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The coping mechanisms of the families of schizophrenics

Matthew Sean Jones

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I am submitting herewith a thesis written by Matthew Sean Jones entitled "The coping mechanisms of the families of schizophrenics." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Social Work.

Maummer Cetingok, Major Professor

We have read this thesis and recommend its acceptance:

Kate Mullins, Jenny Collier, Hugh Vaughn

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Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

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To the Graduate Council:

I am submitting herewith a thesis written by Matthew Sean Jones entitled "The Coping Mechanisms of the Families of Schizophrenics." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Social Work.

Dr. Muammer Cetingok, Major Professor

We have read this thesis
and recommend its acceptance:

Kate Mullins

Jenny Collier

Accepted for the Council:

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Date 11-25-91

THE COPING MECHANISMS OF THE FAMILIES OF SCHIZOPHRENICS

A Thesis
Presented for the
Master of Science in Social Work
Degree
The University of Tennessee, Knoxville

Matthew Sean Jones
December, 1991

DEDICATION

This thesis is dedicated to the memory of
Dr. Carl S. Wilks
whose quiet strength, dignity, compassion, and
professionalism continue to inspire

ACKNOWLEDGMENTS

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ABSTRACT

This study focused on answering three questions which dealt with the coping behavior and characteristics of families with a member who has schizophrenia and whether or not there are correlations among these.

The specific population was represented by a sample of families of patients who were diagnosed as having schizophrenia and were enrolled in a Day Treatment Program. Criteria for families to be included in the study were; 1) patient had to be enrolled in a Day Treatment Program, 2) patient had to reside with the family; 3) patient had to be diagnosed according to DSM-IIIR guidelines for schizophrenia; 4) family had to reside in the catchment area of community mental health center involved in the study. The family reported coping behaviors for 10 days. This included any behavior used in coping with the family member having schizophrenia and his/her illness. These behaviors were correlated with the characteristics of the family; i.e. race, income, residence, total number in family, education level, number of males and females in family, mean age of the family, and number of members employed.

Conclusions of this study support the literature that demonstrate families are impacted by schizophrenia.

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INTRODUCTION

During the mid-1950's, a process called deinstitutionalization was begun that would significantly affect both the families of the mentally ill and the mentally ill population.

Deinstitutionalization began in 1955 when Congress enacted the Mental Health Study Act. This occurred because evidence had surfaced demonstrating that the institutions where these individuals were housed had been ineffective. This was further supported by the Joint Commission in Mental Illness and Health, which was formed by the Mental Health Study Act. This commission recommended closing the "huge psychiatric warehouses" (Kane, 1984, p. 19). It also recommended that preventive mental health services be developed and made readily available to the community.

Deinstitutionalization was furthered when Congress adopted these recommendations and passed the Community Mental Health Center Act of 1963. This act provided funding for the development of community mental health centers. Each center would provide a variety of services to a population of between 75,000 to 200,000 per center (Kane, 1984, p. 19).

The development of these centers, in conjunction with the closing of the large psychiatric hospitals, effectively decreased the inpatient psychiatric population. By 1975, this population had dropped to 191,000, a decrease of 66% from its highest point in 1955 (Kane, 1984,p. 19).

These community mental health centers, which are still in existence today, are geared to meet the needs of the psychiatrically impaired individual. They offer services ranging from crisis intervention to long-term outpatient care for chronic patients. However, missing from their services is anything significant offered to meet the needs of the families dealing with the family member who is mentally ill.

This is a serious oversight as 60% of psychiatrically disabled individuals now live with family members (Strachan, 1986, p. 678). These families began to provide for their family member who is mentally ill far more significantly after the advent of deinstitutionalization. This is continuing to occur, and it is where the concern with the coping mechanisms of the family come to the surface. One study demonstrated that 65% of psychiatric patients discharged from the hospital today return to their families (Kane, 1984, p. 20). This is an estimated one million patients per year. It has also been shown that one-fourth of these patients are "chronically or severely disabled, as they continue to demonstrate periodically severe psychiatric symptomatology (Kane, 1984, p. 20).

In order to understand coping, one needs to understand the context and the circumstances surrounding it. What follows is a broad conceptual framework within which coping has come to be viewed in the field by the researchers and professionals. To begin with, a family member who is mentally ill and his/her illness place a tremendous burden on the family. The family is often ill-prepared and not equipped mentally or emotionally to care for the family member who is mentally ill (Kane, 1984, p. 20). This is evidenced by the hardships that are placed on the family as they attempt to deal with their family member who is mentally ill. These hardships include financial problems due to bills incurred by or for the family member who is mentally ill (hospitalization, medicine, physicians' fees, etc.), curtailment of social activities, and changing of relationships with friends and relatives. Particularly, this last change is partially due to the excessive demands placed on the family in caring for the family member who is mentally ill. In attempts to meet the demands placed on the family by the family member and his/her illness, the family often focuses primary attention on the family member. This, along with the time commitment needed to meet his/her needs, often leads to neglect of other family members' needs (Lefley, 1989, p. 556).

These hardships are also demonstrated in the way that the family reacts to dealing with the family member who is mentally ill and his/her illness. One study showed that the effects on the family related to hardships on siblings, marriages, social life and individual fulfillment of family members (Kane, 1984, p. 21). These families have also shown a "marked tendency" to use their free time in a less active way than families without a member who is mentally ill. They also participate less in cultural activities. Of the families involved in this study, 38% stated this difference was due to the family members' illness (Namyslowska, 1986, p. 401).

The family members are also affected in other ways. 60% of these families reported that the family members' illness disturbed the recreational, sexual, and feeling of security aspects of their family. This study also demonstrated that the children in these families are affected by the family members' illness. In those families with a member suffering from mental illness, significantly fewer children participated in extra school activities, such as language lessons, drama, sports, etc. (Namyslowska, 1986, p. 401-402).

The family must also deal with the behavioral problems of the member who is mentally ill. It has been stated that the bizarre behavior exhibited by the family member who is mentally ill causes the greatest problem for the family. Some of the behaviors are the patients' abusive or assaultive behavior, mood swings, unpredictability, hallucinations, difficulty with sleep patterns, poor personal hygiene, patterns of losing or squandering money, property damage and fire damage, and rejection of medicine despite possibility of relapse (Lefley, 1989, p. 557).

These behaviors by the family member who is mentally ill lead to other difficulties for the family. These include socially offensive incidents in public, conflicts with neighbors, and interaction with various public agencies. These can include law enforcement, mental health agencies or hospitals.

A subgroup of the types of families with member who is mentally ills that face a great deal of these problems as well as others is the family that contains a member who is diagnosed as schizophrenic. Schizophrenia is, by nature, a disruptive mental disorder. Its symptoms can include paranoia, delusional thinking, hallucinations, grandiosity, belligerence, and isolationism. These symptoms are disruptive not only to the individual but also to the family. The family member who has schizophrenia and his/her illness has a direct affect on the family. Some of the problems are social withdrawal, impoverished behavior on the part of the family member, and social stigmatization for both the family and their ill member (Hahlweg et al, 1989, p.112). Those family members who have schizophrenia also exhibit bizarre behaviors. As he/she has little contact outside of family, the family member with schizophrenia develops extreme dependence on a relative who, as a result, withdraws socially. This was evidenced in a study by Creer and Wing (1974) who reported that 50% of relatives studied reported severe impairment of physical and psychic well-being, especially depressive mood and hopelessness (Hahlweg et al, 1989, p. 112).

As has been noted, there is a distinct impact on the families as they attempt to deal with the family member who has schizophrenia and his/her illness. Consequently, a study of how they cope with the family member with schizophrenia is very warranted. It is thus necessary to understand the process that the family goes through in coping with the family member and his/her illness. This area has attracted much less attention due to its tedious and time consuming nature.

CHAPTER 1

STATEMENT OF PROBLEM

I. Purpose of Study

This study examined this coping process, i.e. the behaviors used by family members to deal with the family member with schizophrenia and his/her illness. More specifically, the study attempted to answer the following questions in an exploratory, in depth and comprehensive manner without stating any hypotheses: 1) What are the behaviors used to cope with the family member with schizophrenia and his/her illness? 2) What are the characteristics of the families with a family member with schizophrenia? 3) Do the characteristics of the families and the behaviors used to cope with the family member with schizophrenia and his/her illness have a correlation?

Given that the conceptualization of coping is not clear, no specific conceptualization presented by any of the sources cited was employed. Instead, an eclectic conceptualization inspired by all those presented was attempted here.

For the purposes of this study, coping was defined as the behaviors that the family members participate in as they deal with the family member with schizophrenia and his/her illness. Given this definition, this study focused on the problem-focused and behavioral aspect of coping. This limited the definition in a sense. However, given the fact that this was a descriptive and exploratory study, the author felt that it was in the best interest to work with concrete facts. By working with behaviors, rather than emotions, this was realized.

As the coping behaviors of the family were examined,, this study attempted to explore them in terms of everyday situations. In order to do this, coping was first divided into two primary areas,i.e. 1) behaviors directed towards the family member with schizophrenia and 2) behaviors directed towards the illness, involving different aspects of family coping.

The first primary area included 1) household activities; 2) family socialization; 3) community socialization; and 4) activities directly related to patient care. The second primary area included 1) activities directed towards the illness; and 2) concern of the family.

The first category, household activities, contained those behaviors involved in maintaining the household. This category was further divided into meal preparation, home, laundry, and other. Meal preparation included any behaviors associated with providing meals. The item of home included any behaviors connected with maintaining or improving the structure of the home or its environment for the benefit of the patient. Laundry was listed as cleaning his/her garments. The last item served to gather data that did not fit into the other three items.

Family Socialization was the second major category of measurement. It was sub-divided into two items, passive and active. Passive socialization was interpreted as activities in which more than one person could be involved without direct interaction with the patient. The behaviors for active socialization were interpreted as any activity between family members requiring direct interaction.

Community Socialization was the next major category of coping behaviors. This category was divided into providing transportation, personal needs, and pleasure for the patient. Transportation was interpreted as simply giving the family member with schizophrenia a ride to or from a destination. Personal needs was used to refer to interactions within the community that served to meet the personal needs of the family member with schizophrenia. The third item, pleasure, reported activities occurring within the community and away from the home environment strictly for the pleasure of the family member with schizophrenia.

Patient care was the fourth category. Activities reported were included in this category if they were done directly to, or with, the family member with schizophrenia and were not specifically illness oriented. This category was divided into three items; hygiene, space, and other. The first item, hygiene, included any behavior reported for assisting the family member who is mentally ill in maintaining or improving personal hygiene. The space item encompassed activities reported that served to maintain the family member with schizophrenias' personal living space. The third item was other. This item was again used to gather data that were not appropriate for the first two.

The last two categories comprise the second primary area. These two categories include behaviors that are directed towards the illness of the family member. Illness is the first of these two categories. It included any behaviors reported that were directed specifically towards the illness of the family member. This category had three items; medication, doctor, and other. Medication reported any behaviors that involved the medicine of the family member with schizophrenia. The doctor item included any behavior directed towards the illness that involved a physician, directly or indirectly. The last item served to collect data that did not fall within the realm of the first two items.

The last major category listed was that of concern of the family. In this category, the family was asked to list any area that worried them as they coped with the family member with schizophrenia. Based on the responses given, this category was itemized as health, illness, and interpersonal issues. These concerns were widely varied and are too numerous to list at this time. However, these will be discussed and listed in the appropriate section of this study.

The behaviors used by the family to cope have been discussed as for, with and for/with the family member who has schizophrenia and his/her illness (Table 1). To clarify this, "for" is those behaviors used to cope where the patient is a passive participant. "With" is those behaviors used to cope where the patient is an active participant. "For/With" is used to note those coping behaviors where the patient could be either a passive or active participatant.

While family has been discussed in this paper, little has been done to define it concretely. Family has been defined as "a group of persons of common ancestry" or " a group of individuals living under one roof and under one head". For the purpose of this study, a family consisted of any group of individuals living within the same household and being related by

Table 1

Categorization of Coping Behaviors

	Family Member*	Illness**
FOR[1]	Care for Family Member Hygiene Personal Area Other	Illness Maintenance Medicine Doctor Other
		Concerns Health Interpersonal Safety
WITH[2]	Family Socialization Passive Active	
FOR/WITH[3]	Community Socialization Transportation Need Pleasure	
	Household Activities Meal Preparation Home Maintenance Laundry Other	

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*Coping behaviors directed towards family member

**Coping behaviors directed towards the illness

[1] Family member is passive participant

[2] Family member is active participant

[3] Family member is passive or active participant

ancestry, marriage or other legal act of bringing the members together, i. e. adoption.

As was discussed previously in this section, families were studied according to the behavior they reported as they coped with the family member with schizophrenia. The families were also measured through the reporting of various characteristics. These characteristics included number of people in the family, family income, employment status, mean age of the family, race, residence and education. The number of individuals in the family was also examined in relation to the number of males and females.

Although the patient is neither the focus nor the unit of this study at this time, it is necessary to define the concept of schizophrenia, simply because the families included in this study will be the ones with members who have schizophrenia and their coping behaviors were studied in reference to this illness, specifically. As has been noted previously in this paper, schizophrenia is an illness involving thought disruption. This illness is evidenced through its psychiatric symptoms. Some of these symptoms are delusional thinking, hallucinations, grandiosity, belligerence and paranoia. These symptoms can be exhibited in different combinations and varying degrees, both in the individual and the different phases of the illness. This illness usually manifests itself during the late teen-age years or early twenties. It can develop in an individual as late as his/her fifties. The illness is manifested equally in males and females. A typical profile would be a man or woman, who experienced onset between ages 17 to 25. This individual would exhibit bizarre behavior during the active phase of this illness. These behaviors could include those symptoms previously discussed. They could be evidenced first by bizarre speech patterns, increasing paranoia and isolation of the individual. This person has generally been hospitalized at least once, this being at onset. He/she can expect to return to the hospital during periods of decompensation as the illness progresses. He/she can also expect periods of general stability. This is maintained by psychotropic medications.

For the purposes of this study, schizophrenia was defined by the DSM-III R (Spitzer, 1987, p. 187). This includes the five sub-types. These are catatonic, disorganized, paranoid, undifferentiated and residual. Diagnosis made by the physicians would operationally define those who are schizophrenics.

II. Need for Study

As has been discussed in the introduction of this paper, the impact that the family member with schizophrenia and his/her illness has on the family is clearly evidenced by the sources cited (Kane, 1984, Hahlweg et al, 1989, Lefley, 1989, Vannicelli, 1980, Strachan, 1986, Namyslowska, 1986). Thus, the study of the family's coping behavior helps us to understand this impact. In addition, the rationale for the study was approached from a practice standpoint, also. Although, the primary practice focus is on the client, a significant attempt is also made to provide some limited services to the families, i.e. support groups. However, these efforts have not met with great success. The groups are poorly attended and have little participation. Families are also helped in times of crisis. But, there is a feeling that more can and should be done for these families to help them cope with their family member with schizophrenia and his/her illness. While the agency is interested in helping these families, staff do not know what the families need in the way of services. In order to resolve this, the agency must first make itself aware of who it wants to help and what these families need. This is the practice inspired rationale for the study of the characteristics of the families and their coping behaviors with the family member with schizophrenia and his/her illness. Based on what the families report as important in regards to coping with the family member with schizophrenia and his/her illness, we can examine what services need to be implemented to help the families cope more effectively with the family member with schizophrenia and his/her illness.

III. Assumptions and Limitations

In carrying out this study, several assumptions were made. It was assumed that the contact person in the family could accurately report the coping behaviors of the family towards the family member with schizophrenia and his/her illness. It was also assumed that the behaviors reported by the contact person would pertain to what the families did for and with the family member with schizophrenia and his/her illness and not to what they did for themselves.

It was also assumed that the families would report the activities that they saw as being needed to cope with the family member with schizophrenia and his/her illness. If the behaviors were not reported, it was assumed that the family felt that it did not need these behaviors to cope with the family member and his/her illness.

Several other limitations in the study were noted as well. The fact that an untested instrument was used for data collection is a primary one. The instrument has not been tested for its reliability and validity.

As part of the instrument, the researcher included a page of possible examples of the behaviors to report. This could be a limitation if the contact person only reported behaviors similar to the examples given. He/she could have disregarded behaviors used to cope with the family member and his/her illness that were dissimilar.

Another limitation is that the study relied on self-reporting by the families. The information may not be accurate or complete for several reasons. The family contact person may not have been aware of behaviors used by other family members to cope with the family member with schizophrenia and his/her illness. The family contact person may have been employed and only reported those activities of which he/she were aware. This person could also have forgotten (memory lapses), purposely deleted or added information that was to be included in the study for personal reasons.

This self-reporting could be inaccurate due to the recall problems and length of the reporting period as well. Some of the families may have reported accurately for the first few days and not been as diligent the rest, leaving out some information. Another aspect of the reporting, that of the nature of the content of the family's coping behavior, could act as a limitation. The contact person in the family may not have reported behaviors that he/she felt were embarrassing to the family. The length of the reporting period could also have kept some families from participating.

The size of the sample is also a limitation. It is not large enough from which to generalize to other populations and locations.

Another limitation might be that the families are the ones being served by the two community mental health centers. As such, they might not be representative of all the families with members who have schizophrenia in the study area. Higher socio-economic status families might be seeking help from private psychiatrists and social workers.

Given that these are the assumptions and limitations of this study, the previous studies in this particular area are examined. That is the area of coping and, more specifically, family coping with the member who is mentally ill.

CHAPTER 2

LITERATURE REVIEW

This literature review first attempts to draw a broad historical and conceptual framework within which to understand the concept of coping behaviors in general and until 1980. Second, the more recent literature from 1981 to present on the coping behaviors of the family with a family member with schizophrenia is explored. The date (1980) used to divide the literature into historical and recent was arrived at due to the emergence of literature specifically related to coping and mental illness in the 1980's. Literature specifically pertaining to families with a mentally ill member, including schizophrenia, is also considered.

I. Historical Considerations

Pearlin and Schooler (1978) laid the foundation for the study of coping with everyday life events. They studied life events that were considered both normal and difficult for people. They identified how people coped with these problems, and assessed how efficient these methods were. The researchers examined four areas common to most people: marriage, parenting, household economics, and occupation. They examined coping in three areas: social resources, psychological resources, and specific coping responses. The methods used to cope were judged for efficiency based on variables from each area listed above and also emotional stresses the individual felt after employing the coping methods. They found that "the style and content of coping do make a difference to the emotional well-being of people" (p. 18). It was also determined that the "greater the scope and variety of the individual's coping repertoire, the more protection coping affords" (p. 18). They determined that there were three dimensions of coping: (1) those that change the situation; (2) those that change the perception of the stressful event; (3) those that attempt to control the stress after it is felt (p. 6).

Monat, Averill, and Lazarus (1972), Lazarus and Folkman (1980), and Lazarus, Coyne and Aldurn (1981) have also added much to what is known about coping through several studies. One study (Monat et al, 1972) examined coping reactions of individuals "under various conditions of uncertainty" (p. 238). This was examined through two controlled experiments. In experiment I, using 20 male subjects, there was "one condition of uncertainty - a 50% probable shock at time known, or, relative certainty - a 100% probable shock at time known" (p. 239). Coping was measured physiologically (heart rate, skin resistance level, galvanic skin response, respiration), and affect by self-report. Participants reported how they felt during each third of the trial, which lasted for three minutes. They also rated the intensity of the shock. Responses to statements concerning various mechanisms of coping including avoidance-like thoughts and vigilant-like activities were obtained. It was determined that "knowledge of when an aversive event occurs appears to encourage attention deployment during early moment of waiting. As the moment of confrontation with the anticipated shock approaches, there is a sharp shift in the amount of attention to vigilant-like thoughts" (p. 244).

In experiment II, there were four groups, each composed of ten male subjects. Each group had differing experimental conditions; 100% time unknown, 100% time known, 50% time known and 5% probability that it would occur at all. It was found that in the "time-locked" conditions, the results were the same as the first experiment. In the temporal uncertainty subjects,i.e. persons not knowing when the event is to occur, a decrease in time spent on vigilant thoughts from the first, third or later portions of the waiting periods were reported (p. 242).

In comparing the two experiments, the authors determined that "under conditions in which the person knows exactly when the aversive event is to occur, and regardless of how certain or uncertain he is about whether it will occur, his thoughts turn increasingly toward vigilant examination of the anticipated event as it grows imminent; and this increased vigilance is accompanied by an increase in arousal.

In contrast, under conditions in which the person does not know when the event is to occur, that is, temporal uncertainty, the person's thoughts tend increasingly toward avoidant-like modes of coping, and these coping strategies in turn lead to progressively lowered levels of affective arousal (p. 250). Lazarus and Folkman (1980) studied coping with stressful daily life events in a community sample. This was done with a sample of 100 individuals, aged 45 to 64. These life events were examined in four areas: health, work, family matters, and others. This was also examined by " person involved"; self only, person(s) at work, family member(s) and others. Life events were also "appraised" by participants, by responding to four questions: 1) if they could change or do something about it? 2) if they must accept or get used to it? 3) if they needed to know more about it before they could act? 4) if the event were one in which they had to hold themselves back from doing what they wanted to do? (p. 226).

The authors found that in only 2% of all episodes examined, one type of coping, i.e. emotion-focused or problem-focused, was used. In all others, problem-focused and emotion-focused combinations were used. Of the three areas examined, "person involved" had least import on type of coping used. The context did have a bearing on the coping used. "Work was associated with higher levels of problem-focused coping, and health was associated with increased emotion-focused coping" (p. 230). The family context had no clear impact on the type of coping used. There were differences in coping related to age. These authors felt that stressors changed with age and this led to different types of coping by the individual. There was no significant difference based on gender.

Hamburg and Adams (1967) examined coping studies from a particular vantage point. That point was the use of seeking and utilizing information under stressful situations as a coping method. They examined patients with severe injuries. Coping was seen as behavior that served to keep distress at manageable levels; maintain sense of personal worth; restore relations with significant others; improve chances of recovering bodily functions; and increasing likelihood of selfactualization after physical recovery is attained (p. 278). They found that there was a progression, or sequence, that was followed by the individual throughout this process. This pattern was denial, acceptance, seeking of information and assessing of possible limitations. They also determined that individuals coped more effectively if they were part of a highly valued group, i.e. a patient group; the family; or the community, usually represented by close friends.

Hamburg and Adams (1967) also examined psychological transitions of youths. In this discussion, coping had two components: 1) the effectiveness with which each task was completed and 2) cost to the individual of this effectiveness. The authors discussed that gathering information prior to change, about new roles, about future difficulties, and use of friendship were ways these youths coped.

Doll (1976) studied 125 families to evaluate the effects of returning mental patients to their homes. He found that families would tolerate a high level of deviant behavior from this family member. Having a family member labeled "former mental patient" did not trouble them. They were disturbed by the continual presence of psychiatrically severe symptoms. The severity of the psychiatric condition impacted the household routine. It also affected whether or not the families engaged in social activities with their mentally ill family member or even wanted them to come home at all. While these families were willing to care for their mentally ill family member, they also reported feeling trapped or having feelings of antagonism and fear (p. 184).

Marcus (1977) examining the families of autistic children, focused on the family coping capabilities. Parents reported being anxious constantly. They also tried not to plan too far ahead. Some parents reported seeing their child as a burden, but continued to care for them. Self-esteem of parents, especially mothers, was affected negatively. These parents also suffered from social isolation as caring for their child took a tremendous amount of their time. It was found that parents placed greatest emphasis on their child's language impairment. The behavioral problems were noted as the most painful as they inhibited normal human relatedness. The author stated that parents also cope with many difficulties in dealing with the public. These include discrimination, lack of service, confronting ignorance, attempting to explain bizarre behaviors and suppressing anger or shame. All of these directly affect the family and its members as they attempt to function and fulfill their roles.

II. Survey of Recent Research

Lazarus, Coyne and Aldurn (1981) studied depression and coping of individuals during stressful situations. They did this with a sample of 15 depressed subjects and 72 non-depressed subjects. The authors divided coping into emotion-focused and problem-focused to determine how depressed individuals coped with everyday stresses. They also used the individual appraisal of the situation. It was found that subjects used more problem-focused coping on situations by appraisal as changeable. If the situation was seen to be unchangeable, and therefore need to be accepted, minimization of threat was used as primary coping mechanism. The authors found that depressed persons tended to state that they needed more information before taking action but were less likely to appraise situations as needing to be accepted. The authors stated that this suggested depressed people were inept in taking action more out of feeling uncertain than of being helpless to change a situation.

Billings and Moos (1981) examined coping responses and social resources as processes that regulate the effect of life events on personal functioning with a total of 360 families, including a random sample of families within the community and a sample of alcoholic families. A total of 294 families completed the survey. Information was collected in four areas: 1) negative life change events; 2) coping responses; 3) social resources; and 4) three mood and symptom dimensions-depression, anxiety, and stress-related physical symptoms, as well as demographic information (p. 144). They found that reliance on active attempts to deal with an event and fewer attempts to avoid dealing with it were associated with less stress (p. 144). They found that persons who had more education were more prone to use active-cognitive and problem-focused coping and not as apt to use avoidant coping. They also determined that amount of income was positively related to active-behavioral, active-cognitive, and problem-focused coping (p. 148).

Wheaton (1982) examined coping strategies used by Anglos and Mexican-Americans in southeastern Texas. He examined the " relative efficacy of fatalism and inflexibility in changing the impact of stress on depression" (p. 293). His findings suggested that lower fatalism and less inflexibility have some moderating effect on stress in both groups. It should be noted that Mexican-Americans were found to be less vulnerable overall to the impact of chronic stress.

Brickman et al (1982) examined four models of helping and coping. These are the moral, compensatory, medical, and enlightenment models. In the moral model, individuals are responsible for problems and solutions. It is believed that they only need motivation. In the compensatory model, individuals are not responsible for problems, only solutions. They are seen as needing power. In the medical model, individuals are not responsible for either, and need only treatment. In the last model, enlightenment, individuals are responsible for problems but are unwilling or unable to find a solution and need discipline (p. 368). The authors felt that the wrong choice of a model for a particular situation could undermine effective coping.

Koch (1985) examined two factors important to effective family coping. They were role flexibility and affective reaction and were examined in connection with chronic illness. This model suggests that adapting will be effective when family roles are flexible and the family allows for expression of emotion. The more restrictive these areas are in the family, the less likely the family is to adapt effectively (p. 74).

Barbarin (1983) reviewed the research on black families with regards to ecological transitions. These were identified as stressful changes in role, condition, or setting. Barbarin examined family coping by using the following elements; the stressor; immediate appraisal of the stressor; coping styles which include family constructs, direct problem-focused behavior, and emotion-focused responses; and family resources for coping and coping outcomes (p. 313). This can also include long term adapting. The author used childhood cancer as a means to examine coping of black families. The author noted that there are differences in how black families cope. This could be related to their African-American heritage, but also to issues related to discrimination, personal control, religiosity, family structure, resource availability, and use of formal and informal networks (p. 319).

Personal religiosity and involvement in religion were seen as two ways of coping that offered optimism. These offered ways to explain and accept the fact that one's child had cancer. Discrimination was seen to play a role as well. Negative life outcomes were viewed in a context of individual and institutional discrimination more often in black families. These were suggested as being part of a relatively passive behavioral style (p. 319). This was not viewed as negative due to the fact that an uncontrollable life event (cancer) was involved.

Family structure and resources were seen as influencing coping as well. Single parent families and dual-worker families were seen as being less flexible and having fewer resources. However, when they were also seen as having access to extended family systems as resources, this enhanced coping. In conclusion, Barbarin stated that black families relying on religiosity, flexible role structure, extended kinship and community support would cope more effectively that those families that did not (p. 320).

Noh and Avison (1988) examined the spouses of formerly hospitalized psychiatric patients to determine the level of burden experienced. This study was drawn from a larger study done with 163 spouses of psychiatric patients. The authors examined which psychiatric characteristics of the patient and aspects of family structure affected the perception of burden (p. 377). They found that there is much variation as to the level of burden perceived. Those spouses whose mastery of life events was low were more likely to view their spouse as a burden. Characteristics of the family also contributed. Those factors increasing burden were presence of children, working women, and level of social support.

Methorst and Diekstra (1987) examined, in Holland, the spouses of psychiatric outpatients to determine the level of emotional distress experienced. They started with 153 spouses. Of these, only 105 agreed to participate in the study. Those spouses agreeing to participate were interviewed by the researchers. Areas included in the interview were : 1) experiences of the spouse or changes since manifestation of illness; 2) spouses' evaluation of changes; 3) strategies of coping; and 4) perspectives of the future (p. 430). The spouses' strategies for coping with the patient were categorized as consideration, support, activation and stimulation, confrontation, and organization of help from outside. The spouses attempted to deal with their own problems through seeking a solution to the patient's problem, putting problems into perspective, self-protection, temporary distraction of attention, and self-realization all of which demonstrated positive effects.

Goldstein et al (1989) examined the coping of families and schizophrenics as it related to expressed emotion. This was done with a sample of 36 patients and their families. This coping was examined in the interactional patterns within the family, specifically between the patient and family members. The authors found that in "low expressed emotion" families, criticism between the patient and relatives is minimal. In high expressed emotion families, there is a high rate of criticism between patient and relatives. This study is included because it shows one aspect of how families cope with their family member with schizophrenia.

Boker et al (1989) studied schizophrenic patients and their significant relatives to determine coping patterns. This sample included 11 chronic patients and the majority (23 people) of "first-degree" relatives. Coping was assessed by examining six factors: 1) emotional concern and giving up; 2) active attempts at controlling stress; 3) change of appraisal (cognitive coping); 4) avoidance; 5) need for social support and help from others and 6) substitutive gratification (p. 134). Three groups were studied, the schizophrenic patient, relatives seen as vulnerable(VR) and relatives seen as non-vulnerable(NVR). These last two groups were determined by the presence or absence of an information-processing deficit (p. 132). It was determined that NVR relatives coped similarly to the "normal population". The VR group tended to use active attempts at controlling the situations and change of appraisal most often. The schizophrenic patient coped by avoiding and demonstrating a need for help as the most common responses (p. 134).

Namyslowska (1986) examined families in Poland to determine how they coped with family member with schizophrenias. This was done with a sample of 152 individuals with a schizophrenic spouse. They were compared with 1,832 urban families. The author found that families with a family member with schizophrenia were less active socially and culturally. They also tended to become more isolated (p. 401). Families reported changes being smallest in economical, educational, and emotional aspects. The largest changes were seen in recreational, sexual and feeling of security areas. The methods of coping were listed as moral, emotional, dealing with children, social support, rational and compensatory (p. 403). The author stated that these families opted to remain autonomous but not isolated from the kinship system when coping with the family member with schizophrenia. Their findings indicate that the families are capable of meeting all needs except for that of recreation or socialization.

As has been noted through this broad review of literature, there have been studies done involving coping. Yet, only recently, studies to behaviorally determine what coping consists of have begun to be conducted. More specifically, the behavioral contents of family coping is an area in which there has not been a large concentration of study. There have been even fewer studies done to study the day-to-day, and specific coping behaviors of families with mentally ill members. These studies have primarily focused on how the family environment caused or effected the illness. They have not examined what the family does for the family member with schizophrenia and his/her illness. It appears, from this broad review of literature, that the shift in focus or choice as to what to study has been, to a large extent, due to the conceptual confusion still besetting this particular field of research.

In this respect, Kessler et al (1985) in their review of the research on coping, stated that there were some disagreements concerning coping. The two primary controversies were 1) how coping should be conceptualized and measured, and, 2) the extent to which people are aware of their coping efforts (p. 551).

These conceptual problems notwithstanding, yet appreciating the body of knowledge in terms of the specific day-to-day manifestations of the coping behaviors of families, this study focused on the major question of what specific behaviors does the family employ in coping with the family member who has schizophrenia and his/her illness? Then the subsequent questions of, 1) What are the characteristics of the families with a member having schizophrenia? and 2) How do the behaviors used to cope with the family member who has schizophrenia and his/her illness correlate with the characteristics of the family? were also considered. The behaviors are of family members and they do not in any way include the behaviors of the members having schizophrenia, at all.

CHAPTER 3

METHODS AND PROCEDURES

I. Sample

The population for this study was defined as the families of the patients diagnosed as having schizophrenia from the catchment areas of two community mental health centers in southwest Tennessee; the Jackson Counseling Center/ Jackson Psychiatric Hospital and Quinco Community Mental Health Center. This included eight counties; Madison, Haywood, Henderson, Chester, Hardeman, McNairy, Hardin, and Decatur. These counties were generally rural communities. However, there was one semi-urban area with a population of 50,000 included within this area. Specifically, the population was defined as the families of clients meeting the following four primary criteria: 1) the family member who had schizophrenia was to be involved in the Day Treatment Program at one of the two mental health centers; 2) the client had to reside with the family; 3) the family member had to have a diagnosis of schizophrenia according to the guidelines of the DSM-III R; and 4) the client and the family would reside within the catchment area of the mental health centers.

The sample of 18 itself was non-random and it was selected from the families of fifty (50) active client cases of the Day Treatment Programs of the two mental health centers named above. All of the cases inlcuded in the sample had a patient with a diagnosis of schizophrenia. The families of all of these 50 cases were contacted to determine level of interest in participation. (This will be discussed in more detail in the procedure section of this paper, p. 39ff).

At this contact, it was determined that eight families were not appropriate as the family member with schizophrenia had moved either into an independent living situation or into a boarding home. One family was deemed inappropriate as the other members were low functioning intellectually and could not respond to the study and the client was the head of the household and as such provided the care for others. Furthermore, a total of four other families were lost due to the family member being discharged from one of the Day Treatment Programs during the reporting period. This left a total of thirty-seven families within the population. Of these families, 18 (approximately 49% of the sample) actually completed the study.

These families ranged in size from 2 to 9 members, with 9 families having the most frequent size, 3. The number of males in the family ranged from 0 to 5, with 7 families having the most frequent number of 1. he number of females in the family ranged from 1 to 6, with 8 families having the most frequent number of 1. The mean age of the families ranged from 32 to over 64. The most common group was that of 32-48 having 8 families in this category. Twelve families lived in rural areas and 6 in semi-urban. There were 8 families who reported annual income of 0 - $20,000, 4 who reported $20,001 or above and 6 who did not report. Seven families had less than a high school education and 10 families had a high school education or better. Twelve families were black and 6 were white. The number of family members employed ranged from 0 to 3, with 8 families reporting the most common number, 0.

While the family member with schizophrenia was not the focus of the study, some demographic information was obtained from existing records simply for the purpose of description. Ten of the patients were male and eight were female. The specific diagnoses were also listed. Schizophrenia being the primary diagnosis, the subcategories represented within the sample were; 1) paranoid type, seven clients, or 39%; 2) catatonic type, one client, or 5%; and 3) undifferentiated, ten clients, or 56%. This serves as a description of the population and sample for this study.

II. Instrumentation

A self-report survey form was developed for this study (Appendix A). As this survey form was developed for this study, it has not been tested for reliability and validity. This survey form included a cover letter explaining the study, consent form, demographic sheet, example page and report pages. This survey was to be used for reporting the activities of the family for a continuous ten day period. The ten day period was chosen because it was assumed that within ten days every conceivable coping behavior would be demonstrated by the families.

The demographic page requested information concerning total number of persons in the family and total family income. It also requested a listing of the individuals within the home. The demographic information requested from each individual included age, sex, marital status, education level, employment, and relation to the family member.

The example page listed possible behaviors that could be reported by the family. This list was not exhaustive but was meant to demonstrate the type of activities that could be reported.

The reporting section of the survey had ten pages.

Each page was to be used for reporting the activities of one day. Each day was divided into two separate areas; activities for the family member and activities for the illness. Activities for the family member were to include those behaviors done for and with the family member but not pertaining to the illness. This was to include typical behaviors such as fixing meals, laundry, watching TV, etc. Activities for the illness included any behavior directed toward managing the illness of the family member. These behaviors were to include giving him/her medicine, taking him/her to the doctor, etc.

Both of these categories were divided into sections for morning, afternoon and evening. This was done to help the family contact person divide the day into sections for easier recollection and reporting.

At the bottom of each reporting page was an area designated as areas of special concern. This was to be used by the reporting family member to report any specific problems they had encountered during the day. These could either be in relation to the family member with schizophrenia or his/her illness. The reporting family member was also asked to report any area that concerned, or worried, them in regard to the family member with schizophrenia.

III. Data Collection

Two community mental health centers were selected at which to conduct the study. The community mental health centers were contacted about conducting the study through their facilities. Permission was received at both centers to conduct the study with the families with which they were currently working in the Day Treatment Programs (Appendix B).

The Directors of Day Treatment Services were then contacted. Access to records was granted so that a roster of families with members who had schizophrenia could be developed. Clients with a diagnosis of schizophrenia were placed on a preliminary list. The existing records were examined to determine if the clients lived independently or with family members. The client was deleted from the list if he/she lived independently.

Prior to contacting the families, it had to be determined who in the family to contact. In working with the client, staff generally had one individual within the family that acted as contact person. It was this individual who was contacted about completing the survey. This individual was generally the head of the household. Attempts were made to contact each family in person. This was done by visiting them in their homes. This was not possible in some cases. In these cases, a telephone call was placed to the family.

Regardless of the way in which the family was contacted initially, personally or telephone, the content of the conversation was the same. The study and its purpose were explained. It was explained that participating was strictly voluntary. Lack of participation would not result in the loss of any services or benefits to the family member. The family was apprised of the confidentiality of the information to be gathered in the study. They were also told that they could stop doing the study at any time. The family was also informed that they could leave blank any portion of the survey that they felt was too personal to report. This was related specifically to demographic information. Any questions that the family member raised at this initial meeting were responded to as well.

It should be noted that the discussion of the procedures from this point will involve only those families that agreed to participate after the initial meeting.

When it was possible, the families were contacted mid-way through the reporting process (approximately 5 days). This was done to determine if the contact person was having any problems completing the survey.

When a meeting was held with the families in the home, the researcher was accompanied by the staff member most familiar with the family. Having a staff member accompany the researcher was done for two reasons. One was to increase participation in the study, i.e. the family meeting with someone they knew as a staff member would be more inclined to participate in the study. The second reason was to give the family a person to call if the researcher was unavailable.

As near after the completion of the ten day reporting period as was possible, a meeting was held with the contact person to collect the survey. Again, an opportunity to ask questions or voice concerns was given to the family member. All concerns voiced by the family were responded to appropriatley.

The procedure was changed slightly when attention was turned to the center's main facility. This was due to the large number of families involved, area to be covered, and availability of staff. The families involved lived at great distances from one another. Due to the large number of clients involved in the program, staff were not available to make home visits with the researcher. Given these constraints, an alternative was devised, as follows:

The researcher met with staff and explained the study and its purposes. Staff were asked to call each of the families who were in the sample and part of their caseload. This telephone call was to inform the family that a study was being conducted. The staff members also gave the family all of the information contained in the previous initial contacts. These issues were confidentiality, voluntary participation, etc. The staff member informed the family that a copy of the survey was being mailed to them. The contact person was asked to look it over and decide if he/she wanted to participate. He/she was encouraged to call the researcher if there were any questions prior to starting the survey. After all of the families had been contacted, the survey was mailed out. The staff were asked to contact the family again to make sure they had received the survey. The family was asked at this time if they understood the survey. The staff also fielded any questions regarding the study as they had been informed. Those families that agreed to participate were then contacted after approximately five days to help them with any problems they were having. The family was also informed that they might need to be contacted after they had completed the survey. If needed, the family was contacted for clarification of the behaviors reported.

In contacting the families, it had become apparent that some of the families would not be participating in the survey. While this was for a variety of reasons, the effect would be less participation than anticipated. The families that had declined to participate initially were contacted again. The contact person was asked if he/she had given the survey some thought and perhaps changed his/her perspective. During this process, it was determined that some families had misunderstood what they had received in the mail. When it was clarified for them, a few agreed to participate. It was also determined that two of the families were willing to participate but were unable. This was due to their being illiterate. The researcher chose to conduct telephone interviews with these two families.

The researcher noted that, despite its disadvantages, asking a subject to recall previous events is well-documented in the literature review, especially with respect to recalling life events (Billings and Moos, 1981). As such, there was precedence for the research be conducted in this manner. Also, each of these families were very small. One was composed of two individuals, one being the client. The other contained three members, one elderly, her parent and the client. As a result, both families had one individual acting as caregiver to the client. It was felt that, with one person to report on, the telephone was as valid a source of reporting as the written reports from the larger families.

Data organization for analysis purposes was the next task. The surveys were examined to determine how to categorize the information reported. The coping behaviors listed on the survey forms were placed according to that category of coping in which they fit. (These categories were discussed in the variable section of this report, p. 8ff).

Each survey was content analyzed, behaviors reported and placed in the correct categories. These were then recorded on a coding sheet for entry into the computer for statistical analysis. For analysis purposes, each family was assigned a score on the basis of the number of times it had reported behaviors within a particular category or item, as well as being assigned a score on the basis of its characteristics (i.e. a score on family size simply meant total number of members in the family). These scores were used for the construction of both frequency and correlation analysis tables.

The statistical tests used to analyze the data were simple frequency counts, computation of means, and correlation analysis. Specifically, the first statistical procedure was that of frequency distribution for family characteristics and activities reported followed by computations of the means for activities. The second procedure was to correlate the means for activities with the characteristics of the families. The results of these procedures will be discussed in the next section of this report.

Frequency distribution was done to demonstrate the behaviors reported by the family as it coped with the family member and his/her illness. Also, this reported the number of families that reported each item as they coped with the family member and his/her illness. The frequency distribution was used to describe the family and its reported behaviors.

Correlation analyses were done between each family characteristic and all the coping behaviors. For each pairing of a family characteristic and the coping behavior, all families are included. If there was not a behavior reported by a family, the frequency was recorded as 0.

For studying the correlation between most characteristics and coping behaviors, Pearson's product moment correlation coefficient was used. The level of significance of .05 was set up for the study of significance of correlations. However, there were four family characteristics that were correlated with coping behaviors using the point biserial method. The measurements of the behaviors produced interval data and the characteristics of the family produced dichotomous data. These characteristics were the residence (rural, semi-urban), race (black, white), income (up to $20,000, $20,001 and above), and educational level of the family (up to 11th grade, high school or more). Using this method, the "correlation coefficients of 0.404 and 0.515 are needed for significance (P) at the 0.05 and 0.01 levels, respectively" (Young and Veldman, 1981, p. 156).

CHAPTER 4

RESULTS

This chapter is devoted to the reporting of the findings of the study. The first section describes the characteristics of the families that were involved in the study (Table 2).

Three of the families (approximately 17%) were headed by two parents. Seven of them (39%) were headed by single parents. In every case, this single parent was a mother.

Eleven percent (11%), or two of the families, were headed by a spouse. The same number of families was headed by a sibling. Three families (17%) were headed by an aunt and one (5%) was headed by the child of the client. The number of family members ranged from 2 to 9, with the mean being 3.6. Four families had two members, nine had 3, and two had 4. One family each was represented by six, seven and nine members.

Eight families (45%) reported having no member of the family employed. Five families (approximately 28%) had one member employed. Four families (22%) had two members employed and one family (5%) had three members employed.

Table 2

Descriptive Characteristics of Families

Variable	Frequency	Percentage
Average Age of Family		
32-48	8	44.4
49-63	6	33.3
64-OVER	3	16.7
0	1	5.6
Family Size		
2	4	22.2
3	9	50.0
4	2	11.1
6	1	5.6
7	1	5.6
9	1	5.6
Number of Males in Family		
0	3	16.7
1	7	38.9
2	2	33.3
3	1	5.6
5	1	5.6
Number of Females in the Family		
1	8	44.4
2	6	33.3
3	2	11.1
4	1	5.6
6	1	5.6
Race of the Family		
Black	12	66.7
White	6	33.3
Total Family Income		
0-20,000	8	44.5
20,001 and OVER	4	22.2
Not reported	6	33.3
Numbers of Members Employed		
0	8	44.4
1	5	27.8
2	4	22.2
3	1	5.6

Table 2: con't.

Variable	Frequency	Percentage
Place of Residence		
Rural	12	66.7
Semi-urban	6	33.3
Education Level of Family		
None-11th grade	7	38.8
High School or more	10	55.6
Not Reported	1	5.6

Six families did not report their income. Of those reporting, eight families fell in the low range (0-20,000). Four were in the upper-range (20,001-Above). This gave the reporting families a median income of approximately $17,000.

The race of the families was unevenly distributed with twelve being black and six families being white.

The mean ages of the families ranged from 24 to 70. This mean was significantly effected in the three largest families by the presence of young siblings or other relatives.

The composition of the families varied. Three families, (16.7%), had no male members. Seven families, or 38.8%, had one male member. Two male members were reported in two families,(11.1%). One family each had 3 male members and 5 male members, (5.6% each).

Eight families had one female member, (44.4%). Six families had two female members, (33.3%). One family each had 4 female members and 6 female members, (5.6% each).

The place of residence was also unevenly distributed. Twelve of the families lived in rural areas, (66.7%). The other six lived in semi-urban areas, (33.3%).

The educational level of the family was slightly more evenly distributed. There were ten families with the majority of its members having at least a high school education, or 55.6%. Seven families had less than a high school education, or 38.8%. One family did not report its educational level(5.6%).

The following section is devoted to reporting the frequencies of the coping behaviors listed by the families on the survey form in the different categories. These frequencies will be reported by the specific categories and behavioral items in which the behaviors are reported for ten days (Table 3). The behaviors reported in the "meal preparation" item were fixing or serving breakfast, lunch, or dinner and washing dishes. There were a total of 363 behaviors reported in this item by 18 families for a mean of 20.17. The "home maintenance" item included house repairs, painting, cleaning, or doing the yard. Four families reported in this item with a total of 12 behaviors reported. This gave them a mean of 3. The item of "laundry" was reported by 11 families. There were a total of 25 activities for a mean of 2.27. The item listed as "other" had two families reporting for a total of 8 activities (mean of 4). The behaviors reported in this item were showing the family member how to light the heater, etc.

The behavior reported for the item of "passive socialization," under the category of family

Table 3

Frequency of Activities Reported

Coping Behaviors	Families*	Behaviors	Mean**
Behaviors directed towards coping with the Member			
Household Activities			
Meal Preparation	18	363	20.17
Home Maintenance	4	12	3.00
Laundry	11	25	2.27
Other	2	8	4.00
Family Socialization			
Passive	10	92	9.20
Active	8	34	4.25
Community Socialization			
Transportation	6	15	2.50
Need	11	36	3.27
Pleasure	10	42	4.20
Care for Family Member			
Hygiene	4	46	11.50
Area (personal space)	10	45	4.50
Other	8	28	3.50
Behaviors directed towards Illness			
Illness Maintenance			
Medicine	11	118	10.72
Doctor	3	5	1.67
Other	4	8	2.00
Concerns			
Health	6	24	4.00
Interpersonal	8	19	2.38
Safety	5	9	1.80

* Indicates the number of families reporting behaviors in this category.

** Indicates the mean of the number of activities reported for the ten day period.

socialization, was watching T.V. Ten families reported this behavior with a total of 92 activities. This gave them a mean of 9.2. The eight families reporting in the item of "active socialization" reported 34 behaviors for a mean of 4.25. These behaviors included talking, visits with relatives, playing cards, and phone calls, all including the family member having schizophrenia.

In the Community Socialization category, six families reported behaviors in the "transportation" item with a total of 15 behaviors. This gave those families a reporting a mean of 2.5. The behaviors reported were giving the family member a ride to or from a destination, other than medical visits, need or pleasure. In the item of "need," 11 families reported 36 behaviors with a mean of 3.27. The behaviors listed in this category were shopping, going to the barber shop, etc. The next item, "pleasure," was reported by 10 families for a total of 42 behaviors and a mean of 4.2. The behaviors reported in this category included going to church, going to a friends' house, out to eat, out to play cards, etc.

Under the care for family member category, the item of "hygiene" was reported by 4 families for a total of 46 behaviors reported. This gave those families a mean of 11.5. The behaviors reported for this category were getting clothes ready, combing hair, giving showers, dressing for church, and reminding him/her to brush his/her teeth. The item of "area" (personal space) was reported by 10 families. They reported a total of 45 activities for a mean of 4.5. The behaviors reported in this category were making beds, changing beds, and cleaning his/her room. The item of "other" was reported by 8 families. They reported a total of 28 behaviors for a mean of 3.5. These behaviors included waking up the family member, paying his/her bills, or cashing his/her check.

In the Illness Maintenance category, the item of "medicine" was reported by 11 families a total of 118 behaviors. This gave these families a mean of 10.72. The behaviors reported included giving him/her medicine, preparing the days' medicine, or reminding him/her to take medicine. The item of "doctor" was reported by 3 families. There were 5 behaviors reported for a mean of 1.67. These behaviors were taking the family member to the doctor or calling the doctor on his/her behalf. The item of "other" was reported by 4 families for a total of 8 behaviors. This gave them a mean of 2. The activities included in this category included calling a family member to assist with the family member having schizophrenia, as to his/her illness.

In the category of Concerns, the item of "health" was reported by 6 families with a total of 24 behaviors for a mean of 4. The behaviors related to poor nutritional habits.

The item of "interpersonal concerns" was reported by 8 families for a total of 19 activities. This gave these families a mean of 2.38. The activities reported in this category were related to isolation and personal hygiene to be considered in interpersonal relationships i.e. physical appearance, cleanliness, deoderant use, etc. The item of "concerns for safety" was reported by 5 families. There were a total of 9 activities reported for a mean of 1.8. The activities reported were walking late at night by himself, loss of memory, etc.

The following section examines the results of the correlation analyses done with all coping behaviors and each characteristics of the families.

In the first set of correlation analysis, mean age of the family was correlated with all coping behaviors (Table 4). There were two statistically significant correlations noted. The first was with the item of "medicine". This was a positive correlation ($r=.5118$, $p=.015$). The second correlation was the item of "other" in the category of Illness Maintenance. This was also a positive correlation ($r=.5219$, $p=0.013$).

In the next set of correlation analysis, the size of the family was correlated with all coping behaviors (Table 5). There was one statistically significant

Table 4

Correlations with Mean Age of Family

Coping Behaviors	Correlation (Pearson's R)	P=
Behaviors directed towards coping with Member		
Household Activities*		
Meal Preparation	.0255	.460
Home Maintenance	-.0753	.383
Laundry	-.2597	.149
Other	.0789	.378
Family Socialization		
Passive	-.0493	.423
Active	-.0265	.458
Community Socialization		
Transportation	.0475	.426
Need	-.0283	.456
Pleasure	-.0907	.360
Care for Family Member		
Hygiene	.1976	.216
Area (personal space)	.1245	.311
Other	.3774	.061
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	.5118	.015**
Doctor	.3815	.059
Other	.5219	.013**
Concerns		
Health	-.1386	.292
Interpersonal	-.0675	.395
Safety	.2049	.207

* In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

** Statistically significant.

Table 5

Correlations with Family Size

Coping Behaviors	Correlation (Pearson's R)	P=
Behaviors directed towards coping with Member		
Household Activities*		
Meal Preparation	.1934	.221
Home Maintenance	.6394	.002**
Laundry	.0617	.404
Other	-.0616	.404
Family Socialization		
Passive	.0432	.432
Active	-.1525	.273
Community Socialization		
Transportation	-.1350	.297
Need	-.2222	.188
Pleasure	-.1966	.217
Care for Family Member		
Hygiene	.0411	.436
Area (personal space)	-.0297	.453
Other	-.2457	.163
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	-.2246	.185
Doctor	-.2360	.173
Other	-.2366	.172
Concerns		
Health	.1595	.264
Interpersonal	-.0086	.486
Safety	-.1184	.320

* In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

** Statistically significant.

correlation found. This was with the item of "home maintenance" and was a positive correlation (r=.6394, p=.002).

In the third set of correlation analysis, the number of males in the family was correlated with all coping behaviors (Table 6). There were two statistically significant correlations found. The first was a negative relationship (r= -.4445, p=.032) with the item of "laundry". The second correlation was with the item of "health". This was a positive correlation (r=.6283, p=.003).

In the fourth set of correlation analysis, the number of females was correlated with all coping behaviors (Table 7). There were two statistically significant correlations found. The first was a positive correlation (r=.4820, p=.021) with the item of "laundry". The second correlation was a positive one (r=.5653, p=.007) with the item of "home maintenance".

In the fifth set of correlation analysis, the number of family members employed was correlated with all coping behaviors (Table 8). There were two statistically significant correlations. The first was a positive correlation (r=.4594, p=.028) with the item of "active" in the category of family socialization. The second correlation was negative (r= -.4056, p=.047) with the item of "doctor".

Table 6

Correlations with Number of Males in the Family

Coping Behaviors	Correlation (Pearson's R)	P=
Behaviors directed toward coping with the Member		
Household Activities*		
Meal Preparation	-.1342	.298
Home Maintenance	.2085	.203
Laundry	-.4445	.032**
Other	-.2008	.212
Family Socialization		
Passive	-.1742	.245
Active	-.1781	.240
Community Socialization		
Transportation	-.0577	.410
Need	-.3268	.093
Pleasure	-.3840	.058
Care for Family Member		
Hygiene	-.0327	.449
Area (personal space)	-.0880	.364
Other	-.2008	.212
Behaviors directed toward Illness		
Illness Maintenance		
Medicine	-.0674	.395
Doctor	-.0366	.443
Other	-.2823	.128
Concerns		
Health	.6283	.003**
Interpersonal	-.0111	.483
Safety	-.2388	.170

* In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probability associated with that correlation.

** Statistically significant.

Table 7

Correlations with Number of Females in Family

Coping Behaviors	Correlation (Pearson's R)	P=
Behaviors directed towards coping with Member		
Household Activities*		
Meal Preparation	.3263	.093
Home Maintenance	.5653	.007**
Laundry	.4820	.021**
Other	.1210	.316
Family Socialization		
Passive	.2047	.208
Active	-.0146	.477
Community Socialization		
Transportation	-.1252	.310
Need	.0197	.469
Pleasure	.1262	.309
Care for Family Member		
Hygiene	.1254	.310
Area (personal space)	.0374	.441
Other	-.1155	.324
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	-.2003	.213
Doctor	-.2647	.144
Other	-.0425	.433
Concerns		
Health	-.2997	.114
Interpersonal	.0200	.469
Safety	.0479	.425

* In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

** Statistically significant.

Table 8

Correlations with Number of Family Members Employed

Coping Behaviors	Correlation (Pearson's R)	P=
Behaviors directed towards coping with the Member		
Household Activities*		
Meal Preparation	.3668	.067
Home Maintenance	.3836	.058
Laundry	.2117	.200
Other	-.1297	.304
Family Socialization		
Passive	.1110	.331
Active	.4594	.028**
Community Socialization		
Transportation	.3358	.087
Need	.1086	.334
Pleasure	.3625	.070
Care for Family Member		
Hygiene	.1334	.299
Area (personal space)	.0129	.480
Other	-.1567	.267
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	-.2815	.129
Doctor	-.4056	.047**
Other	-.2996	.114
Concerns		
Health	-.2247	.185
Interpersonal	-.2734	.136
Safety	.0661	.397

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* In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

** Statistically significant.

In the sixth set of correlation analysis, the total annual income of the family was correlated with all coping behaviors (Table 9). There were four statistically significant correlations found. The first (r_{pb}=-.5204, p=.01) was with the item of "meal preparation" in the category of Household Activities. The second correlation (r_{pb}=-.5187, p=.01) was with the item "passive" in the category of Family Socialization. The third correlation (r_{pb}=-.7718, p=.01) was the item "hygiene" in the category of Care for the Patient. The last correlation (r_{pb}=-.5254, p=.01) was the item "other" in the category of Care for the Patient.

In the seventh set of correlation analysis, the race of the family was correlated with all coping behaviors (Table 10). There was one statistcally significant correlation. This was with the item of "transportation" (r_{pb}=-.4575, p=.01).

In the next set of correlation analysis, the residence of the family was correlated with all coping behaviors (Table 11). There was one statistically significant correlation. This was with the item of "need" in the category of Community Socialization (r_{pb}=-.4313, p=.01).

In the last set of correlation analysis, the educational level of the family was correlated with all coping behaviors (Table 12). There was one

Table 9
Correlations with Total Annual Income of Family

Coping Behaviors	Correlation (Point-Biserial R)** r_{pb}	P=
Behaviors directed towards coping with the Member		
Household Activities*		
Meal Preparation	-.5204	.01***
Home Maintenance	-.3105	N.S.
Laundry	-.3617	N.S.
Other	.0699	N.S.
Family Socialization		
Passive	-.5187	.01***
Active	-.2164	N.S.
Community Socialization		
Transportation	.1206	N.S.
Need	-.2663	N.S.
Pleasure	-.1039	N.S.
Care for Family Member		
Hygiene	-.7718	.01***
Area (personal space)	-.0220	N.S.
Other	-.5254	.01***
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	-.0628	N.S.
Doctor	.2157	N.S.
Other	-.3967	N.S.
Concerns		
Health	.3679	N.S.
Interpersonal	.1069	N.S.
Safety	-.3105	N.S.

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*In this table, each item represents the total of 12 families. Six did not report. The correlation coefficient represents the correlation of each item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

**These are correlated using point-biserial as one variable is continuous and one is dichotomus. These are computed manually. Only those which are statistically significant to .05 or .01 are reported here.

***Statistically significant.(N.S.: Not significant).

Table 10
Correlations with Race of Family

Coping Behaviors	Correlation (Point-Biserial R)** r_{pb}	P=
Behaviors directed towards coping with the Member		
Household Activities*		
Meal Preparation	-.1930	N.S.
Home Maintenance	-.0737	N.S.
Laundry	.2037	N.S.
Other	.2226	N.S.
Family Socialization		
Passive	.0567	N.S.
Active	-.3462	N.S.
Community Socialization		
Transportation	-.4575	.01***
Need	.0000	N.S.
Pleasure	.0000	N.S.
Care for Family Member		
Hygiene	-.0074	N.S.
Area (personal space)	.1281	N.S.
Other	-.0308	N.S.
Behaviors directed toward Illness		
Illness Maintenance		
Medicine	-.3774	N.S.
Doctor	-.1812	N.S.
Other	.0779	N.S.
Concerns		
Health	.1727	N.S.
Interpersonal	.1727	N.S.
Safety	-.3937	N.S.

*In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

**These are correlated using point-biserial as one variable is continuous and one is dichotomus. These are computed manually. Only those which are statistically significant to .05 or .01 are reported here.

***Statistically significant.(N.S.: Not significant).

Table 11
Correlations with Place of Residence of Family

Coping Behaviors	Correlation (Point-Biserial R)** r_{pb}	P=
Behaviors directed towards coping with the Member		
Household Activities*		
Meal Preparation	-.1691	N.S.
Home Maintenance	.2210	N.S.
Laundry	-.1478	N.S.
Other	.2220	N.S.
Family Socialization		
Passive	-.3087	N.S.
Active	.0139	N.S.
Community Socialization		
Transportation	.2858	N.S.
Need	-.4313	.01***
Pleasure	-.0432	
Care for Family Member		
Hygiene	-.0566	N.S.
Area (personal space)	-.2788	N.S.
Other	-.2566	N.S.
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	.2065	N.S.
Doctor	.3023	N.S.
Other	-.1583	N.S.
Concerns		
Health	.1727	N.S.
Interpersonal	.2387	N.S.
Safety	.3937	N.S.

In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

**These are correlated using point-biserial as one variable is continuous and one is dichotomus. These are computed manually. Only those which are statistically significant to .05 or .01 are reported here.

***Statistically significant. (N.S.: Not significant).

Table 12
Correlations with Education Level of the Family

Coping Behaviors	Correlation (Point-Biserial R)** r_{pb}	P=
Behaviors directed towards coping with the Member		
Household Activities*		
Meal Preparation	.4189	.01***
Home Maintenance	.2582	N.S.
Laundry	.2074	N.S.
Other	-.3881	N.S.
Family Socialization		
Passive	.1715	N.S.
Active	.2747	N.S.
Community Socialization		
Transportation	.2945	N.S.
Need	.3726	N.S.
Pleasure	.0125	N.S.
Care for Family Member		
Hygiene	.1988	N.S.
Area (personal space)	-.1990	N.S.
Other	.2037	N.S.
Behaviors directed towards Illness		
Illness Maintenance		
Medicine	.2926	N.S.
Doctor	.3676	N.S.
Other	.1470	N.S.
Concerns		
Health	-.2192	N.S.
Interpersonal	.1644	N.S.
Safety	.2213	N.S.

*In this table, each item represents the total of 18 families. The correlation coefficient represents the correlation of that particular item with the variable named at the top of the table. P's are the probabilities associated with that correlation.

**These are correlated using point-biserial as one variable is continuous and one is dichotomus. These are computed manually. Only those which are statistically significant to .05 or .01 are reported here.

***Statistically significant.(N.S.: Not significant).

statistically significant correlation. This was with the item of "meal preparation" in the category of Household Activities (r_{pb}=.4189, p=.01).

It should be noted that approximately half of the sample did not participate in the study. There is no information known about this portion of the population. One could surmise that those families participating represent the more intact families included in the sample.

This concludes the results section of this report. These results will be discussed in further detail in the next section of this report.

CHAPTER 5

DISCUSSION OF RESULTS

The highest frequency (363) of coping behaviors was exhibited in the household activity category, as that of "meal preparation." All the families reported it as a major activity, done on a consistent basis throughout the ten-day reporting period. Although meal preparation seems to be a necessary behavior for the feeding of all members of the family, the mean number of it being relatively higher indicates that the families dine at home more often than not and don't seem to venture outside to obtain food with the family member who is mentally ill. This would support the literature cited as the families would appear to be isolating themselves (Doll, 1976 and Namyslowska,1986).

The second highest frequency (118) of coping behaviors was exhibited in the activities for illness category as that of administering "medicine" to the family member with schizophrenia. It was reported by eleven families as a coping behavior. This is the highest reported item solely meeting the needs of the ill family member. The researcher expected that this category would be reported by more of the families due to the fact that all the members who have schizophrenia are on medication. The also expected that the family members would have been monitored due to the disruptive nature of the illness. Given the disruptive nature of the illness, the researcher assumed that the majority of these family members having schizophrenia are not capable of self-medication. The lack of supervision by the family suggests that the family member having schizophrenia monitors and administers the medicine him/herself. This is not a reliable form of administration of medicine due to the family members' mental impairment. This situation could lead to serious questions of compliance or possible over-medication. The literature supports this possibility (Lefley, 1989, p. 557). In this study, Lefley discusses the rejection of medicine by the patient despite the possibility of relapse.

The item of "passive" family socialization was the third highest frequency (92) item listed. This coping behavior was listed as a coping activity by ten families. The behavior listed for this category was exclusively watching T.V. This behavior was not reported by 8 families. Since this is a typical behavior of most families, it could be expected that all families would do this. It is possible that the families that did not report did not see this item as being part of coping with the family member. It is also possible that the family member with schizophrenia isolated him/herself from the family and did not participate with the family. It is possible that the family member isolating him/herself is the explanation for this as this behavior is a symptom of the illness itself. This withdrawal socially is also evidenced in the literature (Lefley, 1989, p. 556, Hahlweg et al, 1989, p. 112).

While the item of "hygiene" was reported as the next highest frequency (46) category, it was only reported by four families. This means that for the families reporting the activity, the level of activity was high. This could suggest that the family member who had schizophrenia in these four families required more personal care. It is possible that the families reporting had a family member whose illness was more progressed, thereby interfering more with his/her personal cleaning skills. This is possible as the illness is one that causes disruption of thought. It is also important to note that this behavior was not reported by 14 families. This could be because the family member was capable of providing for his/her own hygienic needs. It could also be that the family just accepted that the family member had poor hygiene and did not try to change this. However, there is no evidence in the literature to support this position. There is evidence to support personal hygiene as a problem for the family member with schizophrenia (Lefley, 1989, p.557).

The item of caring for the "area (space)" of the family member with schizophrenia was the next most common activity reported with a frequency of 45. This was reported as a major activity by ten families, and less frequently than the category of hygiene. This would suggest that the level of activity was low. This was not reported by 8 families. It is possible these families had members who were capable of maintaining their own spaces. This area is not addressed in the literature.

The item of "pleasure" in the category of community socialization was next most common with a frequency of 42. It was reported as a major activity by ten families. Thus, the activity level for this category was also low. As was reported in the literature, these families tend to isolate themselves (Doll, 1976, p. 184, Namyslowska, 1986, p. 401). This tendency to isolate could explain the low level of activity in this item. However, there are some other possibilities. First, as these families live in rural areas, the family may not go out much because it is not convenient. It is also possible that level of income effects how much they go out. If the family does not have the financial resources, this would curtail any outings that required money. As is demonstrated by the demographic information, many of these families both live in isolated areas and have a low income level. It is also possible that the family wants to take the family member out, but he/she won't go. The family member may also exhibit bizarre behavior that the family would not want to risk enduring in public. This last possibility is supported in the literature. It has been found that the presence of bizarre behavior by the family member with schizophrenia affected the level of social activities by the family (Doll, 1976, p. 184, Hahlweg et al, 1989, p.112).

The item of "need" was listed next most common with a frequency of 36. This was reported by eleven families as a major activity. Thus, the activity was also low in this category. This would suggest that the families do not interact within the community much, even for the family member's needs. It is possible that the family meets its needs within the community but the family member is not involved in this process. It is possible that these families could get someone within their support system to make these trips for them. As such, these behaviors would not be reported because they were done by someone outside the family and did not include the family member. Due to this item being part of community socialization, it is also supported in the literature according to the discussion given previously regarding isolation (Doll, 1976, p. 184, Namyslowska, 1986, p. 401).

The item of "active" family socialization was the next most common activity reported with a frequency of 34.. It was reported as a major activity by eight families. Therefore, the level of activity was also low, here. It is possible that either the family relates passively as a whole, or does not relate very much with the family member who has schizophrenia, or it does not see this as being part of coping with the family member who has schizophrenia and his/her illness. As was discussed previously, it is also possible that the family is interested in interacting with the family member but this is not possible due to him/her isolating himself/herself from the family. This is supported by the literature as discussed previously (Lefley, 1989, p. 557).

The item of "other" in the category of care for family member was reported next most common with a frequency of 28. This was reported by eight families. Comparatively, this category had a fairly low level of activity, also. This category included behaviors such as waking up the family member, paying his/her bills, or cashing his/her check. This item included behaviors that high-functioning clients could have performed themselves. It is also possible that families did not do these behaviors because they were unable to do them. This could be due to their being employed. It is also possible that these behaviors were done by the family when other errands were being done. As such, these could have gone unreported by being overlooked. This is not addressed in the literature to support this .

The item of "laundry" was reported as a major activity by eleven families, with a frequency of 25. The level of activity was fairly low, here, too. Although this would appear to be a necessary activity for the care of all family members, the low level of activity reported would indicate that the families did not feel that this was a necessary behavior in coping with the family member. It is also possible that this behavior was done by other family members and just not reported. This is not addressed in the literature.

The item of "health" in the category of concerns was next most common, with a frequency of 24. It was reported by six families. For those families reporting, it would seem to indicate that there was a significant amount of concern for the family members' health. This could indicate a greater amount of concern due to a family member with schizophrenia having more health problems beyond schizophrenia. It is possible that these were the concerns being expressed here by those families who are more aware of the patients' health problems than the other families are. This is not addressed in the literature as this is concerned with health problems and not schizophrenia.

The item of "interpersonal" concerns is the next most common activity reported with a frequency of 19. It is reported by eight families. Thus, this is gives it a low activity level. It could indicate that those families reporting have a family member with schizophrenia who has difficulty with some aspect of relationships. As is discussed in the literature, schizophrenia is an illness that causes paranoia, delusions, and hallucinations. These symptoms all affect the perceptions of the family member. They also change the family members' perceptions of themselves and others. As a result, his/her social interactions would be affected. This could cause him/her to become withdrawn and isolated (Lefley, 1989, p. 557). On some occasions, the family member becomes violent. Since the majority of families did not report this behavior, this could suggest that these families are content to allow their family member to remain isolated or are just not concerned about it. It is also possible that some of these family members are not perceived to be isolated as some of the families do not interact within the community regularly. However, this is not supported in the literature.

The item of "transportation" is reported the next most common with a frequency of 15. This is reported by only six families. There is a low mean level of activity as well. It would indicate that the families reporting this behavior, see it as a need in coping with their family member, but do not employ it very often. There were 12 families that did not report this behavior. These families may not have provided their family member transportation out in public. This may have been due to the family not wanting to be seen with the family member due to his/her behavior or appearance. The family members' may have exhibited bizarre behavior that the family was not comfortable with in public (Lefley, 1989, p.557).

The area of "home maintenance" is the next most common item with a frequency of 12. It is reported by four families. There is a fairly high mean level of activity for those reporting. However, this behavior is not reported by 14 families. This is possibly due to the fact that the behaviors in this category are not generally used in coping with the family member and his/her illness, i.e. home repair. It is possible that the families reporting this behavior were the only families participating in this behavior. It is also possible that other families were engaged in this behavior, but did not relate it to coping with the family member. This difference could be due to the nature of the repairs. If the repairs were done to improve the living space of the family member, they could have been reported as coping. If the repairs were not directly related to the family member, they may not have been seen as coping. This is not supported in the literature.

The item of concern for "safety" is listed next with a frequency of 9. This is reported by five families. There is a low level of activity. It is possible that only some of the family members exhibited the behaviors reported in this item, i.e. walking alone at night, loss of memory, etc. It is also possible that other family members' exhibited these behaviors but they were accepted by the family as part of the illness. Another possibility is that the family member exhibited these behaviors but the family was not aware of them. This could be due to lack of supervision or lack of availability of the family being around, either due to employment or isolation from the family by the member who has schizophrenia. One could make an argument that this item would have been reported more frequently due to the nature of the illness and previous studies reporting the impact of bizarre behavior on the family (Lefley, 1989, p. 557, Hahlweg et al, 1989, p. 112, Kane, 1984, p. 20). This was not the case.

The behaviors for the item of "other" in the household category are listed next with a frequency of 8. This item is reported by 2 families. There is very little activity in this item. This item included behaviors that may not have been attempted by all families, i.e. showing the family member with schizophrenia how to light the gas heater, showing him/her how to run the lawnmower. This may have been for several reasons. First, some of the family members may already know how to do these things. It is also possible that the family member is not seen as being capable of doing these things. As such, the family would neither attempt nor report these behaviors. While this is not directly reported in the literature, the lack of reporting in this item may be due to the "impoverished behavior" of the family member with schizophrenia (Hahlweg et al, 1989, p. 112).

The next item is that of "other" in the category of Illness Maintenance with a frequency of 8. This behavior was reported by four families. The level of activity was low. The behaviors reported in this item were those needed to help the family respond to a crisis involving the family member, i.e. call an extended family member to help with a crisis. The low level of activity could have been because the level of incidence was low. This could have been because the majority of family members were stable. As such, they would not be in crisis and others would not be called on for help. It is also possible that other families had crises, but did not call outside the immediate family for help. This could be due to the family having the resources necessary to effectively deal with the crisis.

It could also be that the family did not want to call for help, deciding to try and deal with it themselves or had no resources available to call upon. It is also possible that the family did call for help and none was received due to their having a non-supportive extended family. According to the literature, these families try to be autonomous but do not isolate themselves from their support systems (Namyslowska, 1986, p. 404). This would suggest that they request help when they feel that they need it.

The last item that is reported is that of "doctor" with a frequency of 5. It was reported by three families. There is a low level of activity in the category. This could suggest that the family members with schizophrenia are fairly stable at this time. It is also possible that seeing the doctor is not reported as it is seen as part of treatment for the family member. It is possible that it is not reported because the doctors' visit occurs while the family member is at day treatment. It is also possible that the family may not always be aware the family member had an appointment. It is possible that the doctor-related behaviors reported occurred during a crisis that required a special trip. There is no evidence in the literature to support this. This concludes the discussion of the frequencies of the behaviors reported by the family.

Correlation analysis was conducted to explore the existence of relationships between the coping behaviors and family characteristics. In the following section, the statistically significant correlations found during this process will be discussed.

The correlation between the mean age of the family and the category of medicine is statistically significant. This is a positive relationship. This indicates that the older the family, the more the reporting of coping through administering of or supervision of medication. This could indicate that the older families place more emphasis on medicine as a means of controlling the symptoms of the family members' illness. It could also indicate that these families have patients who exhibit more negative symptoms of the illness, e.g. violence, confusion, etc. These families would in turn be more consistent with medication compliance in an effort to control these symptoms. It is also possible that the value systems of these families are different from younger families. These families could place more emphasis on taking care of the family member with schizophrenia, whereas younger families place more emphasis on taking care of themselves as individuals , overlooking the patient. However, there is no literature evidence to support this position.

The item of "other" in the category of Illness Maintenance was also significantly correlated with mean age of the family. This was a positive relationship. The behaviors reported in this item focused on getting others to help with the family member and his/her illness. It is possible that these families did this more often because they were not able to deal with the patients' problems due to their mean age. As was discussed previously, the families may have more chronic members and, thus, require more outside help due to the severity of the illness and its' symptoms. It is possible that these families had a support system and were able to make use of this in stressful situations. As discussed earlier, the literature indicated that families will not isolate themselves from their support system, but will attempt to stay autonomous

(Namyslowska, 1986, p. 404). This would suggest that these families did not need help with the family member or had no one to call on for help with him/her.

The correlation between family size and the item of "home maintenance" was statistically significant and positive. This is the case because the larger families had either more space to maintain or they might be living in older homes requiring more maintenance. As such, they may have been more inclined to report it as coping behaviors. This is not addressed in the literature.

The correlation between number of males in the family and "laundry" is statistically significant and negative. This would suggest that the more males in the family the less laundry is seen as a means of coping with the family member. It is possible that the males involved in this study participate in activities that are traditionally seen as male. This could also suggest that these families members are less inclined to do for the other family members, specifically the family member with schizophrenia. However, there is no evidence to support this in the literature.

It is interesting to note that there is a positive correlation between number of males in the family and the item of "health" in the category of Concerns. While it is difficult to decipher why this relationship exists, there are some possibilities. One of these is that the families containing more males had members with schizophrenia who were physically ill, thereby eliciting more concern for his/her health. It is also possible that the patients in these families had more difficulty taking care of their health. As such, they would require more assistance. This, in turn, would lead to greater concern on the part of the male members of the family. This is not addressed in the literature.

The number of females in the family is positively correlated to "laundry." This would suggest that families with more females see laundry as a coping behavior for or with the family member. As was the case with the males involved in this study, it is probable that the females generally participate in gender specific activities. The females generally fulfilled stereotypical roles of women in their everyday activity. This is also not addressed in the literature.

The item of "home maintenance" was also statistically significant and positively correlated with the number of females in the family. Although this correlation would seem to refute the statement above that females participate in gender specific activities, females taking care of many household maintenance chores in contemporary living seems to be a plausible explanation for this finding. This is not addressed in the literature.

The number of family members employed was positively correlated with the item of "active" family socialization. This could indicate that the more people that are employed in the family the more these families see active socialization as part of coping with the family member. Since these families have members who are interacting within the community on a regular basis, these families could be more inclined to be involved actively with their family member. There is no evidence to support this. There is evidence to support the family isolating themselves from the community (Lefley, 1989, p. 557).

The number of family members employed was negatively correlated with the item of "doctor" in the category of Illness Maintenance. This would indicate that the higher the number of family members employed in a family the less the family copes by utilizing the doctor. There are some explanations for this. The most plausible is the possibility that these families have less time to take the family member to the doctor due to time spent at their jobs. It is also possible that these families have members who are more stable, thereby requiring less interaction with the doctor. While this is a possibility, there is no evidence to support this.

The income level of the family was negatively correlated with the item of "meal preparation." This indicates that the families with lower incomes reported meal preparation less frequently. It is possible that these families saw this behavior as part of the everyday routine and not as coping with the family member. There is no evidence to support this in the literature.

The income level of the family was also negatively correlated with the item of "passive" family socialization. As the activity for this item was watching T.V., these families could also have felt that this was part of routine and, therefore, not coping behavior. As such, it would not be reported by them. Particularly, given the fact that these families were lower income, this could have been the primary source of entertainment. Whereas, with higher income families, there may have been alternate sources of entertainment, e.g. movies, going out to eat, etc., that were not available to the lower income families. There is no evidence to support this position in the literature.

The income level of the family was also negatively correlated with the item of "hygiene." The most plausible explanation for this correlation is that these families could not afford the items necessary to fulfill these tasks, e.g. deodorant, shampoo, hair products, etc. This is not addressed in the literature.

The income level of the family was also negatively correlated with the item of "other" in the category of patient care. This item was generally concerned with the calling on others for support with the family member. It is difficult to ascertain how this is correlated. It is possible that these families, having low income, did not have access to the means necessary to call for help. If, due to the families' limited finances, they did not have a telephone, how could they call for help is a real question. Also, these families could have been isolated from their support systems. However, this would be contrary to what is reported in the literature (Namyslowska, 1986).

The race of the family was negatively correlated with the item of "transportation." This indicates that black families did not provide the family member with rides to and from places within the community as often as white families did. This is not addressed in the literature.

The residence of the family was negatively correlated with the item of "need" in the community socialization category. This indicates that families living in rural areas reported this coping behavior less often. This would seem to make sense as these families would be more removed from the community. These families are more isolated. The literature also suggests that families do isolate themselves from the community (Namyslowska, 1986, p. 404), but does not differentiate according to residence.

The level of education of the family was positively correlated with the item of "meal preparation." This indicates that families with a level of education equal to or higher than high school reported this coping behavior more often. It is possible that these better educated families had a wider view of coping. These families could have felt that this was included in coping. Inversely, the families with an education level of less than high school could have felt that meal preparation was just a part of everyday life. In this case, those families would not report this as a coping behavior. There is no evidence to support this.

CHAPTER 6

SUMMARY CONCLUSIONS AND IMPLICATIONS

This study tried to answer three basic questions. These were: 1) What are the behaviors used by the family to cope with the family member who has schizophrenia and his/her illness?; 2) What are the characteristics of the families with a family member who has schizophrenia?; and 3) Do the characteristics of the families and the behaviors used to cope with the family member who has schizophrenia and his/her illness have a correlation?

This study attempted to answer these questions with a specific population in mind. The sample for this study was taken from the families of patients diagnosed as having schizophrenia who were enrolled in the Day Treatment Programs of two agencies in West Tennessee. This sample consisted of 18 families. There were four criteria for the families to be included in the study: 1) The family member who has schizophrenia was to be enrolled in a Day Treatment Program of two local community mental health agencies; 2) The family member who has schizophrenia had to reside with the family; 3) The family member had to have a diagnosis of schizophrenia according to the guidelines of the DSM-

IIIR; and 4) The family was also to reside within the catchment area of the community mental health agencies involved in the study.

The most significant and generic finding of this study is that the behaviors reported as being used to cope with the family member who has schizophrenia and his/her illness were not necessarily different from everyday activities of most families, although, these differences were specifically and comparatively studied.

Would it be different for another set of families characterized by higher income? Perhaps, it would be. Yet, the set dealt with in this study is most often characterized as the clientele of community mental health centers. These centers cater to these families and thus need to be responsive to their needs. Thus, looking at what they do and improving their coping is the business of the centers.

Of course, it was understood that there is evidence of the impact of schizophrenia on the family (Kane, 1984). The families responded by being less involved culturally, by participating less in recreation, meeting less of their own needs (Namyslowska, 1986) and by isolating themselves from the community and others (Hahlweg et al, 1989). Doll (1976) showed that the severity of the psychiatric patient affected whether or not families engaged in social activities. The isolation that was shown and discussed in all of these studies was also demonstrated in this study by the low frequency of behaviors used to cope within the community (Table 2). This would seem to indicate that these families also isolate themselves from the community.

Namyslowska (1986) also reported that families with a member who is diagnosed as mentally ill show a "marked tendency" to use their free time in a less active way than families without a member who is mentally ill. This was supported by the high frequency of "passive" family socialization and the low frequency of "active" family socialization (Table 2). This indicated that these families with a member who has schizophrenia interact passively a majority of the time. Findings of this study are in line with Namyslowskas' conclusions.

It could be stated that these families are doing typical day-to-day activities to cope with the illness and the family member, while they were also impacted by the illness and the family member. Since they were apparently capable of maintaining a household within which there is a family member who has schizophrenia, perhaps the emphasis of any intervention on their behalf should be placed on strengthening their behavioral coping responses.

To end, this study attempted to answer three basic questions. While these questions have been answered this area continues to need research. One question that needs to be addressed is How do these families feel as they cope with the family member who has schizophrenia? What kind of emotional toll does coping with the family member and his/her illness take on the other members of the family? These are the type of questions that need to be answered next to further determine the needs of the families with members who are diagnosed as having schizophrenia.

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APPENDICES

APPENDIX A

Dear Family Member:

Enclosed with this letter is the report that we talked about that you are going to fill out. Every day for the next ten days please write down everything you do with your family member.

Some of the things that you write down are going to be things that people do for each other all the time. These will be things like doing laundry, feeding him or her, or giving him or her medicine.

Other things that you do for this family member will be done because they have their illness. These will be things like taking your family member to day treatment, picking up his or her medication, or taking him or her to an appointment.

Remember, also, that we are asking you to write down things that happen only once in a while, like having to take him or her to the hospital, taking him or her on vacation with the family, or having to call the police for help.

The things you say in this report will be kept confidential. That means that no one is going to see them or be talking about them except myself and my advisor, Dr. Cetingok. Please work on this report only if you want to do so. That means that you can stop any time you want to. If you stop, this also means you will not lose any benefits or services from the center.

If you have any questions during the next ten days, while you are filling out this report, please call me. During the day I will be at 1-800-372-8297. At night or on weekends I will be at 989-9266. I will talk with you by telephone while you are filling this report to see if there is anything you want to ask me. At the end of the ten days, when you have completed the report, please mail it back in the envelope I gave you. We will have a chance to talk again when I do this. After you give me the report, if I have questions about it, I may call you.

Thank you very much for your help in doing this work.

Sincerely,

Sean Jones

M. Sean Jones
Social Worker

CONSENT FORM

I do hereby agree to participate in the study being conducted by Sean Jones through the Jackson Counseling Center. I understand that I will be reporting my familys' behaviors towards our schizophrenic family and his/her illness for 10 days. I understand that all information will be kept confidential and will be available only to Mr. Jones and his advisor, Dr. Cetingok.

I understand that I am participating voluntarily and can withdraw at any time with no penalties or loss of service from the center. I have also had the project explained to me orally by Mr. Jones and understand the proceedures involved.

I understand that if I have any questions or any difficulties, I can contact Mr. Jones at 772-4685 during regular working hours.

Signature______________________

Witness______________________

Date________________

EXAMPLE SHEET

DAY

	ACTIVITIES FOR AND WITH THE FAMILY MEMBER	ACTIVITIES FOR ILLNESS
MORNING	COOKED BREAKFAST DID HIS WASH WENT SHOPPING FOR HIM	HELPED HIM GET READY FOR DAY TREATMENT GAVE HIM HIS MEDICINE CALLED HIS COUNSELOR BECAUSE OF HOW HE'S BEE ACTING
AFTERNOON	FIXED LUNCH CLEANED HIS ROOM TOOK HIM TO GET BLOOD PRESSURE CHECKED GAVE HIM A RIDE TO TOWN	TOOK HIM TO A DOCTOR'S APPOINTMENT PICKED UP MEDICINE AT THE DRUG STORE
EVENING	COOKED DINNER WATCHED TV WITH HIM TOOK HIM TO TOWN TOOK HIM TO THE MOVIES WE WENT OUT TO EAT	GAVE HIM HIS MEDICIN REMINDED HIM TO TAKE HIS MEDICINE

AREAS OF SPECIAL CONCERN

HAD TO TAKE HIM TO HOSPITAL

WENT ON VACATION

HAD TO CALL POLICE FOR HELP WITH HIM

FAMILY INFORMATION

Number of members in household: _____

Annual Family Income: _______________

FAMILY MEMBERS

	AGE	SEX	MARITAL STATUS S=single M=married D=divorced W=widow	EDUCATION LEVEL Years Completed	EMPLOYMENT	RELATION To Member
1.			S D M W		YES NO	
2.			S D M W		YES NO	
3.			S D M W		YES NO	
4.			S D M W		YES NO	
5.			S D M W		YES NO	
6.			S D M W		YES NO	
7.			S D M W		YES NO	
8.			S D M W		YES NO	
9.			S D M W		YES NO	
10.			S D M W		YES NO	

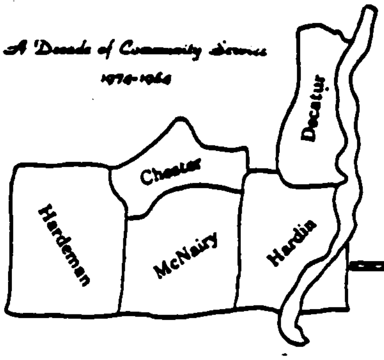
DAY 1*

ACTIVITIES FOR AND WITH THE FAMILY MEMBER	ACTIVITIES FOR ILLNESS
MORNING	
AFTERNOON	
EVENING	

AREAS OF SPECIAL CONCERN

*This form is used for recording and data collection purposes from Day 1 to Day 10.

APPENDIX B



A Decade of Community Service
1974-1984

QUINCO
COMMUNITY MENTAL HEALTH CENTER
Rt. 1, Box 500
BOLIVAR, TENNESSEE 38008

Barry Hale, Executive Director
Telephone [illegible]

April 9, 1991

Dr. M. Cetingok
U. T. College of Social Work
822 Beale Street
Memphis, TN. 38163

Dear Dr. Cetingok:

I met with Mr. Sean Jones regarding research for this thesis involving the gathering of information from families of schizophrenics involved in day treatment.

This letter serves to express Quinco's support for this project and willingness to cooperate with Mr. Jones in his attempts to gather data.

Larry Williams, our Rehabilitation Manager, will serve as the contact to Mr. Jones.

If additional information is needed, please feel free to contact Mr. Williams at 1-800-532-6339.

Sincerely,

Barry S. Hale

Barry S. Hale, ACSW
Executive Director

BSH:mrw

cc: Larry Williams
    Sean Jones ✓

**THE JACKSON COUNSELING CENTER
AND PSYCHIATRIC HOSPITAL, INC.**
238 Summar Drive • Jackson, Tennessee 38301 • (901) 424-8751

March 23, 1990

Dr. Nelle P. Tate
University of Tennessee
School of Social Work
Memphis Branch
847 Monroe Avenue
Memphis, TN 38163

RE: Sean Jones

Dear Dr. Tate,

Mr. Sean Jones is working on an MSW degree.

Sean has indicated to me that he would like to work on a research project and/or some supervised clinical experience at The Jackson Counseling Center/Psychiatric Hospital.

We would be pleased to have Sean work at our facility, with our staff, and as necessary with any of our clients. He has worked with us at the Brownsville Center and we all have a very favorable impression of him and his work.

There are nine MSW's (most licensed Independent Clinical Social Workers , eight doctoral level psychologists, and three psychiatrists on our staff and I believe he can find appropriate supervision and resources.

We would be pleased to work with Sean.

Sincerely,

Andrew R. Eickhoff

Andrew R. Eickhoff, Ph. D.
Executive Director

AE/sd

VITA

Matthew Sean Jones was born in Greenville, South Carolina on January 18, 1963. He attended elementary schools in Chester County (Tn) and Jackson, Tn and graduated from Jackson Christian School in May, 1981. The following August he entered Freed-Hardeman College and in May, 1985 received the degree of Bachelor of Social Work. In August, 1989, he entered the University of Tennessee-Knoxville, College of Social Work, Memphis Branch, and in December, 1991 received a Master of Science in Social Work degree.

He is currently employed as an individual and family therapist, primarily working with children and adolescents, at the Jackson Counseling Center in Jackson, Tn.