything you say will be treated in confidence. Try to see the interview as a chance to air your grievances about things, or, alternatively, an opportunity to discuss some of the things that continue to give you cause for concern.

Don't be worried about how you might be feeling at the moment: in my position as a research Psychologist I have no sway whatsoever over decisions to refer or admit people: this is nothing to do with me.

I was thinking that the best time to come round and see you would be:

e.g. Tuesday 14 August 1990 at 10 a.m.

If you are quite happy with this date and time then please **don't**bother to write back to me: I'll simply come round and see you at the appointed time.

If this date and time is NOT SUITABLE then please write and let me know **when** would be best for me to see you.

I hope that is all clear and understandable to you. The interviews will once again be informal and directed to making you feel both comfortable and at ease.

I look forward to seeing or hearing from you.

Yours sincerely,

David Morrison, Research psychologist, on behalf of**Drs. X, Y, and Z, Consultant Psychiatrists, GARTNAVEL ROYAL HOSPITAL.**"

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