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Social support: The experience of social support by acute-care psychiatric in-patients

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SOCIAL SUPPORT:

THE EXPERIENCE OF SOCIAL SUPPORT BY ACUTE-CARE PSYCHIATRIC IN-PATIENTS

BY

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Bachelor of Arts, Psychology
University of Waterloo, 1991

THESIS

Submitted to the Faculty of Social Work
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for the Master of Social Work degree
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ABSTRACT

This is an exploratory-descriptive study which assesses the social support experienced by acute-care, uncertified psychiatric in-patients. A focus group of in-patients was formed in a provincial psychiatric hospital. The group was co-facilitated by the researcher and a research assistant. The purpose of the focus group was to generate questions which were then used to create a questionnaire about social support. The focus group-generated questionnaire, along with the Norbeck Social Support Questionnaire, was given to 13 other acute-care in-patients at the same hospital. The data were coded and analyzed. By exploring the in-patients' experience of social support, this research project gives preliminary evidence that the respondents perceived that social support is lacking in the hospital. Based on the reported experience of the respondents, recommendations may point to a need for caregivers to have a particular sensitivity to the benefits of ensuring some autonomy for the in-patient. As well, the respondents highlighted issues of shame which they experience in the hospital setting.

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CHAPTER ONE

Introduction

This study explores how acute-care psychiatric in-patients experience social support in the hospital setting. An initial examination of the historical foundation of the institution and the effects of institutionalization created a context for the project. Deinstitutionalization was explored as a movement which has further removed the focus of support from hospital programmes to service development in the community. This study examines in-patient hospital supports and recognizes the isolating effects of stigmatization that a psychiatric in-patient experiences. The premise that social support is vital to one's well-being will be grounded and informed by an elucidation of key concepts of attachment and self psychology theories. Social support is defined as "interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the affirmation or endorsement of another person's behaviors, perceptions, or expressed views; the giving of symbolic or material aid to another" (Kahn, 1979, p. 85).

The idea of offering a hospital setting as an institution for people with mental disorders was first conceived in the early 1800's (Rothman, 1990). The ideas that were discussed promised a reform for the treatment of the insane. No longer would these individuals be kept chained to cell walls in a prison setting, victims of abuse and neglect. Instead, it was hoped that an institution where cure could be had would now be available.

In many of these original asylums, the first individuals who were admitted were often in terrible physical condition. Many died shortly after their arrival. The treatment in the prisons had been so reprehensible that the first group of psychiatric inmates was scarcely alive (Greenland, 1993).

During the first few years, asylum records showed exciting evidence of cures. It appeared as if the idea of a remedial setting in an orderly and regulated environment had been instrumental in the recovery from insanity. Upon closer examination, it was discovered that many of the `cured' had left and then returned to the hospital numerous times, with each departure being recorded as yet another recovery (Rothman, 1990). Questions were raised about the efficacy of the asylum in its ability to offer the promised cure.

Because of the doubts about their efficacy, asylums were having a difficult time securing funds. At the same time, policies were made which forced the asylums to admit a disproportionate amount of subsidized and chronically ill patients (Rothman, 1990). The number of patients increased, the funding decreased, and overcrowding became a widespread problem. Facilities were inadequate and overflowing with patients, most of whom were unable to pay for the service. Whatever kind of curative reform programs had been available, now, due to inadequate funds and/or space, came to an end. Soon the only focus of treatment was the accommodation of patients. An institution that had once promised cure could now only be described as custodial (Ridgway & Zipple, 1990).

In the 1950's, the psychiatric hospital began to be criticized for its uni-dimensional custodial role. Institutionalization, or the results of a prolonged residence in a custodial setting, was seen to be harmful in stifling many of the individual's potentials.

At the same time, some new ideas about insanity gained some prominence. Some of these ideas questioned the very existence of madness (Laing, 1969). This was also the period of significant pharmaceutical advancements. Effective antipsychotic medication made the release of many patients feasible (Baldessarini, 1978). And finally, there was a surge of unionized activity in the mental health services. The government attempted to avoid the costly demands of unions by closing many of the hospitals down. (Webber, 1991).

For all of these reasons, or any combination of them, a movement called deinstitutionalization was begun. Many patients were released into the community, often going to their families (Isaac & Armat, 1990; Ridway & Zipple, 1991). When the family was unable to take on this responsibility, many ex-patients found themselves at the emergency department of the hospital in a state of crisis. What developed was a pattern of increased admissions to the hospitals, following a breakdown in the community (Ridgway & Zipple, 1990).

Statement of the problem

Robert Kahn (1979) has described social support as interpersonal interactions that are supportive in emotional, affirmative, and/or instrumental ways. Emotional support conveys positive feelings from one person to the other. Affirmative support gives the message that the person is accepting the beliefs, behaviors, and opinions of the other person. Instrumental support is the giving of aid, either symbolic or material, from one person to an other. These three aspects of social support will be elaborated upon in this study.

The concept of stigmatization demonstrates how it is that an individual with a psychiatric illness can often be left with inadequate social support. A psychiatric illness is, in our society, a stigma, highlighted by the distressing symptoms which accompany most severe mental illnesses. An obtrusive stigma makes many social situations difficult, due to the discomfort created by the stigma. One solution for the dilemma that this produces is for the stigmatized individual to socially isolate herself[*] (Goffman, 1963). Social supports, so crucial to an individual's well-being, are no longer available to the individual who has made herself inaccessible to meaningful relationships.

Theoretical frame of reference

Much research has been done which links social support to both mental and physical health (see literature review, p.23, for examples). These findings suggest that as human beings we are naturally drawn to each other. I will consider a psychological explanation for this demonstrated need for mutual interaction.

Heinz Kohut has postulated that people serve various psychological functions for each other which are supportive of healthy development of the self. His theory of self psychology focuses on functions that people serve for each other "*throughout their lives*" (Elson, 1986, p. 5). These functions allow for mirroring and modeling, idealizing, affirming, and partnering (Basch, 1984). Although these functions, called selfobject functions, are initially served by parental figures, they continue to be served throughout life by other individuals, activities, and pursuits.

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[*] The use of this pronoun is related to ease of reference and in no way is indicative of beliefs about the gender of psychiatric patients.

Successfully-served functions lead to a cohesive, directed `psychological state', which Kohut referred to as the `self'. The cohesion that these functions facilitate are particularly important for the developing individual. However, fragmentation (or loss of cohesion) can occur at any time in a person's life, and will greatly hamper an individual's ability to move towards her goals and desires (Kohut, 1977).

The social support which Robert Kahn has described, with its notions of material aid, emotional support, and affirmation, in many ways embodies the functions which people require from others in Kohut's theory. Kohut's theory will provide an explanation as to why it is that social support, as an interpersonal interaction, is so necessary for mental and psychological health. With such a theoretical assumption, one can appreciate the potential healing and rehabilitation that can be correlated to the social support system in the hospital.

Implications and contributions of the study

This research study focused on the ways in which acute-care psychiatric in-patients perceive social support. By looking at the question of the nature of social supports that in-patients experience, at least two things are accomplished. First, there is the acknowledgement that the treatment offered by hospitals is still being used and is still in demand. With the current emphasis on deinstitutionalization, many of the mental health dollars are going to community services, and many of the community mental health services have decreased their involvement with the in-patients (Isaac & Armat, 1990; Webber, 1991). Because more dollars are going to the community, and fewer to the hospitals, services in the hospitals are limited and shrinking. In-patients are being neglected and forgotten. This study acknowledges the psychiatric in-patient, with her very essential needs for interpersonal social support and caring attention.

Second, this study offers an opportunity to take a critical look at the operational structure of the psychiatric institution, and to note the effects of this structure on both its patients and staff. By acknowledging the ways in which the structure meets and ignores various needs for supports, a consideration of necessary changes and alternatives is possible.

The purpose of this study thus is to learn from psychiatric patients their own definition of support. The definition will incorporate various aspects of support which are essential to the patient. The study will explore the ways in which the hospital is or is not providing this support. With the contributions of the patients, a consideration will be made about how and if the hospital is perceived to be sufficiently supportive, and whether an alternative to the psychiatric institution would serve as an adjunct and/or modification in the treatment of the chronic psychiatric patient.

CHAPTER TWO

Literature Review

Introduction

The purpose of this study is to examine the social support that is perceived by acute-care psychiatric in-patients. Historically, social support has been considered as it pertained to the deinstitutionalized individual. This study focuses on the institutionalized individual, thereby asserting that social support has relevance within the hospital setting.

Both the hospitalization and the psychiatric diagnosis constitute a stigma which the in-patient must bear. Isolation and depleted social support are often the consequences of stigmatization. The premise of this study is that social support is important for in-patients, and the reasons for this are considered in the exploration of the theories of attachment and self-psychology. As noted previously, Kahn has described social support as "interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the affirmation or endorsement of another person's behaviors, perceptions, or expressed views; the giving of symbolic or material aid to another" (Kahn, 1979, p. 85).

Institutionalization

The idea of providing an institution for the individual who has been diagnosed with a psychiatric illness has very much to do with the conception of the prison. Both the prison and the psychiatric hospital are defined by Erving Goffman as total institutions. In his book, Asylums (1961), Goffman discusses the concept of the total institution. He points out that in our society, people tend to do their sleeping, playing, and working in different places, with different co-participants. In a total institution, however, these things are done in the same place, with the same co-participants. A person's every need can be met only within very rigid boundaries. The total institution effectively forms a barrier between the community and the institution's inhabitants. Many of the characteristics of the total institution inhibit individuality, growth, and certain support systems.

To more fully understand the concept of institutionalization as it effects the in-patient, I would like to explore the history of both the asylum and the prison, whose beginnings are very much linked to one another. This historical analysis begins with a consideration of the public execution.

The public execution which had once drawn a large and satisfied crowd, was, following the Age of Enlightenment, now evoking disgust, anger, and disorderly conduct in its spectators. Torture and public killings were no longer acceptable, and alternate forms of punishment had to be considered. The prison was conceived, a punishment which would protect the society from criminals, and would offer more tasteful and humane treatment to those being punished. Forced confinement/separation was believed to serve as an appropriate deterrent of crime. In The Discovery of the Asylum, David Rothman (1990) describes the prison as a concept which preserved the practise of punishment. "The prison rescued punishment, replacing a whole series of penalties that had lost usefulness and legitimacy" (p. xviii).

The asylum became another institution which separated its inhabitants from the larger society. Its conception was also a response to the growing repugnance to the then-traditional methods of treating the insane. Before the changed public attitude, King George III had been treated in his madness by having his body "immediately encased in a machine which left no liberty of motion. He was sometimes chained to a stake. He was frequently beaten and starved, and at best he was kept in subjection by menacing and violent language" (Rothman, 1990. p. xxii). If nobility was given this treatment, it is not difficult to imagine the atrocities individuals with less prestige were subjected to.

It was common to attempt to beat the craziness out of a person. When this type of behavior was no longer acceptable to the public, as with the punishment of the unlawful, alternatives had to be explored.

The institution of the asylum offered protection both to the society and to the insane. The desire to protect the currently insane, and to prevent further spread of mental illness became very strong throughout America during the 1830's. Rates of insanity had been rising significantly, and there was alarm about what was appearing to be an epidemic. What many came to believe was that progress and civilization were creating a breakdown in the social order, and that this was what was at the root of madness. One leading medical superintendent announced that mental disorder was a "part of the price we pay for civilization" (Rothman, 1990, p. 112). If indeed it was the way in which society was organized that was the problem, then the solution would be to provide an environment which would not have these contaminants. As it was not feasible to change a mentally ill person's environment through the dramatic modification of the larger society, then an ordered and controlled environment would be created that was separate from the troubling society. The proponents of this reformatory thinking promised not only humane treatment but also the cure of insanity. Incidentally, the prisons were also affected by these ideas, and the reform of criminals to law-abiding citizens became a new focus in the incarceration process.

By 1870, it was clear that the reformist ideals were not being met. Yet, both the asylum and the prison remained central to public policy, and continued to grow, along with their populations. "Once again an institution survived long after its original promise had dissolved" (Rothman, 1990, p. 265).

As overcrowding became a predominant feature of the asylums, their custodial elements were enhanced. Different forms of therapy were discarded, classification systems became inoperable, and mechanical restraints and severe punishments became a popular means of maintaining order.

At this time, inflation discouraged legislatures from funding the improvement and expansion of facilities. Growing numbers of admissions filled every available space in the existing asylums, leaving little room to carry out any of the reform programs. The funds appropriated to the asylums for the care of their pauper patients failed to keep up with the inflating costs, so that superintendents were forced to cut back on other expenses that could have supported the reform programs.

Most importantly, the belief system that had created the asylum encouraged a more custodial approach in the institutions. Much emphasis had been placed on the structure of the asylum, both its architectural structure, as well as the ordered, authoritarian atmosphere that was meant to offer hospice from the chaotic and disordered larger society. In the attempts to impress such a large number of patients with the importance of traits such as obedience, respect for authority, and punctuality, humane treatment was often sacrificed. The atmosphere became repressive and harsh in the attempt to maintain the order that had originally been found lacking outside of the asylum.

Rothman (1990) goes on to describe a process which left most asylums with a disproportionate number of poor, immigrant, and chronic patients. He suggests that with such a composition, defense of a curative rather that custodial approach became even more difficult. Instead, many superintendents began to justify the custodial approach, arguing that the only humane manner of treating the insane was to provide them with as comfortable an environment as possible. Comfort had replaced cure. Questions ware asked which supported the custodial approach to incarceration: "...were the insane not somewhat more comfortable in a custodial hospital than in a filthy cellar, prisoners better off in a crowded cell than on the gallows or whipping post, and the poor happier eating the miserable fare of the almshouse [another total institution of the time] than starving on the streets?" (Rothman, p. 294).

As convincing as these arguments may be, it is important to question the doctrines which created institutions such as the asylum. Doctrines based on principles of obedience, authority, and punctuality are susceptible to abuse. Goffman (1961) describes the institution as a place in which inhabitants will suffer the most profound loss of all - the loss of self. This loss is experienced through adherence to bureaucratic principles - obedience, regularity, and respect for authority.

There are many ways in which the self is stripped away in an institutional setting. Upon admission, the individual is separated from the outside world. This "marks the first curtailment of self. In civil life, the sequential scheduling of the individual's roles, both in the life cycle and in the repeated daily round, ensures that no one role he plays will block his performance and ties in another. In total institutions, in contrast, membership automatically disrupts role scheduling, since the inmate's separation from the wider world lasts around the clock and may continue for years" (Goffman, p. 14). Contact with the outside world is limited according to policies about visitors and visiting hours. Many of the roles that were had in society may be lost forever due to the hospitalization, as in the case of the person who loses her opportunity for job advancement.

Once admitted, the patient will experience another loss due to the process of diagnosis, which will become a predominant and new form of identification. More familiar identifying traits will lose their relevance in the hospital setting. The patient will also become aware of the expectations of others in terms of her behavior. These expectations have little to do with the individual; they have everything to do with an ordered operation of the institution.

Many personal possessions must be relinquished upon admittance to the psychiatric hospital. This is "important because persons invest self feelings in their possessions" (Goffman, p. 18). When the institution is unable to provide a means of securing a patient's remaining possessions, property dispossession is reinforced.

It is common for a person to be stripped of her usual appearance, or the means of maintaining her usual appearance. Toiletry (described by Goffman as one's "identity kit" [p. 21]) is often confiscated, with a limited supply kept in locked storage, accessible only through staff who need to be located and available.

In the outside world, an individual is able to protect the personal space of the body, thoughts, actions, and some possessions from anything that might be considered contaminatory. In the institution, the individual is unable to protect her personal space - "objects of self-feeling" (Goffman, p. 23) - from an environment that invades and may contaminate.

The invasion continues as the patient is expected to share a vast amount of self-knowledge, during the admission process, and then continuing on through much of the contact with hospital staff. Self-exposure is continuous, and the experience of being alone and private is seldom enjoyed.

Goffman (1961, p. 37) spends some time discussing a less direct assault upon the self of the psychiatric patient; a disruption in the connection between the actor and her actions. He describes this as a "looping-back". In the larger world, an individual's actions are relevant to a limited number of situations, segregated according to the actor's wants. An action that occurred in the work sphere may never surface in the home sphere. In the total institution, however, different situations are desegregated, so that the way a patient acts in one place will be shared with all staff and made relevant in all of the places the patient goes in the hospital. Outside contacts may even become a part of this information-sharing. In other words, the action or roles taken in one situation will be looped back to the patient in all situations, and the patient is in a position where she is not able to segregate her life spheres.

The control and regularity of the institutional setting impedes all self-expression. Where it might otherwise be desirable and reasonable to postpone dinner by a few minutes, in the institution this will never be so. In this way, the patient is also robbed of any sense of command over her world.

In exploring the various ways in which institutional life is assaultive to the self, one must once again look to the history of asylums. Already in the late 1800's, overcrowding and lack of funds were grave concerns. Institutionalization will be a negative experience when the daily treatment of large numbers of people in inadequate facilities with limited resources is attempted.

For many, institutionalization is experienced as personal failure and as `dead time'. The assaults upon the self are continuously giving the message that the individual has failed or "fallen from grace" (Goffman, 1961, p. 7). The stigma of having a psychiatric diagnosis, as well as the roles one has had to relinquish to the outside world, place the individual in a very low-status position. `Dead time' refers to the sense of time lost or taken out from life while in the institution. "The inmate tends to feel that for the duration of his required stay...he has been totally exiled from living" (Goffman, 1961, p. 68). Goffman contends that it is not the harshness of the institutional environment which accounts for this sense of not-living, but that instead it is the state of social-disconnectedness that comes with institutionalization. By forming a barrier between the in-patient and the outside community, the individual is also being cut off from her social supports. If there are no inclusive social supports available, the loss of self that can occur within the institution will be neither avoided nor recognized. It is reasonable to suggest that health and development could then also become obsolete aspirations.

Deinstitutionalization

In the 1950's, deinstitutionalization, as a movement, spread throughout North America (Ridgway & Zipple, 1990). Its goal was to remove large numbers of people from psychiatric hospitals and place them in the community, to be supported there so that they could live independently. However, an individual may likely not be prepared for life in the community after spending a lengthy period of time in total institution, considering the debilitating affects of institutionalization. Institutionalization has been described as a syndrome "characterized by a loss of functional capacity, deviant behavior and values, and a mechanized existence" (Ridgway & Zipple, 1990, p. 12). However, it seems that the alternative, deinstitutionalization, has not brought improvement to the psychiatric patient's situation. The implementation of this movement has failed to take into account the profundity of the adjustment from the total institution to a precarious and uncertain community.

Deinstitutionalization is described as a solution to the problem of life in the total institution, providing individuals with a "least restrictive environment" (Bachrach, 1980). It has also been described as the government's response to the increasing unionization of mental health workers. Rather that deal with rising demands and costs, the government chose instead to close the institutions (Webber, 1991). Another explanation of the deinstitutionalization movement is related to the pharmaceutical developments which were occurring at the time (Isaac & Armat, 1990). With treatments of the newly-introduced antipsychotic phenothiazines, it was believed that in-hospital treatment was no longer appropriate for many patients (Baldessarini, 1978).

Although no consensus has been reached about the cause of deinstitutionalization, there is little disagreement about the multitude of problems that have been the result of this movement. Erickson (1991) argues for the necessity of psychiatric hospitals because of the community's inability to meet a mentally ill individual's basic needs, such as food and shelter. Hoffman & Koran (1984), as well as

Maricle, Hoffman Bloom, Faulkner, & Keepers (1987), have found high rates of medical illness due to inadequate medical services for individuals with psychiatric illnesses. Test & Berlin (1981) also discuss the inadequate basic health services for this population. While Blanch, Carling, & Ridway (1988) describe community-based treatment centres that are beginning to be developed, Deegan (1988) discusses how the supportive services available in the community make themselves inaccessible to many individuals by way of rigid guidelines. In 1989, clinicians from the Johns Hopkins University Medicine School conducted a study on homelessness in Baltimore and found that 42% of the men and 48.7% of the women had a major mental illness (Isaac & Armat, 1990). This dismal picture is found in Canadian cities as well, where up to 40% of Canada's homeless are made up of ex-psychiatric patients (Webber, 1991). It is clear that much consideration has been, and continues to be given to the support that is still needed for the deinstitutionalized individual.

When many people leave the hospital, "community" really means "family" for them. When the care-giving family members die, or the family breaks down, or is no longer able to provide the necessary care, many individuals find themselves in a condition of homelessness. Earlier-cited findings (Erikson, 1991; Hoffman & Koran, 1984) demonstrate that homelessness is usually accompanied by poor health, poverty, and discrimination.

There have been programs developed throughout North America whose specific goals have been to combat the unfortunate results of deinstitutionalization. Isaac & Armat (1990) describe several such programs in the United States in Madness in the Streets (pp. 290-295). Many of these services were able to see clearly that the problem with deinstitutionalization was that psychiatric patients were being released into a hostile community which did not offer the support that was needed. Some have blamed this on the "myth of madness" (Isaac & Armat, 1990). R.D. Laing (1969) captures the essence of this concept when he argues that the person who has been labelled with a mental illness is actually just trying to cope in an insane world. In his book, The Politics of Experience, he writes that "the experience and behavior that gets labeled schizophrenic is *a special strategy that a person invents in order to live in an unlivable situation*" (1967, p. 114). Many labelling sociologists (i.e. Becker, H., 1963; Erikson, K., 1984; Sheff, T., 1966; & Lenert, E., 1951) contend that it is the individual's environment that labels and therein shapes their behavior. In a psychiatric hospital, according to the labelling theorist, a patient's behavior is perceived as psychotic, because of his diagnosis, and the subsequent expectations of those around him (Isaac & Armat, 1990). The "madness myth", then, was the contention that mental illness is a matter of societal values and labelling, as well as environmental conditions which encouraged coping behaviors that were experienced by society as deviant. It is unfortunate that so many people were impressed with the ideas about the nonexistence of mental illness, because when the public begins to believe that madness does not really exist, it becomes exceedingly difficult to justify the financial support of either psychiatric institutions or community mental health programs.

Since deinstitutionalization reached its zenith in the 1970's, community mental health organizations have shifted their focus towards individuals in the community, resulting in a marked drop in the attention given to hospital patients. As more financial support is being given to community mental health endeavors, the hospitals are facing cutbacks which have forced a decrease in services and supports available to patients (Isaac & Armat, 1990).

Stigmatization

Kahn (1979) has described social support as those social interactions which involve one or more of three components; material aid, affirmation, and emotional support. It is through this social support that a person's power, abilities, and right to exist may be confirmed. In considering the importance of social support, it is helpful to explore the types of things that separate individuals from each other, and that can create a barrier to the receipt of social support. I would like to discuss how the concept of stigma has particular relevance in this exploration. Erving Goffman has carried out an analysis of stigma in his book, _Stigma: Notes on the Management of Spoiled Identity_ (1963). He contends that the stigmatized individual and the normal individual (a person without a stigma) are dependent upon each other, as they are defined by one another. A stigma is defined against normality, as normality is defined against stigma. Rather than having a comfortable relationship based on this mutual dependence, much discomfort is experienced by both normals and stigmatized. Goffman argues that it is the normal's discomfort with the stigma that creates the problematic and shakey relationship between the two. Often, the recommended and desired behavior of the stigmatized individual has the protection of the normal as its goal. In other words, the stigmatized individual will be encouraged to behave in ways which will decrease the level of discomfort for the normal individual. The individual who adheres to this desired behavior is accepted as a mature and well-adjusted individual. Goffman writes:

> "Since the good-adjustment line is presented by those who take the standpoint of the wider

> society, one should ask what the following of it by the stigmatized means to normals. It means that the unfairness and pain of having to carry a stigma will never be presented to them; it means that normals will not have to admit to themselves how limited their tactfulness and tolerance is; and it means that normals can remain relatively uncontaminated by intimate contact with the stigmatized, relatively unthreatened in their reality beliefs" (1963, p. 121).

Many of the difficulties with having a stigma are derived from this discomfort on the part of the normal. One solution that is adopted by the stigmatized person is to alienate oneself from society. Goffman acknowledges that this is indeed a costly solution. One can question the identity of the individual who has chosen this tactic: the normal or the stigmatized? With such a solution, normals will not have to deal with an obtrusive stigma.

Psychiatric illness is a good example of an obtrusive stigma, in that many of the positive and negative symptoms are evident, and interfere with normal processes. (i.e. normal conversation is impeded by flat affect, delusional contributions, or actions that are unpredictable and difficult to understand). By socially isolating herself, the individual is unable to access valuable social services (i.e. social assistance, housing agencies, advocates, and medical attention). Such isolation, as a solution to the discomfort created by stigma, results in many different types of social injustice - poverty, homelessness, starvation, discrimination, and declining, unattended physical and mental health.

Social support

In the past two decades, many researchers have recognized that social support is critically important to an individual's mental and physical health. (for example, Auerbach & Killman, 1977; Billings & Moos, 1985; George, Blazer, Hughes, & Fowler, 1989; Conte & Plutchik, 1986; Delaney, Seidman, & Willis, 1978; and Luke, Norton, & Denbigh, 1981; Sarason, Sarason, & Pierce, 1990). Although social support has received more than twenty years of attention, there continues to be little agreement about its conceptualization and definition (Winemiller, Mitchell, Sutliff, & Cline, 1993). Winemiller et al. (1993) conducted a comprehensive review of two hundred and sixty two empirically-based articles about social support which had been published between 1980 and 1987. What they found was a lack of conceptual uniformity, and much disagreement about the particular category of social support that is being measured. In support of these findings, I discovered in my own literature review that a definition of social support was rarely offered, even though the focus of the research was on the impact of social support.

Despite the many problems about its conceptual definition, social support continues to be linked to improved health, both mental and physical. I will proceed with the emphasis in current literature on the beneficial impact social support has on mental health.

In their research on bulimia, Grissett & Norvell (1992) explored the ways in which an impaired relationship between individuals with bulimia and their environment factored into the onset and perpetuation of their disorder. The subjects for their research were twenty one women with bulimia and twenty one women comprising a control group. The two groups of women completed self-report measures which assessed perceived social support, the quality of their relationships, social skills, and psychopathology. The group of women with bulimia reported less perceived support from friends and family, higher levels of negative interactions and interpersonal conflict, and fewer social skills. When the overall psychopathology was controlled, the differences between the two groups was still significant in terms of negative interactions and level of conflict. The researchers also had observers rate the two groups for their social effectiveness. The group of women with bulimia were rated as less socially effective than the control group. In this study, social support appears to be conceived as a dependent variable, measuring the *perceptions* as well as the behaviors of the individual. The supports were friends and family;

significant others who offered support via their interpersonal interactions with the subjects.

Cauce, Hannan, & Sargeant (1992) looked at the stress-buffering effects of social support during the difficult stage of adolescence. With a sample of one hundred and twenty individuals in their early adolescence, they examined the relationships between negative events, locus of control, social support, and psychological adjustment. The primary points of interest were the potential stress-buffering effects of social support and the combined effects of social support and locus of control on adjustment after a negative event. Family support was positively related to successful adjustment in several domains of the subjects' lives, and peer support was positively related to peer competence and anxiety, and negatively related to school competence. School support was only related to school competence. Although the researchers did not offer a definition of social support, their findings suggest that social support is of an interpersonal nature, and the more significant the supportive other, the more substantial is their impact on the individual. Thus, the family support and then the peer support had more far-reaching effects than did the school support.

Winstead, Derlega, Lewis, Sanchez-Huches, and Clarke (1992) conducted an experiment which also explored the significance of the support person in terms of the impact of their support. Subjects were required to participate in a stress-inducing activity. Before each activity, some of the subjects were supported by friends, while some were supported by strangers. The results indicated that the subjects perceived more social support after they had interacted with a friend. They also showed a lesser degree of depression and presented with more confidence during the stress-inducing activity than the subjects who had received support from a stranger.

Baker, Jodrey, and Intagliati (1992) assessed two aspects of social support, availability and adequacy, for seven hundred and twenty nine severely mentally ill adults in seven state-supported community support services. They used repeated questionnaire surveys which were completed nine months apart. Perceived quality of life interviews were also conducted with the subjects at both times. The interviews included the Bradburn Positive and Negative Affect Scales and the Satisfaction With Life Domains Scale. The availability of social support was found to be correlated to positive affect over time, and was unrelated to negative affect at either interview time. Inadequacy of social support was found to be significantly related to negative affect at both interview times. Availability and adequacy of social support was significantly related to the satisfaction with life domains. A change in the satisfaction with life domains was related to the availability and, to a lesser degree, to the adequacy of the social support. In this research, the assessment of social support was made by measuring the perceptions of the subjects. There was no mention made of the nature of the supports.

Hart and Hittner (1991) examined the relationship between irrational beliefs, perceived availability of social support, and anxiety. With an assumption that individual differences can influence aspects of the social environment, they hypothesized that a) individuals with high levels of irrational beliefs would assess their interpersonal environment as less supportive than would individuals with lower levels of irrational beliefs, b) that the irrational beliefs would be positively related to anxiety, c) that perceived social support would be negatively related to anxiety, and d) that deficits in social support for individuals with a higher level of irrational beliefs may acount for their higher levels of anxiety. Questionnaire data were obtained from a group of 39 college students. The instruments that were used were the Assessment of Irrational Beliefs, the Survey of Personal Beliefs, the Trait Anxiety Scale, and the Interpersonal Support Evaluation List. The findings supported the authors' four hypotheses. They use these findings to discuss a different way of conceptualizing social support. "The social support construct typically is viewed as an independent variable that resides in the social environment and directly or indirectly impacts the mental health of individuals in an antecedent-consequent linear causal manner" (1991, p.582). The authors discuss, and gear their research towards a "conceptual shift toward viewing social support as a dependent variable in that it suggests an important avenue for investigation in the study of individual difference factors that might influence the level of support available to individuals" (1991, p. 582). The focus is on the consideration of the perception of the individual receiving the support, rather than supportive behavior.

Mallinckrodt (1991) also measured the perceptions of the individual in his research which linked the earlier parent-child bonds to the quality of social support and the individual's ability to form a working alliance with a counsellor in current life. Survey data were collected for one hundred and two client-counsellor dyad relationships at three counselling centres. The author measured for a) client and counsellor third-session working alliance ratings, b) quality of the client's current social relationships, as indicated by social support satisfaction, and c) the client's representations of care (emotional responsiveness, warmth, and attention to the client's needs) and overprotection (intrusive control and resistance at attempts to gain independence) in their memories of childhood emotional bonds with their parental figures. The findings of this research suggest that the ability of the individual to form meaningful supportive relationships and to participate in a therapeutic working alliance is related to the quality of her childhood emotional bonds with parents. Social support is conceptualized as the interpersonal network an individual is able to build for herself, and is found to be related to the early bonds the individual had with parental figures; those first attachments in an individual's life.

Attachment and Self Psychology

What the relationship between health and social support points to is the need that people have for other people. It is the material, emotional, and affirming support received *from other individuals* that can encourage an improved state of health; that serve as preventatives for debilitating states such as depression, crisis, suicidal ideation, and addiction. In other words, an attachment is critical for our mental and physical health.

John Bowlby has spent much of his career studying and describing attachment. He defines attachment in terms of the proximity one individual seeks to maintain with an other (1969). He wrote that all species strive for attachment, and that attachment behavior actually supports the survival of the species (1980). The attachment figure, frequently the mother, provides food, protection, and comfort to the infant. Bowlby's theory was conceived partially as a result of H.F. Harlow's work. Harlow (1960) conducted studies which examined the attachment behavior of rhesus monkeys. In this study, infant monkeys in captivity had been separated from their mothers. Cloth and wire objects had been placed inside their cages, and the monkeys were soon clinging to these. In another experiment, the need to cling to and form an attachment with a cloth model was even more urgent than the need to form an attachment with the wire model which provided food.

Another influence for Bowlby was Mary Ainsworth. Ainsworth began her exploration of attachment behavior after observing the failure to thrive in children who had been separated from their parents, and were without adequate attachment figures (1969). She, along with Bowlby, went on to study the manner in which infants and children were connecting with others. Bowlby, in his book, A Secure Base (1988), describes his observations of how the mother serves as a base to whom the child will go when feeling anxious. As the child becomes more autonomous, and begins to explore the world around her, she moves further away from the secure base, for lengthier periods of time. However, the child will return again and again to the secure base, as if for a refueling, before venturing out once more. When the attachment figure is unavailable, signs of distress can be observed in the children. This distress is understood as a natural response: the "anxiety which is felt when the attachment figure is not available [is] useful for the survival of the species, and has persisted as part of our biological makeup" (Klein, 1987). According to this postulation, an instinct has evolved which causes the infant to strive to connect with an other: the attachment figure.

Bowlby (1969) and Ainsworth (1969) both have discussed the damaging effects of a mother who is unable to respond to the child's need for attention and comfort. In their observations, despair was a final stage for the child who was unable to evoke an appropriate response from her attachment figure. This despair becomes an approach to the world, and the effects are evident even in adult life, where the ability to become involved in healthy relationships is severely impaired (Bowlby, 1988). Individuals experiencing social isolatation may develop aspects of this despair, as their lives become void of so many important personal and instrumental relationships.

As the infant develops into an autonomous and independent child, attachment begins to serve a purpose that goes beyond the survival of the species. In his lecture, "Making and Breaking of Affectional Bonds", Bowlby (1979) postulates that the need for protection is not just an infantile need. It is something that we strive for throughout our lives. To be dependent, argues Bowlby, is not equivalent to the need for protection. For infants, proximity provides security and protection. Bowlby differentiates between the dependence of the infant and the adult's desire for proximity: "Dependence is not specifically related to the maintenance of proximity, directed to a specific individual, implying a bond, nor associated with strong feeling" (1979, pg. 133). As adults, proximity meets our need for intimacy; proximity tells us that we are not alone. Bowlby enlarged his concept of attachment to "include the propensity of human beings to make strong affectional bonds to particular others, and he explained love relations, separation anxiety, depression, and mourning as derivatives of attachment and loss" (Combrinck-Graham & Kerns, 1989, p. 79). Bowlby is very clear in stating that the need for proximity described in his attachment theory is a need which persists throughout adulthood (1979).

By claiming a relevance to the attachments that are made in adult life, Bowlby's theory is similar to Heinz Kohut's theory of self-psychology. Both views postulate that what is present at the beginning of life continues on throughout life. Bowlby's concept of the attachment figure shares some similarities to Kohut's concept of the selfobject. While Bowlby has discussed the importance of the attachment figure's ability to be responsive to the needs of the child (1988), Kohut (1977) has postulated that the concept of self is developed according to the other's (selfobject's) ability to empathically respond to the attention needs of the infant (and indeed, the child, adolescent, young adult, and adult). Kohut writes that "when, within the matrix of mutual empathy between the infant and its selfobject, the baby's innate potentialities and the selfobject's expectations converge, it is permissible to consider this juncture the point of origin of the infant's primal rudimentary self" (1977, pg. 83). As empathetic functions of mirroring, idealizing, and partnering continue to be served by others, ego functions can develop which will allow for a sense of self that is both stable and resilient.

Kahn (1979) also describes support in terms of the functions that others serve for the individual. These functions are categorized as affirmative, emotional, and instrumental. Although these functions are not identical to those described by Kohut (1977), they embody the impact of successfully-served functions on the individual. Kohut's mirroring functions affirm the unique identity and worthiness of the individual, as does Kahn's affirmative component of support. Kohut's idealizing goals allow the idividual to merge and find rest with the ever-providing, omnipotent other. Kahn's instrumental component of support also alludes to the other as the provider of essential needs. With Kohut's partnering function, a comradery and mutual regard are established. Kahn is able to partially capture this aspect of selfobject functioning with his emotional component of support, where positive feelings are conveyed from one to an other.

In his discussion of social support, Kahn (1979) describes the supportive other as a `convoy', the vehicle through which social support is provided. "An individual's convoy at any point in time consists of the set of persons on whom he or she relies for support...." (1979, p. 84). Without this supportive other, much research (see literature review, pp. 27-33) suggests that good and/or improved mental health may not be enjoyed.

Kohut (1977) also discusses the consequences of an unresponsive other. He contends that when the other is unable to be responsive and confirming for the young child, the sense of self will be incomplete and fragmented. It is only through a sense of integration of the self that healthy development can occur and fulfilling relationships become possible. For the sake of her identity, the child needs to be attached to others who are responsive and available. By being available, the other is confirming her abilities, her power, and her right to exist.

CHAPTER THREE

Methodology

Design

In its examination of support as it is experienced by acute-care psychiatric in-patients, the study adopted an exploratory-descriptive approach as described by Neumann (1991). It is exploratory in that it is an attempt to gain an increased familiarity and a more thorough understanding of social support as it relates to psychiatric hospitalization. With a better understanding, new ideas and questions can be generated. One goal of this project is to formulate questions and directions for future research.

The project is characterized as descriptive in that it is taking a closer look at a concept that has already received much attention and has already produced many research studies. By examining social support as it occurs in the hospital, there is an attempt to refine the explanations that are already available, and to draw a more inclusive picture of social support and its relationship to psychiatric hospitalization and treatment.

Due to the complexity of the issues that were encountered in the study question, the method chosen for the research was influenced by the triangulation approach. "This term is borrowed from navigational language and refers to the necessity of plotting one's course from at least two points on the compass. In the case of research, triangulation highlights the need to examine a particular problem from a number of perspectives" (Boydell & Everett, 1992). By using both quantitative and qualitative methodologies, this study was able to attain a broader understanding of its focus by gathering two sets of results from different `points of the compass' which were complementary to each other. As well as gathering results which enrich other findings, consistencies and similarities are found through the use of triangulation.

Sampling

The sampling frame was from the hospital records of a provincial psychiatric hospital. Forty-two subjects were drawn from a number of units throughout the hospital whose stays averaged one to three months. With this length of stay, the individual will have had an opportunity to become familiar with and acclimatized to the hospital culture. This length of stay is also short enough to allow for the gathering of recent retrospective information. In an attempt to avoid involving individuals who could be classified as chronic patients, previous admissions had to be no less than six months prior to the current admission. This allowed for retrospective discussion about a life that had been established in the community, prior to the hospital admission.

The sampling method was purposive; the aim of the research was to identify a particular case (acute-care psychiatric in-patient) for further exploration (Neuman, 1991). The goal of purposive sampling has more to do with gaining a more thorough understanding than with finding a sample which will be representative of the larger population. Cases were chosen with the purpose of the research in mind.

There were two distinct but related groups chosen for participation in the research. One group of four was chosen to participate in the focus group. The choice was based on the person's willingness to be a part of a group discussion, as well as the four patients' proximity to one another. Some of the patients had limited privileges, and it would not have been possible for them to meet at another location in the hospital. The only way to deal with this obstacle was to meet in one unit, which was made up of four wards. Group members were drawn from three of these wards.

A second group of thirteen comprised the study sample of the main research. Purposive sampling methods were once again utilized. Both qualitative and quantitative measurement tools were administered to determine the degree of perceived social support for patients within the hospital setting.

Of the original forty-two subjects, twelve were discharged from the hospital before they were able to participate in the study. Eight subjects declined to participate. Several of these were being discharged shortly, and stated this as the reason for their non-participation. Two were not feeling well enough to be interviewed. Three others became suspicious when they were requested to permit the use of a tape recorder, and to sign consent forms. Five subjects were not available in the several attempts to meet. This is to be expected in an open ward, where some patients have privileges which allow them to come and go. It was not possible to find a time when they would be available and on the ward.

Focus groups

Ideally, there would have been five members in each focus group. The researcher attempted to form three groups. However, it was the availability of the participants that determined the actual composition of the groups. It was possible only to form one four-member group. This group was made up of men.

The group was facilitated by the researcher and an assistant. A co-facilitator can benefit the group in several ways. Objectivity is more easily accomplished when there is a second facilitator (Wickham, 1993). In terms of generating a questionnaire that is truly representative of the discussion that has occurred, objectivity was crucial when listening and responding to what was said. Co-facilitating can also accommodate the limits or guides that have been set up for the group (Wickham, 1993). The group adhered to a guide that focused on social support, and it was important to stay within the boundaries of this guide, rather than lose control of the group interview. I. Yalom (1985) has observed that co-facilitators "complement and support one another. Together, their cognitive and observational range is greater: their two points of view generate more hunches and more strategies" (pg. 418).

Focus groups have been developed as an alternative way of conducting research to avoid the acquiescence and social-desirability bias which have both distorted past research findings (Lebow, 1982). Focus groups are also an effective way of measuring the patients' concept of support as opposed to that of the service-giver (Elbeck & Fecteau, 1990).

Focus group results

The group met on two occasions. The first meeting resulted in a two-hour discussion about support. The discussion was guided, with great flexibility, by a list of questions (see Appendix B). During this discussion, eight general themes surfaced:

1) *Basic instrumental support.* The group began by identifying some important instrumental supports.

Cigarettes, coffee, and soda were considered to be as essential as food, shelter, and medical care. The availability of these basic supports was experienced as confirmation of the person's right to exist.

2) *Reliability* was discussed in terms of the awareness that the support person would always "be there for you". The support received from others was measured according to what was offered, and also by how readily that person would be able to provide the support. It was not helpful to have needs for support from a person who was unable to provide for these needs in a timely fashion. Through her accessibility, the support is able to give the individual a sense of control in attaining the support that is needed.

3) *Being listened to* was considered to be an important support. It was important to both have and to offer attention for the things a person had to say. "When you are a patient, you get to hear more than the nurses know about people." It was important for the members to be able to do this for their co-patients. It was insulting when a person did not listen; this was interpreted as, "You don't know anything that I don't already know". When a person did not listen to the individual, the person was treating that individual in a derogatory fashion, giving her an inferior and humble status.

4) It was crucial for the group members to be able to *give support to others*. Listening to other patients was one way that they were able to be supportive. To have the means to buy something for another person, even a cup of coffee, was significant enough an event to positively impact a person's mood for the day. It was experienced as a gratifying exercise in autonomy to be able to provide for another individual.

5) *Respect* was discussed in regards to how negative an experience it was to be treated with disrespect. One member stated that he was "getting tired of the missiles. They [hospital staff] say `shut up' and `come back later'", and he felt angry and hurt by this. To be given respect was to be acknowledged as a fellow human being, deserving of courteous and humane treatment. To be treated with disrespect was to be labelled as substandard, a position of shame and self-loathing.

6) *Self-support* was discussed. Money was considered to be very important because of the self-reliance it represented. "Money is like a symbol. You need it. You need it to go out. You need it for a destination. You need it for a direction." The hospital was described as a place where "nothing can be done....it's a waste of time. You can't do work here, you can't make money." With money, the group

members had a greater sense of control over their very destinies.

7) *Affirmation* was discussed in terms of the acceptance that group members got from other people. One member spoke about the affirmation he received from friends: "My friends understand my way of thinking. They know about me-who I am." To have one's needs for change, development, and activity was described as affirmational support. Activities like therapy group and art class were described as a valuable part of hospital treatment. Some treatment from the hospital staff was considered to be disaffirming. Not being believed by hospital staff was a common complaint, described as a "derogatory" form of treatment. Affirmation served to boost the individual's sense of self-worth, while disaffirming treatment caused the individual to feel shamed and inferior.

8) *Personal space* was discussed extensively. To permit privacy, freedom, and, most importantly, control over that privacy and freedom was identified as critically supportive. Without this control, the members felt that they would suffer from a profound sense of loss or deprivation. The ability to move from one place to another, and also to be able to go somewhere and be alone was something which all members desired.

With special regard for these eight themes, a questionnaire was developed. The focus group met a second time, and considered the items on the questionnaire. Any suggestions were incorporated into the questionnaire.

The group members were requested to comment on their experience of the focus group. They agreed that it had been an enjoyable experience, valued because it offered an opportunity to talk with other patients, and it permitted them to leave their wards. One member expressed regret that the group would not be meeting for further discussion.

Questionnaires

Qualitative

The questionnaire resulting from the focus group's input was the guide for the interviews, and was comprised of forty-three items (see Appendix C). It dealt with the eight themes of support that were raised in the focus group discussion.

There are three approaches to qualitative data collection: the informal conversational interview, the general interview guide approach, and the standardized open-ended interview (Patton, 1980). For the focus groups, the general interview guide was used, as this allowed for a free flow of conversation, limited only by a general guide prepared in order to maintain a focus on social support (see Appendix B). For the face-to-face interviews, a combination of the general interview guide and the standardized open-ended interview were adopted. A questionnaire was prepared based on focus group discussion, and these questions were worded and sequenced in a similar fashion for each respondent. Some flexibility was maintained, and if a concept was introduced by a respondent that was important and not a part of the questionnaire, changes were made to include the concept. The face-to-face interviews were tape recorded.

Although the items on this questionnaire were generated by the focus group discussion, care and attention were given to both the sequencing and the wording of the questions. Based on the suggestions of M.Q. Patton (1980), I began with questions about noncontroversial activities and experiences related to basic support. These questions required straightforward answers that needed a small amount of recall and interpretation. In this way, they were easy to answer. After the respondent was able to answer some of these questions, gaining a sense of confidence and trust, I asked questions that required interpretation, opinions, and feelings about some of the things they had been describing.

Knowledge and skill questions, which could be intimidating for a respondent, were asked along with questions about the experiences that have a bearing on the knowledge and skill. By sharing such an experience, the respondent was able to speak of competencies, and may have felt less intimidated by the knowledge and skill questions.

In considering the tenses of questions asked, I began with questions about the present, then the past, and then, if relevant, about the future. Futuristic questioning requires speculation, and can be intimidating, and could also allow the interviewer to lose control of the interview.

The wording of questions was done with great care. Questions which ask "why", or which require a yes/no response were avoided. "Why" questions are speculative, intimidating, and encourage a drifting from the focus of the interview. On the other hand, dichotomous responses do not encourage discussion, and can also give the respondent a sense of uncertainty, as she tries to guess how much of an answer is required.

Presuppositions were brought into the questionnaire, as they bypass certain steps in the questioning process, and also allow certain things to be said without awkwardness or embarassment. (i.e. Asking a respondent which anti-psychotic medication she is on, rather than whether or not she is taking anti-psychotic medication. The respondent can feel that the activity/opinion/feeling/experience is natural with a presupposition). Neutral questions were asked to encourage trust and rapport. Singular questions, rather than complex, multidimensional ones were used to reduce the respondents' confusion. Clear questioning was attempted, so that the terms and language were understood and congruent with the respondent's world. Throughout the questionnaire, prefatory responses were used to allow the respondent to be aware of shifts of attention and, thus, have the opportunity to gather her thoughts. Supportive and recognition responses were used to allow the respondent to know how the interview was going, and how helpful particular answers and observations had been.

After each interview, I spent a sufficient amount of time listening to the tape recording, reflecting and elaborating where necessary. These reflections were helpful for the data analysis.

In order to ascertain that the questionnaire was indeed measuring social support as defined by the focus group members, I presented it to the group and requested feedback and suggestions about modifications. After making the necessary revisions, I requested feedback from four other people. All of these individuals were professionals, working in community, rehabilitative, and therapeutic services. One of the four consultants was also a consumer-survivor of the psychiatric services, who had spent many years in a psychiatric hospital, and is currently well-established in the community. All of these individuals felt that the questionnaire was adequately dealing with issues related to support; they confirmed the validity of this instrument in its exploration of social support. In their capacity as caregivers, they felt that the issues were pertinent to the services they would attempt to provide as support. The emphasis on both space and the symbolic meanings behind money were noted, as these aspects were not often a consideration in their work. The meaning derived from money, and access to one's own space are often things that are assumed, and will, therefore, commonly go unacknowledged as valuable forms of support. One of the individuals was struck by the questions about others' perception of the respondent. This is the individual who had experienced hospitalization, and, in response to this group of questions, was able to identify the sense of anonymity or invisibility that she had experienced as a patient.

Quantitative

A second questionnaire, the Norbeck Social Support Questionnaire, hereafter referred to as the NSSQ (see Appendix A), was administered in an interview along with the above-mentioned questionnaire. This questionnaire is based upon Kahn's definition of social support as an interaction which includes one or more components of mutual aid, affirmation, and emotional support (1979). Questions are clustered according to: affirmation; affect; aid, short- and long-term; duration of relationship; and frequency of contact. Winemiller et al. (1993) write that the "social support literature...lacks concensus about the particular category of social support that is being examined" (1993, p. 639). When social support is divided into different categories, as it is in the NSSQ, a framework for uniformity is possible within the literature. Thus, there is no total score for social support; the scoring is totalled within each category. If further analysis of the NSSQ results was necessary, the items could be collapsed into the variables Total Functional (affect, affirmation, and aid) and Total Network (number in network, duration of relationships, and frequency of contact). If a subscale analysis was desired, each of the two functional items could be combined into one score for that functional component (Norbeck, Lindsey, & Carriere, 1981). In the NSSQ, the information about the duration, frequency, and number of the contacts was gathered to reflect the size, stability, and availability of the support (Norbeck, Lindsey, & Carrieri, 1981). By studying the structure of the social support network (which includes the consideration of size, stability, and availability), the NSSQ stands apart from most other measurements of social support. This unique trait will "further the development of an empirical basis for understanding social support" (Winemiller et al., 1993, p. 642). The NSSQ measures the perception and utilization of social supports. This is an important component of the questionnaire, because it is an acknowledgement that social support is a function of the individual's perception, and not only of the support that is provided. Thus, decisions about support provision can be made according to individual needs and abilities to access the support.

The NSSQ was designed for clinical research with a health-outcome focus. It was designed to explore the various dimensions of social support in a way that would be straight-forward and uncomplicated for its respondents.

In 1981, the NSSQ was tested on a sample size of 135 nursing students (Norbeck, Lindsey, & Carriere, 1981). Good test-retest reliability (range: .85 to .92) was demonstrated, as well as high internal consistency (.89 or above for each subscale). There was little evidence of social desirability bias.

Validity is limited by the group upon which this instrument was tested. Moderate levels of concurrent validity were found (range = .44 to range = .56). This was determined by administering another social support questionnaire (the Social Support Questionnaire developed by Cohen and Lazarus) concurrently with the NSSQ to forty-two subjects from one of the groups from this study.

More generalizable testing will be required to enhance both the reliability and validity properties of this instrument. However, results that have been collected show promise, and this instrument demonstrates superior reliability and validity when compared to the other instruments measuring social support (Wilkin, Hallam, & Doggett, 1992).

The NSSQ has been criticized for its scoring system (Wilkin, Hallam, & Doggett, 1992). The summed scores are very much a product of the quantity of supports the respondent has in her network rather than the quality of the respondent's support. However, to average the scores would disguise quality in the name of quantity. Norbeck has defended the scoring system by arguing that "a combined score is more valid than an average, because in real life, the quantity and quality of support combine to produce an overall level..." (Wilkin, Hallam, & Doggett, 1992, pg. 128).

The NSSQ is the only measure of social support which includes the measurement of symbolic or material aid (Wilkin, Hallam, & Doggett, 1992). Its conceptual framework is clear, and its administration is simple and takes very little time (approximately fifteen minutes) (Norbeck, Lindsey, & Carriere, 1981).

Data Analysis

Quantitative

The author of the NSSQ has provided instructions for conducting an analysis whereby the results are divided into the categories of affect, affirmation, aid, duration of relationship, frequency of contact, and number of supports in the network. For each of the first eight questions in the NSSQ, the respondent's ratings for each social network member on a given question were summed to determine the score for that question. Because of the small sample size (thirteen), the mean and the standard deviation are calculated for each test score, but are not accepted as critical informants to the research question. The results suggest a direction in which future research with a larger sample size may move. Even with the large sample size, it is important to note that "statistical significance can only tell what is likely. It cannot prove anything with absolute certainty. It states only that particular outcomes are more or less probable" (Neumann, 1991, pg. 315).

The exploration that this research project has undertaken does not attempt to find a particular outcome. Statististical significance becomes less critical, as a hypothesis is not being tested. The reason for including a quantitative component in this project is to offer a second vantage point which may loosely support the results of the qualitative component. The NSSQ is a test which embodies many valuable aspects of social support, and is able to draw out quantitative information which may indicate the depleted nature of the in-patients' support system.

The quantitative results were then used to further explore the adequacy of the subjects' support systems. A Two Independent Samples T-test was conducted between the current study and a study done by Norbeck (1981). In this way, my intention was to ascertain whether the in-patients' perceived support system was significantly depleted compared to another group of respondents.

Qualitative

In analyzing the data collected from the qualitative component of the interview, a three-step coding system was utilized (Neumann, 1991). Initially, there was open-coding, which entailed a general perusal of the data. Divisions into broad concepts and themes were made and then coded. Following this was an axial coding process, whereby each code was closely examined and divided into subcategories. Relationships between the codes, as well as code-relatedness to the research question, was explored during this stage. Finally, selective coding occurred. Data and previous codes were scanned and cases or examples were chosen to illustrate the themes. At this point, it was possible to compare and contrast the codes and illustrations. Neumann (1991) offers an example of the coding system in his description of a researcher's study of a working-class tavern. The researcher openly coded his work when he coded a block of field notes with the theme `marriage'. He axially coded by dividing the general theme of `marriage' into sub-categories such as engagement and weddings. Finally, he selectively coded his field notes by making gender relations a major theme, and then looking for the differences in men's and women's selected discussions about dating, engagements, weddings, etc.

Limits

Some limits to this research study will need to be acknowledged. There is a limit with regard to the generalizability of the research findings. The research was conducted in a provincial psychiatric institution located in Toronto. Toronto is a unique community in terms of the mental health services. It may be that the information gathered from this study will not be applicable to other communities.

Ethical issues present another limit to this research. Although subjects were assured that their treatment was unaffected, responses and participation could still have been impacted by a desire to please, or a fear that treatment and/or privileges would have been witheld.

Finally, ward scheduling presented a concern. On the wards, activities and events are scheduled on a daily basis. The focus groups were difficult to organize because of the scheduling and privileges that were different for each ward and patient. This prevented the participation of some patients, and their valuable contributions were lost.

Because purposive sampling was the choice for sample collection, it cannot be ascertained whether the sample is truly representative of the larger population (Neumann, 1991). There were also patients who were unwilling to participate in the research. Without their involvement, the sample is less likely to be representative.

Ethical Considerations

All of the participants in the study signed a form to indicate that they were willing to be a part of the study (refer to Appendices D and E). At the onset of each interview and group meeting, I verbally clarified the form to the participants to ensure that they have understood it. I also informed them that a synopsis would be made available to any participant who requested this. There were no requests for such a synopsis.

CHAPTER FOUR

Results and Discussion

Quantitative

Results

The NSSQ is a questionnaire which measures the respondent's *perception* of support. I will not attempt to provide explanations for the responses, although I would like to acknowledge that the individual's state of mind may account for the responses to the items on the questionnaire. Rather than using the diagnosis of the respondent to discount her responses, however, I would like to suggest that any considerations about social support adequacy must be made with a focus on the individual. It is when the individual feels that she is supported that the benefits of social support can be enjoyed (see literature review, pp. 27-33).

For each of the eight questions in the NSSQ, each of the thirteen respondents rated the quality of support received from each person in their support network. The ratings were added together for each question, and this sum became the score for that item. Five of the subjects were unable to identify any supports, and therefore scored zero for each item. This, of course, made a substantial impact on the score means (see Table 1).

The small size of the sample takes away from the statistical significance of this quantitative exploration. Therefore, it was necessary to consider some other ways in which the results might be significant. By comparing these results to the results gathered in an earlier, independent study (see Table 1), it was possible to assert a difference that alluded to the depleted nature of the in-patients' support systems. In 1981, the NSSQ was applied to a group of 75 nursing students (Norbeck, 1981). By conducting a Two Independent Samples T-test on the results from this study and the results of the in-patient study, with a probability value of .05, some significant differences were revealed (see Table 2). Each set of mean scores was given a one-tailed test to test whether the 1981 subjects had higher scores than the in-patient group. In all of the test questions, the t_{obs} was significantly lower than the critical value of 1.671. Therefore, the difference in the means was tested and found to be statistically significant. The number of supports and the perceived amount of support in terms of aid, affect, and affirmation is significantly lower for the group of in-patient subjects than for the student subjects. In order for the significance of this difference to be more powerful, the groups being compared should be closer to the same size, and an effort should be made to ascertain the homogeniety of variance for the two groups.

There are some clear limitations to the comparison of the two groups. It is unknown whether a sample of students can be compared to a sample of hospital patients. The subject group of the current study was made up of mostly male, 100% single or divorced psychiatric in-patients of a range of educational and income levels. The subjects in the 1981 study were all female excepting one, with an advanced level of education (an average of 4.4 years of undergraduate studies), and 37% married, none of whom were dealing with a mental illness severe enough to necessitate hospitalization. Their income levels would have been high enough to permit the average 4.4 years of undergraduate university education. Differences in mental health status, marital status, educational and income levels might be an important part of the explanation for the disparity in results between the two groups of subjects' perceptions about their support systems. The direction of the effects is also unknown for the perceptions of the subjects (Are individuals with a psychiatric illness less capable of illiciting support, or do individuals with fewer supports become psychiatrically ill?). An improved version of the T-test would utilize a control group that was better matched in order to be more certain of the homogeniety of variance for the two groups.

Discussion

The results of the quantitative test indicate that the number of supports in the support network and the quality of support received is perceived by the in-patients to be very low. Five of the respondents were unable even to identify one support. The sense of isolation is profound. Many of the respondents were able to identify specific people whose support was significant for them. These supports were often family members. There were friends and community workers identified by some of the respondents. Only two respondents identified hospital staff as part of the support network. One of these individuals was unable to identify specific staff, but put the broad category of "doctors and nurses" in his support network. Only one respondent identified other patients as supports. One respondent identified a pet as an important support. Some of the questions about material aid and emotional support were not applicable for this support network member. One respondent was able to identify nine individuals as valuable support network members. None of the questions could be applied to them, however, as they had ceased to be a part of this individual's life at the onset of his psychiatric illness eleven years ago. One respondent identified himself as an important support.

The depleted state of these support structures is further signified by the comparison to a group of nursing students who completed the NSSQ in 1981. Based on the diminished mood with which the current respondents completed the NSSQ, as well as the information that was shared during the qualitative component of the interviews, there is some indication that the in-patients were aware of the condition of their support structures and desired an improvement. This is exemplified by a statement made by one respondent who was unable to identify any support persons for her network: "I can't write anything down. I think I'm going to have to get some new supports for the future."

Qualitative

Results

The analysis of the qualitative component of the interviews began with an open coding of the information. Two broad categories were identified and termed `autonomy' and `shame'. With the axial coding, subcategories surfaced. Related to autonomy were themes of freedom, privacy, personal space, control of the individual's treatment, as well as of their environment, money, imprisonment, and being believed by others. Related to shame were themes of self-consciousness, self-blame, the inability to accept other patients, the sense of one's ugliness or wickedness, the worthiness of being listened to, and the rights to existence.

In listening to the responses of the participants, I was struck by their unique quality. I am aware that the material that has been gathered has been influenced by the psychiatric illness of each participant. Although I was not informed by hospital staff about the various diagnoses, most of the participants spoke about hallucinations and disordered thinking. This suggested to me that a psychotic illness was the most common diagnosis for the group of respondents.

The hallucinations and disordered thinking had an impact on the responses that were given. The meaning to be had in the answers was not lost, however. In many ways, the metaphors with which I was presented made the meaning even more powerful.

Autonomy

Most respondents would have preferred to have more freedom because it allowed patients to leave the ward when it was too noisy, or when there were other unpleasant distractions. One patient was very grateful that he was able to go outside of the hospitals for walks because "sometimes I don't feel right here, because there is too much noise. People here are crazy more than me". Freedom allowed the patient to practice some independence and to stay connected with the world in which they had lived before hospitalization and was also a way in which a patient could start working towards personal goals. One patient used his freedom to find a place in the hospital where he could meditate, as his personal goal was to reach higher levels of spirituality.

Privacy was in some ways related to freedom. When a patient is first admitted, she is with very few, if any, privileges, and needs to be available for hospital staff to observe her in order to determine appropriate treatment approaches. As the number of privileges are increased, so are the patient's opportunities to enjoy privacy. One patient was admitted to the hospital, and was immediately anxious to have privileges which allowed him to go to places where he could have privacy. He describes the reaction of the staff: "And they were, `Okay, he isn't around enough.' So, I went to my room and did some work, and started talking to the nurses, `Oh yeah, sure, great, whatever.' And as soon as my assessment was over, I took off again". Private moments were important times for the patients to process some of the aspects of their hospitalization; one patient said these moments give "you time to sort of arrange your thoughts".

Personal space was required for these private times, and the respondents felt strongly about having a space that was theirs alone. The anger and hostility was strong when personal space had been invaded. One patient described her feelings when her money had been stolen out of her room: "Well, it makes me feel more than humiliated, it makes me feel God is trying to punish me and to kill me...". Respondents expressed frustration at the limited control they had over securing personal possessions and personal space. One of the patients derived a great deal of comfort from playing his guitar. He had to lock it in a locker, and this would often prevent him from playing it, as it was too much work to find hospital staff to come with the locker key.

The theme of control emerged for all of the respondents. Control over their environments would have made it possible to claim personal space. There was a sense of the external situation being completely out of the control of the respondent, this was acknowledged in various ways. One patient broke the rules that were imposed upon him in order to feel more in control. Another patient left the ward when it seemed to be out of control. Another patient went to his room, where he could shut out the occurrences on the ward. Unfortunately, some of these methods of control were hindered by revoked privileges or locked bedroom doors. Some of the decisions about privileges and flexibility of rules were dependent upon the person who was making the decisions, or the way the decision-maker enjoyed her job. As one patient states, "Some of the nurses are quite...I really don't think that they want to be here. They hate their job, they're quite rude. And then there's some nurses that are really nice that would say, `Sure, yeah, I can save that, if you're not hungry right now'". The result was a further increase of feelings of not being in control for the patient. There was also a feeling that the method of treatment was not within the control of the patient. Medication and diagnosis were believed to be determined by the ward a patient was on, or the doctor the patient was seeing. In terms of his medication, one patient said, "I don't like it when people say I have to take it. Because they took me off it downstairs, and they put me back on it when I came upstairs. And they don't tell me why I'm on it. They just think that I have to be on it". Not one of the patients were even able to say how their doctor would describe them. When asked to speculate on the ways in which their doctor might describe them, many responded with similar statements: "I don't know, you'd have to ask him", and the like. The respondents were not in control of their treatment, nor of the perceptions of the individuals who were giving them their treatment.

Money was a way in which the patient could realize autonomy, as a person could make choices about where to go and how to spend the money. The amount of money given to the patients was inadequate to make any major purchases. The hospital provided the patient with essential needs, therefore, the money was spent on personal habits (smoking, coffee) or on special treats; it was critically important for the patient to be able to do this for herself. As one patient stated: "Money? Oh, that's nice - that gives you freedom, money in your pocket". With money, the patient was also able to make decisions about the tokens of support she would give to other individuals. The ability to make such a gesture was powerful enough to alter a patient's perception of herself. One patient describes his feelings: "You feel good, you feel helpful, you feel that you're productive, that you're healthy".

The feeling of being imprisoned surfaced in several of the interviews. Some of the language which is unique to the prison culture was used to describe the hospital experience. "Being locked away" was how many patients described their hospitalization, separated from the "outside world". As in incarceration, hospitalization resulted in restricted autonomy.

To be believed was to practice some autonomy, as it allowed the patient to represent herself competently enough to obtain the things she may desire. One patient describes how it felt to be believed: "Well, it makes me feel more capable in the sense that I can express myself in a fashion that I'm understood. And I'm perceived to be exactly who I want to be perceived to be".

Shame

If the patient had been unable to obtain credibility for herself from others, she was left to feel incompetent and not credible. The patient would experience a sense of shame. Themes related to shame surfaced many times throughout the interviews. Many of the respondents discussed their feelings of self-consciousness. In The Psychology of Shame (1989), G. Kaufman couples shame and self-consciousness. He writes, "Feeling exposed further opens the self to painful inner scrutiny....The excruciating observation of the self that results, this torment of self-consciousness, becomes so acute as to create a binding, almost paralyzing effect" (p. 18). The hospital was experienced as a place where an individual is being constantly observed, and where their every action is assessed in terms of their illness. One patient described the experience of being observed as a "tribulation". He went on: "Example: Five hundred people in the street. What do you do if these people look at you, in your eyes? If you move one leg, they - every movement!" The hospital was described by another interviewee as a "zoo", with the staff moving from one exposed patient to another.

One patient said, in relation to the idea that being in the hospital was like being in a zoo, that it made no sense for nurses and doctors to listen to him. "They think if you're in a zoo, you wouldn't really listen to an animal. You don't listen to it, you just watch it. And you say things to it, and you observe what it does, and then you leave the cage. It's sort of what goes on around here". Here is the sense that as a patient, one is no longer capable of normal conversations and interactions with other people. Another patient was eager for his release, so that he could have discussions with "normal people". His psychiatric illness and his hospitalization were incapacitating, to the point where conversation was no longer possible. As one patient approached his release date, he found that one of the nurses became more willing to engage in conversation. His interpretation of this was that as he became well enough to leave the hospital, he became worthy enough to be part of a transaction.

This transaction was dependent upon the nurse's perspective of his psychiatric condition. Rather than find blame in the other's ability to deal with psychiatric illness, many of the interviewees took personal responsibility for their illness. One patient spoke about wanting to be with "people who did not lose their sanity". Here is the idea that it is through neglect (losing or misplacing something) that one becomes psychiatrically ill. Another patient felt that if he had lived in a more disciplined and religious manner, he would not have become ill. Even in the comparison of the hospital to the prison one can decipher the patients' belief in their wrong-doing. If the hospital was experienced as a punishment, and it is the psychiatric illness that has brought the patient to the hospital, than to be psychiatrically ill is to have committed a crime.

This sense of wrong-doing may perhaps explain the inability of every interviewee to accept other patients. Shame is a psychological onslaught which makes necessary some defense mechanisms. In their avoidance of other patients and in their proclamations of the craziness of others and not of themselves, the interviewees revealed mechanisms of denial ("They are crazy and I am not"), projection ("They are sick, they are dangerous"), and reaction formation ("I am intelligent, normal, and I am not supposed to be here"), where disgust, morality and shame are felt to the extent that acceptance of other patients is no longer possible (Gay, 1989; Moore & Fine, 1990).

With shame, "we feel fundamentally deficient as individuals, diseased, defective" (Kaufman, 1989, p. 20). The interviewees expressed this sense of defectiveness in various ways. Two patients spoke about their marred physical appearance. One patient spoke about defective vocal chords which made his voice unappealing and difficult to listen to. One patient took responsibilty for many of the world's travesties, which she felt were the results of her personal needs for cigarettes and soda. Her sense of badness went to the extent that a tragedy which has occurred on another continent became the result of her actions. "To feel shame is to feel inherently bad, fundamentally flawed as a person" (Kaufman, 1989, p. 18).

With shame, the feeling of being fundamentally inadequate, one's very right to exist is questioned. It became clear that for this reason, the provision of basic needs was a buffer against shame. By making available a basic need such as food or shelter, one is confirming the individual's right to exist. A patient explains: "If they, the people who are providing for you in this hospital, see fit to give you meals and a bed, then they're encouraging you to live on, to survive. Like, they're not saying `We won't give you anything, because we don't feel you have a right to live.' So, it essentially bolsters your right to live". Inherent in the provision of these instrumental supports is the message that the recipient is permitted to continue living, and to move forward.

During the focus group discussion about support, eight themes were presented. It was around these eight themes that the questionnaire was created. Out of the responses to these questions about support came two dichotomous themes: autonomy and shame. The ways in which the hospital setting allowed autonomy were experienced as supportive, while the aspects of the hospital which fostered a sense of shame were experienced as unsupportive. The ways in which a person's autonomy was restricted served to fortify an individual's experience of shame, while the ways in which shame was prevented served to enhance an individual's sense of autonomy.

Discussion

Erikson has identified one developmental stage as "Autonomy vs. Shame and Doubt" in his theory of human psychological development (Erikson, 1980). "Autonomy vs. Shame and Doubt" is the second stage in Erikson's theory of development, and usually begins in the second year of an individual's life. At this time, the child "begins to experience the whole *critical alternative between being an autonomous creature and being a dependent one*; and it is not until then that he is ready for a *decisive encounter* with his environment, an environment which in turn, feels called upon to convey to him its *particular ideas and concepts of autonomy and coercion* in ways decisively contributing to the character, the efficiency, and the health of his personality in his culture" (Erikson, 1980, p. 56). This description serves as a strong analogy to the hospital setting. While the social interaction with its striving for a new balance in this stage is between child and parent, in the psychiatric hospital the dynamics take place between patient and hospital staff. The most important norm is that of safety: the patient must not present a threat either to herself or to others in order to be released from the hospital. The observations of her behavior form the basis of the decision to hospitalize and then to release the patient.

The psychiatric patient is in a setting where total care is the responsibility of hospital staff. The two-year old child is also in need of total care, and parental figures are responsible for providing this. While examining these shared qualities, I would like to utilize Erikson's second stage of human development. This stage is particularly significant on account of the development of the muscular system which allows the child to "hold on" or to "let go". With this ability comes the enormously valued opportunity for the still highly dependent child to begin practising her autonomous will (Erikson, 1980). The child is able to exercise free choice and self-restraint. This presents a challenge to parental figures, as it becomes increasing difficult to provide care for the child who is experimenting with her new abililities in exerting self-control. However, if "...the child is unprotected from repeated loss of self-control or is subject to excessive parental restraint, the outcome may well be a lasting sense of doubt...as well as a feeling of shame" (Wulff, 1991, p. 374).

It is clear from the interviews that autonomy was very important to the patients. This theme was apparent in the focus group discussion, as well. A patient felt best supported when she was given freedom to exercise her autonomy, and when there were restrictions, resentment was felt. Several interviewees vocalized a need for things to be fair. Restricted autonomy was not fair. For example, privileges were important to one patient because the withdrawal of the privileges would have been unfair. Another patient explained that basic supports were important because of their status as a basic right for <u>all</u> people. In this way, the adherence to a `principle of law and order' was evidenced.

The interviewees talked about the many ways in which they did not feel in control; the ways in which their freedom and ability to make choices were restricted. With Erikson's theory in mind, one can speculate about the sense of shame that would accompany this absence of autonomy.

> "The affect of shame is important because no other affect is more disturbing to the self, none more central for the sense of identity....shame is the source of low self-esteem, diminished self-image, poor self-concept and deficient body-image.

> Shame itself produces self-doubt and disrupts both security and confidence. It can become an impediment to the experience of belonging and to shared intimacy....shame is central to the emergence of alienation, loneliness, inferiority, and perfectionism" (Kaufman, 1989, p. viii).

With shame, an individual subjects herself to critical self-scrutinity, and always will find herself wanting. In shame, there is the urge to hide, to `cover one's face'. Many of the patients verbalized this need to disappear, particularly at the times when they were feeling most vulnerable. When he was sad, one patient could do nothing to help himself feel better. Instead, he would "go and get some sleep". This did not help him to feel better, but it allowed him to disappear. With shame, "one is visible and not ready to be visible" (Erikson, 1980, p.71).

In the hospital setting, an important support is to allow autonomy, thereby inhibiting shame. The information gathered from the interviews indicates that this support was not experienced by the patients. I am drawn once again to Erikson's second stage of psychological development as a metaphor to further understand this phenomenon. He writes, "...the kind and degree of a sense of autonomy which parents are able to grant their small children depends on the dignity and the sense of personal independence which they derive from their own lives" (1980, p. 75).

In his book, Asylums, Goffman (1961) discusses how disenfranchizing the experience of working in a total institution is. The aim of a psychiatric institution is to provide, with decreasing funds and services, treatment to a large number of patients. The job of the institution's staff is to control the patients to the extent that they receive the treatment and to defend the institution and the goals it is attempting to uphold. Goffman argues that job requirements of this nature serve to alienate staff from patients, and take any sense of self-control or freedom of choice away from the staff.

Erikson also refers to the negative effects of working in a bureaucratic organization. He writes that when people "have been prepared in childhood to expect from life a high degree of personal autonomy, pride and opportunity, and then in later life find themselves ruled by superhuman organizations..., the result may be deep chronic disappointment not conducive to healthy personalities willing to grant each other a measure of autonomy" (1980, p. 77). In order to encourage autonomy in others, an individual must experience her own autonomy with dignity. Such an experience may not be readily available to the individual working in a total institution.

CHAPTER FIVE

Conclusion

In exploring the experience of interpersonal support by acute-care psychiatric in-patients, the theoretical assumptions of Kohut's self psychology have been applied in this thesis. The queries about support become pertinent, through the perspective that it is through an attachment to supportive others that we move towards health. It is through support that self esteem is built and maintained, and it is the supportive functions of the selfobject and the self that are critical in the development of an individual's capacity to regulate the self system. With her status as a stigmatized individual, it is particularly difficult for the psychiatric in-patient to develop this sense of esteem for herself.

The purpose of this study was to learn from the psychiatric in-patient about the support she was experiencing.* A small sample of in-patients were interviewed with an instrument based on one definition of support, as well as with questions based on a definition of support given by a

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*I would like to clarify this project's emphasis on the individual's perception with regard to support. It is my contention that characteristics of the individual will direct the experience of support, and any considerations about adequate support provision need to take these characteristics into consideration. What one individual may experience as highly supportive might be perceived by another as inadequate. These characteristics would also be specific to the nature of an individual's mental health status (*i.e.* An individual with schizophrenia might easily feel over-stimulated. Therefore, appropriate support *for this individual* might mean very minimal contact with and involvement of significant others).

focus group of in-patients. The results showed both a perception of inadequate support and some very specific areas around which support could be focused; namely, the issues of autonomy and shame. The subjects of the study expressed a desire for an autonomy in the hospital setting; as well, many experienced a profound sense of shame. These two major themes, autonomy and shame, suggest a replay of Erikson's (1980) second stage in his theory of psychological development: Autonomy vs. Shame and Doubt.

In the asking of the research question, the premises upon which self psychology are built become pertinent. In the examination of the results of this research, Erikson's (1980) theory of psychological development become relevant. There is, however, no divergence, but rather a suggestion that these two perspectives can complement each other, contributing to the richness of the insight to be had in the research.

From a self psychology perspective, the human being has an array of needs which, in order to achieve health, must be met. Initially, others meet these needs, and eventually, through optimal frustration, an individual becomes capable of satisfying those needs herself. Optimal frustration refers to the non-traumatic absense of empathic response by the other, necessitating the individual to exercise self-sufficiency through a process called transmuting internalization (Kohut, 1971). This refers to the way in which an individual becomes uniquely capable of meeting her own needs by utilizing the memory of the functioning selfobject.

The satisfaction of needs is an ongoing and mutual process, not limited to the childhood years. These needs are specific to three areas around which human psychology is constellated. There are two poles, and a tension arc uniting the two. The first pole contains all ambition for power and success, while the second pole contains idealized goals. The tension arc is the psychological energy which directs the talents and skills towards the mastery of the ambitions and goals as represented by the two poles. The relationship between the two poles and the tension arc is referred to as the tension gradient (Kohut, 1971, pg. 98).

Kohut (1971, pp. 96-98) describes how in the first pole, with its strivings for power and success, are needs for a sense of greatness. These needs are met through mirroring functions, where, through affirmative reflection, the other is confirming the individual's vigor, competence, and worthiness. In the second pole, with its ideals and goals, are the idealizing needs. These needs are met through idealizing functions, where the other is available as a calm and omnipotent figure with whom the individual can merge. As part of the tension arc, the needs to partner with an other are met with twinship functions. By partnering with an other, the individual is affirmed as capable and worthwhile alongside another human being.

The function of meeting these different sets of needs for an other is referred to as a selfobject function. When the function is served by the self, it is referred to as a self function. Self and selfobject functions serve to regulate self esteem, monitor stress, and to define and pursue realistic goals (Elson, 1986); they contribute to the individual's ability to be independent, self-determining, and to attain one's goals.

The need to be independent and self-determining begins at a very early age; it begins as soon as the individual develops enough muscular control to begin to actively engage the environment in the pursuit of her goals (Erikson, 1980). Prior to the development of muscular control, the individual uses the environment in a more passive, indirect manner: crying so that an other would be activated to satisfy a need. When the individual develops the capacity to interface with the environment to the extent that she is able to satisfy some of her own needs, she has begun an exercise of autonomy, moving towards initiative. An individual is autonomous when she is able to reach into and utilize her world in order to accomplish a goal; when she is able to set and then to achieve goals.

Kohut (1977) has described the psychologically healthy individual as one who, with a cohesive sense of self, is able to develop and pursue goals. It is through successful connection with others that an individual develops the ability to be realistically goal-driven. For Erikson (1980), it is the mutual regulation of developing autonomy and a cooperative world that guarantees the achievement of goals. Connectedness with a supportive environment is, thus, an essential component of both of these theories.

Erikson (1980) relates the quest for autonomy with the experience of shame. Many of the patients who participated in the research study expressed their shame in a variety of ways. From a need to disappear, to the belief in one's deficient and unappealing features, they were able to indicate that the esteem which they felt for themselves was low. They were also able to express their need for a responsive, supportive environment, one which would allow for autonomous functioning. When the external world is not responsive to the needs of an individual, the individual responds by attempting to satisfy her needs on her own: she attempts to perform self functions. When the self is not cohesive, it is not possible to adequately serve self functions. In the case of the patients who participated in the research project, individuals suffering from a psychiatric disorder, the self has fragmented to pathological proportions.

The world of the hospital was experienced by many of the subjects of this research project as unsupportive and unresponsive because of an inability to provide opportunities for the exercise of autonomy. Important selfobject functions that would allow for the development and pursuit of goals were perceived to be absent from the system. A number of patients identified a resultant sense of shame. There are, then, two factors which might drive the patient to enter into a world of her own. First, there is a sense of shame, which creates the desire to hide away. Second, there is the withdrawal in an attempt to serve for herself the functions which are not being served by the selfobject. Thus, in the absense of autonomy, the patient could move towards a state of autism. Autonomy is the ability of the individual to reach out, grasp, and bring back to herself. Implicit in its meaning is the relationship between self and world; the self is used to exercise control and free will in the external world. Autism is self-ism, where the individual leaves the external world, and attempts to build her own private world. For an individual whose private world is fragmented and falling apart, this can be a frightening and uncertain place to be. If the external world is experienced as frightening and incapable of providing stability and cohesion, one is struck by the overwhelming void with which such an individual must live.

The way that an other can be supportive to an individual's needs for autonomy is to provide opportunities for exploration, as well as respectful sensitivity to the individual's limits. Erikson (1980) has referred to the delicate balance between permitting and protecting, so that an overwhelming shame will not be experienced about one's limits or one's failed attempts. Kohut (1977) also stresses the importance of the balance between the expression of power and competence and the need to rest in the other. The tension arc works to promote a balance between the independence and dependencies of the individual. When there is a balance, the nuclear self can develop as a cohesive unit.

In the hospital, the patient is completely dependent upon the caring activities of others. She is admitted to the hospital because of a severe inability to sustain life, either her own or others'. She is in the hospital because of what she can not do, rather than because of the positive things she is capable of doing. Her abilities and ambitions become insignificant. In the hospital system, in order to provide efficient and smoothly operating services in the face of diminished funds and high numbers of admissions, individuals are governed and controlled in the many aspects of their day-to-day lives. There is little autonomy; the locus of control is external. Even the medication, which is the major component of hospital treatment, serves to fortify the sense of external control. Side effects impair many forms of normal functioning. When the patient is able to function in a more positive fashion, her mastery is often attributed to the successful trial of medication; her self is no longer connected to her accomplishments. In an environment of external control which encourages dependence, it becomes difficult to pursue ambitions and to exercise abilities.

Implications

The Social Worker

The results of the research study have implications for the work that the social worker can do with the psychiatric in-patient. By recognizing the context within which the patient is situated, the social worker can reach an understanding of the selfobject funtions which will be required of her.

Kohut has postulated that the therapist must serve a role that is restorative and that can promote understanding (Elson, 1986). Empathy and countertransference awareness are the therapeutic tools which will enable the therapist to serve this role. In considering the role of the social worker, I am not suggesting that the psychiatric patients be in psychotherapy. The treatment principles of self psychology continue to have relevance for the social worker who is not doing psychotherapy, but is working with the patients within the hospital setting. Through an awareness of the client's needs and felt deficits, the social worker can serve selfobject functions that will restore. By promoting an understanding of how the needs came to be, the therapist can offer an order to the client's world.

The ability to empathize with the situation of the psychiatric in-patient, and to understand why it is that the patient is presenting with particular needs will provide the social worker with information and guidance about the therapeutic interventions which are necessary. In a situation where there is total control and an absense of self-direction, the needs for mirroring and partnering become predominant. The role of the social worker is to be a selfobject who will fill in the gaps, and who will, through optimal frustration, encourage a process of transmuted internalization of these selfobject functions.

The Setting

Kohut (1977) has specified that it is not only other people who serve selfobject functions. Pursuits and environment can also serve these functions. The total institution of the hospital does not appear to serve the necessary selfobject functions. It is a controlled setting built upon principles of order, routine and respect for authority. An awareness of one's own power and movement towards increased autonomy is perceived to be difficult to achieve in this environment. Patients and staff alike may have valuable needs unmet.

A change in the hospital may increase the satisfaction of the psychiatric patient. A smaller setting, as small as ten to twenty beds, offering individualized care may be the ideal situation. In such an ideal setting, patients would be permitted to participate in decisions about their treatment; in this way, partnering functions are being served. The setting would provide the patient with activities that she would enjoy, and that allow her to explore or expand her skills.

The setting would be a part of the larger community, and not separate from society. Various elements of the community, from significant others to community activities, would be brought into this setting in a substantial way. Sensitivity training and other support services would be available to the staff, providing them with opportunities to have their experience heard and confirmed by others. The formation of multidisciplinary work teams is crucial for meeting partnering needs. Services would be regularly used to enhance the teams' ability to perform together. The setting and the work load would permit an abundance of communication between staff and patient. Selfobject functions are often mutual; positive interactions can result in the satisfaction of selfobject needs for all participants.

The setting is envisioned as an alternative to the traditional hospital setting, and not as a graduation from it. In the absence of such an alternative setting, hospital practices could be examined so that patient concerns would be valued. Of utmost importance, the patients in the study have expressed a desire for control in their daily life. Hospital patients can become better educated about their psychiatric diagnosis and medication, thereby encouraging increased involvement and control in their treatment. Aspects of the hospital, such as visiting lounges and extended visiting hours, can provide a welcome to community supports. Activities which serve to draw in the community weaken the boundaries between hospital and society, and could reduce the stigmatization of the psychiatric inpatient. Routine could be less stringently adhered to, and patients could be encouraged to assist with some of the day-to-day tasks. For the staff, there can be more support services and sensitivity training. Services could also be utilized to enhance the multidisciplinary team's ability to work together. In these ways, the needs of both staff and patient for opportunities to pursue ambitions and idealized goals, utilizing their skills and abilities, are, at least

2 of/de 2

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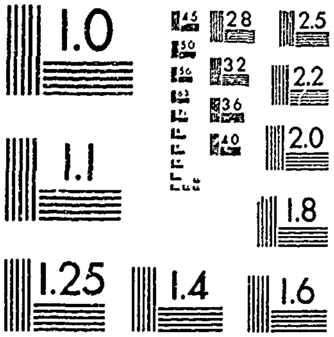

partially, being met. The environment should encourage and permit these selfobject functions to be internally transmuted, thereby enfranchising staff and patients, and inspiring the development and use of self functions.

APPENDIX A

NORBECK SOCIAL SUPPORT QUESTIONNAIRE

Taken from a study by Norbeck, Lindsey, & Carrierri (1981).

Sample page-

For each person you listed, please answer the following questions by writing in the number that applies.

Number______________
Date________________

1= not at all
2= a little
3= moderately
4= quite a bit
5= a great deal

Question #1 How much does this person make you feel liked or loved	Question #2 How much does this person make you feel respected or admired?	personal network Name or Init.	R*
1.______	1.______	1.____________	______
2.______	2.______	2.____________	______
3.______	3.______	3.____________	______
4.______	4.______	4.____________	______
5.______	5.______	5.____________	______
6.______	6.______	6.____________	______
7.______	7.______	7.____________	______
8.______	8.______	8.____________	______
9.______	9.______	9.____________	______
10.______	10.______	10.____________	______
11.______	11.______	11.____________	______
12.______	12.______	12.____________	______
13.______	13.______	13.____________	______
14.______	14.______	14.____________	______
15.______	15.______	15.____________	______

* relationship

(Appendix A continued on next page)

(Appendix A continued)

Questions for rating on the NSSQ*

1. How much does this person make you feel liked or loved? (affect)
2. How much does this person make you feel respected or admired? (affect)
3. How much can you confide in this person? (affirmation)
4. How much does this person agree with or support your actions or thoughts? (affirmation)
5. If you needed to borrow ten dollars, a ride to the doctor, or some other immediated help, how much could this person usually help? (aid)
6. If you were confined to bed for several weeks, how much would this person help you? (aid)
7. How long have you known this person? (duration of relationship)
8. How frequently do you usually have contact with this person? (phone calls, visits, or letters) [frequency of contact]

* ratings are based on a five-point rating scale specified for each question:

Questions One to Six range from 1 = not at all to 5 = a great deal.

Question Seven ranged from 1 = less than six months to 5 = more than five years

Question Eight ranged from 1 = once a year or less to 5 = daily

APPENDIX B

FOCUS GROUP GUIDE

1. What does support mean? What does it mean for you to be supported?
2. What are some things that people have done for you that have been supportive?
3. What are some things that people have done for you that have not been supportive?
4. What are some of the ways in which you have been supportive to other people?
5. Is it only people who can give supports? Can you be supported by animals, things (possessions), and/or activities?

APPENDIX C

QUALITATIVE QUESTIONNAIRE

1. What are some important basic supports for you?
2. Are there reasons other than survival why it feels good to get these things?
3. How do you feel about the person who can help you with these things?
4. Is basic support enough?
5. What are some other important things that you get in the hospital?
6. What other kinds of support do you need?

7. How do you get your privacy in the hospital?
8. How important is privacy to you?
9. What kind of freedom do you have in the hospital?
10. Is it important to have freedom?
11. Would you like to have more freedom?
12. Do you think there are times when your freedom should be taken away?
13. Do you feel you can control the amount of freedom and privacy you get?
14. In what ways do you feel in control of your life?
15. In what way is it important to have control?
16. How do you feel about yourself when you do have control?
17. How do you feel about yourself when you do not have control?

18. When you have money, how do you feel?
19. When you have money, what kinds of things do you like to do with it?
20. Do you think a person can be supportive to themselves?
21. Do you ever do things for yourself to make you feel better? What things do you do?
22. Are you able to do many things for yourself here in the hospital? Does it work--do you feel better?

23. Is it important for you to know that people listen to you?
24. Who listens to you here?
25. Who does not listen to you here?
26. Do many people believe the things that you tell them about yourself? How does this feel?

27. Do other people on the ward know who you are? How do you know this?

28. Do the nurses and doctors know who you are? How do you know this?
29. How would your family describe you?
30. If I asked another patient to describe you, what would they tell me?

31. If I asked your doctor to describe you, what would he/ she tell me?
32. How would you describe yourself?

33. If you needed some basic help, who would you go to? Would they always be there for you?
34. If you needed someone to talk to, who would you go to? Would they always make time for you?
35. If you needed someone to really hear the things you were saying, who would you go to? Would they always be ready to stop and listen?
36. Who are some of the people who like and love you?

37. What does it mean to have respect from other people?
38. Do you feel respected hear? Can you give an example?
39. In what ways do you show respect to other people?

40. In what ways do you support other people?
41. How do you feel when you have been able to be supportive?
42. How do you feel when you have been supported?

APPENDIX D

INFORMATION AND CONSENT FORM (focus group)

You are being asked to participate in a group that will focus on the concept of support. The group discussion will assist in the development of an interview which will be used to explore the ways in which in-patients experience support. This study is being conducted by Trish Van Katwyk, a masters student in the Faculty of Social Work at Wilfrid Laurier University. It is hoped that this study will develop a better understanding of social support, particularly as it relates to the hospitalized individual.

Your participation in the study will involve allowing the group discussion to be tape recorded. There will be a co-facilitator to assist in the group process. Other than the recording equipment, there will be no alterations or intrusions into the group discussion.

Everything in the group discussion will remain confidential. The taped discussion will be used to generate questions that will be used in an interview about support. The tape of the discussion will be kept in a secure place until such time as the questionnaire has been developed. At this point, the tape will be erased.

The information on the tape will remain anonymous, and at no point will any identifying information be related to the content of the material.

Participation in the study is strictly voluntary. You are free to withdraw consent at any time. Participation and/or withdrawing will not affect your hospital treatment in any way. Trish Van Katwyk is available to discuss the research and any concerns you might have about the study. If you wish to discuss the project with her advisor, Professor Dennis Miehls can be reached by phone in Waterloo at (519) 884-1970 ext. 2666. You will receive a copy of this consent form for your own convenience and information.

I have read and understand the above information and give my consent to having this group discussion taped.

Taped at Toronto, Ontario, this _____ day of _____, 19__.

Signature_____________________________

APPENDIX E

INFORMATION AND CONSENT FORM (one:one interview)

You are being asked to participate in an interview that will focus on the concept of support. The interview be an exploration of the ways in which in-patients experience support. This study is being conducted by Trish Van Katwyk, a masters student in the Faculty of Social Work at Wilfrid Laurier University. It is hoped that this study will develop a better understanding of social support, particularly as it relates to the hospitalized individual.

Your participation in the study will involve allowing the interview to be tape recorded. Other than the recording equipment, there will be no alterations or intrusions into the group discussion.

Everything in the interview will remain confidential. The tape of the interview will be kept in a secure place untion such time as the interviews have been analyzed and coded. At this point, the tape will be erased.

The information on the tape will remain anonymous, and at no point will any identifying information be related to the content of the material.

Participation in the study is strictly voluntary. You are free to withdraw consent at any time. Participation and/or withdrawing will not affect your hospital treatment in any way. Trish Van Katwyk is available to discuss the research and any concerns you might have about the study. If you wish to discuss the project with her advisor, Professor Dennis Miehls can be reached by phone in Waterloo at (519) 884-1970 ext. 2666. You will receive a copy of this consent form for your own convenience and information.

I have read and understand the above information and give my consent to having this interview taped.

Taped at Toronto, Ontario, this _____ day of _____, 19__.

Signature______________________________

TABLE ONE

RESULTS OF THE NSSQ (current and 1981 study)

	x-current study	x-1981 study
affect 1	9.62	54.37
affect 2	8.38	53.37
affirm.1	8.46	48.76
affirm.2	8.46	50.24
aid 1	8.15	43.79
aid 2	8.15	36.15
# support	3.38	13.00
duration	14.00	55.87
frequency	10.54	42.77

TABLE TWO

RESULTS OF THE T-TEST p=.05

	df	t obs	crit.val.
affect 1	86	23.68	1.671
affect 2	86	24.72	1.671
affirm 1	86	24.42	1.671
affirm 2	86	23.34	1.671
aid 1	86	22.85	1.671
aid 2	86	20.29	1.671
# supports	86	21.38	1.671

REFERENCES

Ainsworth. M.D.S. (1969). Object relations, dependency and attachment: A theoretical review of the infant-mother relationship. Child Development, 40, 969-1026.

Auerbach, S.M. & Killman, P.R. (1977). Crisis intervention: A review of outcome research. Psychological Bulletin, 84(6), 1189-1217.

Bachrach, L.L. (1980). Is the least restrictive environment always best? Hospital and Community psychiatry, 31(2), 97-103.

Baker, F., Jodrey, D., & Intagliato, J. (1992). Social support and quality of life of community support clients. Community Mental Health Journal, 28, (5), 397-411.

Baldessarini, R.J. (1978). "Chemotherapy", in Nichol, A.M. (ed.) The Harvard guide to modern psychiatry. Cambridge, Mass.: The Palknap press of Harvard University Press.

Basch, M.F. (1984). Selfobjects and selfobject transference: Theoretical implications. In Stepansky, P.E. & Goldberg, A., (eds.) Kohut's legacy: Contributions to self psychology. Hillsdale, New Jersey: Analytic Press.

Blanch, A., Carling, P., & Ridgway, P. (1980). Normal housing with specialized support: A psychiatric rehabilitation approach to living in the community. Rehabilitation Psychology, 33, 47-55.

Bowlby, J. (1988). _A secure base_. New York: Basic Books.

Bowlby, J. (1980). _Loss, sadness, and depression_. London: Hogarth.

Bowlby, J. (1979). _Making and breaking affectional bonds_. New York: Tavistock Publications.

Bowlby, J. (1969). _Attachment, volume one_. New York: Basic Books.

Boydell, K. & Everett, B. (1992). What makes a house a home? An evaluation of a supported housing project for individuals with long-term psychiatric backgrounds. _Canadian Journal of Community, 10_(1), 109-123.

Cauce, A.M., Hannan, K., & Sargeant, M. (1992). Life stress, social support, and locus of control during early adolescence: Interactional effects. _American Journal of Community Psychology, 20_, (6), 787-798.

Combrinck-Graham, L. & Kerns, L. (1989). Intimacy in families with young children. in Kantor, D. & Okun, B.F. (eds.) _Intimate environments; Sex, intimacy, and gender in families_. New York: The Guilford Press.

Conte, H.R. & Plutchik, R. (1986). Controlled research in supportive psychotherapy. _Psychiatric Annals, 16_, 530-533.

Deegan, P.E. (1988). Recovery: The lived experience of rehabilitation. _Psychosocial Rehabilitation Journal, 11_ (4), 12-19.

Delaney, J.A., Seidman, E., & Willis, G. (1978). Crisis intervention and the prevention of institutionalization: An uninterrupted time series analysis. American Journal of Community Psychology, 6(1), 33-45.

Ellbeck, M. & Facteau, G. (1990). Improving the validity of measures of patient satisfaction with psychiatric care and treatment. Hospital and Community Psychiatry, 41 (9), 998-1001.

Elson, M. (1986). Self psychology in clinical social work. New York: W.W. Norton & Company.

Erickson, R.C. ((1991). Mission of the short-stay inpatient unit with chronic patients. Health and Social Work, 16, 70-74.

Erikson, E.H. (1980). Identity and the life cycle. Markham, Ontario: Penguin Books Canada Limited.

Gay, P. (ed.). (1989). The Freud reader. Ontario: Penguin Books Canada Limited.

George, L.K., Blazer, D.G., Hughes, D.C., & Fowler, N. (1989). Social support and the outcome of major depression. British Journal of Psychiatry, 154, 478-485.

Goffman, E. (1963). Stigma. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Goffman, E. (1961). Asylums. Garden City, N.Y.: Anchor Books.

Greenland, C. (1993). The city and the asylum. Toronto: Queen Street Mental Health Centre Archives.

Grissett, N.I. & Norvell, N.K. (1992). Perceived social support, social skills, and quality of relationships in bulimic women. Journal of Consulting and Clinical Psychology, 60, (2), 293-299.

Harlow, H.F. (1960). The nature of love. American Psychologist, 13, 673-685.

Hart, K.E. & Hittner, J.B. (1991). Irrational beliefs, perceived availability of social support, and anxiety. Journal of Clinical Psychology, 47, (4), 582-587.

Hoffman, R.S. & Koran, L.M. (1984). Detecting physical illness in patients with mental disease. Psychosomatics, 25(9), 654-659.

Isaac, R.J. & Armat, V.C. (1990). Madness in the streets: How psychiatry and the law abandoned the mentally ill. New York: The Free Press.

Kahn, R.L. Aging and social support. In Riley, M.W. (ed.) Aging from birth to death: Interdisciplinary perspectives. Boulder, Colo.: Westview Press, 1979, 77-91.

Kaufman, G. (1989). The psychology of shame: Theory and treatment for shame-based syndromes. New York: Springer Publishing Company.

Klein, J. (1987). Our need for others and its roots in infancy. New York: Tavistock Publications.

Kohut, H. (1971). The analysis of the self. New York: International Universities Press.

Kohut, H. (1977). The restoration of self. New York: International Universities Press.

Laing, R.D. (1967). The politics of experience. New York: Ballantine.

Lebow, J. (1982). Consumer satisfaction with mental health treatment. Psychological Bulletin, 91(2), 244-259.

Luke, E., Norton, W., & Denbigh, K. (1981). Medical and social factors associated with psychological distress in a sample of community aged. Canadian Journal of Psychiatry, 26, 244-250.

Mallincrodt, B. (1991). Clients' representations of childhood emotional bonds with parents, social support, and formation of the working alliance. Journal of Counseling Psychology, 38, (4), 401-409.

Maricle, R.A., Hoffman, W.H., Bloom, J.D., Faulkner, L.R., & Keepers, G.A. (1987). The prevalence and significance of medical illness among chronically mentally ill outpatients. Community Mental Health Journal, 23(2), 81-90.

Moore, B.E. & Fine, B.D. (eds.). (1990). Psychoanalytic terms and concepts. New Haven: The American Psychoanalytic Association and Yale University Press.

Neuman, W.L. (1991). Social research methods. Boston: Alyn & Bacon.

Norbeck, J.S., Lindsey, A.M., Carrieri, V.L. (1981). The development of an instrument to measure social support. Nursing Research, 30(1), 264-269.

Patton, M.Q. (1980). Qualitative evaluative methods. London: Sage.

Ridgway, P. & Zipple, A.M. The paradigm shift in residential services: From the linear continuum to supported housing approaches. Psychosocial Rehabilitation Journal, 13(4), 11-31.

Rothman, D.J. (1990). The discovery of the asylum: Social order and disorder in the New Republic. Boston: Little, Brown and Company.

Sarason, B.R., Sarason, I.G., & Pierce, G.R. (1990). Social support: An interactional view. New York: Wiley.

Test, M.A. & Berlin, S.B. (1981). Issues of special concern to chronically mentally ill women. Professional Psych-logy, 10(4), 3-16.

Weber, M. (1991). Street kids: The tragedy of Canada's runaways. Toronto: University of Toronto Press.

Wickham, E. (1993). Group treatment in social work: An integration of theory and practice. Toronto: Thompson Educational Publishing, Inc.

Wilkin, D., Hallam, L., & Doggett, M. (1992). Measures of need and outcome for primary health care. Oxford: Oxford University Press.

Winemiller, D.R., Miller, M.E., Sutliff, J., & Cline, D.J. (1993). Measurement of strategies in social support: A descriptive review of the literature. Journal of Clinical Psychology, 49, (5), 638-648.

Wulff, D.M. (1991). Psychology of religion: Classic and contemporary views. Toronto: John Wiley & Sons.

Yalom, I.D. (1985). The theory and practice of group psychotherapy, Third edition. New York: Basic Books, Inc., Publishers.