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and the treatment process, expressed early in the inpatient treatment episode, between families with whom patients went to live after discharge and families of patients discharged to other settings. We also examined the demographic and clinical characteristics of patients who were and were not discharged to live with family.

Methods

The subjects included 72 patients admitted to a university-based short-term locked psychiatric inpatient unit over a one-year period. All the patients had families who were willing and able to participate in the overall inpatient evaluation and treatment process.

The patients' charts were reviewed retrospectively to determine whether or not they went to live with family members after hospital discharge. Data on the patients' demographic characteristics, clinical variables, and family variables were also compiled from various forms and narrative reports completed in routine clinical practice by the treating physicians, nurses, and family therapists. Clinical variables included primary psychiatric diagnosis, based on *DSM-III-R*; level of overall psychiatric impairment at the time of admission and discharge, based on the treating clinician's rating on the Global Assessment Scale (GAS) (4); a rating of the extent of recent suicidal behavior based on the Longitudinal Inventory of Function and Encounters (5); and a rating of the extent of violent behavior during the two weeks before admission (6,7).

We also examined responses of family members to the Family Attitude Inventory (FAI) (8), which had been completed by the family member identified as most closely involved with and knowledgeable about the patient who was available to work with the inpatient treatment team. The FAI, administered as part of the routine clinical assessment shortly after admission, is a widely used structured clinical interview that has been reliably shown to measure five domains: attitude toward the patient (family's general attitude toward the patient); attitude toward the hospital (family's willingness to

Family Attitudes That Predict Home Placement of Hospitalized Psychiatric Patients

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As the average length of psychiatric hospitalization has decreased, family members have frequently become the primary caretakers for their mentally disordered relatives during all but

the most acute phases of their illnesses. Previous estimates suggest that from 50 to 75 percent of hospitalized psychiatric patients who are discharged to the community return to live with their families (1). A central issue in evaluating patients at the time of hospital admission is determining whether they will eventually be able to live with their families, since this factor will have a major impact on treatment planning.

However, episodes of acute mental illness often create chaos in families (2) and make it difficult to determine whether patients will be able to live with their relatives after hospital discharge. Such information could facilitate planning for aftercare and would be helpful in making decisions about whether alternative community placements should be vigorously pursued. It could also help focus the nature of interventions provided to the family during the period of brief inpatient treatment (3).

The study described here used retrospective chart review to examine the similarities and differences in family attitudes toward the patient

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Table 1

Demographic and clinical characteristics of 72 hospitalized patients discharged to live with family or to other settings

Characteristic	Family (N=38)		Other setting (N=34)	
	N	%	N	%
Sex				
Male	16	42.1	16	47.1
Female	22	57.9	18	52.9
Social class¹				
I to IV	11	32.4	6	21.4
V (lowest)	23	67.6	22	78.6
Marital status				
Single, divorced, or widowed	22	57.9	27	79.4
Married or living together	16	42.1	7	20.6
Ethnic group				
White	21	55.3	26	76.5
Nonwhite	17	44.7	8	23.5
Diagnosis²				
Schizophrenia	6	15.8	8	23.5
Mood disorder	22	57.9	10	29.4
Organic mental syndromes and disorders	2	5.3	11	32.4
Other	8	21.0	5	14.7
Recent suicidal behavior				
Present	23	60.5	12	35.3
Absent	15	39.5	22	64.7
Recent violent behavior				
Physical attacks	9	23.7	7	20.6
Fear-inducing behavior	9	23.7	11	32.3
No violence	20	52.6	16	47.1
Number of previous hospitalizations³				
None	13	46.4	2	9.1
One	3	10.7	5	22.7
More than one	12	42.9	15	68.2

¹ Based on Hollingshead AB: Two-Factor Index of Social Position, New Haven, Conn, Yale University, 1957. Data unavailable for ten patients

² $\chi^2=11.52$, $df=3$, $p<.01$ for comparison between patients discharged to live with family and patients discharged to other settings

³ Excludes 19 patients for whom no data were available

seek help from professionals); rejection of the patient (family's critical attitude toward and emotional involvement with the patient); family burden (disruption to family life as a result of the patient's illness); and social support (the existence of and reliance on a social support system by the family).

Results

Thirty-six percent (N=26) of the 72 family respondents were parents of the hospitalized patients, 32 percent (N=23) were spouses, and 32 percent were other relatives (13 children, eight siblings, and two other relatives).

Before hospital admission, 63 percent (N=45) of the patients lived with their families. Eighteen percent (N=13) lived alone, and 19 percent (N=14) had other living arrangements. After discharge from the hospital, 53 percent went to live with family (14 with a spouse, six with a parent, five with a child, and 13 with other relatives). Eleven percent (N=8) planned to live alone, and 36 percent had other living arrangements (seven in halfway houses, four in board-and-care homes, three in nursing homes, one in a subacute locked psychiatric facility, and 11 in other living situations).

Patients who went to live with

their families after discharge were significantly more likely to have lived with their families before hospital admission (30 of 45 patients) than patients who had not lived with family before admission (eight of 27 patients) ($\chi^2=7.86$, $df=1$, $p<.01$).

Because patients' living arrangements before hospital admission were significantly associated with discharge plans, we employed analyses of covariance (ANCOVAs), using living situation before admission as a covariate, to assess the relationship between the FAI measures of initial family attitudes and eventual decisions about home placement after hospital discharge. Hence the FAI means reported below are adjusted for living situation before admission, which was coded for the ANCOVAs as 1 for patients who lived with family and 0 for patients who did not.

At the time of admission, families with whom the patient eventually went to live after hospital discharge had significantly lower mean scores (indicating more favorable attitudes) on the attitude-toward-the-patient scale than patients who did not live with their families after discharge (respective means were 43.1 and 53.1; $F=5$, $df=2,69$, $p=.029$). The scale measures general attitudes toward the patient through responses to such statements as "[The patient] makes me happy" and "[The patient] is pretty easy to get along with."

Families with whom the patient went to live after discharge also had significantly lower scores on the rejection-of-the-patient scale (8 compared with 10.1; $F=5.62$, $df=2,69$, $p=.021$). The scale measures critical attitudes toward the patient and general level of emotional involvement; it includes items such as "[The patient] is an important part of my life" and "It makes me happy to do things for [the patient]."

FAI scores showed no significant differences between families with whom the patient did and did not live after discharge on the attitude-toward-the-hospital scale (respective means were 23.5 and 25), the family burden scale (respective means were 11.6 and 11), or the social support scale (means were 12 and 12).

In sum, the FAI results suggest that when family members acknowledge feeling relatively negative toward, uninvolved with, or critical of a newly hospitalized patient, the patient is less likely to go to live with the family after hospital discharge.

We also examined the relationship between patients' demographic and diagnostic characteristics and their discharge plans using *t* tests for continuous variables and chi square analyses for categorical variables.

Age was one of the few demographic and clinical variables that showed significant differences between patients who were discharged to live with family and those discharged to other settings. Although level of impairment did not differentiate the two groups at admission, patients discharged to live with family had a mean \pm SD age of 42.8 \pm 18.4 years, compared with 53.8 \pm 24.2 years for those discharged to other settings ($t=2.19$, $df=70$, $p=.032$). Patients discharged to live with family had lower levels of impairment, as indicated by significantly higher GAS scores at discharge (mean \pm SD=52.8 \pm 13.0) than patients who did not go to live with family (mean \pm SD=44.4 \pm 14.2; $t=2.63$, $df=70$, $p=.01$). In addition, as Table 1 shows, patients who had organic mental syndromes or disorders were less likely to be discharged to live with family; patients with mood disorders were more likely to be discharged to live with family. Other demographic and clinical characteristics of the patient groups are also shown in Table 1.

Discussion

These findings underscore the importance of assessing the family's point of view early in the hospital course of adult psychiatric inpatients. The resulting information can then be integrated into the treatment plan in a way that will encourage efficient and realistic allocation of treatment resources in planning for aftercare. Such information may thereby facilitate a collaborative working relationship with the family that is sensitive to the family's specific needs for psychoeducation, respite, or other types of support (9).

Our data suggest that the initial assessment needs to attend to family members' general attitude toward the patient, their level of perceived involvement, and their positive feelings toward the patient and toward their caretaking role. In our study group, the family's willingness for the patient to return home after hospital discharge was not significantly related to the extent of perceived family burden, the family's openness to seeking help from professionals, or the perceived availability of a social support system for the family.

In evaluating whether a family will take an acutely mentally ill patient home after discharge, it appears that the amount of general disruption experienced by the family is less important than the family's overall positive feelings toward the patient. In other words, families with more positive feelings toward their mentally ill family members are willing to cope with a relatively large amount of family disruption and still continue in their caretaking roles.

An additional factor that appears correlated with the family's taking care of the discharged patient is the extent of symptom remission. Understandably, patients who achieve greater reduction in functional impairment are more likely to be able to live with their families after discharge. Similarly, patients who are older and suffer from organic mental syndromes and disorders such as dementia, which often have a progressive deteriorating course, are less likely to be discharged home.

Although this study focused on family attitudes as predictors of community placement, obviously many other considerations are relevant to placement decisions, such as availability of community treatment resources, the patient's symptom course and level of behavioral control, and availability of funding. In addition, further research is needed to identify when discharge to the family has a better or worse outcome for the patient and the family. In any event, the results of this study suggest that initial family attitudes are predictive of eventual clinical decision making about home placement.

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