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PERCEPTIONS OF ADULT CHRONIC SCHIZOPHRENICS DURING PLANNED DISCHARGE

BY

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A THESIS
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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled PERCEPTIONS OF ADULT CHRONIC SCHIZOPHRENICS DURING PLANNED DISCHARGE submitted by BEVERLEY JEAN LORENCZ in partial fulfillment of the requirement for the degree of Master of Nursing.

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Date: 29 Sept/88

Abstract

A qualitative research method, grounded theory, was used to explore the predischarge perceptions of four hospitalized male schizophrenics. Four to six interviews were conducted on each participant over a period of three to five months. Initial comparison of incidents of data resulted in the emergence of broad conceptual categories. Theoretical sampling of data was utilized to further refine these categories and identify interrelationships among them.

The core explanatory variable of chronic schizophrenics' perceptions at planned discharge was "becoming ordinary." This variable accounted for participants' characterization of their preadmission experiences as well as their anticipated future. Because they were unable to "make it" in the community, the participants described themselves as failures. At predischarge, they anticipated eventual acquisition of productive roles in the community. The participants who were "anticipating mastery" of their discharge communities were expecting immediate progress towards their aspiration of "becoming ordinary."

From the participants' perspective, being in hospital is comparable to being in an army "boot camp" because both institutions prepare its service recipients for roles autonomous of institutional roles. Discharge from hospital was sought when the participants either assessed themselves ready to return to the community or they perceived the hospital was not facilitating this return. It is debatable, however, whether deinstitutionalization of schizophrenics has been accompanied with re-integration or "institutionalization" of schizophrenics within the community. Published literature suggests that these individuals continue to occupy marginal roles in the community.

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I. Statement of Problem

Schizophrenia is called the cancer of psychiatry (Green, 1984). Based on the rate of first admissions, the incidence of schizophrenia in Canada is: 31 males and 22 females per 100,000. The estimated number likely to be moderately and severely disabled by schizophrenia is 2.6 person per 1,000 of population. Only 50% of diagnosed-schizophrenics are expected to achieve either a complete or good recovery (Bland, 1984).

In Canada, the number of mentally ill individuals receiving institutional care has declined approximately 50% over a twenty year period. In 1955, there were 425 psychiatric inpatients per 100,000. By 1976, this number had decreased to 219 per 100,000 (Bland, 1984). Research has revealed, however, that over 60% of schizophrenics require at least one readmission (Bland, Parker, & Orn, 1976; Bland, Parker, & Orn, 1978; Cottman & Mezey, 1976). Deinstitutionalization of schizophrenics has resulted in a cycle of repeated admissions known as the "the revolving door syndrome."

Identification of factors associated with schizophrenics' readmission has lead to the development of specific interventions designed to reduce these admissions. Although numerous researchers report reductions in readmissions associated with implementation of diverse community-based interventions (e. g. Seeman, 1981), the overall readmission rates for schizophrenics remains high. The majority of discharged schizophrenics are not attending community-based programs. Caton (1981) reports only 17% of the chronic schizophrenics she studied complied with community-based treatment.

As evidenced by the high readmission rate and the failure of discharge chronic schizophrenics to comply with community-based treatment, further understanding of schizophrenia is required. Although much research has been published about discharged schizophrenics, the researchers have examined the problem from the perspective of care providers. In order to plan and implement effective community-based treatment, understanding schizophrenics' perception of their experience is necessary. Within an institutional environment, schizophrenics are "captive" service recipients. They are not, however, captive service recipients within the community, and therefore are not easily accessed by care professionals.

Although research substantiates the fact that community-based programs can reduce readmissions, the schizophrenic must perceive these programs as beneficial if voluntary participation is to be achieved. Exploration of predischarge perceptions will result in the identification of schizophrenics' primary concerns associated with re-entering the community as well as their perceptions of discharge. Systematic examination of the perceptions of predischarge schizophrenics will contribute to the present understanding of the illness and its effects on individuals.

This study examined perceptions of predischarge chronic schizophrenics who have experienced at least two years of illness. Due to the length of their illness, it was assumed that these individuals would be able to report the experience of bei: schizophrenic in the community as well as the experience of leaving a psychiatric care facility.

Research Question

The primary research question addressed bv the study was:

What are the perceptions of adult chronic schizophrenics during planned transition from the hospital to the community?

Two secondary research questions, associated with the primary question, were also addressed in the study. These were:

> What are the primary concerns of chronic schizophrenics who are anticipating returning to the community?
>
> How do predischarge chronic schizophrenics describe the experience of leaving a psychiatric care facility?

Definition of Terms.

1. *Schizophrenia*: In this study, schizophrenia is defined as the presence of signs and symptoms of schizophrenia according to the ICD-9-CM system of disease classification (International Classification of Disease, Clinical Modification). This classification system defines schizophrenia as a fundamental disturbance of personality, accompanied with characteristic distortion of thought. There are several sub-classifications of the disease based on the predominate presenting symptom of the patient. The two sub-classifications applicable to this study are:

Paranoid schizophrenia: Paranoid schizophrenia is characterized by the presence of relatively stable delusions which are frequently of a persecutory nature. Hallucinations may also be present.

Residual schizophrenia: Residual schizophrenia is defined as the persistence of chronic symptoms following an initial acute exacerbation of the illness.

Delusions: Delusions are maintained false personal beliefs about reality even though objective evidence contradicts this belief.

Hallucinations: Hallucinations are the presence of sensory experiences not originating from external stimulation of that sense organ (United States National Center for Health Statistics, 1978).

2. *Chronicity*: In this study, chronicity was defined as the presence of symptoms of schizophrenia for at least two years. It was not defined in terms of previous hospitalizations because of the possibility that previous formal psychiatric care of a patient may be unknown, for example, hospitalizations in other provinces.
3. *Preddischarge Status*: Predischarge status was defined as the patient, in cooperation with his/her treatment team, was making plans to return to the community, such as, seeking living accommodations in the community. In this study, predischarge status referred only to patients procuring planned discharge from hospital.

II. Review of the Literature

A review of the literature regarding the professional care of schizophrenics reveals four topic areas: neuroleptics, community care, and characteristics of the families and schizophrenics.

The Family

The family of the schizophrenic is either implicitly incriminated as the cause of the illness or acknowledged as the schizophrenic's primary care-giver. These divergent approaches towards the schizophrenic's family have yielded two distinct themes in the professional literature regarding post-hospitalization care.

The family as the cause. When professionals assume that dysfunctional family dynamics perpetuate schizophrenic episodes, interventions are planned to facilitate change in family interactions. Numerous studies on families with schizophrenic members have focussed on the amount of expressed emotion evident in the interfamilial interactions. Expressed emotions are defined as verbal expressions of criticism, hostility, and/or over-involvement (Vaughn, Snyder, Jones, Freeman, & Falloon, 1984). High levels of these emotions are positively correlated with high rates of readmission (Hirsch, 1983; Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982; Leff & Vaughn, 1981; Liberman, Wallace, Falloon, & Vaughn, 1981; Moline, Singh, Morris, & Meltzer, 1985; Vaughn & Leff, 1976; Vaughn et al., 1984). Therefore, the objective of planned intervention is to protect the patient from his/her family environment. Planned interventions include strategies for reducing the patient's face-to-face contact with relatives and/or enhancing the patient's capacity to cope with the stressful environment by prescribing neuroleptic drugs (Hirsch, 1983; Leff & Vaughn, 1981; Rosenfield, 1982; Vaughn et al., 1984). Treatment strategies are also designed to reduce the amount of expressed emotions present in family interactions. These interventions include social skills training (Liberman et al., 1981), education about schizophrenia (Leff et al., 1982; Liberman et al., 1981), and relative support groups (Leff et al., 1982; Shenoy, Shires, & White, 1981).

The underlying assumption of these studies is that there is a causal relationship between expressed emotion and schizophrenic relapse. When the family is envisaged as the primary caretaker, however, no assumptions are made regarding the family's contribution to the etiology of readmission.

The family as the caretaker. When the family is seen as the primary caretaker of the discharged schizophrenic, research studies examine the problems experienced by these families (Hatfield, 1979; Runions & Prudo, 1983; Turkat & Buzzell, 1983). Interventions are designed to develop and strengthen family caretaking skills and include: education about the disease (Falloon et al., 1985; Glick et al., 1985; Hatfield, 1979; McGill, Falloon, Boyd, & Wood-Siverio, 1983), counseling about potential coping strategies (Falloon et al., 1985; Glick et al., 1985), and the establishment of relative support groups (Thornton, Plummer, Seeman, & Littmann, 1981). Neuroleptic drugs are prescribed to reduce the schizophrenic's disruptive symptoms (Mantonakis, Markidis, Kontaxakis, & Liakos, 1985).

Researchers studying the schizophrenic's family regard either the family or the discharged patient as disadvantaged. One exception, in which no assumption is made regarding the relative functional well-being of either, is the study by Scott and Alwyn (1978). Using the results of self-administered paper tests, these researchers report that if congruence is present between the family's perception of themselves and the schizophrenic's perception of the family then the work and social functioning of the schizophrenic is better. However, the informants used in this study were young first admission schizophrenics, with a modal age between 16 and 17 years. A study in which researchers explored the adult chronic schizophrenic's perception of his/her family, including perceived legitimate care behaviors of family members, could not be located.

Neuroleptics

Researchers have unequivocally demonstrated the relationship between relapse in previously maintained schizophrenics and discontinuation or decrease of neuroleptic dosages. Relapse rates are doubled (Goldberg, Schooler, Hogarty, & Roper, 1977; Hogarty, Goldberg, & Schooler, 1974; Hogarty, Goldberg, Schooler, & Ulrich, 1974; Hogarty & Ulrich, 1977; Lehmann, Wilson, & Deutsch, 1983), sextupled (Kayton, Beck, & Koh, 1976), and increased twelvefold (Rifkin, Quitkin, Rabiner, & Klein, 1977) after the substitution of neuroleptic drugs with placebos. Also schizophrenics who experience relapses tend to be more acutely ill (Johnson, Pasterski, Ludlow, Street, & Taylor, 1983; Lehmann et al., 1983) and display more antisocial and self-destructive behavior (Lehmann et al., 1983).

As a result of the dramatic increase in relapse following discontinuation or reduction of neuroleptics, studies were designed to clarify the relationship between drug compliancy and the rate of relapse. Researchers hypothesized that those schizophrenics receiving intramuscular injections of fluphenazine (a neuroleptic) every one to two weeks would experience fewer relapses than those on the oral medication (fluphenazine hydrochloride). The relapse rate between the two groups was not significantly different (Hogarty et al., 1979; Rifkin et al., 1977; Schooler et al., 1980). Individual factors, such as omitting occasional doses, did not account for relapse in schizophrenics taking neuroleptics. It should be noted, however, that those schizophrenics unwilling to cooperate with aftercare were not included in these studies.

Attendance in aftercare programs is associated with reduced readmission rates (Caton, 1981).

Some researchers have focussed on identifying characteristics of schizophrenics who consistently refuse to comply with their medication regimes. Van Putten, Crumpton, and Yale (1976) found that inpatients exhibiting grandiose symptoms tend to refuse drug therapy; whereas symptoms of anxiety and depression are associated with drug compliancy. Acceptance of diagnosis, insight into the illness, as well as more frequent rehospitalizations are also associated with drug compliancy (Nelson, Gold, Hutchinson, & Benezra, 1975). Results from other studies, however, confound these explanations based solely on the characteristics of drug refusers.

Other researchers have examined the relationship between drug compliance and subjectively reported side effects. Statements by schizophrenics reflecting negative attitudes about drug therapy commonly include references to side effects (Davidh..zar, Austin, & McBride, 1986). Drug noncompliance is associated with more severe side effects among self-medicated hospitalized schizophrenics (Nelson et al., 1975). Subtle side effects, such as, decreased ambition, irritability, and restlessness are significantly associated with schizophrenics' reluctance to take drugs (Van Putten, 1978). It is problematic, however, to distinguish between subtle extrapyrimadal side effects and drug dysphoria (Hogan, Awad, & Eastwood, 1983). Regardless of the etiology of subtle "side effects," the subjectively reported experience by schizophrenics taking medications proved to have the greatest discriminatory power in differentiating between noncompliers and compliers (Hogan et al., 1983).

External factors also appear to affect compliancy with medication. Nelson, Gold, Hutchison, and Benezra (1975) report that drug compliancy is affected by schizophrenics' perception of their attending physicians' degree of interest in them.

The study by McEvoy, Aland, Wilson, Guy, and Hawkins (1981) indirectly supports the influence of the health care professionals on schizophrenics' compliance with medication. After interviewing 45 chronic schizophrenics, the researchers found that only 13% of the group are aware of their diagnosis; however, 44% stated they would require medications in the future.

From the results of these studies, it appears that refusal to comply with medications after discharge contributes significantly to rehospitalization of chronic schizophrenics. Discharge from inpatient facilities is often accompanied by referral to a community based treatment team, resulting in the loss of therapeutic relationships developed as a inpatient. These therapeutic relationships are associated with increased drug compliance (Nelson et al., 1975). As such, it would be beneficial and germane to discover how schizophrenics perceive themselves at discharge. For example, do they believe their illness is controlled by medication, or do they believe they are healthy and in control of their emotional state? It appears reasonable to expect that if schizophrenics perceive discharge from hospital as signifying recovery of their mental health, they may also regard continued drug therapy as unnecessary.

The Schizophrenic

Research into the characteristics of schizophrenics in remission acquires particular relevance when one examines the long-term outcome of first admission schizophrenics. A ten year follow-up study of schizophrenic patients (N=88) revealed 64% of the patients required at least one readmission (Bland et al., 1978); during an eight year follow-up of 41 schizophrenics, 67% required further hospitalization (Cottman & Mezey, 1976). Characteristics of schizophrenics are either studied from the perspective of the researcher (using objective, impersonal tests), or from the perspective of the schizophrenic (using subjective descriptions of their experience with the illness).

Two themes emerge in the professional literature describing schizophrenics at risk for re-exacerbations: (a) residual symptoms are a component of the disease itself (Caton, 1981; Glick, Braff, Johnson, & Showstack, 1981; Harrow, Grinker, Silverstein, & Holzman, 1978; Hirsch, 1983; Morgan, 1979; Wing, 1978) and, (b) schizophrenics lack skills to effectively cope with stressful life events (Boker et al., 1984; Canton & Fraccon, 1985; Kayton et al., 1976; MacKinnon, 1977; Rhoades, 1982; Seeman & Cole, 1977; Serban, 1979; Van Hassel, Bloom, & Gonzalez, 1982; Van Putten et al., 1976). Historically, it was assumed that the institutionalization of schizophrenics contributed to the chronic course of the illness in some patients. The failure of hospitalization rates to decline since deinstitutionalization, however, supports the supposition that chronicity is a component of schizophrenia (Caton, 1981; Hansell & Willis, 1977; Harrow et al., 1978). Interventions to compensate for these chronic disabilities include modifying the environment (Hirsch, 1983; Morgan, 1979; Wing, 1978), and prescribing neuroleptics (Wing, 1978).

The second theme emerging from objective studies of chronic schizophrenia is the inability of schizophrenics to cope with interpersonal life stresses and stresses associated with symptoms of schizophrenia. Compared with nonpsychiatrically ill people, schizophrenics have higher stress levels. The level of stress is highest among those diagnosed as chronic and is associated with all life events (Canton & Fraccon, 1985; Serban, 1975). The majority of newly hospitalized schizophrenics are able to identify precipitating events which occurred during the prodormal period of the exacerbation (Canton & Fraccon, 1985). Depression among schizophrenics is correlated with the stress of daily living and insight into personal inadequacies (Serban, 1979). Intervention strategies designed to enhance the coping abilities of the schizophrenic include relaxation training and the development of interpersonal skills (Rhoades, 1982; Van Hassel et al., 1982).

Coping with the disease and its symptoms has also gained attention in the literature. The schizophrenic actively attempts to control his/her symptoms. Fighting back and acceptance are two strategies identified by Cohen and Berk (1985). Social withdrawal and increasing social contact are identified by Kanas and Barr (1984) as two divergent techniques used by schizophrenics to control auditory hallucinations. Seventy-five percent of the schizophrenics interviewed by Boker and associates (N=40) reported compensatory efforts such as testing reality when having hallucinations (1984). Only one study could be found in which the researcher explored schizophrenics' coping with the knowledge of their personal susceptibility to mental illness following an acute psychotic episode. MacKinnon (1977) postulates that the reversal of a psychotic state involving grandiose delusions results in a sense of loss and grief as the schizophrenic must forego the hero role.

Subjective reports by schizophrenics in the professional literature are meager. In addition to descriptions of psychotics episodes, two themes emerge from published subjective reports of schizophrenics: feelings of helplessness and loneliness (Betz, 1980; Linn, Caffey, Klett, Hogarty, & Lamb, 1979) and the lack of professional optimism regarding their recovery (Anonymous, 1986; Lovejoy, 1984; Wescott, 1979).

An incongruence emerges between professionals' appraisal of schizophrenics and schizophrenics' reported experience. The professional views the schizophrenic as having personality weaknesses or deficiencies. These are conceptualized as either irreversible components of the illness or developmental weaknesses, such as, the inability to cope with mundane stress. In comparison, the schizophrenic expresses feelings of helplessness and the need for emotional support and reassurance.

The schizophrenic's concerns and perceived needs when discharged from hospital have not been examined. Nevertheless, numerous researchers have evaluated the effectiveness of aftercare treatment facilities. The next section will review these studies.

Community Care

Three aspects of the community care of schizophrenics are examined in the literature: reduction in the number and length of hospitalization, psychiatric treatment within the community, and residential care facilities.

Reduction of length and number of hospitalizations. The development community-based alternatives to hospitalization has accompanied the deinstitutionalization of the mentally ill. The two main areas of investigation are: (1) brief hospitalizations followed by community referral, and (2) care of psychotic schizophrenics in the community using intensive home visits or residential treatment facilities.

The results of the studies comparing short and long-term hospitalization on schizophrenics' community adjustment are ambiguous. Three different research projects yielded three conspicuously contradictory results. In a study that examines the outcome of a group of schizophrenics at four weeks (Glick, Hargreaves, Raskin, & Kutner, 1975), one year (Glick, Hargreaves, Drues, & Showstack, 1976), and two years (Hargreaves, Glick, Drues, Showstack, & Feigenbaum, 1977), the researchers report that the initial short-term evaluation reveals patients assigned to the brief hospitalization group show significantly less withdrawal, and complain of less subjective distress (Glick et al., 1975). The results, as measured by a global assessment scale, favored lengthier hospitalization, however, at the end of one year (Glick et al., 1976). At the end of a two year follow-up, the outcome still favored long-term hospitalized, especially for those schizophrenics who had good prehospital functioning (Hargreaves et al., 1977). No difference was found between the groups with regards to duration and frequency of rehospitalization, and level of functioning in the community.

On the other hand, Herz (1983) reports that schizophrenics who were briefly hospitalized continue to experience more favorable outcomes throughout one year of follow-up. He reports that these individuals have better social functioning and exhibit fewer residual symptoms. In contrast to these researchers, Caton (1982), after following discharged schizophrenics for one year, reports that the length of hospitalization has no effect on: number of readmissions, level of positive symptoms, social functioning, and aftercare compliance.

There is agreement among researchers regarding the effectiveness of providing intensive community care in place of hospitalization. Significantly more schizophrenics and their relatives report greater satisfaction with community based treatment (Hoult & Reynolds, 1984; Pai & Kapur, 1983), and readmission rates are lower for community treated schizophrenics (Hoult & Reynolds, 1984; Pai & Roberts, 1983). In another study, although the readmission rate for clients in a residential treatment center are not lower than the hospital group, the researchers report that fewer of the community based clients required maintenance medications (Mosher & Menn, 1978).

Living Accommodations. There is a paucity of studies examining the effects of different types of living accommodations on discharged schizophrenics. Most discharge planning is directed towards either aftercare or maintenance medications (Caton, Goldstein, Serrano, & Bender, 1984). Three studies were found that examine nonfamilial, residential accommodations for chronic schizophrenics. Solomon, Baird, Everstine, and Escobar (1980) report chronic schizophrenics living in board and care homes fare better than those living independently. Respondents in board-and-care homes tend to be more frequently engaged in meaningful activities, such as, sheltered workshops or day hospitals. Although Van Putten and Spar (1979) did not find the 'board-and-care' client socially more active, they conclude these homes successfully maintain schizophrenics in the community. Schizophrenics residing in foster homes (more traditional family units) show significant improvement in social functioning in comparison to long-term hospitalized patients (Linn, Klett, & Caffey, 1980), and more favorable outcomes are obtained in foster homes that most emulate the traditional family setting, for example, those homes which do not closely supervise the adult schizophrenic and where children are present. Comparisons between patients living in foster and board and care homes were not found.

Community care of the discharged schizophrenic. A variety of services are present in community treatment facilities that provide aftercare treatment for schizophrenics. The services include: coffee groups (Masnik, Olarte, & Rosen, 1980), social skills training (El-Islam, 1982; Solomon et al., 1980), day clinics (Donlon & Rada, 1976), day hospitals (Niskanen, 1974), and major role therapy (Goldberg et al., 1977). Program evaluation studies have focussed on identifying characteristics of either the program or the schizophrenic that appear related to client outcome.

Particular attributes of schizophrenic clients have been considered when accounting for differences in outcome following program attendance. Negativistic attitudes and passivity characterize clients who fail to improve or who deteriorate in day hospitals (Niskanen, 1974) and during social skills training (Bellack, Turner, Hersen,

& Luber, 1984). Schizophrenics with high levels of residual symptoms and poorer community adjustment tend to relapse more quickly when involved in sociotherapy or major role therapy (Goldberg et al., 1977).

Other studies have examined program characteristics associated with successful treatment of chronic schizophrenics. The need to avoid utilization of confrontational techniques in the treatment of chronic schizophrenics is noted by Masnik, Olarte, and Rosenc (1980). These researchers report group attendance, rather than group participation, is correlated with reduced rehospitalization. The effectiveness of nonthreatening reality orientated groups in reducing chronic schizophrenics' rehospitalization rates is supported by three other studies (Alden, Weddington, Jacobson, & Gianturco, 1979; Melzer, 1979; Seeman, 1981). A significant relationship exists between treatment center characteristics and client outcomes (Linn et al., 1979). Better outcomes are associated with centers that focus on recreational and occupational therapy and utilize primary therapists. In contrast, poorer outcomes are associated with centers that focus on family and group psychotherapy and have a high patient turnover.

Rehospitalization is associated with failure to attend aftercare services (Caton, 1981; Serban & Thomas, 1974). Utilization of these services by discharged schizophrenics, therefore, is a legitimate concern of health care professionals. Caton (1981) reports only 17% of 119 chronic schizophrenics she studied fully complied with their discharge treatment plan. Cottman and Mezey (1976) report that 50% of the schizophrenics followed for 8.5 years after their first admission (N=41) had little involvement with aftercare services. The necessity of designing these services to meet the needs of chronic schizophrenics is implied as the more successful centers are those which meet the subjectively reported needs of schizophrenics: the need for support and social interaction.

Utilization of community services cannot be predicted by the schizophrenic's assessment of their worth. Although 72.3% of 641 schizophrenics stated attendance in aftercare facilities would be beneficial, only 28.3% reported regular attendance in community facilities (Serban and Thomas, 1974). It is apparent that an intervening variable must account for the discrepancy between attendance and attitude towards aftercare facilities. This explanatory variable was identified during in-depth interviews with impending and discharged schizophrenics.

It appears that although much professional attention has been directed towards the fate of the discharged schizophrenic, there has been a failure to systematically assess adult schizophrenics' perception of the planned transition from hospital to the community. To recapitulate, the primary research question addressed by this study is: **"What are the perceptions of adult chronic schizophrenics during the planned transition from the hospital to the community?"** The researcher explored predischarge schizophrenics' perception of this event using grounded theory, a qualitative research approach .

III. Research Method

Dickoff and James (1968) define theory as a "conceptual system or framework *invented* for some purpose" (p.198). These authors emphasize "that theory is invented rather than found in, or discovered in, or abstracted from reality" (p.198). The founders of grounded theory, Glaser and Strauss (1967), contend theorizing from the armchair, rather than from data, may yield irrelevant theories as they do not conceptualize the studied phenomenon.

Grounded theory is the discovery of theory from systematically obtained data (Glaser & Strauss, 1967). Grounded theory is not invented, but rather, it emerges during the process of researching an empirical area of inquiry. Because this theory is grounded in the data, the theoretical concepts will conceptually describe aspects of the studied phenomenon as well as meaningfully explain variation within the data (Glaser & Strauss, 1967). The term "grounded theory" refers to a method of generating theory and the product of this generation. The process of theory generation is cardinal in determining the fit and relevancy of the theory (Glaser & Strauss, 1967). The research method used in this study was grounded theory.

Data Collection

Research Setting

Participants of this study were accessed at a psychiatric care facility located in central Alberta. This facility is a designated treatment center for both involuntary (certified) and voluntary admissions. Study participants were residents of two of the hospital's rehabilitation units. Data collection was conducted in both institutional and non-institutional settings. The contexts of the unstructured interviews are described in the section pertaining to reliability of study results.

Sample

The criteria for selection of informants was:

a) diagnosis of schizophrenia made by the participant's attending physician,
b) chronicity of symptoms of schizophrenia,
c) predischarge status.
d) mental competency to provide informed consent as assessed by the participant's attending physician,
e) eighteen years of age or older, and
f) consent to participate in the study.

Patients were excluded from the study if they had a court appointed guardian under Alberta's Dependent Adults Act.

The sample was composed of four in-patients from two rehabilitation units at the research setting. The participants were young adult males in their twenties and thirties. The diagnosis of three participants was paranoid schizophrenia, and the fourth participant was diagnosed residual schizophrenia. During their hospitalization, all participants had electroencephalographies (EEGs) which yielded normal results.

The participants have lengthy histories of mental illness, ranging from three to fifteen years. Two participants had two previous known psychiatric hospitalizations, and two participants had six and seven previous admissions respectively. Two of the participants had previous admissions to the research setting. Only one participant entered hospital voluntarily. The mode of admission for the other three participants was formal. By the time the study was completed, all participants were voluntary. Some participants did experience a change in their hospital status during the study.

Participants were receiving a variety of treatments in hospital including: milieu therapy, predischarge group therapy, recreational therapy, and occupational programs, such as, ceramics. As well, all participants were receiving drug therapy. The primary drugs prescribed were depot neuroleptics: flupenthixol decanoate and pipotiazine palmitate. Three participants were also prescribed antiparkinsonism agents, in addition to major tranquilizers.

Collection of Data

To discover the perceptions of predischarge chronic schizophrenics, unstructured interviews were conducted on a convenience sample of participants. Interviews were conducted over a period of ten months. The respondents participated in the study for three to five months contingent on the length of their predischarge period. Figure 1 diagrams the number of interviews per participant and the month of each interview. Each participant was interviewed four to six times.

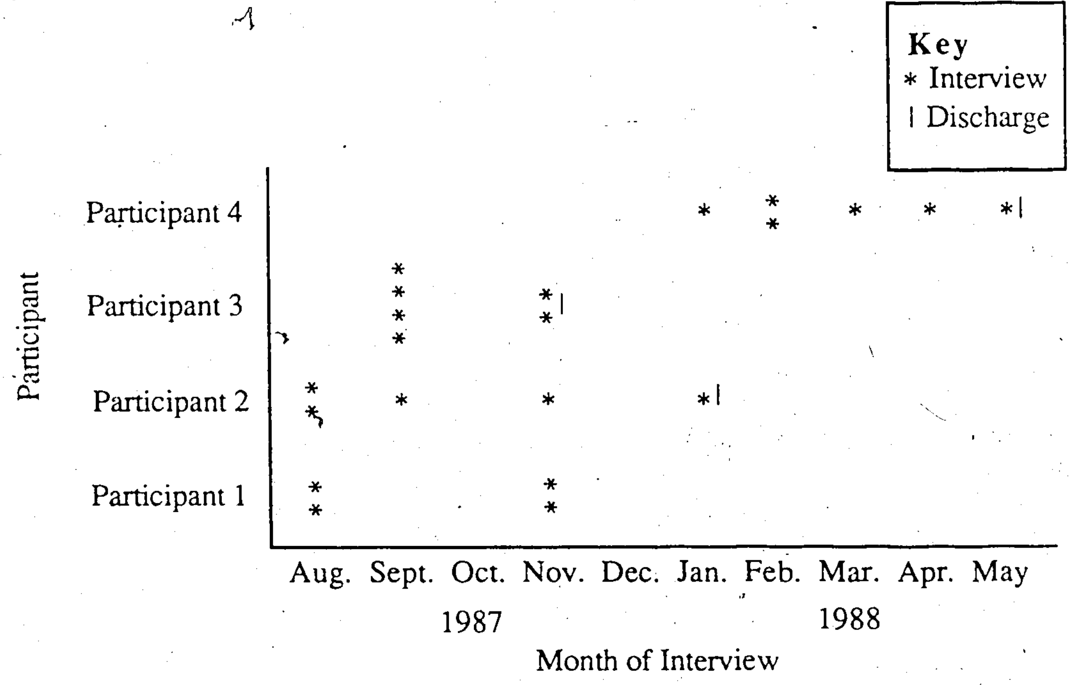

Figure 1. Month and number of interviews per participant.

Because the predischarge perceptions of schizophrenics were unknown at commencement of the study, general opening interview questions were used to facilitate verbalization of participants' perceptions:

> I: I'm trying to get an idea of what it's like to be discharged from hospital. What has it been like for you?
>
> I: Maybe you can begin by telling me what has been happening with you for the last couple of weeks.
>
> I: What is it like to go back into the community?

Verbal probes were utilized to explore participants' responses as well as confirm the researcher's understanding of these responses. The difficulties associated with interviewing schizophrenic informants are addressed in-depth in the final chapter.

Data Analysis

Data analysis was performed on transcribed verbatim interviews. Data were first coded by content to yield substantive codes. Constant comparison of these incidents of data resulted in clustering data to form broad categories. Theoretical sampling in the field was utilized in order to refine these emerging categories and their properties. Purposeful sampling was discontinued when the incoming data failed to yield new information, and the categories were considered saturated (Glaser & Strauss, 1967).

In addition to data collection guided by category refinement, hypothesizing relationships between these categories also provided direction for further data collection. Comparisons were made with the incoming data to either verify or discredit these postulated relationships. Memoing (noting of the researcher's theoretical thoughts stimulated during the analysis) detached the researcher from the descriptive data, thereby facilitating the formation of hypothesis and theoretical codes.

The process of systematic and simultaneous data collection, coding, and analysis yielded a substantive grounded theory, which both describes and explains chronic schizophrenics' perceptions at predischarge. The core explanatory variable of the theory is "becoming ordinary." This concept emerged during data analysis as the primary explanatory factor of participants' perceptions at predischarge.

Ethical Considerations

In addition to concerns pertaining to assuring anonymity, interviewing hospitalized schizophrenics presented two unique ethical concerns. Safeguards instituted to ensure maintenance of participants' anonymity are addressed in the next section. The first concern was related to assessment of competency of potential participants to provide informed consent. Competency entails the capacity of the individual to appreciate the nature of the study and the consequences of participation and non-participation (Picard, 1984). As no judicial test is available in Canada to evaluate competency, Picard recommends that when the competency of one giving consent is questionable, the mental status of the individual should be evaluated by a psychiatrist. In this study, participants were referred to the researcher after their attending physicians assessed them competent to provide informed consent. Inform consent was then obtained from the informant by the researcher.

Safeguards were also instituted to ensure respondents were voluntarily participating in the project. In addition to the use of printed consent documents, the participants' understanding of his consent was assessed by requesting him to paraphrase the content of the consent. Two further safeguards of informed consent were instituted in response to findings reported by other researchers. Palmer and Wohl (1972) report that 12 out of 40 psychiatric patients studied could not read a consent at an acceptable level of literacy. Prior to the first interview, this researcher requested participants to orally read the consents. All participants displayed adequate literacy skills. The second safeguard was in response to findings in the previous noted study and a study by Cutting (1979). These researchers raise important concerns regarding the accuracy and comprehensiveness of schizophrenics' memory over time. Prior to each interview and in order to compensate for the potential loss of or inaccurate recollection of previously presented information, participants were presented with photocopies of the original consent to review .

The second ethical concern was ethical behavior on the part of the researcher if psychopathology was elicited during interviews. If the researcher had concerns for the safety of the informant and/or other people, she was ethically bound to report severe psychopathology to nursing staff or attending physicians. If the elicited psychopathology was not assessed as severe according to the above criteria, the researcher encouraged participants to discuss the matter with nursing staff or their attending physician. These conditions of study participation were noted on printed consent forms.

Risks and Benefits.

This study posed minimal risk to the informants. The greatest risk for participants was breach of their anonymity. Several safeguards in this study minimized this risk. First, confidentiality of the raw data was assured. The tapes were transcribed by the student and were locked in a filing cabinet until completion of the thesis. The tapes were then erased. The transcripts are identified by code names rather than by participants' names. All potentially identifying data, such as personal names, have been deleted from the transcripts. The consent forms, which contain the participants' names, are also stored in a locked filing cabinet at the student residence.

Although irrelevant data has been changed in this final report, participants' quotes are included in the analysis of the data. It is possible, based on these quotations, that mental health professionals intimately involved with these participants may identify these individuals. But it is expected that these professionals will comply with standards of professional ethics and maintain the participants' anonymity.

The participants were informed they would incur no direct benefit by consenting to participate in the study. Although the participants verbalized pleasure with being interviewed, they also noted that the interviews provided no personal benefit. One participant, however, stated he felt reassured regarding the stability of his mental well-being after talking to an "outsider."

Reliability and Validity of Study Results

Reliability

Reliability of a qualitative research is contingent upon the degree which chance factors have influenced the results (Field & Morse, 1985). The three potential threats to reliability resulted from the context of the interviews, interviewer effect, and maturation effects associated with the length of the predischarge period.

Context of the interviews. Study participants were inpatients of a psychiatric care center. Initial interviews were conducted on participants' nursing units and the setting for the interviews was either the unit managers' office or, if that was unavailable, the unit's treatment room. Interviews in the treatment room, however, were interrupted numerous times by nursing staff requiring access to supplies. In order to ascertain if the institutional setting of the interviews affected the quality of information obtained, interviews were also conducted in the hospital's cafeteria, public restaurants, and a public park.

The environment *per se* did not affect the quality of information obtained, but rather, effects were associated with the presence of extraneous conversations and threats to privacy. In comparison to interviews conducted in the public park and on participants' nursing units, participants were more reticent in interviews conducted in the hospital's cafeteria and in public restaurants. Participants were easily distracted by extraneous conversations in restaurants, regardless of the number of patrons present. In addition to being distracted in these settings, one participant verbalized concern regarding the potential for others to overhear the interview.

There was no difference in the quality of interviews conducted in participants' nursing units and in the public park. Both of these areas were appropriate settings for interviews. Altering the context of the interviews enhanced the reliability of the study results because this allows for the effect of the context of interviews to be identified and controlled.

Interviewer Effect. The second potential threat to the reliability of the study results was the potential effect of participants' perception of the interviewer. The printed consent form explicitly disassociated the researcher from adopting a therapeutic role within the hospital. This was verbally reinforced with participants prior to each interview. Participants' acceptance of the researcher's lack of affiliation with the hospital was evident in the interviews. For example, one participant described purposefully misleading the hospital staff regarding hearing "voices." If this participant had perceived the researcher as being associated with the hospital or in a therapeutic role, he would not have revealed this information. The ethical dilemma arising from the acquisition of such knowledge is discussed in the final chapter.

However, the participants verbalized awareness of the difference in status between themselves and the interviewer. They initially verbalized concern regarding the interviewer's perception of them. For example, one participant said "You probably think I'm stupid." When these types of concerns were volunteered by the participants during an interview, the interviewer directly reassured the participants: "No, I don't think you're stupid." This reassurance was effective as it facilitated the development of rapport and enhanced the quality of information obtained.

Maturation Effects. Third, maturation became a potential threat to reliability because of the length of the predischarge period. This period ranged from three to five months for participants who were discharged during the study. The fourth participant remained hospitalized at the completion of the study. The events effecting participants and their accompanying feelings pertaining to this extended wait were included as data and analyzed. This enhances the reliability of the results because the effects of an extended predischarge wait did not randomly affected the data, but rather, they systematically became part of the results.

Validity

Validity is the degree to which the research findings represent reality (Field & Morse, 1985). Application of the medical model to mental illness has deterred research in this area. Weinstein (1979) notes "since the mentally ill (by definition) possess some kind of psychopathology and exhibit various symptomatology, their opinions of themselves or their situation are assumed to be unreliable or irrelevant" (p. 240). This study demonstrates that chronic schizophrenics are able to verbalize their perceptions of predischarge. Three additional sources of data verified the accuracy of the information gained from unstructured interviews.

First, comparison of data with participants' hospital files verified the events described by the participants. Occasionally, the participants interpreted these events differently. However, perceptions are subjective interpretations of experience and therefore cannot be discredited with objective sources of data. The second source of comparison was information volunteered by nursing unit managers. Again, this resource verified the data gained from the participants.

The third source of data-verification was comparison of information obtained in different interviews. Previous interviews were an appropriate source of verification because of the length of time between interviews. The predischarge period for the majority of participants was lengthy (three to five months). If participants had purposefully misled the interviewer, serious discrepancies would be present between the interviews. However, the discrepancies found between these interviews were changes associated with the participants' extended wait for discharge and, therefore, were included as data.

Finally, validity of this theory is furthered by the process of generating grounded theory. Use of constant comparison at all levels of theory generation resulted in corrections of inaccuracies throughout the research process (Glaser & Strauss, 1967).

The researcher had planned to utilize secondary informants to verify the theoretical concepts which represent descriptive data. This, however, was impossible due to the extended delay in receiving institutional approval (six months). Prior to the inclusion of the concepts in the theory, the student verified the concepts with primary participants. As well, although published research on schizophrenia does not address schizophrenics' perception at predischarge, several relevant themes in the literature support the application of the theoretical concepts. Relevant research includes examination of discharged schizophrenics' functioning in the community and attitudes towards hospitalization.

Generalizability of the Results

A substantive grounded theory can be only validly generalized to the population studied (Hutchinson, 1986). The selection of comparison groups determines the scope of generalizability of grounded theory (Glaser & Strauss, 1967). This theory accounts for the perceptions of predischarge chronic schizophrenics. Because of similarities between their situations, these results are generalizable to other chronic mentally ill individuals in the process of being discharged from hospital. Generalizability is possible because the theoretical concepts are detached from the descriptive data they emerged (Glaser & Strauss, 1967).

This theory may have application to other chronically ill people who are institutionalized for treatment and are undergoing the experience of returning to the community. Potential substantive areas of application are predischarge perceptions of physically handicapped, drug addicts, and alcoholics. This theory, however, should not be generalized to these populations, but rather, these populations could be investigated to discover if an emergent fit occurs (Glaser & Strauss, 1967).

IV. Preadmission Experiences: Being a Failure

Individuals do not become psychiatric inpatients solely due to the existence of mental hospitals. Although psychiatric admissions may coincide with the application of the label "mentally ill," numerous factors interact to culminate in these admissions. One factor is the patient's prehospitalization functioning. Participants in this study consistently characterized their preadmission functioning as inadequate. Their perception of their failure to function in the community, combined with the meaning they assign to their admission, produces the context for the occurrence of the process "becoming ordinary." The following section of the paper reviews participants' preadmission experiences and the meaning assigned to hospital admission.

The participants of this study do not envisage their preadmission experiences as occurring within one subjective configuration of the past. Instead, on the basis of their experiences, the participants cognitively fragment the past into two periods of time. These periods are designated the extended past, and the preadmission past. The pivotal point which demarcates these periods of time from each other is the participants' first contact with mental health care. The following quotes from two participants illustrate this phenomenon. ("R" designates the respondent and "I" the interviewer.):

> R: . . . and then I had a lot of freedom. And then all of the sudden, wham, I'm stuck up in a hospital, and I was changed. I was—I didn't—I didn't give a damn for awhile, eh? And then, and then, it got harder, even harder. And then the doctors got at me, and that's where I'm at. The doctors are talking about me, eh? What they think I am, and what they think, feel I want, and what I — what I do, and what I think, and stuff like that.

> I: What ways is the atmosphere "not peaceful"?
> R: [pause] I don't know. Until I went home, I use to hang around with some really good friends, and I found that really relaxing and peaceful. And then I went home and, ah, I ran into this mental health stuff. And I can't say I've had a peaceful moment since.

I: You haven't had a peaceful moment since you've been involved with mental health people?
R: That's right.
I: What's been happening?
R: Uh, I get deeper and deeper into quicksand, I guess. [pause]
I: You feel you're deeper in quicksand?
R: Yeah, there's no way out.
I: I don't understand. There's no way out of . . .
R: Out of mental health.

The themes underlying respondents' references to each of these two periods of time are different. The extended past is best characterized as "the good old days." Conversely, the participants' preadmission past is an extended period of "not making it" in the community, culminating in the respondents' present admission. The preadmission past, which includes previous hospitalizations, ranges in length of time from approximately three to fifteen years. The length of this period is contingent upon the past psychiatric history of the participant.

The Extended Past

Events recalled from the extended past are characteristically experiences which illustrate previous successful management in the community. The participants primarily recalled two types of experiences: previous interpersonal relationships and occupational experiences:

R: Uh huh, someone to come home to. When I worked on the rigs, I was living common-law. I'd come home after work, there'd be a bacon and tomato sandwich there and a beer. The little boy, he'd be jumping and rolling around, giggling, and squealing, and cooing. [pause] And, ah, it made me feel like a man! [pause] Made me feel real good! Like you'd come home after sweating and working your muscles real hard, getting screamed at by some ratty driller.

R: I had a heck of a time on the first couple of rigs I was working on. Finally, I hit one I liked. That was, ah, a step up sub. I got offered a drilling job on one of them, at one time. That's how come I like them.

Although recalled events occurred in the distant past, the participant may speak as though they have occurred recently. For example, one participant dominated his interviews with recollections of his experiences as a laborer. He frequently spoke as if these events had occurred in the recent past. Clarification revealed that these events had occurred more than ten years previously:

> R: Actually, it was tough with that rig. But then I had my cement forms in mind. I had worked for, eh, eighteen months on a drilling rig straight. Seven hours, no, well, it would be seven days a week for eighteen months. And I just wanted to get away.
> I: You'd get pretty tired?
> R: Yeah, I was pretty sick of drilling rigs.
> I: Was that two years ago when you quit?
> R; No, that was, ah, back when I was about twenty-three years old.

Two further points can be made about data gained from participants. First, participants did not reminisce about childhood days with their families. They predominantly recalled experiences away from home or, if still living at home, experiences with their school peers. Second, the participant with the longest history of previous psychiatric care made the fewest references to the extended past. In comparison to the more recent histories of the other participants (three to four years), this participant had a fifteen year history of psychiatric care. This participant's references to his extended past were limited to relating illicit drug experiences shared with his peers:

> R: We had the sense not to smoke drugs, hash or marijuana, after we were on acid because we're an elite We were, we were in [a] generation that was lost in space. We, we had things to do and we did them.

The Preadmission Past

The preadmission past is best characterized as a long period of "not making it" in the community, accompanied by feelings of discouragement, loneliness, and a sense of being overwhelmed. Some participants initiated compensatory behaviors to alleviate these feelings. These behaviors, however, were often dysfunctional because the outcome tended to deepen the participants' feelings of alienation and thereby compounded their sense of isolation from the greater community.

"Not Making It"

"Not making it" is defined by the participants as inadequate functioning in the community. One participant bluntly stated,

> R: Ah, I didn't think I'd get mentally thick—sick. I thought I'd be able to function.

The yardstick generally used to measure their functioning was social norms, which the participants unquestioningly accepted as appropriate standards for self-evaluation:

> R: Kind of instead of going against the grains of society, I'll go along with it.
> I: Do you consider yourself going, as in the past, as going against the grains?
> R: Yeah, with a name like ______, I sure do.
> I: What are the grains of society, going with the grains of society? What does that mean?
> R: Um, laughter, I suppose, and money, [pause] comfortably involved with endeavors.

A second participant stated he had deviated from "the norm, from the righteous side of society":

> I: We were talking about before you went into ______________, you were doing a lot of drugs and alcohol and you flipped out. Can you kind of describe what's flipped out. What happens when you flip out?
> R: Being out of the norm from the righteous side of society. [pause] When you do that, you become persecuted by yourself and the people around you.

Self-comparisons were occasionally made with others in the community whom the participant perceived as having achieved the social norms for functioning:

> R: You can always say that you're gonna make, make something out something, but it doesn't always work. That's, that's the bugger. It's different, it's strange 'cause when—my brothers

> and sisters are all super people. Like not super people, but they all can make something work for them and I can't. I don't know. I don't know why. It's amazing. I've been trying.

Community members (including peers) whom the participant perceived as not emulating these norms are rejected as yardsticks for comparison. One participant described his previous peer group in the community as "the dregs of society" because the group members abused drugs and alcohol. Discharged psychiatric patients living in the community are also rejected as standards for comparison:

> R: . . . you see, I spent some time in another group home. . . . It's not nice at all because you realize that people that are there . . . are there because of the same reason you're there.

The participants based their evaluation of "not making it" in the community on their retrospective appraisal of their personal well-being while residing in the community. They recalled both their level of functioning and accompanying mental well-being.

Self-Evaluation of Community Functioning

All study participants characterized their preadmission functioning as inadequate. They identified two areas of inadequate functioning: employment and intimate interpersonal relationships. Only one participant expressed satisfaction with the quality of his preadmission peer relationships. The majority of participants expressed feelings of loneliness. This lack of a sense of fellowship in the community resulted from either the absence of companionship or the presence of non-supportive peers in the community:

> I: And you find it not such a good idea being alone?
> R: Nah, I miss half of the world. Sleep through half and miss another half . . . the whole world goes by. [pause]
>
> R: My friends generally persecute me. They thought I was a joke.
> I: They thought you were a joke?
> R: Uh huh, they'd play my emotions that way, find a weak spot and tease me about it. It's just a subtle way of giving me

> strength. . . . By joking about somebody's inadequacies, you give them strength. Although you may frustrate them and put them down, but, eventually, you gain strength from the situation.

The presence of peers in the community, therefore, cannot be equated with the availability of emotional support. Although the participant in the previous quote reasoned his peers were helping him by rejecting his behavior, he did not identify this peer group as supportive. He complained of feeling "loneliness to the max" when he attempted to quit smoking marijuana. He also stated that being mentally ill is being frustrated:

> R: You can't reveal your emotions properly—somebody to care about or somebody that will listen.

The second area of inadequate community functioning identified was that of employment. The participants of this study are young adult males in their twenties and thirties. From their perspective, fundamental aspect of "not making it" was their failure to be self-supporting in the community. Only one participant had been employed during the previous two years. He described his job in a convenience store as "boring" and "unfulfilling." Due to termination from his place of employment, this participant had been receiving unemployment insurance for the past year.

The participants expressed ambivalent acceptance of supplementary sources of financial support. Although they recognized their need for this assistance, they perceived social assistance as unearned income:

> I: It sounds like you don particularly like being on it [pension].
> R: [pause] In some ways, it's necessary; in some ways, it's a hand out.
> I: Can you tell me more about that?
> R: Well, you don't ever have to worry about being fired. So the stress there is gone, so it's beneficial that way. Ah, getting something for nothing has always disturbed me, so it's negative in that way. That's my only beef about being on it.

Self-Evaluation of Mental Well-Being

The predominate emotional state recalled by participants is congruous with their perceived functioning in the community. All participants referred to feeling overwhelmed while residing in the community. Some participants explicitly identified stress as the underlying basis for these feelings:

> R: I never missed a day of work, you know. And things were really piling up on me, you know, a lot of stress and stuff like that. My hair was just falling out. You should have seen that. I could go like this [running fingers through his hair]. I could go like this with my [showed researcher hand with hair between the fingers] like that, and have about ten hairs.

Other participants implicated stress in their descriptions of being overwhelmed. These participants recalled feeling: "bogged down," being in a "real panic," "everything was moving kind of fast anyway, just not enough time," and "the whole world was upside down there for a little while."

The level of stress experienced by participants is not temporally related to their admissions. Instead, the participants describe this stress as chronic and encompassing the entire preadmission period. For example, although the preadmission past includes previous psychiatric hospitalizations, the participants did not describe a transient period of reduced stress following these discharges:

> I: How about the other times when you left, how did you feel then?
> R: I felt good. I felt good that I was leaving, but I wasn't as certain as I am now, you know. Like I thought, I didn't think I'd come back but, you know, but, but I still had the problems. I was just on a fake medication, you know. They had me on the wrong meds, and, um, it was just a phony reality. Really, because I was walking around in a daze all day. That's 'cause I was on pretty heavy medication, you know.

A second participant spoke of his anticipated success following treatment:

> R: I took Assertiveness Training and I thought, "Ah, ah, I got it made, I can set myself in any direction I want" and then, it's

> people that get to me, eh. It's the people, it's not the—maybe it is the surroundings. I dunno.

Being Overwhelmed

Participants identified factors which intensified or precipitated feelings of being overwhelmed in the community. These factors are categorized into two main groups: behaviors of the participant and environmental influences. Environmental influences are further subdivided into nonintrusive and intrusive influences.

Environmental Influences

Environmental influences are those influences which participants identify as having an external origin. Intrusive influences encompass intrusions into the participants' cognitive sphere by either known or unknown others. One participant described intrusive experiences as "things that aren't there, but pop in there, out of thin air." Nonintrusive influences are events/conditions occurring in the participants' objective environment.

Intrusive influences. Mental health professionals consider intrusive influences cardinal signs of psychosis, an intrapsychic phenomenon. However, the participants in this study who experienced this phenomenon did not accept this premise:

> R: And, ah, I was laying on my bed and I was—I felt like I was dying. It was this patient next to me cursing me to death. And I was resentful for what he said. And, ah, I felt like my spirit was leaving my body . . .

This experience occurred prior his transfer to the study's setting from a community hospital. Another participant also related experiences of mental intrusion by a known other. He initially expressed disbelief at what was happening:

> R: Okay, okay, just listen to me, okay. That's all I ask. And, um, one day, I was, I was sitting in bed and I was thinking about ________, you know. And I, I felt really bad about it, and everything like that. And I just started crying, eh? And, um, all of sudden, all of sudden, all my thoughts were being displayed, you know. I could hear my thoughts being said. And then I asked them, I asked them through my mind. I said "How, how,

> how do; [are] you doing this?" and they told me "ESP." And I said "That's bullshit, I don't believe in ESP." And they said "Some people have this special gift," you know, and it was really amazing.

Although health care professionals categorize such experiences as intrapsychic, the participants perceive them as being externally generated. Furthermore, the participants continued to conceive of these experiences as interpersonal problems throughout their hospitalization. The following quote illustrates how the participants envisage them as relationship problems rather than indicators of psychological problems:

> I: So when you'd go out, what would happen?
> R: I'd drink a little bit too much [laugh], and get really plastered, and forget to take my meds, and then I'd get sick again and terrible.
> I: What sort of things happened when you got sick again?
> R: Um, . . . I was just hearing really bad voices and, um, telling me really strange things, bizarre things. And I'd believe them and I'd get sick, you know. They'd make me really sick.

For this participant, the presence of the voices was not indicative of illness, but rather, illness resulted from his relationship with them, that is, he believed them.

Participants' feelings of being overwhelmed are directly and indirectly magnified by intrusive experiences. Participants who experienced these phenomena described direct changes in their mental well-being which they attributed to the effect of these experiences. One participant stated he felt "stifled" during these intrusive experiences. Another participant described himself as "mentally restricted":

> R: Um, I was restricted because I felt that there was people reading my thoughts and, um, you know, and knew what I was doing, and everything like that, you know. And that use to bother me a lot. So, I couldn't really function the way I want to function, eh.

This participant also described experiencing an extended period of "total depression" while residing in the community.

The participants' descriptions of the subjective effect of the intrusions are similar as the respondents characterized these experiences as burdensome and restrictive. The indirect effects of these experiences are also similar. Fewer personal resources are available for the participants to utilize when dealing with their nonintrusive surroundings as personal resources are expended managing the intrusive experiences.. The participants' methods of managing intrusive experiences are described in the next chapter.

Nonintrusive influences. The second type of precipitating environmental factors identified by the participants are 'nonintrusive influences'. Nonintrusive influences are events/conditions occurring within the participants' objective environment which the participants identified as burdensome. The two major categories of nonintrusive influences affecting the participants' sense of mental well-being were examined previously. These were the lack of paid employment and the lack of supportive interpersonal relationships in the community. Each contributed to the participants' sense of declining mental well-being in several ways.

The participants described feelings of inadequacy and failure arising from their inability to obtain long term employment. Two participants attributed their failure to obtain paid employment to the lack of understanding employers in the community:

> R: Like I'm not lazy and I like to work, but I just, I can't, I can't connect on [to] a good job or, ah, [a] patient employer.

As well, termination from workplaces adversely affected the participants' confidence in their abilities to function in the community.

> R: I use to work in a glass factory in ________. . . . The guy knew damn well that I was sick, eh, and so he gave me the boot. The same with, um, the same with the—it sort of makes me wonder about myself. Just what — where I am, and what kind of functions I do have, you know.

Several stressful incidents emerged from the lack of supportive relationships in the community. These incidents involve the rejection of participants' behavior by significant others. Incidents described by the respondents include: rejection by members of community institutions, such as, churches, requests by family members to seek alternative living arrangements, and finally, rejection of behavior by peers.

The participants did not describe their community ambience as supportive. Half of the participants related incidents of perceived rejection by other community members:

> R: . . . sometimes, you see, I get the strangest looks, you know. I'm not gonna worry about it. It's too bad for them.

Another participant described himself as a "modern day leper." He also stated:

> R: As soon as someone finds out you've got a disease of the mind, they right away start treating you as a second class citizen. As if they're superior 'cause they're somewhat more normal than you are.

The majority of participants identified specific aspects or events in their social environment which contributed significantly to their feelings of being overwhelmed, for example, rejection by significant others. There was one exception to this. The participant with the longest history of previous psychiatric care indiscriminately described the social community outside the hospital as threatening and punitive. To this respondent, the community is composed of powerful, malevolent others:

> R: . . . if I, if I try to do something, there's always someone out there, that, that's there to outsmart me, you know. So, I gotta be careful, I gotta—I can't just give up, right?

Behavioral Influences

The final contributing factor identified by respondents was the misuse of drugs and alcohol. All participants described drug and alcohol related experiences. Only one respondent reported his alcohol usage as limited to the extended past. The majority of respondents describe continuous use of these substances throughout the preadmission period. Although environmental influences, such as, peer group pressure were present for some participants, all respondents perceived use of these substances as volitional.

The participants accounted for their use of drugs and alcohol in two ways. First, for some participants, the use of drugs and alcohol was expected and acceptable peer group behavior:

> R: In the group I was dealing with it was socially acceptable, and it made me feel good, sometimes paranoid. It would strengthen the ties between me and my friends, so I became to be dependent on them, the dope and the company. It was a socializing skill.

Second, drugs and alcohol were described as an accessible method for reducing feelings of insecurity as well as for augmenting the participants' ability to persevere in the community. The use of these substances was a means for gaining temporary respite from life in the community:

> R: . . . I like smoking hash, you know. It keeps me, it keeps me going. I don't get burnt out and stuff like that. . . . But I like smoking dope and [pause] it's a great antidepressant.

> R: . . . it's just something to get me away from where I am.

Another respondent stated the use of drugs and alcohol alleviated his feelings of insecurity and enhanced his sense of fellowship with his peers:

> I: When you say it helped you feel good, in what sort of ways?
> R: I was able to relax, it took away the frustration.
> I: Frustration from. . .
> R: Self-insecurities.

> R: . . . I felt more at one with people in the room. I could carry out a conversation better.

The behavior was detrimental to the respondent, however, when the intended effect was not achieved. Adverse effects were not attributed to the use of these substances but to their misuse:

> R: I was drinking too much. I'd drink everyday. I was, I was nearly an alcoholic by the time I got out of that place.

> R: I just take, I just, I overindulge. I just do too much of—I go to the bar, I drink myself crazy.

The overuse of drugs and alcohol adversely affected the respondents' mental well-being. The following quote from one respondent best illustrates this effect:

> I: It helped you relax?
> R: Right. Actually it added stress in certain cases too. People get paranoid when they use a lot of dope.
> I: Uh huh, what does it mean to 'get paranoid'?
> R: Oh, cold, clammy physically, and your thoughts racing mentally.

Isolated, indirect effects of substance overuse were also reported by participants. For example, one participant reported he would forget to take his prescribed medication when inebriated. He stated he would hear "really bad voices" as a consequence of his failure to comply with his drug therapy. Only one respondent reported experiencing negative feelings associated with the use of illegal substances:

> R: Guilt because you're breaking the law. [pause] Guilt because you're dependent upon a substance.

This concludes the description of those factors which respondents identified as precipitating or intensifying feelings of being overwhelmed while residing in the community. A few closing remarks will clarify some aspects of the data. First, no influences which facilitated the participants' adjustment in the community were included in this section because none were elicited in the interviews. The participants describe the preadmission period as an extended period of "not making it" in the community.

Second, the respondents identified few volitional behaviors as contributing to their perception of "not making it." It should be noted the researcher has outlined only those behaviors the respondents identify as contributive. Behaviors which others may identify as detrimental to community living, such as violence against others, are excluded because the respondents failed to label them as such.

The final point relates to the time of occurrence of some events the respondents have identified as contributing to the deterioration of their sense of personal well-being. It was noted earlier that the preadmission period ranges from three to fifteen years, contingent on the respondents' history of previous psychiatric care. Influences identified by participants also fit into this extended time period. For example, one respondent stated he believed that being asked to seek alternative living arrangements precipitated his feelings of being overwhelmed. This incident, however, had occurred at least three years prior to his present admission. Personal rejection by a significant other was identified by another participant as a major contributive factor to his sense of social isolation in the community. This rejection had also occurred in the distant past, at least two years prior to his present admission.

Admission to Hospital

The meaning participants assign to their admission to hospital emerged from their integration of three facets of admission to psychiatric hospitals: (1) the level of preadmission functioning, (2) the perceived initiator of admission, and (3) the participant's conception of mental hospitals *per se*. The meaning assigned to hospitalization consists of the behavioral and social implications of admission. The behavioral connotation applied to admission was that it signified to the participant how poorly he was functioning in the community. The social connotation was that admission represented intolerance of the participant's behavior by the greater community.

The first factor influencing the meaning assigned to admission is the respondents' assessment of their preadmission functioning. The respondents described themselves as "not making it" in the community during this period of time. The primary emotional state recalled from this time period was that of feeling overwhelmed and frustrated. The preadmission period ended with the participant's admission to hospital.

The second influencing factor was the participants' perception of who initiated their admission. A striking feature apparent in the data was the fact that the respondents did not perceive their admissions to be a result of their own actions. This phenomenon was apparent regardless of the respondent's admission status: voluntary (i.e., signed self in for treatment) or involuntary (i.e., admission certificates). The following quotes illustrates this:

> . . . and then I got *called back.*
> . . . this was why I got *sent here.*
> . . . I got *committed.*
> . . . *he just sent me* straight up here. [referring to family physician]
> . . . I *got taken* out the room, the police came, off duty, and, ah, you see, there was no evidence. And the next thing, you know, I, I was told "You're beyond our rules, *we're shipping you* to __________". And the next thing I knew, I was in an ambulance and up here.

These quotes are from respondents who were certified at the time of admission. Only one respondent voluntarily admitted himself to hospital. He too described his admission as initiated by others, in his case, his father:

> R: . . . he, *he took me* out for a drive away from the home and, um, *he said to get back* to the place.

This tendency for respondents to perceive their admission as initiated by others is present regardless of the events precipitating the admission:

> R: My doctor was sick and tired of me ODing. . . . he was fed up with me, man. He just wasn't gonna take no more of my shit. *He just sent me* straight up here. He called, as soon as he found out, he called straight up here. He was very firm with me, you know.

Although this participant had attempted suicide, he still attributed his admission to the actions of his physician. Another participant was admitted following a violent attack on another patient in a city hospital. This participant also did not attribute his admission to his violent behavior, but instead, he attributed it to the intervention of others.

Related to this phenomenon was the failure of respondents to identify significant events which resulted in the deterioration of their feelings of well-being immediately prior to admission. Although two participants described events which precipitated their admission, they did not describe any deterioration in their sense of well-being prior to these incidents. Both participants described problems functioning in the community prior to these incidents. For example, the respondent, whose suicide attempt precipitated his admission, described experiencing an extended period of depression while he was living in the community.

> R: . . . it's a terrible feeling living in depression, you know. It really is, um, I've, I've lived with it for years, you know. Like months on end I was living in total depression, you know.

The third factor influencing the meaning assigned to their admission was the respondents' perception of psychiatric hospitals *per se*. Their impression of psychiatric hospitals varied and was dependent on the respondent's previous psychiatric treatment. Respondents undergoing their first admission to a provincial psychiatric treatment center spoke of experiencing trepidation when first informed of their impending admission:

> R: I didn't like it, you know. I, I wondered "Oh, no, they're sending me to ________, a crazy place," you know. Like you hear so many things about _____, and they're such negative things.
> I: What sort of things did you hear?
> R: Um, just, just like this is a really terrible place to come to and a lot of bad memories from the people that come here, usually come back and stuff like that. Just a lot of negative things, you know.

A second respondent stated coming into hospital:

> R: Scared the hell out of me. I'd heard all kinds of stories about ________. I was expecting thumb screws and stuff like that. . . .

> Quite scared. I didn't know what to expect. I was expecting ECT [electroconvulsive therapy] treatment, and large needles, and lobotomies, and stuff like that.

Respondents with histories of previous admissions did not express this trepidation. They tended to regard psychiatric care centers as institutions for people who fail to "make it" in the community. One participant described the hospital as "just a warehouse to start over, I guess." A second respondent stated he was admitted to hospital because he "burns out" in the community. "Somehow I can't function and I can't perform sort of thing." He also stated "it's not too bad" to get admitted.

It was indicated earlier that the meaning participants assign to their admissions consist of behavioral and social components. Behaviorally, their admissions objectively substantiate their perception of themselves as failure:

> R: I seen my folks and I broke down in front of my father. I started crying and he, he took me out for a drive away from the home. And, um, he said to get back to the place. And I said . . . "What about my position in life?", eh? "Why aren't I such a big success like everyone else?"

Another participant stated:

> R: I'm not too proud of the place or myself being in here, I suppose. Just not interested.
> I: Uh huh. When you say you're not too proud of yourself or of the place, how do you see yourself being in here?
> R: Hmm, just about on the bottom.

Socially, admission to the hospital was perceived by participants as symbolizing condemnation of their behavior by the greater community. One participant directly referred to condemnation by others:

> R: I thought I was being condemned and I would never get out.
> I: Condemned by who?
> R: The government. [pause] At least, that's what I thought at the time.

Other participants also made reference to feeling that they were being punished by others for their behavior in the community:

> R: . . . like I didn't do anything to make it in here. . . . I didn't take anybody's life. I didn't murder anyone. I didn't steal anything. Well, I might of stole a pack of smokes or something from the corner drug store, but nothing . . .

Only one participant openly expressed resentment towards those he perceived as responsible for his admission. He stated he "was set up" and maintained others in the community display the same behavior which he felt contributed to his admission:

> R: I get into a fistfight every five or six years, it seems like, or an act of violence of some sort. [pause] And there's other people that I know on the outside that get into fistfights almost daily or bi-daily, and they never get put away.

Admission to a psychiatric care center, therefore, also represents official redress of individual's inability to function in the community.

The respondents' preadmission experiences, combined with the meaning assigned to hospital admission, provides the context for the core variable "becoming ordinary." This context or necessary condition for the occurrence of the core variable is a condition in which the respondent perceives himself as a failure in comparison to others or to accepted social norms. All of the respondents emphasized behavioral inadequacies and not psychological difficulties when discussing their preadmission past.

In addition to providing the context for the core, the participants' frame of reference affirms the phrase used to designate the core. "Becoming *ordinary* " is assigned to designate the core variable in preference to "becoming *normal* ." To some, normality may imply judgement of the psychological well-being of the respondent. In contrast, "becoming ordinary" does not imply this. The respondents of this study emphasized functional normalcy, not psychological wellness.

Discussion

The respondents' actual level of functioning in the community can only be inferred from these data as the participants' preadmission experiences were retrospectively recalled. Their perception of their preadmission functioning has likely been influenced by their admission and subsequent inpatient treatment. No assertion can be made, therefore, regarding whether the respondents perceive their functioning as inadequate prior to admission. However, published research results on the post-hospital adjustment of chronic schizophrenics substantiate the problems identified by the respondents of this study. Although the researchers examined the social outcome of discharged schizophrenics, the results are applicable to this study as all of the respondents have had previous admissions. When readmission occurs, the period of time that was once post-discharge becomes preadmission.

The social outcome for discharged chronic schizophrenics when measured by employment status is dismal. Caton (1981) reports that only 12% of 119 young chronic schizophrenics (mean age of 34 years) had paid full-time employment at some time during the year following discharge. Only one study participant had continuous paid employment throughout that year, and only twenty-seven percent of the participants had worked either part-time or full-time during the year. However, Caton does not specify whether the participants were employed in the competitive marketplace or in sheltered work environments.

Another group of researchers assessed the social adjustment of 46 chronic schizophrenics attending ambulatory treatment facilities. Thirty-six percent of the participants had worked "most of the time" in the three years prior to the interview. Forty-five percent had worked "briefly or not at all" during this time period (Glazer, Sholomskas, Williams, & Weissman, 1982). Again, the researchers did not describe the type of work environment of the employed participants. The researchers also report that the study participants identified employment as one area of poor adjustment in the community. Grusky, Tierney, Manderscheid, and Grusky (1985) did distinguish between employment in the marketplace and sheltered employment. In this study, a two-stage stratified sample of chronically mentally ill adults who participated in community support programs were surveyed. Sixty-nine percent of the sample of 1,471 participants had either a primary or secondary diagnosis of schizophrenia. These researchers report that 25% of the participants were employed at the time of the survey. Of these, 60% were employed in sheltered settings.

Only one published study was found in which the researchers explored chronic schizophrenics' attitudes toward employment. Serban and Thomas (1974) interviewed 516 chronic schizophrenics at admission and discharge from hospital. The researchers report that 71.9% of these participants were unemployed during the two years prior to admission. Only 13.4% had been employed full-time. Of the total participants, 50.8% reported that employment would be beneficial to their mental well-being; 49.2% stated employment had no significant value. Paradoxically, 67.2% of the participants stated they believed reliance on welfare was detrimental to their mental well-being. Serban (1975) also examined the stress experienced by these participants while living in the community. The researcher reports that chronic schizophrenics have the greatest level of stress associated with being unemployed and receiving social assistance in comparison with two other groups: acute schizophrenics (N=125) and a comparable nonpsychiatric control group (N=95).

These researchers substantiate that the majority of chronic schizophrenics living in the community are unable to establish stable employment records. This theme is also recurrent throughout the interviews of this study. The respondents of this study, however, all indicated that failure to achieve stable paid employment in the community was indicative of failure to function in the community. Their inability to obtain paid employment accentuated their feelings of inadequacy. This finding is in contrast to the above noted study by Serban (1975), in which almost fifty percent of the participants stated employment was not beneficial to their mental well-being.

Another theme prevalent in the interviews was the respondents' feelings of social isolation while residing in the community. This sense of isolation cannot be attributed to the absence of social contacts in the community. The majority of participants in the study described frequent contact with either family members or peers. Only one participant described himself as isolated from his family and bereft of friendship. However, all participants did describe themselves as lacking intimate, egalitarian relationships, especially with members of the opposite sex.

Researchers have determined that schizophrenics, in addition to professional support, do have social support available in the community. Caton (1981) found that 50% of the schizophrenics studied reported the presence of another person in the community who would supply needed assistance. Sokolovsky, Cohen, Berger, and Geiger (1978) examined the social networks of discharged psychiatric patients living in a single room occupancy hotel. The researchers report that the most impaired subgroup of schizophrenics residing in the hotel had supportive relationships with other hotel occupants. These social networks were comprised of approximately ten people. They were significantly different in comparison to the networks of schizophrenic occupants with minimal or no residual symptoms and those occupants with no history of psychosis. The chronic schizophrenics' social contacts were more dependent, and the network connections were less complex. (Complexity refers to the degree of variability in the incentives for social interactions within the network.)

Chronic schizophrenics, therefore, do not appear to be socially isolated in terms of available supportive others within the community. Even though these supports are available, chronic schizophrenics continue to describe themselves as socially isolated.

This isolation appears to be associated with the lack of egalitarian relationships in the community. Serban (1975), who studied 516 chronic schizophrenics, reports participants described themselves as feeling highly frustrated in the community. This frustration was associated with the absence of a social life and feelings of total isolation.

The participants of this study consistently recalled feeling frustrated and overwhelmed during the preadmission period. These feelings were associated with omnipresent stress experienced within the community. Although numerous researchers have focussed on identifying precipitating factors related to the onset or exacerbation of symptoms (e. g. Canton & Fraccon, 1985), other researchers have rejected the relevancy of this focus. Serban (1979) suggests research which focuses on precipitating factors may be inappropriate when studying the functioning of chronic schizophrenics in the community. In mental health care, chronicity refers to chronicity of residual symptoms. Discharged chronic schizophrenics are returning to community life with a high degree of functional impairment. Because this impairment encumbers their functioning, stress is inevitable when schizophrenics reside in the community. The rejection of the relevancy of identifying precipitating events associated with exacerbations of symptoms in chronic schizophrenics may be premature.

Research results indicate that chronic schizophrenics residing in the community report more stressful problems that do acute schizophrenics (first admission) (Serban & Woloshin, 1974) and nonpsychiatric comparison groups (Serban & Woloshin, 1974; Canton & Fraccon, 1985). Furthermore, researchers also suggest that the stress experienced by chronic schizophrenics is ubiquitous. Stressful problems are present in all areas of community functioning in which the schizophrenic is actively participating. This is illustrated in Serban's (1979) study of 100 chronic schizophrenic outpatients.

Except for employment and marriage, the study participants reported stressful problems in all areas of activity. Because too few participants were married or employed, the presence of stress could not be assessed. Another study by the same researcher, with a different set of participants, revealed that chronic schizophrenics experienced significantly more stress associated with the absence of these social roles than did participants from two comparison groups: acute schizophrenics and nonpsychiatric respondents. Chronic schizophrenics reported significantly more stress associated with being dependent on social assistance, the inability to establish interpersonal relationships, and parental interference with daily living (Serban & Woloshin, 1974).

Although consensus is present among researchers regarding the prevalence of stressful problems experienced by chronic schizophrenics living in the community, the results of research attempting to identify discrete precipitating events which culminate in readmission are inconclusive. The majority of 516 chronic schizophrenics interviewed by Serban (1975) could not identify precipitating events resulting in their readmissions. Only 38.37% of these participants were able to identify discrete stressful events occurring prior to hospitalization. Those participants who identified specific stressful events stated these events were "secondary" factors contributing to their admission. Rabkin (1980), who reviewed several studies on stressful events and readmissions, concludes that discrete, stressful events alone are insufficient in accounting for rehospitalization. She suggests these events incrementally increase the existing stress of impaired people.

Researchers have focussed on identifying discriminatory stressful events occurring prior to the schizophrenic's admission. The precipitating event, however, may only have a precipitating effect when it interacts with certain environmental characteristics. For example Goldstein and Caton (1983) found the type of living arrangement that chronic schizophrenics were discharged to did not affect length of community stay. However, characteristics of the participant's environment were significantly associated with rehospitalization. The characteristics identified by the researchers were the presence of social support and degree of interpersonal stress evident in the environment. Interpersonal stress affected readmission rates when the environment lacked social support. Unfortunately, the concept "social support" was not clearly defined by the researchers.

The preadmission experiences of the participants of this study are similar to the social adjustment of discharged chronic schizophrenics as related by the above researchers. The participants of this study described extended periods of feeling overwhelmed prior to admission to hospital. Although two of the respondents reported stressful events which resulted in their behavior being brought to the attention of professionals, they did not identify these events as precipitating an acute course of illness. Instead, the participants perceived the events as part of a succession of events culminating in their admission. Their hospital admission arrested a progressive course of feeling overwhelmed in the community. It is noteworthy that all of the respondents consistently described themselves as lonely and bereft of intimate interpersonal relationships.

The participants of this study perceive themselves as failing to "make it" in the community. The preadmission experiences described by the participants illustrates their inability to meet environmental demands faced by "ordinary people." The next chapter examines the respondents' perception of themselves and their anticipated future during the predischarge phase of their hospitalization.

V. Readiness to Return to the Community: "Anticipating Mastery"

This chapter presents the research findings on participants' predischarge perceptions regarding their personal well-being and forthcoming return to the community. The meaning participants assign to their return to the community is different from the meaning they assign to the act of being discharged. This latter definition is addressed in the next chapter.

The primary criteria for selection of study participants was that the participants, in cooperation with their treatment team, were seeking community placement. Although the participants were selected in accordance with this criterion, it is apparent from the data that respondents' expressed desire to leave hospital may not be representative of their assessment of readiness to return to the community.

All respondents verbalized a desire to leave hospital. One respondent, however, was uncertain about his readiness to reside in the community (see figure 2). In contrast, the other respondents anticipated successful transitions to community living. These respondents were "anticipating mastery" of their post-hospital communities. They did not refer to their anticipated future adjustment solely in terms of their ability to manage community demands. The participants who were "anticipating mastery" were anticipating personal excellence in their pursuit of "ordinary" goals. These respondents expected to prevail over community demands and pursue their aspirations of being independent and self-sufficient. "Anticipating mastery," therefore, refers to the respondents' belief that they can attain their personal goals by way of their interactions with their environments.

Desire	Anticipated Functioning	Readiness
R1: I wanted to get the hell out of this, hospital that's what I want.	If I was, if I was, ah, to go out in the world, I'd never make it. I just can't, I just can't put it together. I can't put enough of myself together.	Absent
R2: Ah, I just don't like spending my time in here.	I'm looking—I'm kind of excited about finding a job and earning some money to put in the bank.	Present
R3: I don't, I don't like being here, you know. I'd jump at the chance to get out of here.	Um, I see myself working, and I see myself myself progressing. I see myself as being single and loving every minute of it.	Present
R4: [It's been] long enough. Half a year, half a year to me anyway. That's as much as I want to spend in this place.	In a month from now, I should be on AISCH [pension], working part time, attending programs, getting back into society on a even basis, or a controlled basis rather.	Present

Figure 2. Comparison of participants' desire for discharge and anticipated community functioning.

Indicators of "Anticipating Mastery"

The participants expressed "anticipating mastery" of post-hospital communities in three ways: (1) by anticipating successful transition to community living, (2) by planning concrete strategies for attaining goals in the community, and (3) by expressing positive self-regard.

1) Anticipating Successful Transition to Community Living

The participants "anticipating mastery" perceived returning to the community as an opportunity to "start over". In contrast to their recalled preadmission failures, these participants anticipated positive post-discharge experiences. Discharge, therefore, does not precede resumption of their previous life in the community; instead, it ushers in "new life":

> R: It's gonna be a new experience. I'm looking forward to it, and it's gonna be wonderful.

> R: It's a new beginning in the sense that, um, I'm starting my life over. I'm, I'm moving out of the house, and, you know, I'm gonna be going to school and all those things.
>
> R: Just a new beginning for me anyway. . . . Oh, just starting to hoard things for the future again. Maybe buy a new car or whatever.

These respondents were anticipating successful transition to community living:

> R: It'll be a lot of hard work too, you know. Like it'll definitely, you know, be it's pros and cons, but I'm sure that I'll be able to adjust and fit in right.
>
> R: I feel most comfortable out in the community right now. After living in a place like that [hospital], I think I'm more than prepared to survive in the community.
>
> R: I found it hard to make a living before, but now life seems a lot simpler.

They also stated they were ready for discharge. One participant stated "I'm just ready to go. I, I can't put it into words. There's, you know when you're ready to and I'm ready to go". Another reported being "ready and able to deal with myself and society".

Only one of the participants was unequivocal regarding future inpatient treatment. This participant stated his problems are resolved, and "this time I won't be coming back. Like this is the last time I'll be here. I know that for a fact." The other two participants expressed uncertainty regarding their need for future rehospitalization. This uncertainty is associated with their speculation that their present state of personal well-being could decline. One participant stated "I'll never have to come back to a place like this again. If I ever got sick, I hope I don't have to come back to this place."

The fourth participant did not characterize his impending return to the community as indicative of "starting a new life." This participant perceived his forthcoming return to the community as a continuation of his preadmission "struggle to make it":

> R: It's the people that get to me, eh? It's the people, it's not the— maybe it's the surroundings. I dunno. Something's gotta hook on my line or something. Because always when I'm there, . . . if I try to do something, there's always someone out there, . . .

> that's there to outsmart me, you know. So I gotta be careful. I gotta. I can't just give up.

This participant was not anticipating successful transition to community living, but instead he verbalized uncertainty regarding his readiness to reside in the community:

> R: Probably end up back here in another half year. Will be some tiny . . . incident at the group home. Either that or 'cause I can't find work. Somehow . . . I can't function and I can't perform sort of thing.

As evidenced by the preceding quote, this participant was also uncertain regarding his need for future readmissions. His uncertainty, however, was associated with lack of confidence in his current competency to manage in the community.

The participants' characterization of their anticipated community environments did not account for the variances in "anticipating mastery" of these environments.

Anticipated Community Environment

Participants' anticipated community environments can be categorized into two types: (1) nonthreatening, hospitable environments, and (2) threatening, malevolent environments. The participants were equally distributed into these two types of anticipated community environments.

Nonthreatening, hospitable environment. Two participants characterized their discharge communities as offering both employment opportunities and emotional support from family members and friends. Although only one participant perceived this environment as having charitable attributes, neither perceived the environment as punitive or restrictive:

> R: I got a job waiting for me in _____. I got buckets of money waiting for me in, ah, ________, which is a nice town. I'm closer to the phone. . . . I'm never broke either. I can always phone up service rigs and go to work for them. Um, . . . they make about the same. Like, ah, you can work about maybe ten days for a service rig and make a month's pay.

> R: It just goes . . . to say, you know, all you have to do is hold out your hand, you know. If you're in need, that's all you have to

> do is hold out your hand and it's given to you. It's a great song, you know. This is a great country. . . . It's a great country, you know. Everything is set up for me, you know. There's, you know, I don't have to be a genius to, you know, survive and nothing like that.

Threatening, malevolent environment. Two participants characterized their anticipated community ambiences as threatening and malevolent. They described these environments as containing anonymous, punitive others. One of these participants described the world as "painful" and anticipated requiring daily deprogramming "from all the nasty people" in the community.

> R: I suppose that's the hardest thing that happens to a person during the day, out in society is slander and common assault. . . [Common assault] is double talking a person when he's having another conversation. . . . [Two conversations going on at once,] one malicious and one benign.

> R: Somebody that's—what's the word I'm looking for—is, ah, up to date on my problems. Is able to counsel me at the daybreak and the day end. [pause] That's about it. Somebody to deprogram me at the end of the day. . . . Well, everyday somebody gives you certain information, derogatory or positive or whatever. And you just gotta sort the good from the bad and have a good night.

Although this participant stated supportive friends are present in his community:

> R; I've been in contact with a few of my friends that are still my friends. And they are gonna be happy to see me out of there [hospital] and they're being very supportive in that way.

he also speaks of being "damned" by the "righteous people. The ones that feel too self-righteous. There's a difference between righteous and self-righteous".

The second participant did not identify any sources of emotional support within his discharge community. He characterized the world as oppressive and immoral:

> R: You know, like . . . if the world doesn't settle down, like there will be bugs and everything else. People will be putting bugs in people's brains. And it's all a Chinese factor, right? Like the Chinese are out to kill, eh? I don't know why, but they're out to frighten the world, its population and to seduction. It's . . . very terminal. It's . . . you have to be careful or you can get caught in

> that. Who knows. . . . It's very sin. . . . It's a . . . big sin. It's a large sin and I do[illegible]t—being part of it.
>
> R: I mean there's . . . a lot [illegible] young in the world . . . that are really strong. And, um, and, ah, their power tripping ways take them wherever they wanna go. They power trip at the face of the person.

The first indicator of "anticipating mastery" is *anticipating the successful transition to community living*. The participants who assess themselves ready to return to the community characterize their return as "starting over." In contrast, the participant who does not assess himself as ready to return to the community does not express the belief that the entry into the community is an opportunity to re-establish himself in the community. He does not perceive his forthcoming discharge as having much impact on his present life course.

2) Planning Concrete Strategies for Attaining Goals in the Community

The second indicator of "anticipating mastery" is planning concrete strategies for attaining personal goals in the community. Although one participant defined his impending return to the community differently, his long-term aspirations are similar to those expressed by the other participants.

Aspirations

All of the respondents want to gain a sense of personal achievement in the community. Prior to their admissions, they occupied marginal, dependent community roles. At predischarge, they expressed a desire to become productive, self-supporting community members:

> R: It's my turn . . . to give back to society. . . . I've taken so much, why not return it? I've lived my life in sin and I'm not afraid to admit it. It's about time I did something good for the world.
>
> R: I'll do it. I have lots of time yet but, you know, but I wanna start producing and making some constructive progressions in life.

> R: I wanna work. I wanna get back. I wanna work in the work force. I wanna work for a living, earn a living.

The majority of participants preferred manual labor employment; only one participant aspired to become a professional. This participant, however, planned to finance his education by working in restaurants. The places of employment preferred by the other participants were:

> R: I'd like to learn how to, I wouldn't mind managing a . . . greenhouse.

> R: Um and then I'm gonna be a carpenter again.

> R: Warehouse work would be nice. I had a couple of jobs like that. I enjoyed it. Shipping and receiving.

Although they did not consider their past employment histories in the community, the participants did not perceive their employment aspirations as unrealistic ambitions considering their age and gender.

Three of the participants also aspire to establish long-term relationships with members of the opposite sex. They believe these relationships would contribute to their sense of fulfillment in the community:

> R: . . . because I want a lasting relationship. I've seen how happy some married couples are. I've seem my brother and his girlfriend. They're married common-law. But, ah, a long standing relationship means security for me.

> R: I want a nice wife, and, you know, a happy little family, you know, to raise. And, you know, be my own and that. That seems great. That's what it's all about.

These participants stated, however, that the attainment of financial self-sufficiency was prerequisite to seeking interpersonal commitments with others. The participant who characterized his return to the community as continuation of his "struggle to make it" did not make reference to anticipated or desired interpersonal relationships within the community.

The following quotes illustrates the participants' long-term aspirations.

> R . . . full time job, a steady girlfriend, some leisure activities. I think that would make for a healthy lifestyle . . . um, just the everyday things.

> R: I'm gonna make a promise to myself that I'm gonna get out of that group home in ______, and get an apartment. And earn a . . wage and eventually, eventually get back on my own and eventually earn my own keep, you know.

> R: . . . just going to school and getting a good education so I can get a good job and so, you know, I can eventually get a girlfriend and settle down and have a family, you know. Work to live. . . . So that's what I want out of life. That's what I'm working towards. Yeah, I'll get it someday.

The long-term aspirations of these participants were to become "ordinary." In his last interview, a respondent confirmed the use of the concept "ordinary" to characterize his future aspirations:

> R: To be as ordinary as possible. [pause] Like mother wanted me to go into law, but ah, law and politics. I don't think I'll ever be able to do that now. I'm too scandalous.
> I: As ordinary as possible. In what sort of ways?
> R: As far as holding down a job. [pause] Ah, [pause] just holding a normal job, leading a normal life. Going to the movies once a week. Taking a girlfriend out for dinner. Cleaning house.

The participants did not anticipate instant fulfillment of their aspirations, and all of them described strategies for gaining entry into the community.

Gaining entry to the community. In order to leave the hospital, the participants recognized their need for living accommodation and financial support in the community. Securing living accommodations was a concern for these participants as they anticipated being unable to return to previous residential arrangements. Although the participants aspired towards independent living in the distant future, this was not an immediate post-hospitalization preference. Most of the participants initially anticipated placement in alternative living arrangements (approved or group homes) within the community. One participant anticipated living with family members. Recognition of their need for companionship and support in the community was the respondents' underlying rationale for seeking shared accommodation:

> R: Ah, this time I feel I'll be stronger and more capable of dealing with it, especially with living in a group home situation. I'll have support there . . . you have somebody to talk to after the day and reveal your problems to.

The participant who planned to reside with family members stated that independent accommodation "seemed kind of lonely, I guess. I don't know if I could handle it".

The respondents who requested referrals to alternative community placements perceived themselves as having a choice regarding these placements. For example, one participant stated procurement of an alternative community placement would hasten his attending physician's decision to discharge him:

> R: They [alternative living arrangements] are the easiest and quickest way to get discharged. . . . Well as long as you have a place to live, you get a discharge. As long as someone is willing to take responsibility for you.

When clarification was sought regarding independent living accommodations, he stated, "I'd probably get a place and be discharged. [pause] Just that I feel an approved home is the best situation for me right now."

This freedom of choice, however, was limited by the respondents desire for discharge, combined with their reluctance to enter into independent living arrangements. The respondents agreed to the first available placement that accepted them, regardless of their assessment of the appropriateness of the placement. The following two quotes illustrate this. Both participants' statements describe their impression of proposed alternative living arrangements following evaluative placements at the residences. Both participants, however, intended to be discharged to these community placements.

> R: Temporary, I don't want to live there very long. If I'm there for a year, I'm . . . it's gonna be a miracle 'cause I know darn well

> the people of _______ don't—aren't—isn't—aren't, they're not ready for me and I'm not ready for them.
>
> R: . . it's a different situation, um, it's not an easy one to do, you know. Especially like, . . . I don't really like her. [laugh] To tell you the truth, to tell you the truth, I don't really like her, and I don't like the way she does things. But it's my only home for right now, so I'm just gonna, you know, do the best I can, and you know, try to try to make it work, you know, and everything.

Only one of the four participants obtained accommodation in his preferred community placement. This was the participant who planned to return to residing with family members. The plans of the participants who sought alternative living arrangements failed to materialize after the community agencies rejected them as candidates for placement. Two of the three participants consequently decided to seek independent living accommodations within their preadmission communities:

> R: Well, I figured the group homes weren't available to me and the approved homes weren't available for me in the _______ area. The next best thing to do was get a place of my own.
>
> R: . . she's been feeling a little bit sick so she didn't really need the extra stress on her, or anything like that. So, um, she just said that she couldn't take me and that. . . . I'm ready to find my own place. Like I wanna go to school and stuff like that, you know. I don't wanna be sitting in here any longer.

At the time this study was completed, the fourth participant remained in hospital.

The second immediate concern for the participants was the arrangement of financial support. All of the participants aspired to achieve financial independence in the distant future. However, immediate financial support was required in order for the participants to be discharged; this was arranged by the hospital's social services department. Although the participants' expressed satisfaction with the financial support available to facilitate their return to the community, they perceived this support as temporary assistance.

Anchoring future aspirations. The participants aspire to become independent, productive members of their community. The above noted courses of action are aimed at gaining entry into the community. In addition to addressing these immediate concerns, the participants "anticipating mastery" of their community environments formulated plans of actions oriented towards attaining their aspirations. The participant who did not perceive entry into the community as an opportunity to "start over" did not formulate plans beyond his immediate attainment of community placement.

The participants who characterized their entry into the community as "starting a new life" cognitively anchored their future aspirations in community oriented strategies. The intended outcome of these plans was to establish themselves in the community, culminating in the achievement of financial self-sufficiency. Because financial self-sufficiency was perceived by the participants as a prerequisite to romantic commitment, explication of employment strategies dominated this section of the data.

These participants were cognizant of the influence of community factors on employment opportunities and anticipated retaining supplementary financial support until paid employment was obtained:

> R: I'll, I'll try to find a job. If I can't find a job, I'll live off social assistance awhile until I can go to school.
>
> R: Um, Canada Pension said that if I couldn't work they would pay me four hundred dollars a month, and I figure that's fair. If I can't work at least I won't starve or put anyone out.

Two participants anticipated rapid transition to productive roles in the competitive marketplace. Both of these participants initiated their plans for procuring employment in the community prior to discharge. The first participant contacted family members regarding employment opportunities in his community. The second participant, who aspired to become a nurse, planned to enroll in high school upgrading courses offered at a community college and he obtained a college application form during a leave of absence from the hospital.

The third participant did not anticipate immediate employment in the competitive marketplace. Because this participant assessed himself as needing a slower transition, he sought self-satisfaction in the community through less competitive means. He was the only participant who purposefully planned to attend community-based treatment programs. This participant believed these treatment programs would facilitate his transition towards self-reliance:

> R: I don't know if it's life skills, or whatever it's called. It'll be psychotherapy in one degree or another, and rehab in another. [To put me] in a position to be able to go back to work again.
>
> R: In a month from now, I should be on AISCH [disability pension], working part time, attending programs, getting back into society on an even basis, or a controlled basis rather.

If unable to obtain part-time employment, he stated he may volunteer to work with the Canadian Mental Health Association as an alternative means of contributing to the community.

All of these participants, however, anticipated contact with health care professionals in the community. Only the aforementioned participant perceived these professionals as having a role in facilitating his adjustment to community life. References to community-based professionals made by the other two participants pertained only to follow-up drug therapy. Neither of these participants expressed unconditional acceptance of the continued need for drug therapy in the community.

The first participant compared mental health care to quicksand:

> R: Well, you're not ever gonna get away from it. . . . like I'll have to go home and I'll have to take medication for the rest of my life.

Although he verbalized reluctant acceptance of continued drug therapy in his interviews, statements to a family member negated this acceptance. The family member told the researcher that the participant had suggested he may discontinue his medications after discharge. When this relative informed him compliance with his drug therapy was a condition of his accommodation, he consented to comply with continued drug therapy. The second participant planned to seek professional assistance in undertaking a drug-free trial in the community:

> R: Like when I get to ______, I'm gonna see a doctor, and I'm gonna gradually take myself off this, and see how I do, you know.

The participant who assessed himself as not ready to return to the community did not describe strategies to anchor future aspirations. Beyond those of obtaining community placement, this participant was indecisive regarding his future plans:

> R: I don't know. . . . If I can't find something to do, I might have to leave it. . . . Well, I go into the group home on December the first, I guess. They promised me that, go into the group home on December the first. So I got that but then I, I don't know how I'll manage after that.

Furthermore, this participant verbalized recognition of his inability to formulate concrete future plans of actions. For example, beyond his inability to obtain employment, he could not identify a basis for his jobless status:

> R: I don't think there is. . . . I'm gonna go out and earn it. So, I just don't know how to go about it. I need guidance. . . . [From] people, myself, things around me.

This participant also expressed recognition of his need for further rehabilitation in the community but his references to community-based treatment are uncertain. He did not establish either explicit time lines, or anticipated behavioral outcomes he hoped to achieve by attending community based programs, as did the participant noted previously.

> R: Well, I'd probably have to be a whole bunch of rehabilitation somewhere. And that's maybe what I'm just sort of entering into. Maybe I should take . that daycare program up at the hospital in ________. Well, I'm gonna have to do something in ________ so maybe that'd be a good start.

The second indicator of "anticipating mastery" is *planning concrete strategies for attaining personal goals in the community*. Although all participants aspire to become self-supporting community members, apart from strategies associated with gaining entry into the community, one participant did not formulate concrete plans for attaining his long term goals. This participant did not assess himself as ready to return to the community and was unsure about his future plans.

3) Expressing Positive Self-Regard

The third indicator of "anticipating mastery" was expressing a positive self-regard. The self-references made by respondents also varied with their assessment of their readiness to return to the community. Those respondents who perceived themselves ready for discharge expressed positive self-regard. These participants characterized their present mental well-being as improved in comparison to their preadmission well-being:

> R: I just feel better about myself. I'm able to breath properly. I've got a song in my heart, a whistle on my lips.

> R: I feel really good about myself. I like myself a lot.

Although the third participant did not make direct self-references, he described himself as feeling less "bogged down" and "discouraged."

> R: Well, I kind of hope I'm never in this—get bogged down and as bad shape as when I started anyway."

In contrast, the participant who assessed himself as not ready to return to the community made disparaging self-references.

> R: I'm, I'm just a creep, you know. I'm just a creep in sheep's clothing. . . . I'm just afraid whether you'll think I'm a joke or something—as some kind of a last joke going on in the universe,

> or something really stupid. . . my mind is so small, you know. Sometimes I feel like I don't even have a mind.

This participant also described himself as "degenerating" and "pretty screwed up," and he did not identify any changes in his mental well-being since his admission to hospital:

> R: You know, I'm, ah, I'm pretty screwed up, man. But later on maybe I'll get it together. But [pause] it's still the same. I'm, I'm a human being, right? . . . I just hate the thoughts going [on] in my head.

Moreover, he consistently described his mental well-being as having deteriorated since his first contact with mental health professionals:

> R: I started to do stupid things at home so my father figured I needed help and I probably did. But I don't know what kind of help it was. It didn't seem to help too much. . . . When I went there the first time, it never [worked] so . . . look at where I am now. I'm worse off than I was when I went in there. I would have been better off just to stay the hell away!

> R: But I, I don't think I'll ever be the same as I was when I was growing up. I don't know how it happened. I just got involved. I got the first series of treatment and then, and then I just never recovered, you know.

The variance in the participants' self-regard was also reflected in their feelings of self-confidence. One participant described self-confidence as:

> R: Being able to walk into a place with my head up. Being able to sit down and be pleasant and bright; order a meal without any hassles within myself.

Statements indicative of self-confidence are present in the interviews of the participants who assessed themselves as ready to return to the community:

> R: Oh, I admit I have problems, it's just that I've learned how to deal with them.

> R: I've got the brains and stamina enough to, um, take advantage of this and make something out of my life.

The participant who believed he was not ready to return to the community described his present abilities as inadequate.

> R: It's only manual dexterity and skills . . . that if I had more accomplishment and more know how, I wouldn't be in trouble.

In addition, this participant continued to express feelings of being overwhelmed:

> R: Somethings, somethings make it—somethings will start me up and then shut me down, eh, in this hospital. It's very unreal. Sometimes I feel better than others and then automatically I'll switch back to a bad mood.

And he characterized himself as "decentered":

> R: I don't have any problem, you see, I don't happen to have a center of gravity there, that's all. I go tumbling down the hill all the time.

This participant sense of a lack of self-autonomy precluded the co-existence of feelings of self-confidence.

The third indicator of "anticipating mastery" was *expressing positive self-regard.* The participants who assessed themselves as ready for discharge expressed feelings of positive self-regard and self-reliance. In contrast, the participant who assessed himself as not ready to return to the community continued to describe himself as being overwhelmed and was self-depreciating.

Gaining Control of Intrusive Experiences

In this section, two respondents' predischarge perceptions of their intrusive experiences are reported. These participants describe gaining control of the effects of these experiences on their behaviors. As a result, they describe unique changes in their well-being, in addition to the aforementioned generalized improvements in their well-being. Also, disagreements with hospital professionals regarding their readiness for discharge based on the presence of these experiences resulted in these participants assuming a more assertive stance when seeking discharge. The participants' pathways to discharge are described in the next chapter.

The particular control behaviors initiated by the participants were derived from their perception of the nature of the intrusive experiences. The respondents did not verbalize absolute acceptance of professionals' contention that these experiences are intrapsychic phenomenon:

> R: It's true, let me tell you. As God is my witness. I believe it's because I . . . hear voices, and I know for sure that it's true, because they can read my thoughts. Like I have someone right now even reading my thoughts.

Another participant stated what he hears is "real":

> R: I figure I don't hallucinate it half as much as what I hear.
> I: Yeah, you've told me that before — what you hear is real.
> R: Generally. I'll grant some of what I hear . . . is garbled, is misinterpreted by me. But if I misinterpret something, I generally ask the question "Why" or "What" or "Did you say that".

The failure of psychotropic drugs to eradicate these experiences was interpreted by the participants as substantiating their contention that these experiences were objectively real:

> I: And that's when they tried you on that new drug?
> R: Yeah, yeah,but it didn't work, you know. I mean if there's a transmitter in your room, I mean, no matter I was on 900 milligrams of chlorpromazine a day and I was still hearing voices. So that must tell you something. I could be on 1800 milligrams of chlorpromazine a day, and I could still hear voices if they're there. Lately, they haven't been there.
> I: But if they're there, they're there.
> R: They're there, they're there. No drugs gonna—I know what I hear. I know what I see.

The second participant also related similar beliefs:

> R: With this medication, the super drugs they put me on, and the heavy doses they put me on, I shouldn't hallucinate. . . . Actually I didn't tell them that. I—the thought just came to me. I'm gonna use it the next time they tell me I'm hallucinating. Usually, I just kept my mouth shut and grin and bear it.

These participants' attempted to identify external sources of the auditory stimuli. One participant maintained that his proclaimed source is indisputable:

> R: . . . she believed that I hear voices, but she didn't believe there was a transmitter in my room, you know. And, of course, there is, you know. It might not be inside my room, but it's, it's just

> outside my room possibly, you know. And I hear these voices. That's it.

The second participant expressed greater uncertainty about the source of these experiences. He stated some of his auditory stimuli *maybe* hallucinations. He defined hallucinations as "hearing things that aren't there". Distinguishing between objectively-based auditory stimuli and hallucinations, however, was difficult for this participant. An experience was classified as a hallucination only after all possible sources of environmental causation were eliminated:

> R: . . as in where I am, where I am in relation to the room. What I'm picking up could be conversations down the hall. It's echoing or it could be something coming through the air vent that's shares with, like the nursing offices. There's an air vent that comes down and I can sometimes hearing them talking in there. . . . Then if I can't, if I can't analyze it scientifically and decide, if I can't give it a feasible reason where it's coming from, then I decide it's a hallucination.

Nevertheless, this participant accounted for probable intrusive experiences by referring to a broad range of potential environmental sources:

> R: Well, lately it's been—I've been called a child abuser, a faggot. . . . Staff do it to stress me out and see if I can take it or not. Patients do it just to be downright nasty. They want some sort of power over each other. . . . It's like a pecking order in a hen house.

> R: Oh, [pause] one of the games like "Wear my face" or [pause] something like that, or stuff like that. . . . If you look at somebody and they don't like the way you look at them, they'll say "Wear my face". . . . It means you're suppose to hallucinate and think that you're wearing their face. This is a reminder that you are not suppose to look them in the eye.

> R: Yeah, it's hypnosis is all it is. Suggestion and feeling suggestions, and—I don't know. Half of the hallucinations I ever got in my life are due to hypnosis.

When this participant was not experiencing or discussing probable intrusive experiences, he was able to relate to these experiences as if they were hallucinations:

> R: If I have an overload of information, I hallucinate. Uh, [pause] that's about it, and when that happens, I get frustrated and

> angry, and I get paranoid. . . . I kept hearing other conversations and figured they were talking about me.
> I: During that, do you realize what's going on?
> R: I do now.

However, when the participant was experiencing these sensations during the interviews or was discussing probable intrusive experiences, he related to them as if they were objectively real experiences. For example, this participant was frequently distracted during the interviews. He would occasionally turn his head aside and mutter profanities. He attributed the cause of his distraction to environmental stimuli, such as, voices in a passing car.

Regardless of the attributed source of these experiences, both participants described gaining some control over the affects of the experiences on their behaviors. The methods used to gain control may be classified as proactive and reactive behaviors. Proactive behaviors are behaviors initiated by the participants in order to affect the quality/quantity of the incoming stimuli. In contrast, the intent of reactive behaviors is to modify the participants' response to the incoming stimuli.

Proactive Strategies

Modification of the quality and/or the quantity of incoming auditory stimuli was achieved by enacting behaviors designed to alter one of two aspects of the intrusive experience. The first type of proactive behaviors is a behavior directed towards the perceived source of the stimuli. One participant described confronting the perceived source in order to suppress further intrusions:

> R: I was taking my meds, minding my own business. And another guy was talking while I was distracted. And then all of the sudden he starts calling me "Faggot! You fairy! Everybody hates you!", and this and that, and started walking away. And I yelled out his name, right, very loudly. And he turned around and says "Ah, you faggot, fairy! You coward!" I blew up, just went into a rage! . . . I jumped him. I pushed him down actually.

Proactive behaviors directed towards the perceived source of the auditory stimuii are not necessarily aggressive behaviors. The second participant described using his "voices" as mediators in order to bargain with the perceived source of the intrusive experiences:

> R: I'm still trying to get them to tell me that she'll have coffee with me, but I can't convince them. [laugh]
> I: You can't convince them yet?
> R: No, I try try everything, I'm telling you, I do.

As well as attempting to contact the perceived source through his "voices," this participant also endeavored to establish contact through associates of the perceived source living in the community:

> R: . . . and she just wrote me a letter back and just told me everything was okay, you know. Everything was—"Hey, you never did that much to our family." And, you know, "We forgive you for anything that you might of done." And all that so, you know, everything is okay.

It should be noted that the content of the intrusive experiences of these participants are markedly different. The "voices" of the first participant were punitive, while the "voices" of the second participant were positive and nonthreatening.

[illegible]nd type of proactive behaviors involved deflecting incoming stimuli by [illegible] attention away from the intrusive "voices." These behaviors were implemented by the participant who heard punitive "voices". Redirection strategies include concentrating on conversation with others and concentrating on bodily movements:

> R: I was a little stressed out in the restaurant tonight. You were there and you were talking to me, so I didn't feel too bad. . . .. So I just kept listening to my mouth chewing, and listening to you, and I felt okay.

Reactive Strategies

The intent of reactive behaviors was to alter personal responses to auditory stimuli. Reactive behaviors consisted of both passive and active behaviors. Both participants described passively ignoring auditory stimuli:

> R: I don't let certain things bother me anymore. By certain things I mean just small problems that arose in day to day life living in an institution. . . . Ah, I would say people stealing things spiritually [pause] or giving things spiritually. Things that can't be seen . . because I feel that as long as I'm breathing and thinking, that I don't have to worry about spiritual things anymore. And it's—if they're there, they're there. And if they're not, they're gone.

> R: I know that they're lies. I know that they're lies. They're not, they're not truth. They lie so I just don't believe them. . . . I just don't believe everything I hear these days. I use to believe in everything I was told, eh?

The participant who heard punitive "voices" described implementing active-reactive behaviors. These were purposeful behaviors designed to reduce the participant's feeling of anger and tension:

> R: I sigh and relax. Make yourself be nonviolent. Make yourself be as calm as possible.

> R: Then it's a fantasy and then I resolve that and say "That was a fantasy and I'm not going to listen to it anymore and it's not there" and go onto something different. . . . With me it goes away. Sometimes it takes a little work. Sometimes I have to go take a bath or a long walk or just go to sleep and forget about it.

This participant perceived psychotropic medications as an adjunct to his reactive strategies:

> R: It's, ah, a matter of over abundance of stimulus or stimuli—I hallucinate. Where with the neuroleptic drugs, the tranquilizers, or neuroleptic would be a major tranquilizer, I don't freak out about it anymore. It comes and passes. . . . I feel sedated but not restrained. [pause] Uh, the violence in me is restrained but the rest, the freedom of thought isn't.

The participant who described his present intrusive experiences as nonthreatening did not perceive his medications as affecting these experiences or his immediate reaction to them. He stated the medications alleviate his feelings of depression:

> R: Now I feel, I feel lots better. This flupenthixol is a miracle drug. It is! It is! Who ever invented it, I'd like to write them a letter and tell them "Thank you for helping me." I really would because it's, it's so good that I feel, I feel so much better. It's— it had an antidepressant effect on ya and, um, it's so much better.

Gaining control over the effects of these experiences contributed to the participants' sense of improved well-being. Prior to gaining this control, the respondents characterized the intrusions as repressive. In order to protect their well-being, the participants reacted either through acting out behaviors or withdrawal. Gaining control of these experiences attenuated their repressive effects, thereby allowing the participant to redirect his attention to other aspects of his environment.

The participants' predischarge descriptions of the effects of intrusive experiences on their personal well-being are antipodal to those recollected during the preadmission period. One participant recalled being "preoccupied" and "mentally restricted" as a consequence of these experiences. At predischarge, he described himself as emancipated from these effects.

> R: You know, they don't, they don't interfere with my, you know, they don't preoccupy me too much, you know. They don't interfere with my daily routines and stuff like that. . . . I can go out and do the things that I want to now. And before, I was basically restricted mentally, you know.

The other participant recalled being "distracted and "frustrated" by these experiences. He characterized himself as being in a "cold rage." During the predischarge period, this participant describes this rage as dissipated. "I'm much more calm, my head is clearer. . . I don't feel the inner turmoil that I use to." He also stated he was less distracted. "I'm able to read and write again. I'm able to listen to television and radio again".

One further aspect of these data requires highlighting. This is in relation to how the participants accounted for the uniqueness of these experiences, with the attending belief of personal well-being. The participants rejected professionals' contentions that these experiences were intrapsychic phenomena. Accompanying his rejection was the implicit rejection of the accompanying premise that the presence of these experiences inferred mental illness. The participants accounted for the uniqueness of their experiences by attributing their reception of these intrusions to exceptional characteristics possessed by themselves or by the source of the intrusions. For example, in one interview, a participant asked the interviewer if she heard a voice call him "murderer." He stated her failure to hear this voice was due to her less "acute" hearing. The second participant accounted for his unique experiences by attributing the source with exceptional ability. He stated "she hired a person that has this special gift to read my mind". The participants, therefore, perceived themselves as psychologically ordinary people with extraordinary experiences.

Discussion

Three of the four study participants anticipate relatively straightforward acquisition of productive community roles. Research on psychiatric inpatients' attitudes towards hospitalizations suggests that predischarge patients may have high expectations prior to their return to the community. Weinstein (1979) reviewed quantitative studies in which the researchers reported psychiatric patients' attitudes towards hospitalization. The participants displayed favorable attitudes in 78.9% of the 38 studies reviewed. Patients' attitudes towards hospitalization, however, vary at different stages of the experience. Weinstein reports that these attitudes tend to become favorable during participants' hospitalization and immediately prior to discharge.

Follow-up studies into the community demonstrate that favorable attitudes tend to decline following discharge (Weinstein, 1979). Small, Small, and Hayden (1965) reinterviewed study participants sixteen to twenty months following their discharge. These researchers report approximately 50% of participants who had shown positive attitude shifts during their hospitalization reported a decline in the favorableness of their attitudes towards their hospital experience. Research by Allen and Barton (1976) substantiate the results of the above noted researchers. The polarity of participants' attitudes measured at admission, discharge, and follow-up were neutral, positive, and negative (0 + -) for patients from acute care units, and negative, positive, and negative (- + -) for patients from chronic care units. A negative shift in attitude is also evident in these participants at follow-up.

In this study, the participants who reported greatest alleviation of their feelings of being overwhelmed and being failures evaluated their hospital experiences positively in terms of help received and anticipated successful adjustment to community living. If the participants' experiences in their communities are negative, it is probable that these attitudes will also show a negative shift. If the community milieu does not facilitate the process "becoming ordinary," these participants may re-enter the preadmission phase of their hospitalization, which is characterized by feeling overwhelmed and labelling the self as a failure.

"Anticipating mastery" refers to the respondents' beliefs that they can attain their personal goals through their interactions with their environment. White (1974) distinguishes mastery from coping by the type of demands that each of these concepts involves. Mastery refers to successful management of everyday, familiar tasks; coping refers to successful management of difficult, unpracticed tasks. According to White, both of these terms are subordinate to adaptation, which is the acceptable compromise the individual achieves in his interactions with his environment. Another distinction between the two terms may be proposed. "Anticipating mastery" of the environment involves anticipating management of a multiplicity of everyday tasks. In contrast, anticipating coping generally refers to anticipating management of a circumscribed set of tasks.

The nature of the participants' anticipated community environment did not account for differences in anticipated mastery. One participant, who characterized his expected environment as threatening and malevolent, was "anticipating mastery" of that environment. Mechanic (1974) states that the contention that successful adaptation requires an accurate perception of reality is a common misconception. This may also be true for mastery. The aforementioned participant developed strategies to augment his capacity to deal with his threatening environment. These strategies involved the utilization of community resources, i.e., community-based treatment programs and alternative living arrangements.

Relevance to the Core Variable "Becoming Ordinary"

The core explanatory variable for the results of this study is "becoming ordinary." All participants did not anticipate "becoming ordinary" in their immediate post-hospital period. The predischarge participants who were "anticipating mastery" of their communities were anticipating immediate acquisition of productive community roles. These participants were: (1) anticipating successful transition to community living, (2) planning concrete strategies for attaining goals in the community, and (3) expressing positive self-regard. One participant not "anticipating mastery" of his discharge community, anticipated eventual progress towards the achievement of independence and self-sufficiency. The concept "anticipating mastery," therefore, differentiates between the participants predicting immediate or eventual progress towards "becoming ordinary."

The participants' experiences in hospital may provide the personal framework for "becoming ordinary." This framework is the participants' anticipation of personal success in their community. In order to anticipate success, the participants must relinquish their perception of themselves as failures. However, being institutionalized precludes membership in the greater community. "Becoming ordinary," therefore, is a process which cannot be experienced in the hospital. The next chapter describes the participants' perception of their hospital experience, including pathways to gaining their discharge.

VI. The Hospital Experience: Being in a "Boot Camp"

One participant said that being in hospital is analogous to being in an army "boot camp." He made this analogy based his comparison of the similarities between the structures and the functions of these organizations. Being a psychiatric inpatient is comparable to being an army recruit because the hospital: (1) segregates patients from the pedestrian community, (2) stay is temporary and is to prepare patients for community living, (3) is a residential facility established and managed by service providers for service recipients, (4) is a receptacle for "conscripted" service recipients, and lastly, (5) is an institution in which interpersonal relationships are based on "expert authoritarianism":

> R: It's like entering boot camp in the army. . . . It's an exercise in discipline for yourself, the staff, from the staff. You have to be good. . . . When you are able to accept discipline from somebody that's in a position to give it to you, and have discipline for yourself, take care of yourself, that's when you're ready to leave.

Although the other participants did not make this analogy, their interviews confirmed the appropriateness of this comparison.

Being in a Boot Camp

1) Segregates Patients from the Pedestrian Community

The participants perceived the hospital as an institution detached from the community. They described their admission in terms of being "sent away" from their preadmission communities:

> R: He just sent me straight up here.
> R: We're shipping you to __________.

In contrast, leaving the hospital, is referred to as "re-entering" the community.

> R: It's a re-entry into society.
> R: It'll mean I'm finally accepted back into society.

Furthermore, the participants perceived that the hospital was detached from its surrounding community. "Well, you're a few miles from any civilization. It's extremely quiet outside." Excursions into the neighboring town are referred to as going "up to town" or "going into the town."

Leave of absences from the hospital were sanctioned excursions into the pedestrian community. The participants characterized these leaves as trials to evaluate their readiness to return to the community:

> R: It's just that I'm feeling more adapted to it as each L.O.A. confirms.
> . . . ready and able to deal with myself and society.
> R: I was—I wasn't making no trouble at my approved home, you know. I was being in on time and going to sleep and not getting up quite when I was suppose to, but that can be worked on.

Leaves of absence, therefore, were planned, temporary reintegrations into the community. Excursions into the hospital's adjacent town, in contrast, were assigned recreational connotation because they are privileges granted by the hospital's professionals:

> R: A couple of weeks ago I got full privileges. . . . I'm able to go to town and come back when I please. I can walk into town whenever I want to. I don't have to check in during the day. I just have to be here for meal times and med times.

Despite being outside of the geographical boundaries of the institution, the participants with town privileges continued to see themselves as appendages of the hospital community.

<u>2) Stay is Temporary and is to Prepare Patients For Community Living</u>

The belief that psychiatric hospitals are institutions for treatment of people unable to function in the community persisted throughout the interview . During a termination interview, one participant stated that psychiatric care centers are for:

> R: People that are emotionally sick or have psychological problems or physiological problems. That means they just can't cope with society on a day to day level.

All participants perceived their hospitalizations as temporary and anticipated returning to the community in the future. "At least there's a beginning and an end to ______, anyway." According to these participants, the primary function of the hospital is to resolve their personal problems, thereby facilitating their return to community living:

> R: It's, you see, it's an establishment for putting you back on your own again.

> R: The facilities good, you know. I'd suggest it to anyone that is having problems coping with life, and you know, you know, just to get their problems set up.

The participants believed that guardianship issues should not be the primary concern of the hospital staff:

> R: Perhaps it's not so much of a dodge as people covering their back, covering their backdoor. Making sure when I go home I'm not a time bomb and go out and get physical. Go out and start trouble, eh?

When the participants perceived guardian concerns being accorded precedence over perceived treatment needs, they verbalized feelings of anger and frustration:

> R: I find it's an insult. I don't go around generally attacking people, verbally or mentally, or verbally or physically, rather.

3). Is a Residential Facility Managed by Service Providers for Service Recipients

Recipients of psychiatric care live in a milieu created by others. Admission to a psychiatric hospital compels individuals to relinquish previous lifestyles, and adapt to communal institutional living and the concomitant imposition of standards of expected conduct. However, the characteristics of institutional milieu vary within the hospital. The hospital is partitioned into nursing units: each with a designated patient population. The milieu of these units varies markedly, contingent on the type of service provided by the unit. All of the participants were admitted on admission units and later transferred to rehabilitation units.

Admission units. The participants' reference to their admission unit was consistently negative. They recalled the experience of being incarcerated, that is, being "locked up":

> R: I didn't like it at all when I was on ______, you know. It was . . . terrible, you know. Just . . . the feeling of being locked up is just an awful feeling, you know. I can never stand being in jail or anything like that, you know. Like I wouldn't do anything to go to jail or anything like that, you know. But I don't know . . . it was a terrible feeling. I can't even explain it, you know. I just, it's just . . . terrible, you know, being locked up like that. Like, like you're locked up in a cage, eh? You can't go nowhere. You can't do anything. Sure they have pool tables, and they have ping pong tables, and they have juice, and they have people around to talk to, and stuff like that, but still it's not a good feeling to be locked up in a place like that.

Consistent with their description of these units as incarceratory, the participants also described the service providers as authoritative:

> R: The staff can be extremely domineering on the admission wards. It's their . . . exerting their authority. And you come to know, and come to grips with the reality of being in an institution, where there are certain rules that must be followed.

> R: They lock you out of bed, and go along there, and hustle you in a group all the time.

Two other themes present in the data pertaining to admission units were references to being over-medicated and receiving impersonal care:

> R: It's a very heavy sedate ward. They sedate you like crazy on the ward and then they send you to another ward from there if you're not able to leave. Well, usually the stay is quite long, eh? So you get fed up to the point where you're kicking or hitting someone and they send, they fire you into another part of the hospital.

One participant stated he could not recollect his feelings regarding his transfer to a rehabilitation unit because

> R: I was pretty knocked out and wacked out, severely medicated, and I was very confused. . . . I was just being handled like a crate.

Rehabilitation units. The participants' reference to these units was both positive and negative. The quality of their evaluation was contingent upon their standard of comparison. When the participants compared these units to the admission units, their references were positive.

> R: Well, on ______, like that's a pretty open ward. There's a lot of freedom there. There isn't much freedom on—when I first came in here.

> R: . . . the same thing only not an intense. They're more of your buddies here. Once you get better, it's sort of like, ah, after shock.

> R: I came over to ________, and it was even better, eh? You know, open ward. I can come and go as I please, you now. I don't have to check in at any time, you know, I can just go out whenever I want to, you know, and that was great.

However, when the participants' standard for evaluation was their previous lifestyle, these units were also characterized as being similar to "jails." Instead of incarceration as it did in the participants' references to the admission units this penal comparison referred to group living and regulation of behavior by others.

> R: I have to eat meals with a lot of people. I have to sleep in my own cubicle with other people around. I have to sit in the same room with a lot of other people. [pause] If I fist fight, I'm in trouble. [pause] If I blow my cool, I get medication . . . and I have people exerting an authority over me. I'm use to being independent and living on my own.

> R: Just whereas your freedoms are confined to a certain area. You have to be in at a certain time. Um, your meals are all cooked for you. You go down, stand in line like you would in jail, you know, and get your food, and, you know, eat and then go back up to the ward. Take you meds, hang out for awhile, you know, make a call once in awhile, have visitors once in awhile.

> R: Um, just, um, 'cause you're, you're restricted to a ward. You gotta be in at a certain time. Um, you have to get up in the mornings and go to work, you know. . . . I've never been to jail

> so I can't—I'm just saying it as a fact that, um, that it seem like to me, it's, it's a lot like what jail would be like.

4) Is a Receptacle for "Conscripted" Service Recipients

As stated in the previous chapter, participants attributed their admission to the interventions of other people. No participant described his admission as self-initiated. Subsequently, the participants characterized the hospital community as being comprised of two broad groups of people: "insiders" and "outsiders." From the participants' perspective, service recipients are the "insiders" and service providers are the "outsiders" of the institution. "Insiders" are totally immersed in the institutional milieu; whereas "outsiders," in addition to creating the milieu, are detached from it:

> R: The way they give their treatment. . . . It's based on real society. [pause]. . . On being on the outside. How an outside person would deal with you. After all, they are from the outside. Living, working on the inside. We have to live it but they work it.

Admission to hospital resulted in participants being assigned membership to the "insiders" group. This mandatory group assignment, however, was not accompanied with statements of affiliation with that group. All participants desired to be disassociated from the "insider" group:

> R: You have to come back [from LOAs] and sit around with sick people again and listen to them cry and whine. You know, I suppose, I suppose, I suppose it's to evoke some compassion in a person, but to live with it, day in and day out, gets kind of tiring.

> R: What am I doing here? You know, there's all these sick people around me and, you know, I'm totally sane, you know. There's nothing wrong with me. How am I suppose to feel?

Another participant told the researcher that the other participants she was interviewing were "crackpots." Although the participants did make occasional references to peer relationships with other patients, they described these patients as not "sick".

Participants desired to be affiliated with the "outsider" group. Because they perceived nursing staff as exemplars of this group, the respondents aspired to emulate their qualities.

> R: . . . something like the people here in this hospital. Like the . . . nurses and stuff. [pause] You know what I mean.

One participant attributed his career aspirations of becoming a nurse to his experiences with the hospital's nurses:

> R: I just met a lot of nice nurses and stuff like that and I like the job that they do and everything like that. and that's what I'd like to be doing myself, eh?

A third participant explicitly rejected affiliation with the "insider" group. He described the nursing professionals as his "peers":

> R: Talking to the staff is, because they're educated. I've got a certain amount of education myself. . . . To me, they're my peers unless, unless the patients have been to school and studied. It's just not the same.

<u>5) Is an Institution in Which Interpersonal Relationships are Based on "Expert Authoritarianism"</u>

"Expert authoritarianism" refers to relationships characterized by obedience to experts. Four recurring themes in data resulted in the application of this term to describe the relationship between hospital's professionals and participants. These themes were:

a) Institutional privileges and community resources were accessed throug[illegible] professionals.

b) The decision to "promote" patients was the prerogative of experts.

c) Experts' assessment of readiness for "promotion" was valued by t[illegible] participants.

d) Participants were compliant with aspects of their treatment they consider non-therapeutic.

Institutional privileges and community resources were accessed through the professionals. At admission, professionals imposed constraints on participants' freedom of movement. Personal liberties were incrementally regained as professionals granted participants privileges. The participants described a hierarchy of privileges comprised of three levels. The first level, close watch, requires that the participant be accompanied by staff members when leaving the unit. When limited privileges are granted, the participant is "Allowed to go out for a few hours at a time, not up to town, but to stay on the hospital's grounds". Acquisition of full privileges authorizes the participant to leave the hospital's grounds. However, they are required to return to their units for meals and medications. One participant, with full privileges, described himself as a "trustee": "Well, now that I'm a trustee, it's not too bad". Based on the "notes the nurses take every night," privileges are granted by participants' attending physicians.

Community resources were also accessed through professionals. The type of formal community assistance sought by participants was contingent on their personal resources in the community. Supplementary means of financial support are required by all participants in order to leave the hospital. Financial support is arranged by the hospital's social services department. Participants did not express any difficulties accessing this support:

> R: I kept on him [social worker] by asking him about getting out, and making arrangements to get my AISCH [pension] reinstated, and things like that. So he went down with me a week ago Thursday, a week ago today, and we got the ball rolling for paper work on my AISCH.

The second type of formal community assistance sought by participants was alternative community placements. Three participants required access to these placements because they were unable to return to previous living accommodations. Two groups of experts must approve participants' candidacy for placement: hospital professionals and community placement operators.

The hospital's professionals referred participants to community placements. As previously indicated, participants had a choice regarding placement in alternative living arrangements. However, access to the hospital's social workers was limited because of these professional's caseloads:

> R: We tried various placement programs, and seeing as the social worker is dealing with thirty to sixty other people at the same time, I have to wait my turn.

Operators of community placement residences assess the suitability of the participant for the placement. Although the hospital's professionals assess the participants' readiness for placement, community placement professionals frequently did not concur with these assessments. Two of the participants were rejected as placement candidates; the third participant was conditionally accepted. One participant who was rejected was advised by community placement operators to reapply for placement in one month:

> R: They said come back in a month. We're not turning you down permanently. We just feel that you are not ready yet, and we want you to come back in a month and reapply.

The operators of another participant's placement imposed conditions on his relocation.

> R: I, ah, I'm happy to go there but I wasn't, I didn't want to go on their arrangements. They wanted me to come there in a matter of three or four LOAs [leave of absences], four LOAs and at the first of December move in.

The decision to "promote" patients was the prerogative of experts. Participants' procurement of discharge from the hospital was contingent on obtaining assent from their attending physicians. The act of discharge was an action performed by others. The following quotes illustrate participants' perception of their subordination to professionals' prerogative:

> R: Actually if they said a few days and that was a week ago, it should have been a couple of days ago. . . . I don't think they're in any rush to let me go.

> R: . . . just the fact that she [physician] wouldn't , you know, she wouldn't let me go, or nothing like that, you know. She wouldn't, she was being obstinate with me and stuff like that. Especially after I saw that other doctor, um, you know. She . . . really wanted me to stick around for awhile.

> R: Every time I say within two to three weeks, it ends up being a month later. So . . . I believe them when they come up to me one day and say "________, pack your bags. We're going to ________".

> R: It's like the donkey and the carrot. Holding the discharge in front of my nose, and then, the last minute snatching it away.

All participants were voluntary patients at the time of the study. They verbalized awareness of their legal right to leave hospital:

> R: . . . and now that I got the voluntary status, I know that I have the choice to leave. I can leave.

> R: Of course, I could, I could leave right now. I could just pack my things and say I'm going. There's nothing they could do about it.

Although limited personal resources did prohibit the participants from discharging themselves against medical advice, the participants sought professional discharge even when alternative community resources were obtained. The participants' desire for professional "promotion" was related to their perception of the professionals' area of expertise, which is examined in the following section.

Experts' assessment of readiness for "promotion" was valued by the participants. The hospital's experts evaluated participants' mental well-being and formulated authoritative judgements regarding their readiness to return to the community.

> R: Well, the doctor, Dr. _______, didn't believe me. She . . . believed that I was still too sick to go out into the community.

> R: They've decided that I'm more coherent in my speech, I'm not deluded, or I have very few delusions. Things that aren't gonna make me incompatible with the people around me, or on the outside.

Professional concurrence of readiness to be discharged was important to the participants who assessed themselves ready to return to the community:

> R: By going through, going through the ropes, to use a cliché, I feel more comfortable having the approval of somebody professional saying, "Yes _____, you're ready to leave."

Professional assent to leave hospital was interpreted by these participants as representing professional confirmation of their "sanity".

> R: It will mean that I am certifiably sane. . . . and I can say to somebody, if somebody says to me, "Ah, you're crazy," I can say "No, I'm not. I've got a piece of paper to prove it."

> R: Well, that's a good feeling [to get discharged]. At least you know you're half sane anyway. . . . Well, [pause] you never know. There could be something wrong, like you watch on TV all the time.

The participant who assessed himself as not ready to return to the community, expressed uncertainty regarding the meaning of being discharged from hospital. When asked what discharge meant to him, he stated "I don't know. I'm not around, I'm not around any of my relatives".

Participants were compliant with aspects of their treatment they consider non-therapeutic. Participants characterized themselves compliant with all aspects of their hospital care, regardless of the perceived therapeutic value of specific interventions. They complied with therapies they considered non-therapeutic because of their subordinate position within the organization and the accompanying dependency on the benevolence of experts:

> R: They told me, they told me the shots that were being taken. So I just. . . . agreed with that and went peacefully, you know. I wasn't gonna put up too much of a fight, you know. . . . I could have, you know. I could have really raised hell, you know, around here but there's no use in it, you know. There's no satisfaction out of it, you know. I don't get nothing out of it for raising hell so I'll . . . just do what they tell me to do, you know. For once in my life, I'll listen to somebody, you know, rather that doing my own thing, you know. Yeah. . . . Ah, it would get me nowhere. It would just upset things, you know. Screw up the whole system and, you know, it's . . . not worth it.

One participant stated he attended structured therapy sessions he perceived as non-therapeutic because

> R: If I wanna get a place in the group home or approved home in ________, I have to go through this course.

Two participants stated their vocational programs had no therapeutic value. Compliance with authoritative directives accounted for their attendance:

> R: They send you to OT for one hour a day, you know, and you're suppose to work and stuff like that, you know. But I just . . . find little use in it, you know. I . . . don't like it. Maybe I'm a rebel. I don't know, but I don't like it one bit.

Only one respondent assigned therapeutic value to his participation in vocational program. He did not, however, perceive these programs as facilitating the development of work skills, but rather, they provided an environment to test his ability to manage stressful situations:

> R: When I started working in the snack bar, I felt more competent about being around more other people, and being—putting myself in a social situation where the noise level and the conversation level was quite high—the potential for getting strained.

Although participants disliked institutional living, their overall evaluations of their hospital experiences were not negative. The participants who had previous admissions to the institution were neutral regarding their hospital experience: "Oh well, it's not too bad [to be here]. I can think of worse places." The participant who stated his hospitalization had not facilitated recovery of his mental well-being described his treatment as exemplary:

> R: I can't . . . see any better way than doing it than the way they are doing it. Just exactly the way they are doing it. 'Cause they're coming as close as I think they'll ever come to problem solving. As far as I am concerned.

The two participants who experienced their first admission to the hospital evaluated their overall experiences positively. In comparison to the treatment they received in community hospitals, both of these participants characterized the professionals as "caring", and the hospital as offering the "best" treatment in Alberta:

> R: If you're sick and you need treatment, it's probably the best in Alberta or in western Canada. I'd say Alberta for sure seeing as I've been in a few hospitals around. If you want treatment, it's good for a certain amount of time.

From the participants' perspective, the primary function of the hospital was to ameliorate personal problems which hinder their functioning in the community. Therefore, discharge was sought when participant evaluated themselves ready to return to the community or perceived the treatment provided in the hospital was not facilitating this return. The next section describes the participants' pathways to discharge.

Pathways to Discharge: "Getting Out"

The study participants perceived that discharge from hospital was granted by the experts. These participants verbally exhibited diverse patterns of discharge behaviors. There are three patterns of "getting out" behavior evident in the interviews: marking time, taking charge, and breaking out. The particular pattern of behavior demonstrated by participants was contingent on the interaction of two factors: self-assessment of readiness to return to the community and self-assessment of the likelihood of being discharged. Figure 3 illustrates the interaction between these conditions and subsequent pattern of "getting out" behavior.

Each of the four cells in the following diagram describes constellations of behaviors displayed by the participants. As the conditions determining the behavioral pattern vary, there is an accompanying change in the "getting out" behavior. If there is variation in the conditions affecting his discharge, one participant can be classified as fitting into more than one cell.

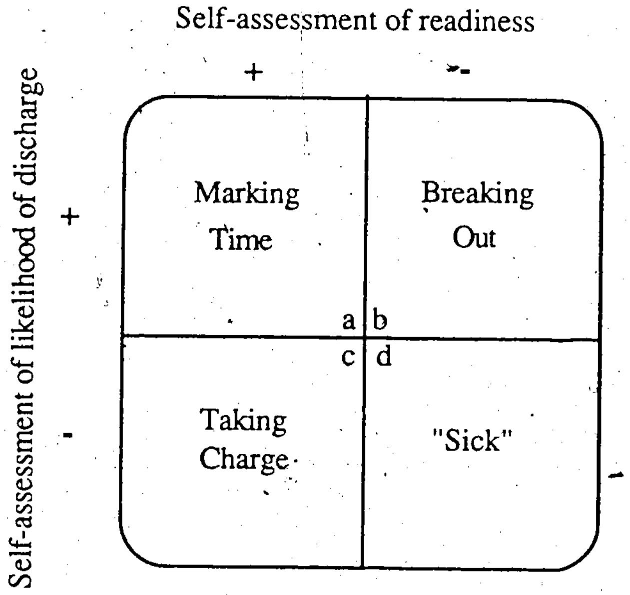

Figure 3. Pathways to discharge: Patterns of predischarge behavior.

Marking Time

Participants marking time were enduring continued hospitalization:

> R: I'll . . . make the best of it. I'll just do my thing, and just wait. I'm just doing time right now.

This pattern of behavior was present when participants assessed themselves as ready to return to the community and assessed the likelihood of getting discharged as probable. The verbal indicators of marking time are attributing present inpatient status to lack of available alternatives in the community, and characterizing predischarge behavior as "doing time."

Attributing present inpatient status to the lack of available alternatives. The participants marking time assessed themselves ready to return to the community. They accounted for their continued inpatient status by referring to their lack of personal resources necessary for community living.

> R: I feel like, you know, I don't have any other place to go right now, so you know, it's . . . peaches and cream as far as I'm concerned, you know, for . . . the time being.
>
> R: Ah, [pause] I'm in a hurry if they got some money that I can live on. . . . I don't have anything to live on unless they are going to give me a pension.

Characterizing predischarge behavior as "doing time". When the participants were exhibiting marking time behavior, they asserted their continued hospitalization was non-therapeutic because they had regained their mental well-being. From the perspective of these participants, the hospital provided temporary accommodation until community placement was realized.

> R: I feel it in my soul, you know. I don't need to stay here any longer. I'm just bumming off the government right now, you know, waiting so. . . . It's a joke. It's a total joke. I . . . there's nothing more that they can do for me, you know. Like I'm just doing time, that's all I'm doing.
>
> R: I'm just waiting for placement.

Feelings of boredom and frustration accompanied extended waits for community placement:

> R: I've been waiting for almost two months, I'd say. So . . . it gets rather impatient, you know. I get bored to tears sometimes

> here, you know. But I just try to look for things to do, and go down to the snack bar and have coffee, and stuff like that when I can. And see girls and socialize a bit, and that's about it.

> R: I've been waiting for placement for the last two and a half months. . . . It's frustrating. It's like waiting for a big pay-off in a lottery.

<u>Breaking Out</u>

Participants breaking out of hospital were returning prematurely to the community:

> R: I wanted to get the hell out of this hospital. That's what I want.

This pattern of "getting out" behavior was present when participants assessed themselves as not ready to return to the community and assessed the likelihood of getting discharged as probable. Although the convergence of these conditions to determine a pattern of "getting out" behaviors appears to be improbable, nevertheless this behavioral pattern was evident in the interviews. The two verbal indicators of breaking out are characterizing continued inpatient status as futile in terms of expected outcome of treatment and impulsively proposing to leave hospital.

Characterizing continued inpatient status as futile in terms of expected outcome of treatment. Participants manifesting breaking out behaviors assessed themselves as not ready to return to the community. However, they perceived the hospital's treatment was not facilitating recovery of their mental well-being.

> R: I have to get hold of my folks and tell them that I'm coming up that way and then head, maybe head west. Because, um, . . . I can't seem to get it together here.

> R: I get very terrified as you can notice. Unless that's what basically I am. I'm just terrified of this place. . . . I'm terrified of what it can do to me and where it can take me. . . . Um, the fact that it's . . . gonna take me nowhere.

Impulsively proposing to leave hospital. These participants stated their present hospital stay was non-therapeutic. The rationale for this judgement was their perception that treatment was not improving their mental well-being. The primary motive of seeking discharge, therefore, was to get away from the hospital. These participants impulsively proposed to leave hospital without consideration of their expected proficiency with managing in the community, or the availability of placement:

> R: . . . the more I think about it, the more I think I should just pack up and leave right now.
>
> R: Yeah, we should take off tonight, and just go there for awhile.
>
> R: I have to get a hold of my folks and tell that I'm coming up that way and then head, maybe head west.

Taking Charge

Participants taking charge were purposefully demonstrating their readiness to leave hospital:

> R: When I first got turn[ed] down for the group home, and then it became a real battle. . . . Well, I had to prove myself, that I was ready to be discharged. And, ah, [pause] that's about it. I just had to prove that I was ready, capable of surviving on my own.

This pattern of "getting out" behavior was evident when participants assessed themselves ready for discharge and assessed the likelihood of being discharged as improbable. The two verbal indicators of taking charge were attributing present inpatient status to professionals' unwillingness to authorize their discharge and characterizing present patient behavior as "convincing" professionals of their readiness to be discharged.

Attributing present inpatient status to professionals' unwillingness to authorize their discharge. Participants exhibiting taking charge behavior perceived they were ready to return to the community. They attributed their present hospitalization to professionals' refusal to discharge them:

> R: I felt that they were just playing games and trying to keep me in here as long as possible. . . . I think they are just grasping at straws to keep me in here.

> R: I felt pissed off because she's [physician] looking at me as if I'm sick and I have a psychiatric problem, and I don't. I'm totally sane! . . . I swear to God on my mother's grave. I'm totally sane. There's nothing wrong with me, not a thing. There's no reason why I should stay here any longer.

Characterizing present inpatient behavior as "convincing" professionals of their readiness to be discharged. The underlying basis of the difference between participants' and professionals' assessment of participants' readiness to be discharged was disagreement regarding the criteria for readiness. Participants perceived that their readiness to leave hospital should be evaluated on the basis of continued evidence of the behaviors which precipitated their admissions, regardless of the presence or absence of other abnormal symptoms:

> R: I'm not gonna OD, that's, it's not the point of the voices. It's the point of, of me ODing all the time and taking too many drugs, and stuff like that. And I'm not gonna do that no more because I feel good. There's no reason why.

> R: Ah, probably on my admission file, there's some strange things about my sexual nature and . . . what I was hearing at the time. [pause] I was hypnotized. . . . They're holding it against me.

Because participants perceived the major problem behaviors were eradicated, they evaluated themselves as ready for discharge.

In order to institute behaviors intending to convince professionals of their readiness, these participants identified behaviors they thought professionals used as criteria for assessing readiness for discharge. The participants then initiated behaviors with the intended outcome of convincing professionals of their readiness for discharge. The participants who exhibited "taking charge" behaviors were also those participants who described intrusive experiences.

The first participant speculated that professionals' criteria for his readiness to be discharged was his demonstrated ability to control his anger:

> R: I think it was anger control—is the main thing that they are concerned about.

His anger was associated with threatening and punitive intrusive experiences which he attributed to others in his immediate environment. Although the participant did not perceive his reaction to these intrusions as inappropriate, he described purposefully controlling this reaction in order to prove his readiness to be discharged:

> R: In my case, I have to play a kitten, and take shit and abuse from everybody. . . . in my case, that's like taking away the wings off an airplane. . . . In the — in the fact that I don't use it for aggression, I use it for self-defense.

> R: I was quiet and kept to myself—didn't lash out in anger at anybody. At least when I did, I made peace afterwards, which is exactly what I did today. He still thinks he's got one up on me but I'm laughing inside at him anyway. It's a children's game.

The second participant speculated that his attending physician wanted his "voices stopped" prior to his discharge. "Um, I'm not sure—probably about the voices and everything. They wanted to get those stopped and so, I don't know." He initiated behaviors to convince his physician this had occurred:

> R: By just talking to him patiently and, um, telling him that, um, I wasn't hearing voices anymore. So I . . . told a little white lie, but I don't . . . need to be in hospital any longer. . . . Well . . . I just told them that just because they're asking me about my voices and, you know, I . . . don't hear them all the time anymore, you know. Um . . . just once in awhile I hear them, and they don't preoccupy me, so there's no problem there, you know.

Although the behaviors described by these participants were different, the intended effect was the same, that is, to convince professionals of their readiness to be discharged.

Both of these participants avoided situations in which they would have to address the source of these experiences.

> R: And she [physician] wouldn't believe me that there's a transmitter in my room, so I just refused to talk to her after awhile, you know.

When the second participant was told by professionals he was hallucinating, he stated "I just kept my mouth shut, and grin and bear it." Following the physicians' authorization of their discharge, both participants characterized their attending physicians as being on their side:

> R: I feel great now that Dr. ______ has realized I'm no longer a danger to myself or society. So, she's on my side now.
>
> R: He's [physician] . . . basically looked at it in my . . . eyes and seen that I'm ready to go, so . . . I think he's carrying through with it, eh?

The fourth cell in figure 3 (cell d) consists of patients who do not assess themselves as ready for discharge and do not consider it likely that they will be discharged. They were considered "too sick", and were excluded from the study. Ideally during the course of recovery, patients would move from cell d to cell a, prior to exiting the hospital. However, participants in this study moved from cell a to cell c when disagreements emerged between them and the hospital professionals regarding their readiness to leave hospital. These disagreements were precipitated by rejection of candidacy for placement in alternative living accommodations.

To the participants, being in hospital is comparable to being in an army "boot camp". In addition to organizational and structural similarities, the primary function of both institutions is to prepare its service recipients for roles autonomous from institutional roles. Participants of this study sought discharge from hospital when they assessed themselves ready to return to the community or they perceived hospital treatment was not facilitating this return. The three types of "getting out" behaviors verbally exhibited by participants are marking time, breaking out, and taking charge.

Discussion

Mentally ill individuals do not want to be institutionalized. Moreover, psychiatric patients, including participants of this study desire to be disassociated from other mentally ill individuals, Research results indicate psychiatric inpatients do not internalize identification with the "hospital world." Karmel (1970) analyzed psychiatric patients' responses to her research question "Who am I?". She reports that the participants hospitalized for at least two years manifest a decrease in their "home world" social identity. This decrease, however, is not accompanied with a corresponding rise in their personal identification with the "hospital world." These results are also evident in participants who had been hospitalized for fifteen to twenty years. The researcher concludes that the study participants did not internalize a personal identity based on their roles as mental patients.

A possible explanation for mental patients unwillingness to associate with other mental patients is their own attitudes towards mental illness. Although this study did not examine participants' attitude towards mental illness, other researchers have. Giovannoni and Ullmann (1963) compared psychiatric inpatients attitudes towards mental illness with the attitudes elicited from a normal population during a previous study. In this study, the participants rated the concepts "Neurotic Man," "Average Man," "Psychiatrist," "Insane Man," "Father," and "Me" on rating scales. Both the psychiatric inpatients and the normal comparison group rated the "Insane Man" as "dirty, bad, cold, dangerous, unpredictable, [and] worthless" (p. 399). The results of this study are congruent with these findings. The study participants reject affiliation with the patient group, and desire to emulate the qualities of nursing staff.

VI. Conclusion

All participants recalled pleasant experiences from their extended past. Moreover, they described this past as discontinuous from their preadmission past, which began with their first contact with formal mental health care. The preadmission past is an extended period of "not making it" in the community, culminating with their present admissions.

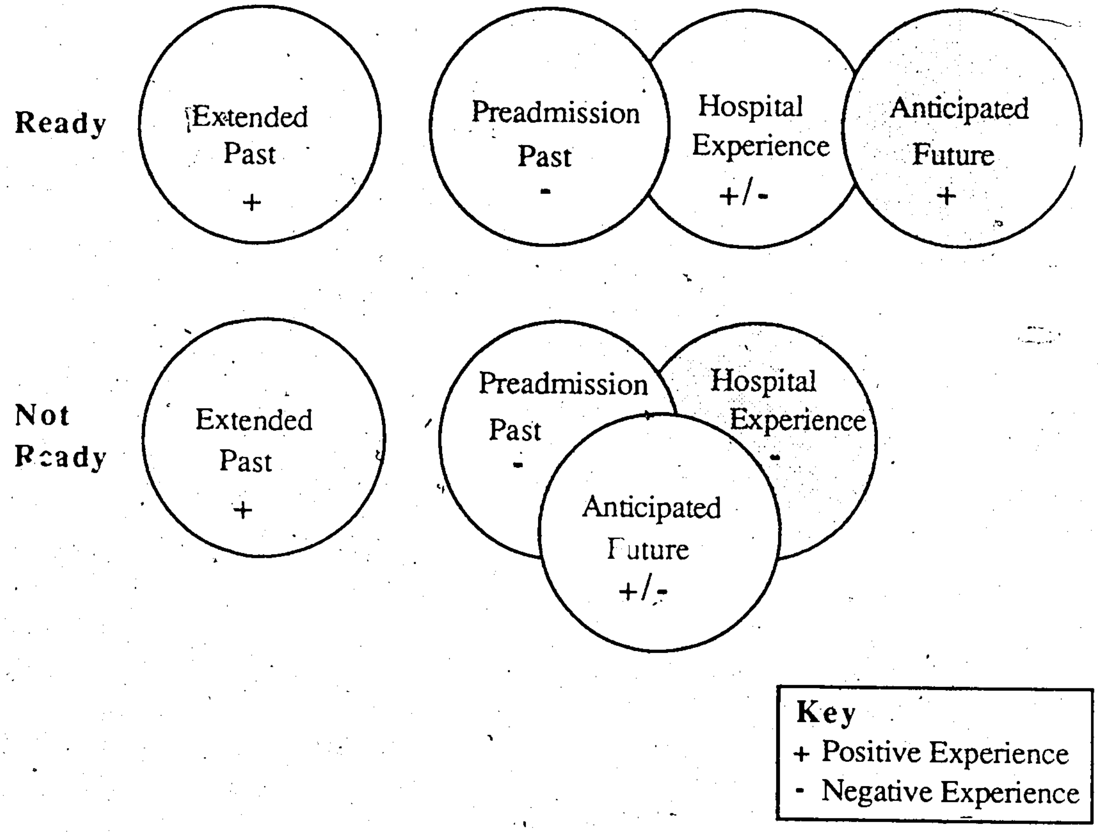

Figure 4. Actual and anticipated life experiences of study participants.

The actual and anticipated life experiences of participants are schematically presented in figure 4. The first row of circles (figure 4) represents the life-experiences of participants who assessed themselves as ready to return to the community. These participants were "anticipating mastery" of their community environments and characterized their immediate future as "new beginnings." Their life experiences therefore, can be depicted as progressing linearly.

The second set of circles (figure 4) represents the life experiences of the participant who did not assess himself as ready to return to the community. This participant characterized his immediate future as a continuation of the preadmission "struggle to make it" and predicted the need for future rehospitalizations. Because he anticipated eventual acquisition of productive community roles, the circle representing his anticipated future is not obliterated by circles representing present hospital and preadmission experiences.

Becoming Ordinary

The core explanatory variable of the results was "becoming ordinary." A process labelled "becoming ordinary" outwardly appeared to be paradoxical. Adults are not generally viewed as striving for ordinariness, but instead, towards outstanding life careers. When viewed from within the participants' frame of reference, however, this concept lost much of its paradoxical impact. The participants' frame of reference was their preadmission experiences. All participants described themselves as failures during this extended time period because they were "not making it" in the community. Their admission to hospital removed them from overwhelming community environments.

At predischarge, all participants aspired to become self-supporting and independent. All participants, however, did not anticipate immediate progress towards "becoming ordinary." The predischarge participants who were "anticipating mastery" of their communities were also anticipating immediate acquisition of productive community roles. From their perspective, they were "becoming ordinary." The participant who was anticipating continuation of his preadmission struggle to "make it" in the community was not anticipating immediate progress towards "becoming ordinary." Self-assessment of unreadiness to return to the community was accompanied with anticipated inability to manage in the community and the prediction of the need for future rehospitalizations. Figure 5 schematically presents the process of "becoming ordinary."

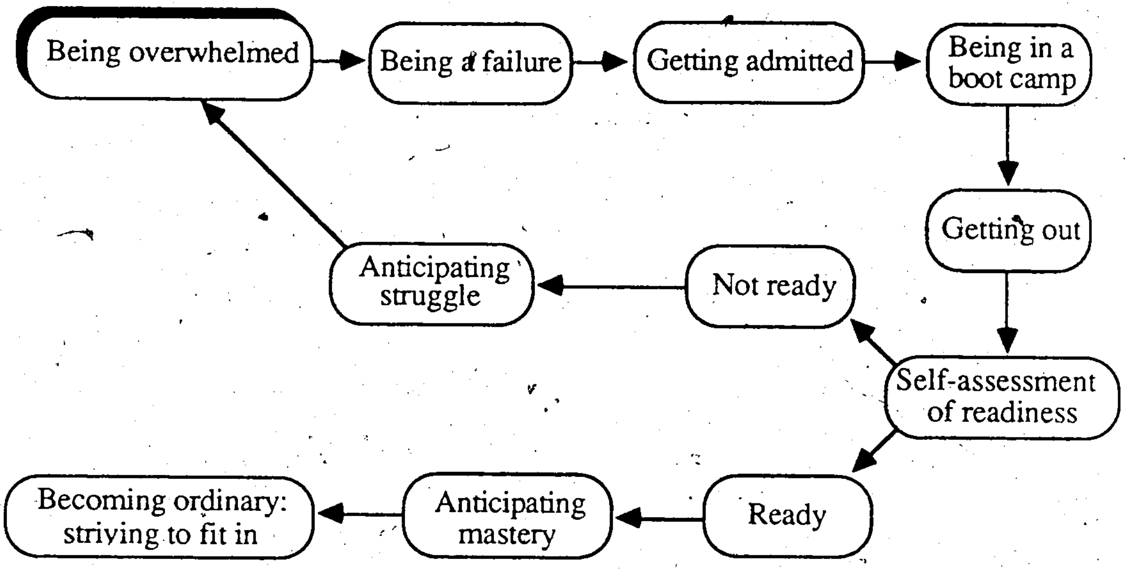

Figure 5. Flow chart depicting process "becoming ordinary."

The concept, "becoming ordinary," embodied participants' perception of their anticipated future as well as their past experiences, and subsequently, it was superordinate to all other concepts. To recapitulate, participants who characterized themselves as past failures in the community were anticipating assuming "ordinary" roles in the community. "Becoming ordinary" was the belief of participants that they would become normal, productive community members.

Discussion of Results

The hallmark of modern psychiatry is the deinstitutionalization of the mentally ill from large specialized hospitals. For the majority of schizophrenics, however, deinstitutionalization does not augur adjustment to community living but rather, a cycle of repeated admissions known as the "revolving door syndrome." Schizophrenics' participation in community-based treatment programs is associated with reduced readmission rates (e. g. Seeman, 1981). The majority of chronic schizophrenics, however, do not comply with planned aftercare (Caton, 1981) and the overall readmission rates for these individuals remains high. Canadian based researchers, Bland, Parker, and Orn, report that over 60% of schizophrenics will require at least one readmission (1978).

This researcher explored the perceptions of predischarge chronic schizophrenics. All of the participants were experiencing readmissions and, therefore, had previous experience with returning to the community following hospitalization. The study participants anticipated eventually "fitting in" with their discharge communities. They were "becoming ordinary." The majority of these participants expected their forthcoming experiences in the community to be different than their previous experiences. These participants were anticipating immediate acquisition of contributive membership roles in the community.

It is debatable, however, whether deinstitutionalization of schizophrenics has been accompanied with re-integration or "institutionalization" of schizophrenics within the community (Rachlin, 1978). Present community-based treatment of schizophrenics sets them apart from other members of their community. These treatments are aimed at either changing the schizophrenic or modifying his/her immediate environment. Strategies designed to change the individual include: medications (e. g. Goldberg et al., 1977), social skills training (e. g. El Islam, 1982), day hospitals (e. g. Niskanen, 1974), and group therapy (e. g. Masnik et al., 1980). Treatment interventions designed to modify the schizophrenic's immediate environment include: family therapy (e. g. Glick et al., 1985), relative support groups (e. g. Leff et al., 1982), family education (e. g. Falloon et al., 1985), and alternative living accommodations (e. g. Solomon et al., 1980). Although these diverse treatments are based on different assumptions regarding the etiology of schizophrenia, their implementation has a common effect on the schizophrenic. All of these therapies distance the schizophrenic from others in the community.

Research comparing the outcome of schizophrenics in developing countries and industrialized countries suggests that the type of community environment affects the outcome of schizophrenia. Researchers associated with the World Health Organization did a two year follow-up of schizophrenics with "relatively recent" diagnoses in nine countries. The researchers were able to trace 97.1% of the original cohort (N=1202), and completed re-examinations of 75.1% of the cohort (averaged from numerous centers). These researchers report a more positive outcome is associated with schizophrenics residing in developing countries (Sartorius, Jablensky, & Shapiro, 1977).

Other researchers have substantiated these results. Waxler (1979) followed consecutive first admission schizophrenics in Sri Lanka (N=66) for five years. This researcher reports comparable results to those obtained in the WHO study. Schizophrenics in Sri Lanka, like the non-industrial countries included in the WHO study, showed consistently more favorable outcomes than schizophrenics living in industrialized countries. Warner (1983) suggests three possible explanations for these results: different cultural definitions of mental illness determine treatment as well as stigma associated with it, developing countries have socially acceptable work that schizophrenics can do, and the presence of extended families provides a broader base for emotional support.

The recent discovery and development of oil resources in the Arabian Gulf provided a research setting in which traditional and industrial cultures could be compared within one indigenous population. El-Islam (1979) compared the outcome of schizophrenics living in extended families with those living in nuclear families in Qatar. Nuclear families emerged with the development and accompanying wealth associated with oil. This researcher followed schizophrenics (N=540) for one to seven years (average length of follow-up was 4.2 years). In comparison to those living in nuclear families, the outcome of schizophrenics living in extended family setting was more favorable. Comparison of these living arrangements revealed that extended families more closely supervised medications, tolerated minor behavioral abnormalities, allowed temporary withdrawal, assisted in normalizing the schizophrenic's symptoms into socially-shared belief systems, expected no reciprocal feedback from the schizophrenic family member, and occupied their leisure time (El-Islam, 1982).

Within industrial countries, schizophrenics continue to occupy marginal roles in the community as evident in their reports of social isolation (e. g. Serban, 1975) and high unemployment rates (e. g. Caton, 1981). Grusky and associates examined the social adjustment of chronic mentally ill individuals in the United States. The majority of the 971 participants had either a primary or secondary diagnosis of schizophrenia (69%). These researchers report that work and community bonding were significantly correlated with personal and community adjustment. Family bonding was not. They also report service use was positively associated with community bonding and negatively associated with work and family bonding.

The participants of this study described themselves as "becoming ordinary" and anticipated eventual acquisition of productive community roles. Their references to community-based treatment programs were limited to programs they identified as facilitating their return to the community. The majority of participants perceived alternative living arrangements would facilitate this return to the community because shared accommodations would offset feelings of social isolation. However, only one participant described other community treatment programs that would facilitate his transition to productive community roles

Program attendance is positively associated with community bonding (Grusky et al., 1985). The bonding of schizophrenics with their communities, however, can only occur if the community environment facilitates this bonding. Meaningful re-integration of the mentally ill in the community requires the support of community members (Borus, 1978). If community-based treatment is not accompanied by acceptance of chronic mentally ill individuals, these treatments will only serve to "institutionalize" the schizophrenic within the community. This study demonstrates that schizophrenics do not want to be marginal members of the community.

> R: I'm a lot cleaner in my mind from the lack of street drugs and I've [got] more insight into myself and other people. I've seen the extreme cases, the dregs of society. Now I can look for the quote beautiful people, and see how they react. . . . I can put my gutter life behind me and start living like a normal human being again.

Implications for Mental Health Care

The study results have implications for three aspects of mental health care of chronic schizophrenics: inpatient care, discharge planning, and community-based care.

Inpatient Care

As a consequence of their inability to function in the community, the participants of this study characterized themselves as failures. Admission to a psychiatric care facility objectively substantiated this negative self-evaluation. Hospital professionals' awareness of patients' negative self-regard and understanding of the basis of these feelings will facilitate the delivery of professional, empathic care. In addition to encouraging verbalization of these feelings, inpatient interventions may be directed towards exploring patients' expectancies as well as establishing realistic intermediate goals.

Patients perceived professional staff, especially unit nursing staff, as role models. Professional behavior towards patients is mandatory to maintain this perception. Patients' positive regard for professionals is the foundation for the development and maintenance of therapeutic relationships.

Finally, understanding individual's perception of intrusive experiences is a prerequisite for providing professional interventions. For some patients, drug therapy does not eradicate mental intrusions and these patients must learn to effectively cope with these experiences (Falloon & Talbot, 1981). A nonjudgemental approach by professionals will facilitate patients' disclosure of these experiences. The participants who related these experiences also described numerous coping strategies. Facilitating open disclosure of these experiences will provide professionals with information so they may reinforce effective coping strategies and discourage inappropriate strategies.

Discharge Planning

The first major finding of the study relevant to discharge planning was that predischarge schizophrenics exhibit diverse behaviors associated with procuring their discharge. These behaviors are noted on figure 3 (page 91). Expressed desire to leave hospital may not be representative of patients' readiness to return to the community. Assessment of readiness to return to the community is necessary in order to plan community care. Patients who assess themselves as not ready to return to the community but insist on leaving hospital will require intensive community support. Although these patients are "breaking out" of hospital, planned discharge may be more beneficial than discharge against medical advice without planned support. Assessment of patients' strategies for attaining their personal goals in the community may be the most comprehensive method for assessing their readiness to leave hospital. To plan concrete goals, the patient must assess his ability to function in the community as well as anticipate community demands. Referrals to community agencies, therefore, can be made on the basis of patient needs.

The second major finding was the desire for shared accommodations in the community. The participants of this study accepted community placement, regardless of their evaluation of the appropriateness of the placement. Although professionals may seek patients' assessment of placement following evaluatory leaves, patients may not openly disclose their feelings because of their awareness of the lack of alternative choices. Effective discharge planning requires community resources be available to patients, such as, diverse alternative living arrangements.

Community Care

The majority of participants perceived discharge from hospital as representing expert confirmation of their "sanity". This belief of schizophrenics has implications for compliance with drug therapy as well as participation in community-based programs. Patient education and counseling regarding drug therapy must continue in the community. Non-compliance with medication is associated with high rates of readmission rates (Goldberg et al., 1977 & Lehmann et al., 1983).

Second, participants' belief regarding their "sanity" was accompanied with a desire to "fit in" with their discharge communities. This suggests that these patients would be more willing to attend "practical" oriented community programs, rather than programs oriented towards individual psychotherapy. For example, from the perspective of these young adult males, attainment of paid employment was the initial step towards "fitting in." Although employment counseling may assist patients with seeking jobs, appropriate employment opportunities must exist in their discharge communities. The development of alternative employment opportunities in workplace which do not segregate mentally ill individuals from other community members may be necessary.

Suggestions for Further Research

The exploratory nature of this study has yielded results which indicate areas requiring further research. Research on these areas would expand present understanding of the experience of being a schizophrenic as well as the experience of returning to the community from a psychiatric care facility.

1. The majority of predischarge schizophrenics in this study anticipated successful transition to community living. A longitudinal, qualitative study following patients into the community is required to identify the effects of community demands on the process "becoming ordinary." "Do discharged schizophrenics continue to display the process, or do their experiences in the community result in the emergence of different processes?"

2. The study results demonstrate that patients' expressed desire to leave hospital may not signify their self-assessment of readiness to return to the community. A potential research question suggested by the study results is: "Does patient's self-evaluation of readiness to return to the community predict outcome in the community?"

3. A qualitative study designed to explore schizophrenics' perception of mental illness is needed. The majority of participants perceived discharge from hospital as confirming their "sanity." Exploration of the question "How do psychiatric patients

define mental well-being and mental illness?" has potential implications for inpatient and community care as well as drug therapy.

4. Exploration of post-discharge schizophrenics' needs in the community would facilitate planning supportive follow-up in the hospital. At predischarge, the majority of participants of this study anticipated relatively straightforward transition to community living. Inclusion of discharged schizophrenics in a study would facilitate identification of community-based needs emerging from experienced deficiencies in the community.

5. The study sample needs to be enlarged to include both genders as well as a range of ages. A relevant study question could be: "What is the effect of age- and sex-related social norms on schizophrenics' perception of themselves and their functioning?"

6. Assessment of community members' attitudes towards mental illness and re-integration of psychiatric patients into the community is needed. Results of such a study has implications for the preparation of predischarge mental patients as well as the development and implementation of public education programs.

Discussion of the Method

Accessing Informants

Problems were encountered accessing study informants. This difficulty was not related to problems associated with gaining access to suitable candidates in the research setting. The researcher reviewed predischarge patients' chart with unit managers and suitable participants were referred to the researcher by their attending physicians. All participants who met study criteria agreed to participate in the study. Several potential participants were excluded from the study because they had court appointed guardians. The researcher did not anticipate problems accessing informants. Prior to commencing the study, discharge statistics for the research setting were examined. These statistics revealed that an adequate base of discharges had occurred during the months prior to the study.

Initial criteria for inclusion of participants was modified to include participants with a history of continuous drug and alcohol use. The inclusion criteria was modified because of the high prevalence of use of these substances among potential participants. Three of the four study participants had a history of continuous drug and alcohol abuse. As the results indicate, they primarily accounted for use of these substances by referring to alleviation of feelings of being overwhelmed in the community. For these participants, abuse of drugs and alcohol was part of their experience of being a schizophrenic in the community.

The results of this study emerged from analysis of data gained from four respondents. There is an inverse relationship between the number of subjects and the depth of data collected; the fewer the subjects, the greater the depth of data collected (J. Morse, personal communication). Generating grounded theory involves the discovery of theory from data, rather than verification of preconceived concepts (Glaser & Strauss, 1967). In order to generate a theory relevant to the area of inquiry, the researcher must obtain an adequate depth of data to ensure accurate representation of the substantive area (Glaser & Strauss, 1967). Initial sampling was performed on respondents with knowledge of the experience of being a predischarge schizophrenic. As substantive categories began to emerge, participant sampling was replaced with theoretical sampling, and sampling was conducted on the basis of the developing theory (Glaser & Strauss, 1967).

Adequacy of the sampling of this data should be evaluated on the basis of the integration of the theory as well as it relevancy to the substantive area (Glaser &

Strauss, 1967). The intent of the researcher was to theoretically account for the perceptions of chronic schizophrenics during predischarge. Because the theory is grounded in data obtained from predischarge chronic schizophrenics, this theory is relevant to their experiences. The interrelationship among the concepts supports the researcher's contention that the theory is integrated. All concepts in this theory are components of the core variable, "becoming ordinary." Integration of the theory, however, does not imply that the theory will fully explain all potential variation in predischarge perceptions of chronic schizophrenics. Theory generation, itself, is a process, and gaps in the theory represent opportunities for further expansion of that theory (Glaser, 1978). This theory, however, does account for a broad range of predischarge behaviors. The quality of data gained from four respondents, therefore, was adequate to generate a theory about the predischarge perceptions of chronic schizophrenics.

Interviewing Informants Who Are Schizophrenic

An informant is an individual who has knowledge about an area of inquiry and is willing to share this knowledge with the researcher (Field & Morse, 1985). All informants are not equal in terms of their depth of knowledge or their ability to verbalize this knowledge. Schizophrenics are not generally considered "good" informants if the criteria for evaluation is comprehensiveness of their responses and complex development of ideas.

In comparison with nonpsychiatric individuals, the speech of schizophrenics is different. Researchers report that schizophrenics exhibit more frequent speech errors, fewer well formed sentences, and more frequent repetition of words and false starts (Fraser, King, Thomas, & Kendell, 1986). Allen (1983) states chronic schizophrenics characteristically display "poverty of thought" which is evident in their "poverty of speech." The speech of chronic schizophrenics contains less complex ideas, fewer ideas, and less variety of ideas, in contrast with the speech of a normal comparison group (Allen, 1983). Schizophrenics, therefore, are "poor" informants in terms to their ability to verbalize ideas.

In order to elicit participants' perceptions at predischarge, it became apparent during initial interviews that the researcher's technique of interviewing required modification. Although informants volunteered information, they did not generally develop their ideas:

> I: Tell me about the group home. What is it like to be going there Monday?
> R: Uh, [pause], going there Monday? It'll, it reintegrates me into society at a team level.
>
> I: What was happening?
> R: Ah, actually just a ridiculous test of my mind.
>
> I: What's it been like [to be in hospital]?
> R: Oh, something I'd rather not do again, I suppose. [pause]
> I: In what sort of ways?
> R: Ah, I just don't like spending my time in here.

The researcher initially increased the length of silence during interviews to determine if the informants required more time to cognitively formulate their responses. However, use of longer periods of silence was not accompanied with further gains of data. In the following quote, the numbers in brackets refers to the length of silence in seconds.

> I: What's it been like for you to spend your time in here?
> R: Uh [19 seconds], ah, I'd, I'd just like a peaceful atmosphere [8 seconds]. I don't know. [32 seconds]

Two interviewing techniques effectively facilitated respondents' elaboration of responses: frequent verbal probing and direct leading questions. Two types of verbal probes were used. The first was short, general statements or questions requesting more information:

> I: What was that like?
>
> I: How about now?
>
> I: And then what happened?

The second type of probe used was short, summary statements followed by verbal probes for specific information.

> I: How did you come to this type of feeling, just to do what you are told to do?
>
> I: When you say you can't make it on your own, can you expand on that a little bit?

Direct leading questions were also utilized to facilitate elaboration of previous responses. These questions were used when a silence occurred in the interview and the previous topic had been explored. Direct questions guided the informants to previously volunteered information which required further elaboration.

> I: It seems like you have plans for what you want to do when you get out. I haven't really got a picture of what it is like to be discharged. Can you go into that a bit?
>
> I: Can you just go back and describe to me how it came about that you went into the group home?

Unstructured interviews can be conducted with schizophrenic informants. The quality of the interviews should be evaluated in terms of the ability of these informants to verbalize their subjective perceptions of their experience. This will facilitate modification of interviewing techniques to enhance participants' elaboration of their responses. The researcher doing grounded theory, however, must ground the content of probes and direct leading questions in previously obtained data.

The researcher's previous experience as a psychiatric nurse was helpful when interviewing these informants. Because of her background in psychiatry, the researcher did not react with disbelief or surprise when strange data was elicited. As well, the researcher felt comfortable with participants who displayed unusual behavior. For example, during interviews, one participant would turn his head to the side and mutter profanities.

Ethical Concerns. The researcher encountered ethical concerns during interviews with two participants. The first participant purposefully misled treatment staff about the presence of his "voices." Action was not taken by the researcher because: (a) the participant verbalized awareness of his behavior as well as understanding of potential consequences of this behavior, and (b) the content of the "voices" was not punitive. The participant did not verbalize feelings of aggression towards himself or others.

The second participant was an ethical quandary. This participant verbalized bizarre beliefs regarding the researcher's use of the interviews:

> R: 'Cause you're getting it all on tape, eh? Then taking it back and putting it on a Cosmic wheel, and pretty soon I won't be anywhere except for in my own head.

Following this statement, the interview was immediately discontinued, and clarification was sought by the researcher. Because the participant verbalized clear understanding of the use of the information, the interview continued:

> R: You'll probably use it for your term paper or something, or that's what you're hoping for.

This participant also verbalized suicidal ideations during an interview and his potential for suicide was assessed:

> I: Whenever I come and see any other guys, I'll come up and say "Hi" to you.
> R: Yeah, if I'm still around, if I'm not dead by the time you come back. If I don't decide to commit suicide or something.
> I: If you don't decide, what do you mean _______?
> R: Yeah, if I can't handle something, right, a bit large. Anyways, you see, like [pause] I can't remember the second half of that saying. [pause]

I: _______, can I just interject here a bit? It bothers me when you say "If I don't commit suicide." Has that been on your mind?
R: No.

No further action was taken because clarification revealed the participant was not suicidal at that time. Although seeking further clarification may have disrupted the process of obtaining data, these interruptions were ethically unavoidable.

Generating Grounded Theory

The process of generating a theory about the predischarge perceptions of chronic schizophrenics has been both arduous and rewarding. Feelings of accomplishment accompanied the emergence of theoretical concepts from the data. Achieving and maintaining theoretical sensitivity to the data, however, was difficult. Theoretical sensitivity is an intellectual openness towards the data to ensure that the theory emerges from the data and not from preconceived assumptions of the researcher (Glaser & Strauss, 1967). Initial anxieties of the researcher regarding the quality of the interviews resulted in her seeking information on preconceived areas of concerns. Explication of implicit assumptions and reinforcement of the need for theoretical sensitivity resulted in acceptance of the quality of interviews as well as modification of interviewing techniques.

Grounded theory was an appropriate research method for gaining knowledge about the perceptions of predischarge schizophrenics. Unanticipated results were obtained because the participants were encouraged to 'teach' the researcher what their experience is like. Results unanticipated by the researcher include the presence of different predischarge behaviors, the participants' desire to "become ordinary", and the participants' description of gaining control of intrusive experiences.

Summary Of the Study

A qualitative research method, grounded theory, was used to explore the predischarge perceptions of four hospitalized male schizophrenics. Four to six interviews were conducted on each participant over a period of three to five months. Interviews were recorded and data analysis was performed on the transcribed verbatim interviews. Initial comparison of incidents of data resulted in the emergence of broad conceptual categories. Theoretical sampling of data was utilized to further refine these categories and identify interrelationships among them.

The core explanatory variable of chronic schizophrenics' perceptions at planned discharge was "becoming ordinary." This variable accounted for participants' characterization of their preadmission experiences as well as their anticipated future. Because they were unable to "make it" in the community, the participants described themselves as failures. At predischarge, they anticipated eventual acquisition of productive roles in the community. The participants who were "anticipating mastery" of their discharge communities were expecting immediate progress towards their aspiration of "becoming ordinary."

From the participants' perspective, being in hospital is comparable to being in an army "boot camp" because both institutions prepare its service recipients for roles autonomous of institutional roles. Discharge from hospital was sought when the participants either assessed themselves ready to return to the community or they perceived the hospital was not facilitating this return. The three types of "getting out" behaviors verbally exhibited by the participants were marking time, breaking out, and taking charge.

It is debatable, however, whether deinstitutionalization of schizophrenics has been accompanied with re-integration or "institutionalization" of schizophrenics within the community. Published literature suggests that these individuals continue to occupy marginal roles in the community. The schizophrenics of this study desired contributive membership roles within their communities.

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