The Family, the Patient, and the Psychiatric Hospital: Toward a New Model

Formulated by the Committee on the Family

Group for the Advancement of Psychiatry

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STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of Psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

The Family, the Patient, and the Psychiatric Hospital: Toward a New Model was formulated by the Committee on the Family. The members of this committee are listed on the next page. The following pages list the members of the other GAP committees, as well as additional membership categories and current and past officers of GAP.
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Most psychiatric patients are brought to the hospital by their families, and when hospitalization is over, most will return to their families. This report describes an approach to the psychiatrically hospitalized patient which includes the family as an integral part of the treatment. Such an approach has major advantages over the more familiar treatment which focuses attention only on the individual patient. We believe that the evidence in favor of a family-oriented approach is now so substantial as to mandate its addition to the traditional treatments. We also suggest that psychiatric hospitalization will be made more effective to the extent that it considers the patient’s interpersonal context as an additional and major locus for therapeutic intervention. We will show in this report that a family perspective is useful at all times and with all patients, and that only a careful family evaluation enables one to make the specific decision about the indications for family therapy.

The deinstitutionalization of psychiatric patients and the increasing brevity of psychiatric hospital treatment have placed a new burden on families. Without an alliance between the hospital caregivers and the family, the gains of a short hospitalization are all too likely to be lost and a revolving-door syndrome made more likely. Furthermore, the family-oriented approaches show increasing evidence of efficacy. Recent advances in methods of working with the families of the mentally ill, including but not limited to psychoeduca-
tional techniques, have made family treatment more effective. These approaches have led to better global outcome and lower rehospitalization rates of discharged psychotic patients.

We believe that the evidence in favor of a family-oriented approach is so substantial as to mandate it as an essential treatment component. Working with the psychiatric patient in isolation from the family has led all too frequently to alienation and anger of the family and in part explains the anger of some lay groups against mental health professionals. Moreover, therapists, including family therapists, have all too often seen the family as a cause of the patient’s problems. The newer theoretical conceptions and treatment approaches will permit the patient, the family, and the professionals to join together to mitigate the effects of the tragedy of severe mental illness.

An inherent tension, admittedly exists between the rights of one individual and the welfare of others, between setting a predominant focus on one entity and maintaining perspective on ecological relationships. Furthermore, the uniqueness and value of the individual has been a central theme in Western culture and especially in American history and ideology. Our mythology is that the United States was largely settled by men and women who often immigrated alone and went west alone. The Bill of Rights protects individuals’ freedoms to shape their own destinies—to enjoy their successes and to reap the harvest of their failures.

Traditional medical approaches have reflected these individualistic themes, although there is a current trend toward family medicine. Despite the obvious value of epidemiologic studies and public health interventions, medicine has maintained its traditional primary investment with the sick individual and his or her disease. Indeed, physicians often are drawn to medicine precisely because it permits both individual responsibility for outcome and room for the individual entrepreneur. Medical and psychiatric social work developed in part to work with families of patients, thus complementing medicine’s individual focus.

Both biological psychiatry and psychoanalysis, with their roots in medicine, also have viewed problems largely as contained within the individual. The patient traditionally has participated in psychiatric treatment by taking medication or by recounting associations. Families brought patients to hospitals, provided historical data, and paid the bills. Even today, these are the practical limits in many hospitals, in part because there have been no effective techniques to change families.

In the years after World War II, investigators began to explore the etiology of schizophrenia by studying family members in interaction with each other. These pioneers were building on the foundations of work with the family developed by Adolf Meyer, Harry Stack Sullivan, and the social work profession. Other clinicians became interested in the contribution of studies of the family and therapeutic interventions with behavior problems, neurosis and psychosomatic illness in children. Increasingly sophisticated theories of family functioning and a panoply of treatment methods evolved in the decades which followed.

Initially, families were studied with the notion that they might be involved in the development of psychopathology. Sometimes the patient was seen as the victim of the family, as a scapegoat or symptom bearer for the rest of the family. Gradually it became clear that any search for one “cause” was not useful. Families and patients were locked into inflexible patterns of interaction, ways of relating which had to change in order for the patient to improve or to maintain improvement. More recently, instead of being viewed as the cause of the patient’s illness, the family has sometimes been seen as the victim of the illness, so that the blaming has come full cycle. Fortunately, therapists and theorists alike increasingly recognize the family not only as a resource for change and a source of strength for its members, but also, most recently, as the crucial mediating influence to ensure (or discourage) treatment compliance.

A theoretical framework commonly used by family ther-
apists is a “family systems approach,” an ecological view which underscores the fact that family functions are different from any simple sum of component members. Each person is viewed in interactive relations with the other family members. While each one strives for personally unique goals, the totality functions to maintain a coherent family system, preserving its essential traditions, myths, patterns, identities, and values. Family members deal with each other in terms of the family’s and each individual’s concepts of fairness and justice (Bozsormenyi-Nagy & Spark, 1973).

Often the family seems to be at an apparently steady state, but it is always evolving because of the inevitable changes that time and biological development bring. Sometimes it responds with creative novelty, at other times with stagnant and ineffective inability to change when change is called for. The notion of the evolution of families as life events occur (e.g., a young adult leaves home, a loved one dies, a baby is born) differentiates this view of coherence from that of a fixed homeostasis. Indeed, it can be said that the critical issue for families is what state to evolve toward, what to preserve of the past in order to manage the present competently and anticipate the future.

In the last two decades the focus of psychiatry has moved to attend to the significance of ongoing rather than historical family relationships, and to the relevance and complexity of the family system. However, while the theories of etiology and/or maintenance of emotional disorders have changed to include a broadened appreciation of family factors, treatment practices have not fully exploited this progression. This is especially true in, although not limited to, hospitals.

**HOSPITALIZATION AND FAMILY FUNCTIONING**

There are two aspects of looking at the issue of hospitalization in relationship to family functioning. One is from the point of view of how the hospitalization affects the family; the other is how the family affects the treatment processes in the hospital. In the past, with the rationale of “protecting” patient and family from each other, there had evolved a tendency to minimize the connections of families to their ill members during acute hospitalization. In such cases, however, this strategy forces the hospital to become responsible for the patient in a way that separates symptom and patient from context. The unfortunate effect of this is most visible after long-term or repeated hospitalizations. In the process of attempting to return the patient to the community, the patient has little support and family members often feel hurt, angry, frightened, embarrassed, or incompetent in helping the patient. When families then disrupt a therapeutic plan by not cooperating or by withdrawing the patient, it usually reflects the professionals having overlooked the family’s perspective on that plan.

Hospitalization can have a powerful impact on the family. It may leave the family feeling blamed for the patient’s problems, or irrelevant for treatment to occur, or unclear about how to be helpful now. Or hospitalization can facilitate ongoing change toward optimal goals for both the patient and the family.

Family-oriented programs can be implemented within existing hospital facilities when hospital staff and administration view the family as a resource and the individual members as caring and concerned about each other and their relationships. The most important factor in such programs is a creative approach to each family as it seeks to find its strengths and its own solutions to problems.

We will describe how hospitalization can be a more useful intervention when the hospital setting maintains a practical and philosophical commitment to working with families. Hospitalization sometimes occurs in the course of ongoing treatment, or it may be the event which initiates treatment. But we believe hospitalization is best seen as one episode in a treatment process, providing an additional and special set-
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...ting in which the process occurs. The hospital is a more manageable environment in which to influence variables of interpersonal distance and to involve different persons to help effect change. The hospital is not only an important therapeutic adjunct for severely disturbed individuals, but also, and more significantly, a setting in which individuals and families fixed in dysfunctional patterns can begin the process of change. Hospitalization need not be the “end of the road”; rather it can be a “new beginning” for both the patient and the family.

Hospitalization can organize major therapeutic interventions in the family system, in addition to merely bringing temporary relief to a stressed system by offering asylum. The family can provide extensive information, continuity, and support. Maintaining connections between the patient and his or her ecological roots while involving the family in the treatment regimen offers better opportunities for comprehensive therapy and for the management of medication, helps establish a better living environment, and facilitates more effective rehabilitation of the patient.

The next three chapters explore family intervention in three stages of the hospitalization process. The problems of including the family (broadly defined to include “significant others” who may not be “blood” relatives) in psychiatric treatment planning are viewed from the perspective of the patient, the family, the provider of service, and the institution—a systems overview. The patient and family are first followed through the process of evaluation and the decision about hospitalization versus alternatives like partial hospitalization (Chapter 2). Then, the characteristics of a family-oriented inpatient treatment program are described (Chapter 3). The final stage consists of the aftercare programs which evolve to make use of the resources of the patient’s contexts, including the family (Chapter 4). Throughout the discussions, we contrast an individual treatment perspective with a family orientation in order to illustrate the differences in treatment outcomes and costs. In Chapter 5, we explore some of the ethical dilemmas surrounding the choice between a family and an individual approach. Finally, we offer as an appendix a “consumer guide” which may help families as well as hospital staff appreciate the family’s role in the treatment process and what families can expect from a family-oriented approach.
FAMILY ASSESSMENT AND THE DECISION ABOUT HOSPITALIZATION

Involvement of the family in the assessment process for hospitalization can influence the decision about hospitalization in many ways. Sometimes, the family’s resources may offer viable alternatives to hospitalization. If hospitalization does occur, it will take place as a part of a treatment plan which involves thinking about and enlisting the family as a vital collaborator. This chapter explores each of these factors.

THE PRECIPITATING CRISIS

A 16-year-old boy is brought to the emergency room by a frightened parent after the youngster had discharged a .22 rifle in the general direction of his mother.

A depressed outpatient father of two becomes agitated in a treatment session and declares his intent to drive his car into a concrete bridge abutment.

A young single mother with chronic back pain asks for a stronger prescription, and the therapist realizes she is addicted to pain-killers.

A sullen husband brings his wife into the emergency room, stating that she has again become withdrawn, is talking crazy, and needs to be rehospitalized.

Several weeks after her daughter’s wedding, a middle-aged woman’s behavior is marked by withdrawal, sitting, staring, and wringing her hands.
A grandfather, living alone, becomes disoriented and stops eating and caring for himself.

These episodes emphasize that individuals are members of families and it is necessary to understand complex relationships in order to assess the problems and make decisions about disposition. The events described led to requests or demands for potent professional intervention, i.e., hospitalization. The “crisis” stimulates an evaluation of what is the best way to help.

**PATIENT MANAGEMENT WITH AN INDIVIDUAL ORIENTATION**

Traditionally, the hospital has been used when a more controlled environment is needed. There are a number of simple, practical factors above and beyond the patient’s symptoms that are regularly involved in the decision about hospitalization. Is a hospital bed available? Are alternatives to hospitalization available in the given community? What is the patient’s financial status and health care payment possibilities? Private psychiatric hospitals which prosper on bed occupancy readily accept “paying” patients. But those patients who cannot afford treatment are referred to a public facility or an alternative outpatient plan is developed. State hospitals and other crowded public facilities, which receive little third party or direct patient payments, may be more stringent about their criteria for admission and may utilize alternative care more frequently.

But the major factor in the decision to hospitalize is the orientation of the clinician. If he or she sees working with the family as a frustrating but unavoidable part of the job, family coping skills and strengths will be only cursorily evaluated. In such a situation, instead of exploring the family’s strengths for possible alternatives to hospitalization or as a clinical resource, the clinician is more likely to see hospitalization as the only means of moving in a positive direction.

**Case example:** Larry and Ethyl F. called the police to help them with their 16-year-old son who, they stated, had tried to kill his mother by shooting at her with a .22 rifle. The parents called the police who picked him up and took him to the emergency room where he was evaluated individually by the psychiatrist on call. The boy, still angry and additionally frightened after his trip to the hospital in the police wagon, declared hysterically that he would kill his mother and his father too. The examining psychiatrist determined that he was potentially homicidal and in need of emergency hospitalization. The parents (one a mental health professional) were asked primarily for admission data. Investigation of the family situation in any depth was postponed until the patient was settled “in a safe place,” i.e., the closed unit of the hospital.

This is a fair example of the management of many psychiatric patients who express frightening and dangerous behavior. The family is cowed, but its relative passivity is encouraged by the mental health professional’s activity. Without full knowledge of the family context of the crisis, the clinician is obliged to respond to the immediately dangerous disturbance evident in the individual’s behavior.

**EXPLORING THE FAMILY CONTEXT**

In the pressing situations which lead to evaluation for hospitalization, is there time to assemble family members? And who should be summoned? What is the timing? And what will be the process of including them in the assessment and decision-making? Of course, if the patient has been brought in by family members, they will have indicated their interest and sense of responsibility for the patient. If the patient arrives alone or is “dropped off,” who should be called? And when?

To a great extent, such questions address the issue of relational responsibilities in family systems which change during the life cycle. Parents of a younger still living at home
naturally will be involved in their child's care; usually this will also be true for the parents of a young adult who fails during an effort to live independently.

If the patient is married, the spouse as well as the patient's parents will be included as relevant family members. Admission often activates the spouse's loyalty conflicts between the patient and the in-laws. Although very young children of the disturbed patient may not need to be included in the initial assessment and decision-making sessions, attention should be given to how they can later become informed participants in what is happening to their parent and what will be happening to them as children of a parent who is mentally ill and hospitalized.

What about children? At what age should they be involved in decisions about hospitalization of their parents? Children are entitled to be cared for, but there are many families in which children have long assumed the function of supporting a parent. This is true in single-parent families and in other families where the family hierarchy is diffuse. When the parent is a chronic relapsing patient, the children usually are very aware of the parent's problems and should be included in the solutions to be implemented. Furthermore, the burden of an ill parent at home may substantially compromise a child's ability to function. For elderly people, their adult children often are the family, obviously to be included in the decision-making process.

Other relevant family members will often surface if inquiry is made about interested family members. It should be stressed that these family members are consulted not to place the burden of responsibility on them for caring for their ill members, but to enlist their help in planning and implementing the best course for the patient. The evaluating professional should make every effort to find out who are the important, accessible family members and what is the degree of their availability. This effort is the beginning of a family assessment and will be rewarded amply both in making a disposition and in implementing it. The assessment of family systems resources is an essential part of the overall assessment.

THE APPROACH IN FAMILY ASSESSMENT

Assessment of the family helps determine which therapeutic option will be best at this time, for this identified patient, in this specific context. Such an assessment can occur only when two conditions are fulfilled: 1) The professional person must feel comfortable gaining access to and obtaining the needed family data; and 2) the family and patient must feel some sense of trust in the clinician.

Because the family is prominent in his or her thinking, the clinician arranges for at least the primary persons in the family drama to be present face-to-face. The professional person's sensitivity to the context extends also to the physical setting. Obviously, a jail holding cell or the ledge of a tall building restricts both family participation as well as the comprehensiveness of professional evaluation. A busy emergency room with multiple interruptions limits both the family's experience of respectful continuity and the professional's attention. However, even when a crisis must be addressed in this kind of setting, the presence of family members is nonetheless essential for an understanding of the emergency. A relationship will be formed with the therapist and a basis established for a more leisurely evaluation in a more suitable setting at a later time.

Ideally, the clinician should meet the family in a room sufficiently large to accommodate everyone with a modicum of privacy. There must be enough time for everyone's stories to be heard and considered. The therapist must approach the family members in a way that suggests they are participating as colleagues in a problem-solving task, rather than as people being blamed for the problem.

Often, however, assessment about psychiatric hospita-
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AsseSSment occurs in less than leisurely circumstances such as when there is an abrupt precipitating event or emergency. The professional may use phone contact with family members or may have to engage in decision-making processes “under the gun” without sufficient data about the distressed person’s pool of social resources. Police, psychiatric emergency teams, or community-empowered agencies may have to be used to contact disturbed persons in situ; occasionally, the psychiatrist makes a home visit.

A danger in the assessment process is that the family may focus on the identified patient as the problem and may encourage the professional to do so. Especially in critical circumstances, even the systems-oriented professional is not immune from seeking causes or finding fault in order to understand how a difficult situation came to be. Family members must be made to feel that they are not being blamed, but are participating together in a problem-solving task.

If a symptomatic individual is seen as having a functional disorder, the consultant is prepared to explore the relevant contextual patterns in both diagnosis and intervention. Even if the patient has a condition now thought to have a largely biological substrate, such as a psychosis or affective disorder, it is just as vital for the consultant to focus on the context of the illness rather than on the “illness” itself. The investigation with the family naturally includes personal and family histories. It is important, too, to examine the interpersonal aspects of the problems and to identify the interactional patterns which may have a bearing on current difficulties.

ASSESSMENT FOR HOSPITALIZATION

The clinician who has a family perspective about treatment will inevitably think about hospitalization in the context of a treatment plan for the entire family. Thus, concerns about the patient’s condition will not alone determine the professional’s decision. Wynne (1982) has detailed the data that family therapists need for treatment planning. These data include the presenting problem and its context, the family composition, the family’s expectations and wishes, previous attempts to work on the problems and the results of such efforts, the family’s resources, and the therapist’s observations of family transactions.

On the other hand, Fleck (1983) has emphasized the importance of family leadership, the boundaries between members, the levels and kinds of emotion, family affects, the effectiveness of family communication and problem solving, and the developmental stages and goals of the family. These differing guides to evaluation suggest the range of data that are available in family interviews.

Family members provide information more freely when they feel the therapist understands and appreciates them and is reasonably empathic about their needs. The first rule of assessment, after bringing the family together, is to clearly accept and label their actions in the current crisis as well-intentioned and caring for the identified patient. This is a significant part of the joining process which involves personal confirmation and validation, and which underlies most effective therapy. Even when family members are infuriated, hostile, and clearly desirous of getting rid of the patient, it is possible to recognize that these are natural feelings under the circumstances, that symptomatic or ill individuals can be infuriating, and that the intensity of the response reflects involvement and concern for the patient.

A second rule in the assessment process is that the evaluator is in charge. Each system requires a leader; hierarchy is important. Thus, by assuming leadership in this situation and by discovering the natural leadership operations within the family, the professional underscores this important system function. It is important that the therapist have a clear view about being in charge. Prehospital evaluations can often threaten to get out of hand under the pressures of criticism and unmodulated affect, all of which expresses the urgency
of the situation. Some clinicians argue that it is important for these feelings to manifest themselves, but we feel that at this stage it is preferable to err on the side of eliciting competent behaviors—that is, all of those coping skills and strengths which are still available, even in this critical situation.

Let us look at the previous case example from a family perspective:

Case example: Larry and Ethel's 16-year-old boy lost control and discharged a .22 rifle in his mother’s presence. His mother called her father, a football coach. The father enlisted the aid of a friend who was a family-oriented psychiatrist. At the psychiatrist's office, the family provided the following information: 1) The boy was furious after he had been grounded and his car keys taken away because of two minor car accidents in the preceding week, the last one only two days prior to the crisis; 2) The boy stated that he had shot the .22 rifle at the ceiling, not at his mother; 3) His history was one of trying to bully his parents into doing for him what he wanted; examples included their giving him an expensive car as soon as he was able to get a license, as well as other items they could barely afford; 4) Although bright, he was doing poorly in school.

The psychiatrist identified a pattern in the family that went as follows: The mother would attempt, weakly, to set some limits and resist the boy's demands. The father would give in to “keep the peace,” apparently afraid that his son would become like those youngsters he coached. Although bright, the boy was doing poorly in school.

In the psychiatrist's office, confronted with the combined frustration of his parents, the boy was chastened by the consequences of his behavior and acknowledged that he found himself in a pickle. He admitted that the scene had gone too far. His mother did not believe that he wanted to kill her. She herself appeared depressed, felt isolated and overwhelmed, and did not know how to handle her son. She expressed frustration at not being backed up by her husband. The father recognized that perhaps he had felt too much of the burden of dealing with his son to his wife and that he had tended to get involved only when there was some sort of crisis.

From this perspective, the therapist observed sympathetically that the boy himself must feel overwhelmed with these kinds of family problems. He noted, further, that neither the boy nor his parents seemed to know how to handle the situation. He then added that the youngster had successfully brought the problems to the attention of the outside world, perhaps in the hope that the family could, with some help, work it out. With this definition of the situation, the family could participate without fear or anger in the decision about whether to work on the problem on an outpatient basis or to press for hospitalization. They now clearly saw the family as participating in the problem. The family was the “patient.”

At this point, if the family were feeling reasonably comfortable that all of the members would be helped in the ongoing treatment, they might agree to an intensive outpatient program with the initial goals of working out family rules and limits so that nobody would be betrayed or cheated, and eventually the parents could be on the same side.

When the evaluator sympathetically gathers information while concomitantly diffusing the patient's or the family's efforts to attribute blame, the process of evaluation is further facilitated. The more someone hears, “I can appreciate your upset in such circumstances,” the more it is likely that mature feelings will emerge. When the evaluator goes on to diffuse a specific or unifocal search for the cause of the problem to include the confluence of many forces involved, this too may help loosen the ties of the participants to a blame-guilt cycle.

The “multilateral” position (Boszormenyi-Nagy & Spark, 1973)—i.e. considering each person's perspective and contribution—of the evaluating professional not only promotes the best chance of engaging the members of family, but also provides an opportunity for evaluation of their flexibility and responsiveness. When the family’s desire to have the symptomatic member “put away” is reframed as everyone’s need for a different kind of space for growth at this time, cautious and curious glances may be exchanged, signaling family ability to shift perspectives. On the other hand, the family mem-
bers and patient may remain affectively and cognitively immobile, unable to consider any alternative possibilities at the moment. In either case, the evaluator has gained important information about the family and has set a tone for possible hospitalization that includes the family as a constructive force in the ongoing treatment.

For example, if the youngster in the aforementioned case is still angry and demanding about the sanctions levied by his parents, while the mother remains overwhelmed, reproachful of her husband, and says she can't take it any more, and the father persists in defensive helplessness, hospitalization may be chosen as a context to begin the work with the family. Hospitalization would provide a cooling-off period, a sense of the critical nature of these events, and an opportunity for remoralization.

**ALTERNATIVES TO HOSPITALIZATION**

When the clinician includes the family in the prehospitalization assessment, other factors in the decision on whether or not to hospitalize will be: 1) the family's readiness and skill to care for the patient in a less restrictive setting; and 2) the family's need for relief from the stress of caring for the patient.

There are several alternatives to hospitalization in acute family crises that can be considered if the clinician views individual problems in the context of ongoing family living. We will discuss two of the most prominent alternatives — treatment in the home and partial hospitalization.

In home treatment, the disturbed person remains in the home and the family routines are not disrupted by the removal of a member. Such a management approach may require regular, frequent visits to a treatment facility, home visits by a treatment team, or employment of persons from outside the family for substantial portions of each day.

Home treatment services have been successful in a variety of settings around the country (Friedman, Becker & Weiner, 1964; Pasamanick et al., 1967; Langsley et al., 1968, 1969, 1971; Smith et al., 1976; Fenton et al., 1979). In these varied clinical settings, there is a general consensus that at least 60 percent of the patients could be treated in the home and thus avoid hospitalization.

Friedman et al. (1964) found in their home treatment service that when the patients were evaluated for admission first in the emergency room, it was almost impossible to maintain the patient outside the hospital. The results were much superior in preventing hospitalization if the evaluation began initially in the home. Their overall conclusion was that early intervention is the key to successfully maintaining severely disturbed patients outside of the hospital. However, other researchers (Langsley et al., 1969) selected their patients randomly from those who were presented to the emergency room and judged to need admission by the emergency room psychiatrist. Working with an active home visiting team, they were able to avoid hospitalization and to decrease the amount of time the patient was disabled and unable to work.

The results from treating suicidal and acutely psychotic patients in the home suggest the following:

1. The treatment facility must have a team of professionals who are oriented toward family intervention, and who are dedicated to this approach.
2. The results were at least as good as and sometimes better than traditional psychiatric hospitalization in short-term follow-up and about the same in longer-term follow-up.
3. The costs of managing the crisis effectively out of the hospital are much less than the costs involved in hospitalization.

It is also quite possible to care for severely disturbed individuals in a partial hospital setting either by utilizing day
hospitalization, with the family actively involved in the management of the patient during the night, or by having the patient in the hospital at night with the family involved with the patient during the day. A careful assessment of the family patterns, sources of strength, and characteristics of the individual patient determines the choice of the time interval for which institutional assistance is more important.

The duration of day hospital treatment tends to be longer than that of inpatient settings, but the day treatment group shows a reduced frequency of hospital returns (Wilder et al., 1966). There are a number of demonstrations with the similar conclusions that partial hospitalization is a viable, effective, and more economical approach to the treatment of severe emotional disorders. However, these exist in few areas of the country. The inpatient hospital is still the most prevalent and available facility for the treatment of severe emotional crises. A significant portion of the problem is related to the financial policies of the health care system that reimburses more generously for hospitalization than for the less expensive community-based alternative. It also is possible for some professionals to make more money working with patients in the hospital than when engaged in the difficult struggle to create and maintain outpatient care and support options. Third-party payers often are geared to reimburse for full hospitalization, but do not understand or have the facilities to handle either partial care or intensive outpatient care to the extent required to support those programs so that they can be successful.

All the community-based programs, whether partial hospitalization or home treatment, require a great investment of time and energy on the part of a dedicated professional and paraprofessional staff. Few such programs have been maintained and very little attention is currently given to developing them despite their effectiveness. Lack of financial support has been blamed for their discontinuation. Professional burnout occurs also. And because there is so little social and financial support for these programs, often they are not maintained after pilot funding has been spent.

Nowadays, as our awareness of family relationship resources increases, the characteristics of the family not only are a major factor in the decision to hospitalize, but also determine the ultimate effectiveness of the hospitalization as a significant intervention in the patient's difficulties (Withersby, 1977; Gould & Glick, 1977). The important relationship between the family and the hospital in the implementation of a satisfactory program has resulted in the felicitous term "institutional alliance" (Stewart, 1982), referring to the mutual understanding between the family and the hospital staff.

In some hospitals, the institutional alliance is implemented by developing a contract which serves as a written agreement between hospital staff and the family about the contributions of both sides to the treatment program and care needs of the patient (Combrinck-Graham, et al., 1982). This contract is initiated at the time of admission evaluation, then elaborated later when both the hospital staff and the family become increasingly familiar with each other. On the other hand, Stewart (1982) describes four stages in the building of institutional alliances, beginning with the crisis of the patient which brings the family into contact with the hospital, going on to the separation which will occur when the patient is finally admitted and other family members go home, continuing with the family's reinvolve in in-hospital programs, and ending with evaluation, which represents the stage at which the family offers itself for more intensive involvement in the understanding of the problem and its treatment. It is stressed that different families may go through these stages with different timing. There are at least two kinds of families with whom building the institutional alliance will be particularly difficult—disengaged families, in which individuals feel little connection to each other and may be little affected by the crisis, and families who are characteristically hostile and suspicious of unfamiliar "outsiders" (Reiss et al., 1980). Yet there
is enough evidence to demonstrate that such a powerful intervention as hospitalization can be so much more successful with the family’s involvement at the outset that clearly these efforts should be made.

THE DECISION TO HOSPITALIZE

Ultimately, the decision will be made on the basis of the following “enabling” factors:

1. The availability of hospital facilities;
2. The patient’s ability to pay for them;
3. The skill and orientation of the evaluating psychiatrist;
4. The participation and disposition of the family;
5. The family’s willingness and ability to care for the patient;
6. The availability of viable alternatives to hospital care.

When the evaluating professionals include the family in these deliberations, the process of making a decision becomes the basis of a “family alliance” which can substantially and positively affect the progress of treatment.

3

THE HOSPITALIZATION AND FAMILY INTERVENTION

In this chapter we describe the traditional psychiatric hospital with its unintended, but frequent, alienation from families, and we point out the shortcomings of the inability to effectively include the family. Using the family model, we then define some ways of working with the family of a hospitalized patient, ranging from the extreme of actually hospitalizing family members along with the patient to utilizing a variety of family interventions as part of the therapeutic plan to help the patient recover (Glick & Kessler, 1980). The focus of the chapter is on the new model (or orientation) focused on the family. Specific techniques, although touched upon here, are described in detail in Chapter 4. Table I summarizes some features of the discussion.

Once an individual was admitted to a psychiatric hospital, that person was traditionally defined as the patient. The staff took over the care of the patient, while the family gave a history and then withdrew. In some situations, on the assumption that the patient needed separation from family stresses and responsibilities, the family was not allowed to visit during the early part of the hospitalization. This practice, which is still prevalent in some hospitals, has resulted, at best, in the staff viewing family members simply as purveyors of historical information and payers of bills. At worst, they were seen as individuals who had played a major role in causing the patient’s symptoms and made nuisances of themselves by
interfering with treatment. Social workers, rather than psychiatrists, were usually delegated the task of dealing with these family-engendered problems.

Prior to the availability of effective somatic treatments, hospital stays were much longer and already-fragile families were often broken. Even now with shorter stays, public hospitals are often geographically distant from family members, making access difficult. Furthermore, since the hospital is associated with much fear and stigma, many families are only too happy to stay away.

In the 1970s, hospitals began to struggle with the newly introduced model of family therapy which suggested that illness was embedded in a family context and often directly responsive to other family members. New social workers were hired to “do family therapy,” but the rest of the treatment package was unchanged. This made the social worker’s job difficult and conveyed a confusing message to the family.

This model of hospitalization frequently has the unintended effect of promoting further hospitalization down the line. Recent evidence (Mattes et al., 1977a, 1977b) suggests that when a mentally ill individual is hospitalized for long periods of time (i.e., separated from his or her family and integrated into the hospital environment), a less than optimal coping pattern begins which sees hospitalization as the solution to the family problem. This pattern may be repeated each time the individual manifests the same disturbances.

A family-oriented hospitalization, on the other hand, views the problem in systemic terms. All persons in the family system are considered (in varying degrees) as interacting with the problem, and hospitalization is geared to supporting family functions (Glick & Kessler, 1980).

**BACKGROUND**

In some cultures, families are considered a vital part of the psychiatric hospitalization of any of their members. Because
of a scarcity of trained professionals and other resources such as food, families are essential to care for the needs of the identified patient. In fact, families often stay with the patient in or near the hospital. The assumption in these other cultures reflects different patterns of family care and affirms that the patient is an integral part of the family network. It is unthinkable that the patient would return anywhere but to the family (Bell & Bell, 1970).

Based on this concept, a number of innovative hospital programs in our culture have included more than one family member in the hospitalization. These programs fall into three categories: 1) those which attempt to identify the entire family as the patient (Abroms et al., 1971; Bowen, 1966; Combrinck-Graham et al., 1982); 2) those which attempt to use family resources in treatment of a disturbed family member and to change roles and functions in the family during the intensive treatment phase of the hospitalization (Bowen, 1966; Combrinck-Graham et al., 1982; Bhatti et al., 1980; Grunebaum et al., 1982; Grunebaum et al., 1963; Lynch et al., 1975; Main, 1958; Nakhla et al., 1969); 3) those which use the hospital as a laboratory for change in familial relationships (Abroms et al., 1971; Bowen, 1966; Combrinck-Graham et al., 1982; Bhatti et al., 1980; Nakhla et al., 1969; Whitaker & Olsen, 1971).

A pilot experimental effort to include more than one family member in the hospital was reported from Wisconsin (Abroms et al., 1971; Whitaker & Olsen, 1971). Here, admitting more than one family member became the rule. Since it was an adult ward with an already established milieu, family members who had not considered themselves to be patients were quickly socialized as patients by the others in the community. Staff members became aware of how they themselves were incorporated into the family triangles, and maneuvering in these patterns became a conscious part of the treatment experience in the hospital. One program has continued to treat a small number of families (in two apartment inpatient facilities) (Combrinck-Graham et al., 1982). Another effort involved the hospitalization of infants along with their psychotic mothers as a means of observing and of having the opportunity to foster a better mother-child relationship (Grunebaum et al., 1963; Grunebaum et al., 1982; Main, 1958). These experiments involved considerable effort, however, and, in most cases, when certain committed staff left the ward, this kind of family intervention was discontinued.

**A MODEL FOR INPATIENT FAMILY INTERVENTION**

Hospitalization should be viewed in most cases as an event in the history of the family, an event that can be devastating or valuable depending upon the skills and orientation of the therapeutic team. When hospitalization is viewed in this way, it becomes central to understand the role of the patient in the family system and to support the family as well as the patient. The hospital becomes an important therapeutic adjunct not only for severely dysfunctional individuals and their families, but also for families who are stuck in modes of relating that appear to interfere with the development and movement of individual members. For these families, hospitalization aims to disrupt the family set; this disruption can be used to help the family system to change in more functional ways.

Family-oriented programs can be implemented within existing hospital resources, though there is a general trend toward adapting and revising hospital environments to include family members in patient care. (This trend is also noted in other specialties, such as “rooming in” in obstetric and pediatric units.) Effective programs involve the staff, from admission clerks on up, in building an alliance with the family. Stewart describes this as “the engagement of the family with the institution in a relationship that achieves mutual understanding and support and establishes clarity, acceptance, and commitment to mutually agreed upon goals for
the treatment of the hospitalized patient" (Stewart, 1982). This active reaching out is different from a commitment to change-oriented family treatment. Involvement of the family (as we are describing) makes possible the avoidance of staff overidentification with the patient against the family, as well as reducing the stigma of psychiatric hospitalization and increasing system-wide motivation for aftercare.

Many different types of staff/family interaction are possible and helpful. One may separate the tasks of alliance building, formal family therapy sessions geared to change, and staff and family interaction around medications, visits, and so forth, which can also have a therapeutic function. An example of an innovative, well functioning family-oriented approach in an inpatient setting can be found in Table II.

Table II
Inpatient Family Intervention*

| Definition: Inpatient family intervention (IFI) is work with the patient and his or her family together in one or more family sessions. It is aimed at favorably affecting the patient's course of illness and course of treatment through increased understanding of the illness and decreased stress on the patient. It has been carried out by inpatient social workers, first year psychiatry residents, or both together as co-therapists. |
| Description: |
| 1. Assumptions |
| 1. IFI does not assume that the etiology of the major psychotic disorder lies in family functioning or communication. |
| 2. It does assume that the present-day functioning of a family which the patient is living in or in frequent contact can be a major source of stress or support. |
| 2. Aims |
| 1. IFI aims to help the family to understand, live with, and deal with the patient and his or her illness; to develop the most appropriate possible ways of addressing the problems presented by the illness and its effects on the patient; to understand and support both the necessary hospital treatment and long-range treatment plans. |

*The material for this section has been taken in part from a study, Inpatient Family Intervention: A Controlled Study, funded in part by an NIMH Grant (MH#34466) and was drafted by Drs. J. Spencer and L. Glick.

2. It aims to help the patient to understand his family's actions and re-actions and to develop the most appropriate possible intrafamily behavior on his part, in order to decrease his vulnerability to family stress and decrease the likelihood that his behavior will provoke it.

III. Strategy and Techniques
A. Evaluation
1. Evaluation is accomplished in one or more initial sessions with the family, with the patient present when conditions permit. Information gained from other sources is also used.
2. The patient's illness and its potential course are evaluated.
3. The present effect and the possible future effect on the family are determined.
4. The family's effect on the patient is evaluated, with particular reference to the stress caused by expressed emotion and criticism (EE).
5. Family structure and interaction and the present point in the family life cycle are evaluated in order to determine whether particular aspects of the patient's role in the family are contributing to exacerbations of illness or to the maintenance of illness and/or impairment.

B. Techniques
1. The family and patient are usually seen together.
2. Early in the hospitalization an attempt is made to form an alliance with the family that gives them a sense of support and understanding.
3. Psychoeducation: (a) The family is provided with information about the illness, its likely course and its treatment; questions are answered. (b) The idea that stress from and in the family can cause exacerbation of the illness is discussed. (c) The ways in which conflicts and stress arise within each family are discussed, and a problem-solving approach is taken in planning ways to decrease such stress in the future. (d) The ways in which the illness and the patient's impaired functioning have burdened the family are discussed and plans made to decrease such burden.
4. In some cases, the initial evaluation of subsequent sessions suggest that there are particular resistances due to aspects of family structure or family dynamics that interfere with the accomplishment of (2) and (3) above. If it is judged necessary and possible, there may be attempts in one or a series of family sessions to explore such resistances and make changes in family dynamics. Such attempts may use some traditional family therapy techniques. Such families may be encouraged to seek family therapy after the patient's discharge.
INPATIENT FAMILY INTERVENTIONS

Goal setting and joint treatment planning

Short-term goals with the family must emphasize that the
treatment in the hospital will not attempt to solve all the
problems the family has ever had. Goals should focus pri-
marily on core problems such as:

1. What brought the patient into the hospital?
2. What has contributed to the maintenance of the iden-
tified patient's problems or to the family disequi-
lbrium? A common cause is a medication compliance
issue.
3. What will be important in planning the posthospital
period? (This question emphasizes the importance of
discharge planning early in the hospitalization [Tauber,
1964].)

Family work in the hospital setting will endeavor to increase
communication between family members. Impaired families
often have difficulty not only in sitting down together but
also in discussing their problems and in coming to shared
decisions. Family sessions conducted in the hospital can pro-
vide a forum for this process.

Goals for changes in family functioning should be set only
after very careful evaluation of how the family functions.
Goals should have a limited focus on roles, behavior, and, if
appropriate, separations that will allow the identified patient
to function satisfactorily and to return to family and com-

munity. In some cases, a family therapist will raise the pos-
sibility that the identified patient live with someone else.
Changes in roles may be suggested, e.g., that the father
should take over managing family finances from the mother.
The therapist may support the restructuring of family rela-
tionships. The breadth of the changes will be limited by the

amount of time available for hospitalization, the strength of
the working relationship, and the responsiveness of the fam-
ily.

Finally, after evaluating the family, defining the work to
be done, setting goals, increasing communication, and work-
ing on family change, (including how the family deals with
“precipitants” and “crucial issues”), the therapist will attempt
to connect the family to posthospital family therapy re-
sources. It cannot be overemphasized that the purpose of
hospitalization is to help the patient and the family feel and
function better in the community, not in the hospital.

Because one of the goals of hospitalization is to improve
the functioning of the patient and the family, family inter-
vention sets the stage for such a change after completion of
the hospital stay. It allows for dysfunctional family patterns
to be identified, perhaps to be changed in the hospital, and
the new patterns to be tried out, when possible, prior to
discharge (Tauber, 1964). Carried out this way, family in-
tervention may lessen family resistance about having the
identified patient at home. Most important, it enables families
who might have “resisted” therapy to get engaged in useful
treatment. Thus, when the patient leaves the hospital, family
treatment can continue. Clinical impression suggests that
family treatment begun in the hospital may decrease the risk
of subsequent rehospitalization.

Techniques and process

Most family therapists believe that family therapy should
begin immediately even if the patient is very symptomatic.
However, the family will sometimes refuse to be involved in
family sessions in the hospital until the symptoms of the
identified patient are minimal, and some therapists will in-
clude the patient in the sessions only when the acute symp-
toms start to diminish (Guttman, 1973).

Family therapy should usually last throughout the entire
hospitalization. The nature and duration of the sessions also depend upon the goals and the length of hospitalization. Some families need to be seen three times a week for two hours and others once a month for fifteen minutes, but most settings use a once-a-week format. Progress can be gauged by noting the progress of family therapy sessions, their consequences, and the effects of any home visits by the patient.

Almost all of the wide range of approaches to family therapy are potentially useful in the hospital setting. However, a family psychoeducational program is central for most problems that now require hospitalization. Work with individual families may include the structural approach, family psychodrama, and family sculpting. These approaches to treatment may be particularly effective with a hospital population because they stress activity and enactment rather than talk.

The primary hospital therapist is in the best position to work with the family because he or she has the best overall grasp of the case. The advantage of one therapist (compared to two or more therapists) doing both the individual and the family work is that the therapist can understand each person's position rather than become allied or involved in a struggle between patient and family. This major advantage outweighs the potential disadvantages, such as the therapist becoming confused over which system level to work on or issues of the violation of confidentiality. When staffing patterns permit, it is often advantageous for another staff member from the ward to participate, such as one of the nurses or social workers.

Some therapists believe that family therapy in a hospital setting is the most difficult kind of psychotherapy and therefore recommend that every family therapist have a cotherapist to share the emotional strain. In a hospital setting, this arrangement might be more practical than in a private practice. On the other hand, no research suggests increased efficacy when a cotherapist is present, and time constraints may make cotherapy difficult to carry out. Furthermore, a notable

inequality between the two cotherapists, such as a staff physician paired with an inexperienced nurse or medical student, often typifies cotherapy arrangements, and this setup mirrors and inadvertently models inappropriate behaviors to the family.

The need for maximal communication among staff members must be reconciled with the need of the patient (and family) and the therapist for confidentiality. Communication among staff members seems crucial for effective treatment. The family should therefore be told that the therapist will have available, and may use, all the material from both the individual and family contacts to help the family function better.

Psychoeducational workshops and multiple family groups are especially helpful to families of psychiatric inpatients and especially to families with chronically ill members. The family's interaction with other families will provide experiences in the commonality of problems. Most families with psychiatric difficulties cannot find these experiences outside the hospital. In fact, many of these families are quite isolated within their own communities. The multiple family interactions also demonstrate particularly effective ways of coping with the problems they share. Family members have the opportunity to see themselves reenacted in another family's struggles and can therefore develop new perspectives on changes within their own family group.

Family therapy has been carried out by all members of the hospital treatment team. During family visits, or at other scheduled times, nurses can meet with the family. In fact, visits may be used extensively in family work, either formally or informally. In planned visits, selected family members can be invited or given tasks for the visit. Visits to the patient can also be restricted because no plan for constructive use of the time has been made by the family. Occupational, art, and recreational therapists can also involve the family in treatment. They can prescribe activities for the family such as
preparing a meal together, doing a family mural, putting on a performance, or going on a picnic.

Passages to leave the hospital can be planned to make specific contributions to the family work. When the patient begs to be allowed to leave, or the family asks to take the patient out, the question is, “What will you do together? How will you make it different from before?” The invalid mother may be required to help with the meal preparation; the patient father may work on a project with his children or take them out somewhere; the unruly adolescent may negotiate some time with his peers with a curfew at home. With clearly articulated plans, the outcome of a visit or a pass can be evaluated fruitfully.

Medication is a treatment modality which involves the family significantly. Families who are unmotivated for family therapy per se will sometimes participate willingly in family work toward the goal of achieving effective pharmacotherapy. Most professionals know that medication has a vital role in managing the affective disorders and schizophrenias, but families are not all so educated. Psychoeducational workshops for families of patients with schizophrenic disorder and affective disorder present the basic information on etiology, prognosis, and treatment, as well as the necessity, effectiveness, and function of the medication, and coping strategies. Despite the value of such groups, the nuances of dosage and administration are best negotiated on an individual basis; if key family members are involved, the negotiations may inscribe the best compliance and beneficial effect.

**Case example:** A 17-year-old boy was admitted after having been extremely agitated and disoriented at home, refusing to eat or sleep. The working diagnosis was schizophrenic disorder. In the hospital he continued to be wary, eating only when his mother sat with him and avoiding participation in the activities involving other patients. The staff had decided to administer neuroleptic medication. They sat down with the boy and his mother and explained their observations and concerns. They then described the drug and the effects they hoped it would have. They also discussed side effects and remedies for these, and focused specifically on how the boy and his mother would be able to evaluate the effectiveness of the drug. Specifically, if the boy were to find out that he could think more clearly and understand what is going on around him, then the medication would be working and he could then help the staff decide what will be the best dose.

The boy hesitated, and his mother had some questions. Finally, however, she told the boy that she thought he should try it, and he agreed. Two days later he said that he felt better and wanted to stop the medication. The staff told him that there had not really been enough time to evaluate it, and they spoke again with him and his mother. Again she told the boy that she wanted him to take the medication. Again he agreed to do so. A week later he said he felt better but wondered if an increased dose would help him sleep better. In another conference with his mother a new dosage schedule was arranged.

The boy and his mother had a difficult kind of relationship through this experience. His mother had been consulted as a parent and her competence to evaluate and help her son was underscored. The boy, on the other hand, had a new experience of negotiating with his mother. Decisions were not made for him, but he was included along with his mother in an active decision-making process. As the hospitalization progressed he felt freer to ask questions of both his mother and the staff, and the answers helped to clarify the confusion of his psychotic state. In this way the neuroleptic and the contextual experiences may have worked synergistically.

Psychoeducational programs within the hospital include families in the process of evaluating learning disorders. With children having school difficulties, for example, family members can work in the school setting to learn how to help their child and to discover areas of competence. Families of poorly socialized individuals may need to participate in a regularly scheduled and structured set of activities of daily life where commitments are made to schedules and to each other. These
special plans will be individualized from family to family depending upon the need and upon the general commitments of the family members both to the activity in the hospital and to their other responsibilities.

THE STAFF AND THE FAMILY

When the family is a major consideration in hospital treatment, all of the staff will know how the patients’ treatment plans include their families. The interface of family and staff through routine contacts will be a rich interpersonal context in which functional and dysfunctional patterns may be enacted. Staff may appreciate that family members can help in providing the extra care when close observation or precautions are needed because of agitation or risk of suicide. Since it is often true, however, that family members can increase or decrease the symptoms, staff must be careful in seeking the involvement of the family until the relationships are fully understood. Nonetheless, a patient who is too agitated to fall asleep may be more readily settled down by a familiar family member than by an unfamiliar staff person. A violent or distraught individual may respond more readily to the intercession of family members than to the staff.

Case example: A 27-year-old, youngest of three sons, was hospitalized for his third psychotic break with a diagnosis of major affective disorder. Periodically, he became agitated and disoriented and threatened the hospital staff and other patients. When his family was called, they were able to calm him down without the necessity of administering additional medication. Future outbursts of this kind were prevented by the ready availability of the family by phone. His subsequent hospital course was smooth, and discharge was accomplished earlier than originally anticipated.

An unfortunate side effect of hospitalization is that staff can be drawn around the patient into a conflict configuration, which is remarkably similar to the family’s patterned response to the patient. An assessment of staff interaction around a particular patient, for example in a staffing, may reflect important emotional and organizational issues in the family. When the staff cannot settle down to a serious discussion of a particular case, they may be reflecting the family’s propensity not to take themselves seriously. When staff are persistently confused about the facts of a case, they may be reflecting the ambivalence of a thought disorder, or confused communications, or the lack of important data due to a family secret. The staff may be divided in their opinions about the family. Sometimes the division is in the form of those who favor the patient versus those who sympathize with the family, which often reflects an intrafamilial need to split or scapegoat. The staff, or a part of the staff, may also identify with a part of the family system that has frustrated them. For example, just as the patient is beginning to improve, the family may want to remove the patient. The situation can change as the frustrating subsystem no longer has to hold out against the staff. These staff responses are useful diagnostically. As we have indicated, a staff that is well informed about the family issues in a particular case may be better able to assess their own responses in this light and to develop intervention strategies that use these rich staff resources in the family treatment.

Case example: A 14-year-old girl, living with her divorced mother, had engaged in a series of self-destructive behaviors. Her mother had pressed for her hospitalization, hoping that this would lead to residential placement of the girl, as she, the mother, had many troubles of her own and could not cope with the child. The girl refused to live with her father.

A consultation was requested because arrangements had been made for the girl to go to a local state hospital and, as the time was approaching for her to leave, the mother changed her mind and said that the girl was better and that she would take her home. The staff was angry at the mother
and felt "set up." They said that they would have the mother sign the girl out against medical advice if she insisted on taking her home. The staff was particularly angry because they originally had been opposed to long-term treatment, as the girl did not seem that "disturbed." They had made the arrangement because they were considering the possibility of the girl returning home, the mother-daughter dyad became so tumultuous that the girl threatened suicide. The consultant observed that the staff was also very angry with the girl, who clearly was not appropriate for a state hospital and had thoroughly frustrated them.

After meeting the girl, the consultant understood how infuriating this defensive, bright, and completely uncooperative patient was. In the context of the staff's helpless fury, the girl's only ally was her mother, and this explained her change of mind to a decision to take the girl home after all. A plan was developed for a "family session" where the girl would bring an ally or friend from the ward, while several staff members would take up different sides of the mother's wishes both to take the girl home and to have her placed leading to a successful discussion without polarization.

The community of families and staff provides a general context for family change. Family nights are traditionally offered in hospitals so that families and staff can meet informally to exchange information. Such meetings can also be structured as multiple family settings or as family group workshops or task forces.

GUIDELINES FOR INPATIENT FAMILY INTERVENTION

Family-oriented approaches are admittedly not a panacea. Indeed, there are times when the family clearly should not be involved in the treatment. Moreover, in certain phases of treatment, individual or group therapy of the patient may be the treatment of choice.

Costell et al. (1981) have suggested that with some families the patient will function better outside of the family structure.

A. Bentovim (personal communication, 1982) has suggested, based on clinical experience, that family intervention is ineffective when the family or a family member is particularly "malignant."

The only controlled study of family intervention in an inpatient setting is a study (in process) by Glick et al. (in press), in which inpatient family intervention (with a heavy family psychoeducational component) is being compared to standard hospitalization without family intervention for patients with schizophrenic disorders and affective disorders. The sample includes 130 patients and their families for whom family intervention is indicated and who are randomized to one of the two treatment conditions. Both conditions are conducted with the use of treatment manuals. Assessments are made at admission, discharge, and six and 18 months postadmission, using patient and family measures on multiple dimensions from the vantage points of patient, family, and independent assessors.

Preliminary results from global outcome data obtained from the first three-quarters of the sample at discharge and at six months suggest that, for all groups combined, the family intervention is more efficacious than the comparison treatment. From the point of view of diagnosis, family intervention is more efficacious for schizophrenics with good prehospital functioning and for patients with affective disorders (especially females), but does not seem efficacious for chronic schizophrenics (although it is helpful for their families). In a like vein, clinical experience suggests that the specific interventions of psychoeducational groups can help the often demoralized family of the chronic patient to reestablish itself as a viable unit and lessen the burden of shame, guilt, despair, and isolation (McLean & Grunebaum, 1982).

The effectiveness of psychoeducational groups in preventing rehospitalization will be discussed in the next chapter. In our experience, however, some type of family intervention, from the wide range of family psychoeducation through
classical change-oriented family therapy, is almost always indicated. Even when the family is not available, interested or involved, the designated patient needs to be reconnected to another system.

4

DISCHARGE AND AFTERCARE WITH THE FAMILY

As we have described, going to a psychiatric hospital for the first time is traumatic, painful, and usually filled with negative implications to the patient, the family, and the larger community. No less so (but for different reasons) is the event of discharge from the hospital. Patients are often caught up in a system they only dimly understand. They are “processed” and then sent out into the community with great uncertainty about how they can reorganize their lives.

This chapter deals with the task of including the family in the planning and management of the hospitalized patient’s discharge into the community. Involving the family in the patient’s posthospital treatment requires little overall change in the health care delivery system, but rather utilizes existing psychiatric institutions without radically redefining illness, treatment, or the social roles of patients, families, and therapists.

Our focus is on urgently needed ways to increase patient functioning and therapeutic efficacy, with emphasis on evaluations, comparisons and outcomes. The presentation is divided into two parts: 1) working with the families of psychiatric inpatients who are not defined as chronic, and 2) working with the chronic psychiatric patient. This distinction is made and utilized because individuals, families, and institutions recognize the difference and respond quite differently to the two conditions. With a first and second psychotic break or inpatient experience, patients and their families
usually see the illness as an interruption of their life and expect a return to normality. If third and subsequent hospital admissions occur, there is a slow but dramatic change in the definition of the patient from someone who has an illness to be treated and cured to someone who is qualitatively different (and by inference inferior) to “normals.” This definitional change requires significant alterations in treatment approaches.

**WHEN THE INPATIENT IS NOT DEFINED AS CHRONIC**

Most psychiatric patients at first and second admission still have strong family and social ties (Rose, 1959). For such patients, legal, social, and economic forces in American society pressure for rapid discharge. The legal principle of “least restrictive care” dictates one major impetus. Many social groups, including those which purport to represent psychiatric patients’ rights, advocate reducing the power of those in positions of social control (i.e., professionals, administrators). Economically, legislators and third-party payers are increasingly aware that lengthy hospitalizations threaten their already tenuous cash flow.

These varied pressures, in conjunction with advances in treatment, e.g., medications, have resulted in a precipitous drop in hospital stay for psychiatric patients. Hospitalizations which were calculated in months in the 1960s are now reported in days, with enormous impact on our health care delivery system and on social concepts of mental illness and treatment. The psychiatric system, previously defined as a benevolent controller of social deviance, now has a less powerful image as only one of many social factors, while the mentally ill are understood as people needing help to establish and maintain a clear and socially reinforced role in the community.

Traditional psychiatry, with its emphasis on the individual, may not have been the best model for these dramatic changes in role definition. In the past, the family of the psychiatric patient was often seen primarily as a source of problems rather than as a potential ally. That view, with its implicit elitism, is out of step with current understanding. When patients are discharged without an adequate treatment plan that includes the family, they reappear to be processed and discharged again in a never-ending spiral which unfortunately tends toward chronicity, hopelessness, and increasing isolation from the community. This is the so-called “revolving door” phenomenon (Talbott, 1971).

**Planning for discharge**

At first and second admission, most patients have family members concerned about their welfare. Since hospital time is being dramatically reduced, these family members must be involved in discharge planning. Whether in a public or a private setting, psychiatrists, psychologists, and social workers can interact with the family as partners in rehabilitation. Planning sessions that deal with the needs of the patients and the family alike are essential in promoting the patient’s effective reentry into the broader society. As stated in Chapter 3, the hospital with a family orientation begins discharge planning on admission.

Data from a variety of sources indicate that any kind of severe emotional illness that requires hospitalization can best be treated by including the family in intervention efforts (Goldstein et al., 1978; Anderson et al., 1980; Falloon et al., 1981). Evidence accumulates that families can be significantly more helpful following discharge when mental health professionals provide clear information, take the family’s circumstances into account in aftercare planning, and attend to the interface between the identified patient and family members.

One stark, simple, and compelling reason for family involvement is the necessity for patients to continue on medication (May, 1975). Previously hospitalized patients who
resist acknowledging their illness are often resistant to continuing drug treatment after they feel better; chronically ill patients are frequently confused and have difficulty remembering dose amounts and times (May, 1978). Patients are more likely to take their medication when the family is watchful and cares (Fallon, 1981; Goldstein et al., 1978).

For patients whose medical appointments are spaced four to six weeks apart, reinforcement for continuing drug treatment can be provided by concerned family members who know they are a part of the treatment team. Explanation of the goals, effects, and side effects of medication, given to family members and patients together, will prevent confusion, distortion, and misunderstandings about this vital aspect of ongoing treatment.

Even if the hospital stay has been short, the newly discharged patient has been removed from the community and the family, defined as mentally ill, and separated from the vital social network that provides security and personal identity. For mothers who have been hospitalized, child care has been in the hands of others, and the family has necessarily adjusted to functioning without her. Fathers have been relieved at least temporarily of the responsibility for parenting and breadwinning. As the family has realigned, they often see the discharged patient as an interloper or at best a guest, and have little confidence in his or her ability to reclaim a significant family role. Children and adolescents who often were already puzzling and disturbing to the family are further isolated by the institutional treatment process.

The first principle of effective aftercare is to address the social network of the patient reentering the community. What are the stresses that rendered the patient unable to continue in his or her social role? What are the changes necessary to allow the patient to reclaim and improve family or community functioning?

Case example: John H., a 25-year-old welder who was married and had one child age 3, was brought to a metropolitan emergency room because he had precipitously left his job, announcing to his wife, Mary, that he was designated by God for a special mission. He attempted to coerce her into helping him bring the good news to the whole world. Because of his agitated state and marked change in manner, Mary was frightened and called John's mother for help. Together, Mary and her mother-in-law convinced John that he needed a checkup at the hospital.

In the emergency room, John was diagnosed as having an acute psychotic state, and was sent to the City/County Mental Diagnostic Center, where he was given a phenothiazine and put on the docket for court-directed admission to the state psychiatric hospital. The phenothiazine reduced John's agitation but did not significantly change his ideas, so the Mental Diagnostic Center and the court arranged treatment in the state mental hospital located some 40 miles from his home. There he received individually-oriented treatment, including medication and group therapy. Mary H. was asked to provide historical information, but no further contact with her was requested.

After 21 days of hospital treatment, John was cooperative, even docile, and no longer preoccupied with his special mission. Mary was notified and John was discharged to her care with a 3-week supply of medication and an appointment at the community mental health center closest to his home.

Though John did not speak of his special mission, Mary was still frightened and worried by his hesitancy, his confusion, and other differences from his premorbid state. John refused to go to the community mental health center and refused to continue his medication. Twelve weeks after hospital discharge, he once more became insistent on his mission to convert the world and angry with Mary for not assisting him. Mary once again called her mother-in-law to help arrange treatment for John.

John's experience in the psychiatric hospital was, if not typical, a familiar one. His illness was seen as an individual problem, the treatment plan was directed to that individual
difficulty, and his family was dealt with in a perfunctory manner. The results provided one more statistic for the revolving-door phenomenon. John will frequently go to the hospital, be discharged, and return to the hospital in a short time. The effects on his marriage, his ties to his mother and his child, and his relationship with his employer will undoubtedly be adverse.

**Family-oriented aftercare**

Progressive treatment programs currently functioning in the United States are believed to be effective in changing the course of patients like John H., increasing their chances of rehabilitation and successful reentry into family and community and reducing their probability of chronicity. These programs include:

1. Active involvement with the family prior to discharge.
2. Explanation of the necessary posthospital treatment program to the patient and the family members.
3. Exploration with the family of stresses that precipitated the patient’s illness.
4. Developing a shared perspective on future stresses that might threaten the patient’s functioning capacity.
5. Planning strategies to diminish or successfully cope with these stresses.
6. Arriving at a family approach to the necessary professional assistance in the posthospital phase of the illness, including medication and family counseling.
7. Evolving awareness that a patient’s difficulty is shared by the whole family, and that everyone who cares about the patient can and should avail themselves of professional help toward resolution of this family crisis dramatized by the patient’s illness.

Such programs immediately diminish the isolation of the patient as “sick” or “bad” surrounded by the well and the virtuous. Everyone in the family system is defined as caring, concerned, and potentially useful in solving family problems. Use of these principles has in some instances reduced the six-month rehospitalization rate of first- and second-admission schizophrenics from 30 percent to zero (Goldstein et al., 1978).

Once a previously hospitalized psychotic patient establishes contact with an aftercare center, the difference between an individual and a family orientation to mental illness becomes even more dramatically evident. An individual orientation typically evolves into infrequent visits to the treatment facility, with a focus on drug maintenance. Family members are expected to assist in bringing the patient to the clinic but are not part of an active treatment program. Such an approach has the advantage of simplicity and short-term practicality, with the professional staff defining themselves as attending to the patient rather than to the complexities of the patient-family environmental unit.

This approach, however, falls short of what is presently possible to increase treatment efficacy. If a psychiatric illness is defined as a family crisis and the family is expected to participate in aftercare, rehospitalization decreases and social functioning increases (Anderson et al., 1980). A family orientation to psychiatric illness is necessarily a multilevel systems approach. Once the illness is redefined as a family event, treatment will be multifocused, with biological, individual, family, and social variables considered in intervention.

Adequate treatment of major psychiatric illness usually requires drug therapy (Goldstein et al., 1978). However, drug therapy alone does not lead to social recovery from schizophrenic disorder (Mosher & Keith, 1979) or major affective disorder (Davenport et al., 1977). Optimal treatment consists of an ecological or social network approach (Pattison, 1973) concerned with helping the patient return to or develop family and community roles.
Clear evidence points to family factors such as high “expressed emotion” (principally criticism and emotional over-involvement) tending to produce high relapse rates for schizophrenia regardless of the drug treatment (Vaughn & Leff, 1976). There is also impressive evidence that family or couples therapy with affective disorder patients following hospitalization can decrease subsequent morbidity (Davenport, 1981).

Family-oriented aftercare of psychiatric patients has the goals of decreasing family anxiety about the patient and increasing family members’ self-confidence, their knowledge about the illness, and their abilities to react constructively to the patient. These goals are realized by providing information, reducing family stress, and enhancing the social networks of the patient.

Let us return to John H., treated conventionally in the preceding case history, and present his case as it would be treated with a family orientation.

Case example: Before discharge, a mental health professional (psychiatrist, psychologist, or social worker with family treatment skills) arranged at least three family sessions which included John, Mary, John’s mother, and John’s daughter. (John’s mother had been widowed two years previously and lived close by.)

In these interviews, it was established that John had a mental illness, and certain stresses were identified by the family as important in the production of his illness. His father was a college professor and had always pushed John to academic success. John had only a modest interest in school and was happy to stop after high school and get a full-time job. When he married his high school sweetheart at the age of 19, his parents expressed their disapproval by cutting off communication with him and with his new wife. Only after the death of his father had Mary tentatively established a relationship with John’s mother.

John had also been a person who kept to himself, rarely spending time with his buddies in high school or where he worked. He was a “model” employee and a “model” husband who brought his paycheck home to Mary each week, leaving it to her to handle the family’s finances.

After his father’s death, he became more withdrawn, speaking occasionally to Mary about how he had disappointed his father and was in a dead-end job going nowhere. Mary was frequently critical of John’s earning capacity, believing him to be bullied by his boss and not getting the recognition and advancement he deserved. John’s mother was also critical, pointing out that if only he had continued his education he could have provided for his family more effectively.

Once the delusion (dream) of a special mission was identified as an understandable attempt by John to rebut all the criticism, both mother and wife accepted the fact that their wishes for John had contributed to his breakdown. They needed him and relied on him, but had been unaware of how inadequate he felt. There was some change in both mother’s and wife’s attitude toward John. They realized that he did the best he could.

The whole family was informed of the importance of John’s continuing his medication and of their being a part of the aftercare program.

At the community mental health center, John and Mary and John’s mother came for the first appointment, already programmed to see the family unit as needing help. Mother and Mary needed John and John needed them. Medication was vital, but was only a part of the treatment package. It was up to the family to help John see himself as a lovable and significant person, important to his wife and daughter and to his mother.

Further work was focused on helping John define attainable life goals for himself and on increasing each family member’s sense of value, choice, and goals. This treatment plan was carried out in the aftercare program, with the therapist’s goal being to increase John’s social functioning and to diminish the probability of his rehospitalization.

Problems to overcome in family-oriented aftercare

Family resistance. Family members’ willingness to be involved in the patient’s treatment program may vary in in-
tensity. If, at the onset of hospitalization, the family is treated as part of the team, their resistance to involvement in aftercare can be minimized (Glick & Clarkin, 1982). The longer the hospitalization, the more difficult it is to mobilize family support (Rose, 1959). A staff that appreciates the potential of family help in rehabilitation, that does not assume that patient illness represents family failure (Terkelsen, 1983; Grunebaum, 1984; Terkel, 1984), and that recognizes the very real burdens that a patient places on family members can eliminate or at least diminish this resistance.

Institutional resistance. Both public and private treatment of the mentally ill encompasses a powerful lingering tradition of the asylum, a place where people with mental breakdowns should go and stay. If these same people are discharged, they are supposed to be well; if not, then they are “chronic” and must be kept on medication, with frequent episodes in which they return to the asylum (Talbott, 1979). These attitudes have not yet been appreciably altered by the family treatment movement. In part this is due to poorly articulated explanations of family involvement.

An implication that the mental illness is the “fault” of or “caused” by a deficient family encourages a destructively simplistic attitude: sympathy for the patient and hostility toward the parents or spouse as noxious agents. Even the family-oriented professional’s effort to change the context from “identified patient” to a family system problem can decrease the institution’s ability to help families and the family’s trust of the institution. Approaching illness as a family phenomenon is often misperceived by family members as, “Not only are you responsible, but you are crazy, too” (Lamb & Olliphant, 1978).

In both inpatient and outpatient settings a frequently overwhelmed staff must be helped to see patients’ families both as sources of help and as suffering people with the same rights to respect and dignity as staff and patients (Appleton, 1975).

Lack of personnel trained to help families. Inpatient units lack the tradition of experience in viewing patient hospitalization as an event in the life of a family (Glick & Clarkin, 1982). Outpatient settings have focused on the patient, and in most instances do not know how to help family members alleviate their burden or be more useful to the patient (Hogarty, 1971). Training programs are urgently needed to help professionals understand a family systems and a network approach to psychiatric illness. Drugs and concern for individual thinking and feeling are not enough. People do well or poorly in large part as a result of establishing and maintaining viable social roles in the family and the larger community.

WHEN THE PATIENT IS DEFINED AS CHRONIC

Effective treatment of the chronically ill psychiatric patient currently presents more problems than in former years. The excitement of the 1960s provided by the use of new psychotropic drugs was followed in the 1970s by the community health center experiment. The latter somewhat naively generated optimism related to a community-based but individualized approach to psychiatric illness, utilizing early discharge and deinstitutionalization techniques to return the patient to the community for ongoing treatment. The 1980s have begun with disenchantment. Deinstitutionalization is seen as a way of reducing the cost of caring for the mentally ill rather than as part of a coordinated, comprehensive, and continuous system promising real benefit for patients or the public (Bachrach, 1976). Drug therapy has proved to be necessary, but not sufficient, to increase functioning, particularly social functioning (Goldstein et al., 1978; Anderson et al., 1980). The term “revolving door” itself reflects considerable skepticism about whether we can do much about severe and chronic mental illness (Talbott, 1979).

Many community outpatient facilities have resisted the
mandate to work with chronic mental patients, much less with their families, viewing this activity as simply “baby sitting” for people who are incapable of using treatment (Lamb & Oliphant, 1978). Outpatient programs have so far lacked sufficient money, interest, and skills to develop effective, carefully targeted programs (Hogarty, 1971). Despite consistent findings that approximately two-thirds of chronic patients have interested family members who will absorb some or all of the burden of caring for these patients when discharged from hospital (Minkoff, 1979; Pepper, 1980), treatment facilities on the whole ignore the chronic patient’s family.

The mental health professional’s usual view of family members as being critical (Hatfield, 1979) and overly emotional (Vaughn & Leff, 1976) was and may still be translated to a family etiology of the patient’s illness (Appleton, 1975) rather than considered as a response to the illness and its stresses. Dysfunctional families are more apt to have dysfunctional members (Lewis et al., 1977), and specific family processes relating to the ease or difficulty of negotiating are associated with health or illness of offspring (Beavers, 1977). However, there is no evidence for the destructive leap from correlation to linear cause and effect (or etiology).

The preponderance of data concerning severe mental illness, including major affective disorder and schizophrenic disorders, strongly suggests that many factors at different system levels (neurotransmitters, individual temperament, dyadic and family relationships, community and cultural variables) are significant in the evolution, onset, and course of such illness (Davenport, 1981; Scheffen, 1981; GAP Report, 1984). To be most effective in treatment, psychiatrists must be knowledgeable about these multiple aspects of human systems. Of all the systems levels shown to be significant, family factors currently are least attended to and least utilized.

Many mentally ill people are presently moving toward chronicity with an overwhelmed psychiatric establishment providing inadequate care. Professionals are unable to mobilize needed assistance from funding sources or the community, and are unaware of the potential value of families to help these patients.

**Usual course of a chronic patient**

After the third and subsequent hospitalizations, patient, family, and community tend to view the problem in a new light (Kreisman & Joy, 1974). What was previously seen as an intrusion on the usual expectation of health is now defined as reality—patients are accepted (or rejected) as inadequate and incompetent in social functioning.

Psychotropic drugs have become the mainstay of treatment with these patients; visits to the clinic are widely spaced and of short duration. Helping with the quality of relationships is acknowledged as important, but little is done. The family, even more than in acute illness, is seen as having two limited functions: 1) bringing the patient to the clinic, and 2) providing housing and money. Otherwise the family is assumed to be of little significance.

In general, the chronic patient functions poorly and frequently returns to the hospital for further treatment. Some mental health experts have redefined hospitalization as a positive feature of psychiatric services, pointing out that any chronic disease brings on inevitable low points that require more assistance than in times of relative remission (Schepers-Hughes, 1981), but this is a minority opinion.

**Case example:** Eve L., age 33, wife and mother of two girls, ages 10 and 8, has been hospitalized in a state hospital 5 times in the last 10 years, each time with a diagnosis of some form of schizophrenia. Phenothiazine has been prescribed regularly since she was 23, though periodically she refuses to take the medication and this often presages another hospitalization. Her husband, Calvin, age 36, a shipping clerk for a major...
corporation, has continued to view Eve as his responsibility even though he is no longer hopeful of her recovery. He has insisted that Sarah, age 10, and Sally, age 8, respect their mother and help Eve when she seems confused, forgetful, or emotionally overwrought.

Eve visited an outpatient clinic once every eight weeks to review her “progress” and renew her prescriptions. Clinic personnel did not attempt to engage Calvin, Sarah, or Sally in programs to help them be a family with Eve. Recently, Eve became withdrawn and began to mutter that Sarah and Sally are imposters taking the place of her real children. She stayed up nights and slept most of the day, ignoring her defined responsibilities of preparing breakfast and dinner for the family. Calvin reluctantly took her for still another admission to the state hospital.

Here are the classic elements of the chronic patient: multiple hospitalizations, decreased functioning, treatment focused only on the medication of the patient, and an ignored family system. The family feels isolated, overwhelmed, often guilty (Lamb & Oliphant, 1978), and family members have no idea how to deal with their ill member other than to arrange a return to the hospital.

The usual outcome is another hospitalization, with the patient becoming more discouraged and more rigidly defined as insane, further estranged from husband, children, and community. No attention is given to the family burden, e.g., the lives of the patient’s daughters or the strain on her husband. With this or another hospitalization, her husband will very likely divorce her (Adler, 1955). The patient is a good candidate for discharge into a void, becoming a “bag lady,” detached from family and friends, and avoiding psychiatric assistance.

**Treatment course with a family systems orientation**

When treatment of chronic patients includes a family perspective, we have good reason to expect that the outcome will be better, i.e., that they will maintain greater social competence and be less likely to lapse into end-state social deterioration (Anderson et al., 1980; Falloon et al., 1981). Although the value of a family focus has been demonstrated in a number of programs, a coordinated thrust for its priority in treatment planning is lacking. When mental health professionals understand the problems families have rather than are, the orientation of aftercare changes and the treatment possibilities improve (Kint, 1977).

**Psychoeducation.** Since the majority of chronic patients have interested families, there must be a focus on education for the whole family concerning the illness and how the family members can deal with it. For example, if a patient is diagnosed as schizophrenic, family members need (and greatly appreciate) information regarding schizophrenia (Anderson et al., 1980; Dinic et al., 1978). Ideally this will start in the hospital.

An organized, thoughtfully planned program for the education of family members, including evenhanded information about the various organic, genetic, family, and environmental theories of etiology, can increase family member orientation and confidence. This kind of educational program also invites family members and patients to become partners with professionals in exploring ways of dealing with the tragedy without making anyone a villain.

One effective psychoeducational program reported by Anderson and co-workers (Anderson et al., 1980) describes an informative workshop for families of schizophrenics that includes information not only about the illness but also about management, family communications, and self-concern. Management information includes helping family members to see the need for setting limits to avoid overstimulation and for creating comfortable living space and interpersonal distance without rejection. Information regarding communication includes the importance of clarity, simplicity, and control of personal attacks and tirades. Self-concern issues
cover the importance of viewing the illness as similar to a chronic physical illness, with family members needing support from friends, extended family, and other families within the educational program.

**Family groups.** A second necessity for aftercare that "thinks family" is to arrange meetings of groups of parents or families of chronic psychiatric patients. Evidence is clear that having a chronically ill patient in one’s family causes family members to be hesitant and uncertain about continuing previously enjoyed friendships (Lamb & Oliphant, 1978). Adult friends often act in a way that is less direct and "walk on eggs"; for example, they find it difficult to tell of their own children’s achievements and successes. These friends frequently cannot offer any help or advice to the affected family. And families are all too often ashamed of their situation.

Professionally-led family, parent, or spouse groups for relatives of the chronically mentally ill can mobilize and promote the sharing of all family members’ sometimes painfully gained knowledge. When asked by family members what to do when patients behave in frightening ways, professionals often retreat into such ineffective responses as, “What do you feel like doing?” They may also use equally ineffective direct and absolute advice, e.g., “Lock him out of the house.” People who have similar problems are apt to be more practical, less sweeping, and quite specific. What to do when the patient threatens suicide, or the importance of having someone to talk with, or how to mobilize help in a crisis, or how to defuse anger in the patient—these are ordinary and valuable subjects in family group work, with family members educating not only each other but also the professionals who lead such groups (Dincin et al., 1978).

Family groups appear to be significant even when the approach does not emphasize the lessening of high "expressed emotion." Family members typically feel confused, afraid, demoralized, alienated from their friends and extended family, and inclined to blame each other. Education about the nature of psychiatric illness does much to diminish some of these painful reactions. Discussing their experiences with each other, the group provides the opportunity to share with others going through a similar experience. Members teach each other techniques of coping, gain support in finding a life for themselves (one which all too often has been put aside in the wish to care for the patient), and finally share the grief of the lost hopes for the ill member.

**Self-help groups.** A third desideratum is the availability of self-help groups that require no ongoing tie to mental health professionals. Such groups have existed for years, providing members with information, socialization, and a platform for social action. Family-systems-oriented and other contemporary professionals will now encourage such groups, with their emphasis on self-control and personal effectiveness rather than on pathology and dependency.

Many chronically ill people and their families have felt impotent about their family lives and excluded more and more from ordinary social relations. Self-help groups can aid in developing self-esteem and better functioning. Skills developed outside the family can help family members to reorganize their interactions with each other in family meetings and at home (Lamb & Oliphant, 1978).

**Independent living.** Young people (ages 18-30) who have severe and chronic mental illness often remain at or retreat to home, thus placing a great burden upon family members and also encouraging potential regression to more childlike, dependent behavior (Dincin et al., 1978). After hospitalization, they return home to a family that, although caring, may have little knowledge of how to act. Family members are uncertain whether to insist that the former patient go out on his or her own, or to operate as a fortress, taking in and defending the wounded member from the world at large.

When the patient can function outside the home, mental health professionals can help parents let go, working with the patient and the family to arrange an outside living situ-
ation which is more acceptable to the patient, less conducive to regression, and less burdensome to the other family members. Some discharged schizophrenic patients do better in an independent living situation compared with going back to the family of origin (Dincin et al., 1978; Haley, 1980; Brown et al., 1958). With married discharged patients, of course, the thrust will be toward developing the functioning capacity of the current family rather than fostering independence from it.

**Alternative living possibilities.** Halfway houses, foster homes, even day hospitalization, are all included in this category. A family systems approach to chronic mental illness acknowledges that it is sometimes desirable to develop and make available alternative living arrangements away from the original biological family unit.

As previously indicated, families with high degrees of expressed emotion have a higher risk of early rehospitalization (Vaughn & Leff, 1976). If the family has low expressed emotion, the patient can return to the family of origin with a more moderate risk (Brown et al., 1972); if the family has a high degree of expressed emotion, another living place may be needed. Arrangements may be made for a more neutral environment, encouraging family visits but acknowledging that the patient is in a separate household. Such an approach does not ignore the family; indeed, accurate family assessment must guide the arrangement.

**Family finances.** No professional person using a family system approach will ignore the powerful influence of money on the reestablishment and maintenance of mental health. The patient who remains outside a hospital is less of an economic burden to society. However, family members often need encouragement and information to search for needed resources.

**Respite.** Family members get tired. To help their chronically ill members remain out of an institution, they often struggle with their own fears as well as with obstacles placed in their way by professional people, society, and the patient. Many also experience an ongoing state of mourning over lost dreams and possibilities (McLean & Grunebaum, 1982). Recognizing the need for an occasional rest period, family-oriented treatment facilities should offer a variety of respite services. These may include day hospital facilities and outpatient activities continuing all day during every major holiday (Dincin et al., 1978) so that family members have some life and time free of worry for their own activities.

**Hospital readmission.** Though the above-described collaboration between professional people, institutions, and families of the chronic patient can increase patient and family functioning and morale, sometimes the burden is too great. In these situations, all parties may share in deciding that a short rehospitalization of the chronic member is the best solution. Hospital readmissions help everyone when the family is exhausted, but especially so before the patient retreats to a homicidal, suicidal, or totally regressed state. The hospital, although costly, still (but increasingly less so) serves as an asylum, a refuge for the patient and a respite for the family. When this decision is reached by consensus, the goal of maintaining family ties by regular home visits is still reasonable.

**Family treatment.** Professionals who "think family" in aftercare of chronic patients also use a range of family therapies. These therapies, when they work best, are simple and practical. They focus on the needs of all family members and do not provide a structure which encourages blame or attack. Therapy with these families focuses on diminishing criticism and overprotectiveness and on clarifying communication. It helps to maintain a more stable position between the poles of despair and unrealistic expectation, and it increases each person's sense of importance and effectiveness in promoting the goals of every family member.

There are a few pioneering centers of intense clinical and research interest in family treatment of the severe and
chronic psychotic patient (Anderson et al., 1980; Falloon et al., 1981; Dinin et al., 1978; Haley, 1980). In the main, these programs deal with the schizophrenic patient who lives with his or her family of origin. They utilize practical, nonjudgmental work with family members, usually emphasizing an extensive exchange of information. Anderson's group in Pittsburgh is exemplary in this respect. The first priorities are to connect with the family, decrease guilt and excessive emotionality, decrease the negative reactions to the illness, and decrease family stress. Their second phase focuses on helping members to understand the illness and to enhance the family social network. The third phase consists of maintaining the patient in the community, strengthening the marital coalition, diminishing dysfunctional behavior, and increasing the responsibility accepted by the identified patient. The fourth phase attempts to rehabilitate the patient into normal community roles and to increase the effectiveness of individual family members (Anderson et al., 1980).

While the Anderson and the Gluck groups conducted sessions in a hospital setting, Falloon et al. (1981) report favorable results in conducting family therapy within the patients' homes. In their study, florid psychotic relapses were nine times more apt to occur for patients receiving individual treatment than for those receiving a practical, problem-oriented, negotiation-centered family therapy. This approach can effectively be translated so as to be applicable in the outpatient system of large state mental hospitals. And in these settings working relationships with parent groups such as the Alliance for the Mentally Ill is a valuable partnership (McLean & Grunbaum, 1982).

An effective family systems orientation to chronic schizophrenia must take into account the many systems levels of the disease's manifestations. It allows for a sensible concern with individual difficulties and maintenance of proper medication, and then focuses on the problems of family members in becoming and remaining partners in the therapy of the ill person (Hatfield, 1979). It requires a strong effort to reduce the critical and overemotionally involved qualities of family life, and provides family members with alternative goals and purposes as the improving patient needs less outside concern and control. Some families, but not most, are able to go beyond this level of functioning and make use of the growth-promoting, individuating possibilities of family work focused on process and feelings (Anderson et al., 1980).

Case example: If Eve J., and her family had the opportunity of working with a family-oriented aftercare facility, the procedures and the results could have been as follows.

Eve and her family, after discharge from the hospital, were quickly contacted by the outpatient facility. A member of the aftercare staff had become acquainted with them during the hospitalization. Calvin, Sarah, and Sally were offered a place in the ongoing multifamily group for people with chronically ill family members. They were invited to come with Eve for a Saturday conference, attended by many families like themselves, to learn and to ask questions about the disease that has so much influenced their lives. In this group, with other families struggling with similar problems, Calvin and the children could talk about the anger, embarrassment, shame, guilt, and isolation that they experienced.

Family therapy focused on Eve's desire to be more effective and competent as a wife and mother and on the family members' stated desire to help her to function better. After an exploratory period, it became apparent that although Eve had always resented Calvin's mother because of her repeated illnesses, Calvin had increasingly depended on his mother to care for him and the children. Family therapy then addressed the highly practical issue of helping Eve claim, gently and gradually, her parenting role. Calvin's mother was invited to be recognized as a major contributor to the family and at the same time to relinquish some of the extra responsibilities of the last 10 years.

Mixed feelings were everywhere prevalent. Calvin wanted his wife to do more, but was afraid that she would fail. Eve wanted to move back into the family, but had always resented
the conventional housewife role. Calvin's mother was happy to believe that her son could have an effective wife, but somewhat grieved that her contributions might not be necessary in the future.

And so it goes. Professionals can act as catalysts to produce family and social change, always helping to increase choice, to clarify communication and boundaries, and to help each person avoid the role of scapegoat or villain.

CONCLUSION

As psychiatrists have gradually learned about the causes and the nature of severe mental illness, our ability to help patients and families cope has increased. Drug therapy has added to our effectiveness and is usually well utilized. A family systems approach that recognizes family members as needful allies in the care of the mentally ill has a great capacity to increase the efficacy of treatment. Although there are isolated programs that illustrate this potential, a coordinated, widespread family systems approach does not yet exist in the aftercare of acute and chronic psychiatric patients. On a humanitarian as well as a cost-effective basis, this should be a priority of psychiatrists interested in alleviating the pain of severe mental illness.

5

ETHICS IN FAMILY-ORIENTED TREATMENT

Ethical issues in psychiatry, as indeed in all of medicine, have revolved around "a right and good healing action taken in the interests of a particular patient" (Pellegrino, 1979). The therapist is expected to be nonexploitative of the patient and cognizant of the individual's needs for privacy, confidentiality, and choice. Ethical as well as technical considerations demand a focus on the patient's growth and change. These requirements have generally been interpreted as requiring that the therapist keep contacts with other family members to the absolute minimum in order to preserve the privacy and intensity of the therapeutic relationship.

The therapist who adopts a systems point of view faces a new set of ethical issues. If he/she considers the family as a unit that includes the identified patient, rather than separating patient and "environment," the therapist then must consider taking action for the good of the several individuals within the family, and for the family system as well, what Boszormenyi-Nagy and Spark (1973) have called "multidirected partiality."

The first ethical dilemma the therapist faces, in fact, is whether to move to a family systems framework at all, since it often seems far more simple to work with the individual, a treatment approach that has a great deal of historical data which suggest that it is often effective. However, as discussed elsewhere in this report, the patient's "illness" is embedded as a part of system functioning, and at the least is highly
reactive to systemic issues. Furthermore, treating the individual patient has an inevitable impact on the family. In certain circumstances, individual treatment has been found to be detrimental to the family system. For example, extensive research supports the belief that treating a patient in individual therapy when the primary issue is a marital problem can lead to increased divorce (Gurman & Kniskern, 1978). It could thus be considered an ethical blind spot for the therapist not to acknowledge and deal with the reality that other family members are being greatly influenced by the intervention and their welfare is at stake as well.

Changing from the individual to a systems approach can be extremely confusing, since the good of the identified patient or of any one particular person in the family is not always necessarily for the long-term good of the family system. A family system which includes a psychotic spouse will probably function better if both partners remain in the system. However, the individual needs of the spouse who is not ill may sometimes be better met if he or she leaves to seek a new life elsewhere. This conflict of good can be extremely difficult for the therapist, especially if there are children involved. Even if the good of one family member is in fact the good of all in the long run, many short-term stresses in the family may be created by involving all members in therapy.

Once the therapist has made the leap to a systems approach, the specific ethical dilemmas in dealing with family systems become apparent. This is best detailed by example.

Case example: Mrs. Allan, a 40-year-old married woman with two teenagers, makes a suicide attempt during the summer months. The attempt is severe and seems to be directly related to marital conflict and to the impending exit of the children from the home. The first dilemma that arises at an ethical and a technical level is whether or not the patient should be hospitalized. At the technical level, one is faced with the question of the patient's needs for safety versus the fact that she could probably be cared for at home and might become overly dependent on the hospital staff should she be hospitalized. On the ethical level, one must also consider the needs of other family members and the effect on the family of the mother's hospitalization. On the other hand, if the therapist requests that the patient be treated at home, the family must become directly and deeply involved in her caretaking until it is clear that the crisis is over and that she is safe from another suicide attempt. Since it is summer, the teenage children will be home. What issues are raised for the family by having mother at home? Can the therapist prevent the father from hiding at work and placing this responsibility on the children's shoulders? Who will speak for or offer help to the eldest son, who has already offered to give up his out-of-state college in order to live at home and go to school nearby?

In this case, the therapist chose to hospitalize the patient, believing that the crisis could be best handled by getting her away from the family system for awhile, allowing things to settle down, and then working with the family while she was in the hospital. The patient told the therapist she was very depressed due to the thought of being alone for the rest of her life with a cold, distant, and critical husband. She also admitted that she had had an affair which had broken up the year before. The therapist, seeing the husband and wife together, found that at least when in the presence of his wife the husband was cold, critical, and distant, particularly when the wife showed any signs of desire to control the situation. When she became depressed, he became marginally more affectionate.

The husband was clearly invested in the marriage and did not wish to leave. He said, however, that he did not wish to participate in therapy and that this was his wife's problem; he instructed the therapist to "fix her up and send her back." In the evaluation sessions, the husband became increasingly uneasy whenever any of his behaviors were challenged. The problem now is the next step in therapy. What is the treatment of choice? Since the therapist believed that the suicide attempt was directly related to severe marital conflict, at a technical level the treatment of choice would be couples therapy. How-
ever, this choice would directly clash with the husband’s wishes for privacy and no treatment. There is now a conflict of goods—the husband’s wish for privacy versus the wife’s need to grapple with the situation so that she would have some other way of dealing with it besides another suicide attempt. The therapist faces a series of ethical choices in terms of how much pressure he can reasonably put on the husband and in what directions to press in order to get him to participate in therapy. In this case, although the long-term good of both people did not conflict, the short-term wishes certainly did.

The issue of how much one can insist that other family members or other people participate in a person’s treatment becomes even more difficult when dealing with nonrelated persons. For example, can one ask the roommate of a hospitalized college student to participate in therapy? What about aunts, uncles, or, as in network therapy, neighbors? Issues of confidentiality, privacy, and responsibility can become very delicate in these instances.

If one spouse comes into treatment, another clear dilemma occurs. What are the ethics of keeping the other’s possible sexual liaison secret? This difficult problem often occurs when someone has been treating a spouse in an inpatient setting and becomes involved in dealing with the family system. (An extensive review of the issue of secrets is given by Karpel, 1980.) This is a complex technical issue because it is hard to tell which option—therapist disclosure, requesting patient disclosure, or keeping the issue secret—is best for the family.

If in the above case the husband refuses treatment, what then are the ethics of the situation? Individual treatment with this woman is likely to end in the direction of her gaining strength herself and finally leaving. The therapist may feel privately that the patient might do better by extricating herself from the relationship, but of course he cannot be sure. The husband’s needs and the family’s needs will probably be best met if the wife remains at home. Although the therapist may attempt to remain nondirective, he will find it very difficult to completely avoid suggesting, even indirectly, the direction in which the woman should go. Indeed, anything directed toward increasing the wife’s self-esteem will encourage her to confront her husband or to gain skills by getting a job, which in the absence of concomitant change in the husband may increase the chance of a separation.

In all of the issues described above, therapists must be aware of ethical issues and their own value systems. The therapist must be able to clarify the ethical issues and to state them for the family. It is impossible to be totally “neutral” just as it is impossible to avoid having values. To assume an ethical position in family-oriented treatment, the therapist must accept some responsibility to all the family members and attempt to consider the conflicting needs of different persons and of the different levels of organization with which he or she is dealing. L’Abate (1982) and Sider & Clements (1982) offer excellent discussions of these issues.

Both administrative and fiscal forces are today leading to shorter hospitalizations and increasingly early discharge of patients to their families. In turn, families are often assuming responsibilities at great personal burden. We believe that family-oriented treatment must include an ethical commitment to all members of the family. The model we are proposing increases our profession’s appreciation of both the burdens upon and the potentials inherent in the family.
APPENDIX

PATIENTS, FAMILIES, AND HOSPITALS: A GUIDE FOR CONSUMERS

A hospital unit which chooses to move to a system-oriented framework faces the problem of resocializing staff, patients, and families. The following guide is intended for use specifically with families as a way of encouraging their understanding and cooperation. Part I, which may be used alone, reviews the family's tasks at various stages of the patient's hospitalization. Part II covers the details of a family meeting and some of the usual areas that may be discussed. It addresses itself specifically to change-oriented family therapy. It is not designed for psychoeducational approaches, although it may, of course, be used as a supplement. The guide may be altered to fit the specific institution. Families often appreciate specific written suggestions or information, and we offer this as one possible format.
PART I. THE FAMILY AND THE PSYCHIATRIC HOSPITAL

Families influence people. This is not news. People have always known how important their families are—the families they were reared in as children and the families which they live in as adults.

Psychiatric professionals have increasingly been recognizing the power of families. After many years of being gently but firmly excluded from psychiatric consulting rooms and being told that the problem the patient is having is purely an issue between patient and psychiatrist, family members are now being invited in. This has important implications if someone you love has been in emotional pain.

This guide is written for families of people who have been admitted to psychiatric units as patients. Its purpose is to tell you what you can do to be helpful to the person in the hospital, to the doctor, and to your whole family. We hope it will increase your comfort and understanding of what’s going on and help you to begin a dialogue with the hospital staff.

PSYCHIATRISTS LOOK AT FAMILY SYSTEMS

First of all, you will want to have an idea of how psychiatrists today see families. Psychiatrists have learned to see families as systems—as a group of people whose interactions affect each other—rather than collections of separate individuals whose behavior is determined mostly by their past. Children sometimes respond to tension in the house by “acting up” (making the adults even more upset, making the kids more upset, etc.). Similarly, adults may in more subtle ways develop symptoms which both stem from and contribute to family distress.

What about somebody who has a serious enough problem to be admitted to the hospital? Can that problem really be chiefly the product of family interaction? Psychiatrists who are also family therapists see two ways of thinking about this problem. One is that in fact the whole family is having a problem; the one who goes into the hospital expresses the most “noisy” symptom, but it is the entire family that is stressed.

On the other hand, there are families where there is a lot of stress, but no one develops symptoms. There are also people who develop symptoms when the family seems to be in no distress at all. Most psychiatrists feel that there are certain illnesses that are more likely to involve the person’s physiological, biochemical, and hormonal systems. In such instances, medication is often recommended. Most psychiatrists feel that manic-depressive illness, schizophrenia, and some depressions need medication as well as “talking therapies.” However, medications alone, although very important, are not enough, because people who have such problems are still very vulnerable to stresses. They do much better if family stress is decreased. Psychiatric illness is difficult for all family members, so the family needs help coping, too. In that situation, the job of the family therapist is to reduce family stress as much as possible.

It is also true that some psychiatric illnesses have been shaped significantly by the experiences of a person’s early years, so that individual therapy is still one important way of working with the individual’s past, but still active, history. However, the immediate problem is often a family stress, and it makes sense to try and help everyone deal with that as well. If the family, including the patient, can do something to ease the tension or reduce the symptoms, obviously that should be done.
ADMISSION TO THE HOSPITAL

Deciding when to take a family member to the hospital is a very difficult thing. Particularly if this is a first admission, families worry for a long time about whether or not hospitalization is necessary, and decisions about which hospital and which doctor are often even more confusing and frightening. If it is a second or third admission, family members may feel disgusted, tired, worried, guilty, or relieved that finally they can get some rest.

Particularly if the family member has become out of control or abusive, the thing that people want most often is to get that person into the hospital and then to get away quickly. Even if you feel this way, you still need to participate as much as you can in the admissions procedure. You may feel helpless about dealing with your family member but you are still the best source of information about what has been going on with both the patient and your family. The doctor may be an expert at coping with symptoms, but he or she needs your information badly. So if you don’t stay, you miss the chance to tell how you see things: what happened, how you tried to cope, what the family situation is at home. In addition, your relative will eventually be coming out of the hospital, perhaps very soon in these days of shorter hospitalization. If you don’t have a chance to get to know and help the physicians and staff, you have less of a chance to know and to influence what’s going to happen next.

If your relative has been admitted into the hospital in the last 24 hours, you should find out as soon as you can about how the hospital works. You will want to find out whether the primary person taking care of the patient is the doctor or a mental health team (including psychiatrists, psychologists, social worker, nurse and other therapists), what the visiting hours are, when the staff will be willing to see you as a family, and how you can help. You will want to know how you can contact a member of the treatment team and what is the best way to do that. You will also want to know something about the philosophy of the particular hospital and unit regarding your participation.

IN THE HOSPITAL

In most hospital units, you will be asked to come in and talk to the psychiatrist and members of the team, usually the social worker or the nurse. Some families don’t want to do this, feeling that it’s hard to take time off from work, that they’re going to be blamed for the illness, or that the illness is only the patient’s problem. The best thing that you can do for the patient is to be available. In addition to history, most hospitals want at least a few meetings with the family, patient, and therapist together. This often produces considerable anxiety. Here you are being asked not only to give information but perhaps to consider how you and the patient and other family members interact with each other. However, it is important that the staff know how you and the patient interact even if not all family members are living together. If there are other family stresses, now is the time to deal with them. The distress of one member (who, for example, may be very depressed) may be masking other issues such as marital problems, problems with one’s aging parents, or troubles with the kids in school. But very often these hidden stresses, some of which have been kept secret or underground, are central issues. This is a time when all family members can work together to understand the family system and the ways they relate to each other and to decide whether or not there are ways they might try to make it work better.

The hospitalization period is also a crucial time for you to find out how the doctors understand the patient’s problem and what you can do to make the situation easier. If you had a child or a relative with asthma or diabetes, you would want to find out while the person was in the hospital what kind of medications they needed, what you could do to ease the
situation, and what to look out for. If you're given all of the information only an hour before discharge, you would find it much more difficult to absorb and remember it. It's best to have a chance to discuss things at intervals during the hospitalization. This gives you a chance to think things over, to ask appropriate questions, and to think about what else you need to know.

In the hospital, patients clearly have a right to privacy when they talk to a therapist, and so do you. When you talk to the staff, you should discuss the question of whether or not what you say will be shared with the patient. However, if there are really important issues, continuing to keep them a secret usually doesn't make things better. If the issues you've been afraid to talk about are really very crucial, the team will try to help the family talk about them together in a way that is therapeutic for everyone. Basically, the staff should be on everyone's side, because everyone in the family is in some way affected by the problem.

What if you're not a family member, but a neighbor or a friend who has been involved with the person now in the hospital? How are things handled then? If you're important to the patient and have been asked to come in, the team will want some information from you as to how you see the situation and some idea about the kind of relationship you and the patient have. With people who are cut off from their families or whose families live far away, your help may be particularly important in terms of support, understanding, and planning. You, the doctor, and the patient will want to decide together how much responsibility you can reasonably take in terms of visiting, discharge planning, time, effort, and concern.

DISCHARGE PLANNING

The period of discharge is often extremely stressful for everyone. Feeling unsure of themselves and afraid of what people will think about them, patients often come out of the hospital feeling tense and uneasy. They go home to a family who may still be very confused about how to act. What everyone needs depends upon the individual situation. Discharge management is best planned by everyone talking with the physician and the team in the hospital.

To a large extent, whether or not the hospitalization has any lasting effect is related to discharge planning. Discharge planning shouldn't mean only referral for individual therapy for the patient, perhaps once a week, although that is often one of the central elements of aftercare planning. The family needs to know if the person is on medication and, if so, what the side effects are and whether anyone in the family besides the patient has responsibility for making sure that the medication is taken. In addition to medication and individual therapy, there are many other different kinds of aftercare planning available. Day programs, group therapy, and vocational rehabilitation are some of the common possibilities. Family therapy is often very helpful whether or not the person who has been hospitalized is seeing a therapist alone.

You as family members also need to think and inquire about what most concerns you about the patient's discharge: what the patient does during the day; whether he or she will return to work; how he or she will deal with you. You need to discuss with the team what plans are being made to deal with the issues you see as important. You need to know how the team understands the person's problems and how you fit in. You will also want to make sure that there are plans to follow up with you, particularly with those of you with whom the patient will be living. In addition, you will have your own needs and concerns. If the team hasn't talked to you about them, you need to insist. Make sure that there is enough time to discuss the issues that concern you.

DEALING WITH THE HOSPITAL

Psychiatric hospitals have changed greatly in the last 30 years. From being frightening and unpleasant places, they have
become comfortable and sometimes even pleasant. With the increasing emphasis on a variety of treatments, they have also become more complicated, so that the patient and family may have to deal with a bewildering variety of doctors, nurses, social workers, and aides. When you are feeling worried and upset yourself, this may be very difficult. Certain ways of handling things make things easier.

1) Ask the team which staff person should be your main contact person in the hospital—it's usually either the patient's doctor or the social worker. When you need something, call that person first. Find out who will be available for phone calls when your contact person is not available and when you're particularly worried. Get to know the team members and make sure they know that you are concerned and involved. As much as possible, try to get your information from only one contact person. Sometimes keeping notes on your exchanges will be helpful.

2) Appoint one family member as your spokesperson, and avoid having four or five different people call your contact person with the same question. Your spokesperson should do most of the calling and arranging. When there are family meetings or decisions, however, the whole family should be there, not just your spokesperson.

3) If you are getting contradictory information from the aides, the nurses, and the physicians, tell your contact person. If you're unhappy with the treatment your family is getting, talk to that person and ask for an explanation. Don't be afraid to tell him or her if you think something is going wrong.

4) Remember that the staff members are human. Staff members in a hospital are trying their best. They also may feel tired or worried or not sure about how to handle a particular situation if they haven't thought it through. They may not be able to get back to you immediately when you want them to. It doesn't mean they're not concerned. You need to find a way to work together with them. They don't want to fight with you anymore than you want to fight with them. If you assume that they're trying to help, everyone will feel better.

5) What if your judgment conflicts with that of the psychiatrist? Remember that psychiatrists are human beings too. They are not always right. Although they are experts at handling human problems, you are the expert with your relative. You have lived with or known this person longer than the team has. You have more information about how he or she behaves and what kinds of things are upsetting. It is sometimes difficult to decide whose judgment you should trust, particularly if you have a relative whom you're very worried about, or if different family members disagree. What if the doctor, for example, says that the patient needs another two or three weeks in the hospital and you think he or she should go home? Or what if the doctor thinks that the patient might be ready to go home and you are afraid that he or she still can't function? There are no easy answers here. If you, the patient, and your doctor cannot reach satisfactory agreement, you have the right to ask for a second opinion or a consultation. You have the right to ask for information, reading material, and a discussion of all the available data. If the patient is an adult, much of the final decision making will have to be left to the patient and the doctor, but particularly if the patient is returning to live with you, you have a great deal of influence over the planning. You are the patient's family. Don't underestimate your importance.
PART II. WHAT HAPPENS IN A FAMILY MEETING

WHO COMES TO THE FAMILY MEETING?

Family therapists differ in terms of whom they want to see. If a married adult patient is admitted, usually the first contact will be with the spouse, and the therapist will begin with the couple together. If there are children, the children will need to be discussed. Depending upon their ages, they may or may not come to the meeting. Whether they come or not, children need to know something about what is going on. They are frightened when a parent is in the hospital, and trying to keep it a secret won't make it any better. Those secrets don't get kept very well. With adolescent patients or unmarried adults, usually parents are involved in the meeting, and sometimes brothers and sisters. Anyone who is living in the house and whose input is important to the family may be invited to the session. If you think there is someone important whom the therapist doesn't know about, you should suggest bringing that person. You need to remember this is a chance for you to get something for yourself. If you've been feeling bad or uncomfortable or guilty, or if there have been stresses in the family you haven't been able to cope with, this is the time to get help.

WHAT WILL BE DISCUSSED?

Therapists need to know how family members behave with each other, so they sometimes ask family members to talk with each other. Every family has its own pattern and style. The therapist needs to know what the problems are and also how the family functions. Do certain people fight? Do certain people listen to each other? Is someone usually left out of the discussion? The therapist wants all family members to talk about how they see things, because everybody in the family sees things differently. Some therapists want to know about the family's history and some don't. The therapist isn't interested in everyone spending an hour blaming each other and saying hurtful, painful things. The therapist is there to make talking more satisfying, to help people understand each other and figure out how to solve their problems. If there is something that is particularly painful and you don't think you can say it in the first session, then you can wait until another session when you've gotten used to the therapist and the situation.

After learning about the family, the therapist will want to offer some practical help. Couple and family sessions are usually direct and to the point. They deal with here-and-now things, rather than with things that happened many years ago. In general, particularly when someone is in the hospital, the therapist will be down-to-earth in dealing with the present crisis and how to handle it best.

WHAT ISSUES WILL THE MEETINGS FOCUS ON?

Separateness and closeness between generations

It's very difficult to know how much to be involved in a child's life. This is particularly true because children change so rapidly. Moment-to-moment concern, which is the appropriate response from a parent for a 2-year-old, is less appropriate for a 6-year-old, and even less appropriate for a 16-year-old. No parent can judge perfectly how “far away” he or she should be at a particular moment.

Many families get stuck at transition points. Perhaps the child has moved on to a new stage where more distance is needed, but the parent is still seeing or treating the child as if he or she were younger. For example, a 29-year-old having trouble moving out of the house was living at home with his parents and not working. The family went to a store to buy
shoes and his father, without thinking, leaned over and tied the son's shoes. The father was giving the son a powerful message about how old he thought his son was. Of course, the son was contributing to the situation by not telling his father that he was at least capable of tying his own shoelaces. When the hospitalized member of the family is a young adult still living at home, the family will usually need help trying to understand how much to be involved with their son or daughter's problem and how much space to give the young person to act independently.

These "boundary" issues also come up with married couples who have parents who are still very much involved in their lives. Perhaps one of the most delicate issues in marriage is learning how to include members of the family one grew up in, while still seeing one's own marriage as the central and primary relationship. Very often issues like these can produce a great deal of stress. The therapist can help you decide if your family members might function better with more or less space at this time.

Who's in charge

In families that work well, it's clear who's in charge. Usually the in-charge people are both parents working together. In single-parent families, sometimes the mother and the grandmother are in charge. The issue is that everybody should know whose word is the last word—where the buck finally stops. This also means that parents must work together as a team, even if they sometimes disagree. In some families, one parent teams with a child instead of with the other parent. For example, mother and child are very close and father isn't involved, or he complains or reverses decisions from a distance. All family members usually contribute to having this happen—the father by being uncertain about how to be involved with the children, the mother by feeling that since she is "the mother" she must take complete control, and the children by paying attention only to the mother. In families where a child has been violent, it often appears that the child is in control and that the parents have lost all authority. Families particularly have trouble deciding who's in charge when the parents are having trouble getting along, or when the child is at a difficult age, such as adolescence.

The question of who's in charge is even more difficult when the child has been labeled psychiatrically ill. It is seldom that parents agree precisely on how to handle a child who is functioning well, let alone someone who is in psychological pain. The therapist can help you to clarify and work with decision-making in your family.

Communication and problem solving

This is a very central issue for couples, as well as for parents and children. Most people could use some help learning how to tell each other clearly what they want and, more importantly, how to negotiate what they want when compromise is necessary. Many people have good skills in communication and discussion outside the family, but somehow feel that rules are different in the family, that other persons should be able to sense what they want without their having to ask for it. Perhaps someone is so sure that the other person won't give him something so he doesn't ever ask. Family members also need to be able to define problems and then solve them. This is one of the most helpful and easiest things a family therapist can teach.

Closeness and intimacy

This is an issue for everyone in the family, but most obviously for couples. Many people haven't learned how to be close and warm with each other, particularly people who come from homes where there was constant criticism or fighting. It's also difficult if the people who are living together don't
have styles that match. For example, some people find it easy to talk about their feelings, and some people are more reserved. When the couple can't learn to deal with each other in a way that allows both to change a little, it can be very difficult.

**DOES FAMILY THERAPY CHANGE PEOPLE?**

Family therapists feel that family members, by changing themselves and the way they interact, can help change each other. That's very different from the concept of blame. Therapists know that no family member deliberately sets out to hurt someone else. However, that doesn't mean one is behaving in the best way one possibly could. The therapist's job is to open up options—different ways of seeing and behaving—that will allow the situation to work better. This is a major advantage. If it is only the "patient" who can change, the other family members have to sit around waiting for him or her to decide whether or not to do it. But if you have some measure of control, you can start right away by doing something to change the situation. This is a great relief.

Family therapists can help you change by allowing you to talk about your feelings or by suggesting specific changes in behavior that will alter family patterns. For example, if Dad has been sitting on the sidelines not knowing how to help the family, the therapist may plan something specific for Dad and the kids to do.

**CONCLUSION**

When someone in your family has distressing psychiatric symptoms and has to go to the hospital, that is one point in a long process. It started long before the person went to the hospital and the efforts of the family to deal with it will continue long past the hospitalization period. The hospital experience is one small part of the family's experience to-
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THE PATIENT, THE FAMILY, AND THE PSYCHIATRIC
HOSPITAL: TOWARD A NEW MODEL

Most psychiatric patients are brought to hospitals by their families, and
most will return to their families. This valuable Report from the GAP
Committee on the Family describes an approach to the hospitalized
patient that includes the family as an integral part of the treatment and
that has major advantages over the usual individual treatment alone. The
Report views the problems of including the family from the point of view
of the patient, the family, the staff, and the institution — a systems
overview.

The patient and family are first followed through the process of
evaluation and decision-making for or against hospitalization versus
another alternative — partial hospitalization. Then the characteristics of
a family-oriented treatment program are described, followed by a
presentation of the essential aftercare programs that make use of the
patient’s family and other resources. Finally, the Report discusses the
ethical dilemmas surrounding the choice between a family or individual
approach.

Also included in this Report is an unusual Appendix that provides an
actual “consumer” guide describing for the family and patient, as well as
hospital staff, the role of the family in the treatment process.

The realization that the patient may not be the only person who is
“sick” is brought into focus with case examples. The implication is that if
the patient is treated without the inclusion of his or her family and if the
family has no understanding or insight into the patient’s illness and
needs, the therapy will lead not to recovery but to the “revolving-door
syndrome.”

This Report will be of interest to all members of the psychiatric
hospital staff as well as to clinicians who deal with patients on an
outpatient basis. The newer theoretical conceptions and treatment
approaches presented in this Report show how the patient, the family,
and the professional can join together to alleviate the effects of mental
illness and lower rehospitalization rates of discharged patients.