SELF-ESTEEM, FAMILY PERCEPTION, AND THERAPY PREFERENCES OF DEPRESSED INDIVIDUALS: AN EXPLORATORY STUDY

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BY

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ABSTRACT

Self-esteem, family perception, and therapy preferences of depressed individuals: An Exploratory Study.

This exploratory study investigated the relationship between depressive symptomatology, self-esteem, and perception of family environment of depressed adults. In addition, the study identified the depressed adults' preferences for support and therapy when experiencing depressive episodes. A convenience sample of 25 male and female adults from two health care facilities participated in the study. Data was obtained on admission, discharge, and one month post-discharge. The Beck Depression Inventory measured depressive symptomatology; Tennessee Self Concept Scale assessed self-esteem; Family Environment Scale reflected family perception of cohesion, expressiveness, and conflict among members; and the Subject Profile form provided demographic data and subjects' preferences for support and therapy.

Findings revealed a persistently low self-esteem among subjects and a fairly constant perception of the family

environment over time, even with great alleviation of depressive symptomatology at discharge and one month follow-up. An interesting finding was that depressed adults perceived their families as lacking in expressiveness. Subjects also indicated several preferences for support and therapy. A noteworthy observation was the subjects' insistence of empathy from staff and others. The results clearly suggest depressed individuals need empathic understanding from care-givers. Both the depressed member and the family must be included in the assessment and treatment process for effective interventions.

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CHAPTER 1

THE PROBLEM

Background of the Problem

Psychiatric admissions are a major problem facing the health care system today.. The continuing high rate of readmissions in the psychiatric population has one of become one of the major areas of concern in the mental health field. Studies of recidivism reflect the high readmission rate in this population (Bassuk & Gerson, 1978; Franklin, Kittredge, & Thrasher, 1975; Solomon, Davis & Gordon, 1984; Wessler & Iven, 1970). The phenomenon of rising psychiatric readmissions is also well known in other parts of the world (Gillis, Sandler, Jakoet, & Dickman, 1985).

Several studies note that of those individuals readmitted to Canadian facilities between one-half and two-thirds were readmitted in the first 12 months after discharge (Fakhruddin, Manjooran, & Nair, 1972; Wood, Meier, & Eastwood, 1977). It is estimated that within six months, 30 to 40 percent of psychiatric clients return; within a year 40 to 50 percent do so; and within three to five years, 65 to 75 percent of

clients return (Anthony, Cohen, & Vitalo, 1978). Gillis and associates (1985) note psychiatric readmissions amounting to as high as 42 percent of total psychiatric admissions within a one year period. This clearly suggests that of those clients presently admitted to psychiatric facilities, approximately 50 percent of these clients are potentially at a risk for readmission within a year.

Of the various psychiatric disorders, depression has ranked as one of the major psychiatric disorder warranting readmission. A recidivism rate of 47-84 percent has been reported in the literature (Beck, 1967). Acute care psychiatric facilities continue to admit and readmit individuals suffering from depression. A recent study of a large Canadian city with regard to lifetime prevalence of psychiatric disorders in the community indicates that one in ten persons have had an affective disorder, most of whom received a diagnosis of major depressive episode (Bland, Orn, Newman, 1988). Such high prevalence of depressive disorders presents a highly complex and challenging task to nurses working in psychiatric facilities.

As the rate of psychiatric readmissions, specifically readmission with depressive symptomatology, continues to escalate, there is an urgent need for health care professionals to examine some of the factors that may be associated with the perpetuation of this phenomenon. This examination may then assist the caregiver, particularly nurses, in identifying individuals at high risk for possible recurrence of depression before the onset of the depressive episode. In addition to the early detection of potential recurrence of depression, identifying some of the contributing factors may also have implications for nursing therapy, providing the nurse with a broader base for intervening from a holistic perspective. Nursing care plays an important part in the mobilization of individual coping capacity and in influencing recovery from mood disturbances.

Self-esteem plays a central role in most psychological theories of depression. Many depressed persons experience low self-esteem (Beck, 1967; Tennen, Herzberger, & Nelson, 1987). Both self-esteem deficits (Abramson, Seligman, & Teasdale, 1978; Beck, 1967; Becker, 1979; Freud, 1950) and dysfunctional

self-esteem maintenance (Alloy, 1982; Becker, 1962) have been posited as critical to the development of depressive episodes.

Numerous research studies provide evidence that depressed individuals typically devalue themselves (Beck, Rush, Shaw & Emery, 1979; Karoly & Ruehlman, 1983) and in fact, have an organized negative view of self (Kuiper & Olinger, 1986). Recent research evaluating the role of self-esteem in depressive attributional style noted a high correlation between self-esteem and depression (Tennen, et al., 1987).

Moreover, the investigator's clinical experience as a mental health nurse has led to questions about the existence of a relationship between self-esteem and depressive symptomatology. In clinical practice, the investigator has often noted that depressed clients have demonstrated disturbances in self concept, exhibiting a low self-esteem upon admission and frequently during the hospital stay. An essential aspect of providing nursing care involves assessing the individual's self-esteem, how self-esteem affects the person's coping capacity, and implementing strategies aimed at promoting improved self-esteem in

individuals. Knowledge of an individual's self-esteem, therefore, becomes significant when studying recurrence of depression.

Recent research evidence also points to a significant relationship between the family environment, psychiatric symptomatology, and relapse. Studies that have assessed the family system and its relationship to psychiatric symptomatology in members suggest that the symptoms in family members are an expression of family conflict or disequilibrium (Bernstein, 1980; Billings & Moos, 1982; Langsley, et al., 1968; Tyerman & Humphrey, 1981). Several other research studies suggest that family conflict, lack of cohesion within the family, and less emphasis on expressiveness by family members, are highly related to physical symptoms, obesity, anxiety, depression, and behavior problems in family members (Fowler, 1980; Moos, Bromet, Tsu, & Moos, 1979; Moos, Finney, & Gamble, 1982; Moos & Moos, 1984).

Recent clinical and research literature (Coyne 1976a, 1976b; Strack & Coyne, 1983) has shown that depressive disorder does not occur without the influence from other factors; it is embedded in a

complex social matrix in which the client and family members mutually influence each other in a continuous process. The hypothesis that people prone to depression come from a non-supportive and conflict-ridden family environment has generated much interest in family research and literature. More recently, the literature suggests that negative family interactions may tend to maintain or exacerbate depressive symptomatology (Coyne, Kahn, & Gotlib, 1987). Furthermore, recent research findings indicate families of patients with major depressive disorder as consistently showing impaired family functioning (Miller, Kabacoff, Keitner, Epstein, & Bishop, 1986).

In clinical practice, the investigator has frequently encountered depressed clients relating a history of a non-supportive family environment and a high level of family conflicts. Therefore, an understanding of the relationship between the family environment and depressive symptomatology in a family member becomes significant and necessary if nurses are aiming at developing more effective therapeutic strategies to reduce the recurrence of depressive episodes among their clients.

According to existing literature, mental health consumer research has concentrated on outpatients; mental health professionals and researchers have paid little attention to the opinions of hospitalized psychiatric clients in their treatment plan (Case, 1983). Very few studies have addressed psychiatric inpatients' attitudes toward their hospital treatment (Delaney, 1984, Wesenberg, 1984). To the investigator's knowledge, no research study eliciting depressed psychiatric clients' preferences of support and therapy exists. Research which adds to the body of literature in this area is valuable for two reasons: (1) No present research exists in this area with regard to the depressed population; and; (2) Research on client's opinions and preferences for treatment have implications for improvement of existing mental health services.

Finally, any attempt at understanding and recommending ways to, reduce the high rate of psychiatric admissions and amelioration of psychiatric symptomatology effectively, is a worthwhile endeavor, as it may serve to decrease the demand for resources that this population is presently placing on the Canadian health care system.

Problem Statement

Health care professionals in acute care psychiatric facilities are being confronted by an increasingly high number of individuals manifesting depressive symptomatology. Recidivism studies indicate a continuing high rate of readmissions of depressed individuals. This escalating rate of readmissions among the depressed psychiatric population warrants a closer look at the factors surrounding this phenomenon.

Readmissions in the depressive population have been shown to be influenced by several factors notably within the individual and the family system. Of particular interest are studies on the role of self-esteem and the family environment in recurrent depressive symptomatology. A review of the literature, and the investigator's clinical experience, suggest a need to understand the relationship between the individual's self-esteem and his/her perception of the nature of the family environment, as it relates to the individual's potential of being at high risk for recurrence of depressive symptomatology.

The examination of the relationship of self-esteem and the family environment may facilitate early identification of an individual's potential for experiencing a subsequent depressive episode. Identification of some of the contributing factors may also have implications for nursing therapy. Necessary and prompt support and therapy including the involvement of families in assessment, treatment process, and follow-up, may be provided to minimize the degree and number of depressive episodes.

In addition, this examination becomes particularly significant if more emphasis is to be placed on maintaining individuals in the family and community settings and assisting in the delivery of community-based health care. Moreover, if self-esteem, and a certain type of family environment are actual predictors of certain depressive episodes, then noting these circumstances within the community at large, holds great promise for primary prevention efforts.

The lack of literature on hospitalized psychiatric clients' preferences of support and therapy, warrants a need to conduct research in this area. Such study may have implications for improvement of existing

mental health services in general, and for the depressed adults the possibility of closer matching of treatment based on client preferences. Identifying preferences of support and therapy is deemed relevant, as it could also provide valuable information with regard to subjects' preference of family as a source of support during a depressive episode.

This study investigated the relationship between depressive symptomatology and two variables, self-esteem and nature of the family environment, specifically in relation to the dimensions of cohesion, expressiveness, and conflict within the family of depressed adults. This was done at three different times - admission and discharge from a psychiatric facility, and one month post-discharge. The study also elicited information with regard to subjects' preferences for support or therapy while experiencing a depressive episode. The study was limited to adults diagnosed with an affective disorder, who were depressed upon admission to the psychiatric facility.

Review of the Literature

A literature review was undertaken to explore the major variables of the study, namely self-esteem, family environment, and therapy preferences, and their relationship to depressive symptomatology. Specifically, the review of the literature pertains to: (a) Depression and recidivism, (b) Self-esteem and emotional health, (c) Self-esteem and depressive symptomatology, (d) Family environment and psychiatric symptomatology, and (e) Therapy preferences of depressive population.

Depression and recidivism

There is considerable variation in the literature with regard to the frequency of relapses among individuals with an affective disorder. As early as 1942, in a longitudinal study of 25 to 30 years follow-up, Rennie reported a relapse rate of 79 percent (97 of 123 patients) in adults with depression. When the author included those patients who had at least one manic attack as part of their illness, with the original group, the proportion of relapsed individuals

increased to 84 percent (142 of 170 patients). (These figures do not include 14 patients who committed suicide after the first admission or who remained chronically ill.) According to this author, more than half of the depressed patients had three or more recurrences of depressive symptomatology (Rennie, 1942).

Lundquist (1945) reported a relatively lower rate of relapse than was noted by Rennie (1942). A 49 percent incidence of relapse was reported among manic-depressive patients, and according to the author, an overwhelming preponderance of relapses occurred in the first nine years (Lundquist, 1945). This study only studied manic-depressive patients. Closely related is a study by Stenstedt (1952) who reported a 47 percent incidence of relapse with manic-depressive patients. The literature suggests that the incidence of relapse is greater among unipolar depressed individuals as compared to the manic-depressive population.

Several other recidivism studies note a high readmission rate in the psychiatric population (Bassuk & Gerson, 1978; Franklin, et al., 1975; Gillis, et al., 1985; Wessler & Iven, 1970). However, these studies do

not provide a breakdown of diagnostically related readmissions, thus making it impossible to identify the recidivism rate in the depressed population.

The importance of considering a high relapse rate among the depressive population is highlighted by studies of psychiatric readmissions in Canadian facilities. These studies indicate that between one-half and two-thirds of readmissions occur within the first 12 months after discharge (Fakhruddin, et al., 1972; Wood, et al., 1977). Part of the readmissions include individuals suffering from depression, thus suggesting early relapse among the depressive population.

Self-esteem and emotional health

The literature demonstrates a relationship between self-esteem and the emotional health of individuals. The relevant literature review of self-esteem is presented here.

Lynch (1968) conducted a two part descriptive study to examine the relationship of intense human experience to psychological openness and self concept. Of relevance here is the second part of this study

which involved 54 selected subjects (from an original sample of 217 anonymously selected adults) whose self-esteem was examined in relation to the effects of the subjects' most intense human experience. The self-esteem was measured by the Total Positive Score (Total P Score) on the Tennessee Self Concept Scale (Fitts, 1965). The effects of the intense human experience were categorized as either an Opening Effect (reducing defensiveness and increasing the readiness for additional experiencing) or a Closing Effect (increasing defensiveness, withdrawal, and avoidance).

The findings of Part II of Lynch's (1968) study demonstrated a significant relationship between self-esteem and psychological openness. The majority of the subjects whose experiences were judged as Opening had significantly higher P Scores than those for whom the effect of an intense experience was Closing. Twenty-two of the 27 subjects with high self-esteem reported Opening Effects and only five subjects reported Closing Effects. Of the 27 subjects with lower P scores, only three reported Opening Effects while 24 subjects noted their experiences as Closing. Lynch's (1968) work demonstrates a strong

relationship between the degree of positiveness of self-esteem and the effects of previous, significant experiences.

Wargas (1968) has provided further evidence of the relationship among self-esteem, positive experiences, and psychological health. The study was conducted on 90 male college students. The self-esteem of the students was measured by the Total Positive Score (Total P Score) on the Tennessee Self Concept Scale (Fitts, 1965). The positive experiences were measured by the Positive Experiencing and Behavior Scale (Puttick, 1964). Psychological health was measured by attempting to simultaneously test several different theoretical approaches and criteria regarding the characteristics of an emotionally healthy person. The instruments utilized to measure psychological health were: 1) Tennessee Self Concept Scale or TSCS (Fitts, 1965), 2) California Psychological Inventory or CPI (Gough, 1957), 3) Fundamental Interpersonal Relations Orientation-Behavior Scale or FIRO-B (Schutz, 1966), 4) Self-Disclosure Questionnaire (Jourard & Lasakow, 1958), and 5) Tape recordings of subject's self-disclosure, and dominant voice qualities such as

pitch, loudness or tempo (Markel, 1965).

According to Fitts (1965), the individual's self concept is related to emotional health or self-actualization. Gough (1957), on the other hand, focuses upon a set of personality and behavior traits, and Schutz (1966) focuses upon interpersonal behavior as indicators of emotional health. Jourard and Lasakow (1958) focus upon the individual's ability to disclose oneself to others, and Markel (1965) upon voice qualities, as indicators of a healthy personality or an emotionally healthy person.

The findings of Vargas' (1968) study showed the same subjects as acquiring a high level, or better-than-average level, of emotional adjustment on each instrument utilized. The study also noted that those subjects who reported the highest frequency of positive experiencing generally had healthier personalities than subjects reporting medium or low frequency of positive experiencing.

Furthermore, there were significant differences noted between subjects who experienced high incidences of positive experiences and those who experienced low incidences of positive experiences. Not only did the

high group evidence significantly more positive self-esteem, but on all four TSCS subscales which measured various forms of emotional malfunctioning, these subjects were depicted as operating on a healthier level. These data support the position that self-esteem and level of emotional health are significantly related to each other. Vargas' (1968) study demonstrated the existence of a relationship between positive interpersonal experiences, positive self-esteem, and positive emotional health.

Evidence with regard to the relationship between affect and self-esteem is available in several studies. Watson and Clark (1984) contribute to this issue in a review of what they term Negative Affectivity (NA). These authors interpreted NA as a mood-dispositional dimension that reflects individual differences in negative emotionality and self-concept. They argue that individuals high on NA are particularly susceptible to threats to self-esteem. Poor self-esteem and negative mood states are highly related because of a tendency to dwell on and magnify mistakes, disappointments, and threats. In support of their thesis, these authors examined a wide variety of

measures of anxiety, depression, and maladjustment as representatives of negative affect. Individuals high in NA were shown to feel more dissatisfied and inadequate than did those low in NA (Watson & Clark, 1984).

Following the work of Watson and Clark (1984), an attempt has been made to test several hypotheses with regard to self-esteem and associated affect. Lorr and Wunderlich (1988), recently reported a study on self-esteem and negative affect. These authors designed a bipolar Profile of Mood States (POMS) to measure six bipolar mood states: Composed-anxious, agreeable-hostile, elated-depressed, confident-unsure, energetic-tired, and clearheaded-confused, of 102 male high school students.

The study supported that individuals low in self-esteem reported greater Negative Affect (NA) than those high in self-esteem. (The means were 41.53 and 32.16 for the Low and High groups, respectively.) Negative Affect was defined as the sum of scores on the half scales for anxiety, hostility, depression, self-doubt, fatigue, and confusion. Interestingly, the correlative hypothesis stating that individuals high

in self-esteem report greater Positive Affect (PA) than those low in self-esteem was not supported. There was no significant difference with respect to PA among the High (N = 57) and Low (N = 45) groups. (The means were 67.96 and 64.36 for the High and Low group, respectively.) Positive Affect was defined as the sum scores on the half scales for relaxed, agreeable, elated, confident, energetic, and clearheaded.

Self-esteem and depressive symptomatology

The literature suggests a relationship between self-esteem and depressive symptomatology. Pertinent literature review is presented here.

A study by Fitts (1972) provided data on 104 patients diagnosed with depressive reaction (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 1952), who were administered the Tennessee Self Concept Scale (TSCS). The findings of the study indicated a very heterogeneous group as evidenced by the ranges of scores and large standard deviations. However, when examining individual profiles, the group appeared

more homogeneous than was first apparent. Only four subjects (3.8%) had profiles similar to the normal profile of the TSCS. These subjects, plus 18 other subjects (17.3%), accounted for the large group variances. The majority of the group (78.9 %) showed similarities on many of the scores. For example, 98 percent scored above the norm on the Number of Deviant Signs Score (NDS Score), indicating "deviant" self concept, and only 10 percent scored above the norm on the Total Positive Score (Total P Score), reflecting low self-esteem.

Laxer (1964) investigated changes in the self concept of neurotic depressive and other psychiatric patients. The findings of this study indicated that the depressives exhibited a low self concept on admission to a hospital and moved to a higher self concept at the time of discharge.

A recent research study emphasized a high correlation between self-esteem and depression. Tennen and Herzberger (1987) studied depression, self-esteem, and attributional style of 109 male and female undergraduate students. According to these authors, self-esteem not only may be an indicator of

susceptibility to depression, but rather vulnerable self-esteem (instead of low self-esteem per se) may be more often a significant precursor of depressive episodes. The authors, however, did not elaborate on what constitutes "vulnerable" self-esteem.

Another research study conducted by Tennen and associates (1987) also highlighted the significance of self-esteem in depressive phenomena. These authors studied a clinical sample of twenty-three adult psychiatric patients (13 women and 10 men) from an inpatient psychiatric facility, for association between measures of depression, self-esteem, and attributional style. An important finding of this study was the strong association between depression and self-esteem. There was a high correlation between depth of depression and level of self-esteem. This correlation was as high as the individual scale reliabilities, reflecting differences in the role of self-esteem for mild compared to severe depression (rather than statistical artifact). (The study employed the Beck Depression Inventory and the Tennessee Self Concept Scale, for measures of depression and self-esteem, respectively.)

Family environment and psychiatric symptomatology

The literature points out the significance of the family in influencing the health and well-being of the family members and consequently its involvement in psychiatric symptomatology. Research studies associate relapse of psychiatric symptomatology with individuals who perceived their family environment as consisting of less family cohesion, less expressiveness within the family, and a high level of conflict and control in the family (Moos & Billings, 1982; Moos, Finney, & Chan, 1981; Moos, Finney, & Gamble, 1982; Moos & Moos, 1984).

Vaughn and Leff (1976) investigated the effects of criticism on relapse rate of schizophrenic and depressed patients, and found that depressed patients were much more sensitive to criticism. Depressed patients who were criticized by relatives upon their return home, were three times more likely to relapse in nine months than those patients whose relatives were less critical of them. Hooley, Orley, and Teasdale (1986), more recently replicated the association found by Vaugh and Leff (1976). In their study, 59 percent of the patients with a critical

spouse relapsed. These authors conclude that depressed patients may have even less tolerance for criticism than schizophrenic patients.

These two studies clearly suggest a critical family environment as conducive to the recurrence of depressive symptomatology. In addition, it has been more recently suggested that negative family interactions may tend to maintain or exacerbate depressive symptomatology (Coyne, et al., 1987).

Miller and associates (1986) examined the family functioning of five psychiatric groups (Diagnostic and Statistical Manual of Mental Disorders, DSM-III, American Psychiatric Assosication, 1980): categories of major depression, schizophrenia, adjustment disorder, alcohol dependence, and bipolar mania (N = 86) and a group of nonclinical families (N = 23) using the patients' and family members' self reports. The results of the study indicated that families of psychiatric patients reported significantly impaired family functioning when compared to nonclinical families. A unique finding of this study was that families of depressed patients showed more severe and consistent impairment than families of other

diagnostic groups' (Miller, et al., 1986).

Studies of particular significance are those which have assessed the nature of the social climate of families using the Family Environment Scale (FES), (Moos, 1974; Moos & Moos, 1981), thus providing uniformity in the dimensions of social climate examined.

Fowler (1980) examined the relationship between early displays of behavior problems among pre-kindergarten children and the family environment as assessed 18 months later with the Family Environment Scale. Problems such as developmental delay, and, speech and language deficits in these children were associated with the mothers' reports of a less cohesive family environment. Moreover, signs of shyness and anxiety were associated with less organization and control. The study also noted behavioral displays of aggression and hostility to be related to a less cohesive family structure.

Tyerman and Humphrey (1981) studied the family environment of adolescents referred for outpatient psychiatric services ($N = 24$) and of adolescents individually matched on demographic and family status

characteristics (N = 24). The findings of the study showed the family environments of the adolescent patients (those referred for psychiatric treatment) as being lower in cohesion, expressiveness, independence, and intellectual-cultural and active-recreational orientations, and higher on conflict, than those of matched controls.

Similar results were seen in another study conducted by these authors on a group of adolescents referred for psychiatric treatment and a demographically matched control group (Tyerman & Humphrey, 1983). Lower family cohesion was noted in families of adolescents referred for treatment than in those of matched controls. In addition, these researchers noted that adolescents who perceived greater family cohesion were likely to report fewer physical and emotional symptoms. The combination of high life stress and low family support was very strongly related to adolescents' symptom complaints.

Moos and Billings (1982) have examined symptoms of emotional disturbance in children of relapsed and recovered alcoholic patients, and that of matched controls, in relation to the family environment. The

study identified three groups: two groups of patients (recovered and relapsed, N = 51) from a larger sample of persons who were treated for alcoholism in an urban setting, and one group of sociodemographically - matched (for family size and age, ethnicity, education, and religion of partners) controls (N = 51).

The families with alcoholic members were studied six months and two years after treatment, thus noting the distinction between relapsed (n = 23) and recovered (n = 28) alcoholic patients within this time period. The family environment was assessed by the average of the husband's and wife's perceptions of the ten dimensions of the Family Environment Scale (FES). The time of administration of the FES is not noted for all three groups (recovered, n = 28; relapsed, n = 23; community control, N = 51).

The findings of the study indicated more emotional problems, especially depression and anxiety, in children of families with a relapsed alcoholic member than in children of the control families. There was more than twice as much reported disturbance in the relapsed (52.2%) as in the control (22.0%) or recovered alcoholics' families (14.3%). The health and

functioning of children from families of recovered alcoholics was comparable to that of children from control families.

The nature of the family environments, as reported by the individuals and their spouses, differed for all the groups (relapsed alcoholics, recovered alcoholics, and control families). Relapsed alcoholics and spouses reported less cohesion and expressiveness, including less emphasis on independence, achievement, intellectual-cultural, moral-religious, and active-recreational orientations, than that reported by recovered alcoholics and their spouses, or by partners of control families. In addition, parents in the relapsed group showed less agreement about their family environment, suggesting increased incongruence among partners.

These findings thus denote that children in a family environment which is less cohesive and expressive, and has less emphasis on independence, achievement, intellectual-cultural, moral-religious, and active-recreational orientations, and increased parental incongruence in relation to perceived family environment, demonstrate increased emotional problems,

especially depression and anxiety. The study also establishes that children who were located in cohesive, well-organized families with less conflict and less parental incongruence showed better emotional adaptation.

It is relevant that dimensions of the family environment appear to be significant predictors of children's symptoms. In addition, it is relevant that family environment could have also been a factor in the relapse of persons treated previously for alcoholism. This is clearly demonstrated by the fact that the family environments of relapsed and recovered alcoholics differed significantly.

The literature suggests the emergence of a trend in the family environment of members with psychiatric problems. When compared to normal families, distressed families are lower on cohesion, expressiveness, independence, and intellectual-cultural and active-recreational orientations, and higher on conflict and control, as measured by the Family Environment Scale (FES) (Moos & Moos, 1981).

Several researchers have found similar results with families experiencing emotional disturbance in its

members. For example, Scoresby and Christensen (1976) in studying clinic (seeking help for family problems at a university counselling clinic) and "non-clinic" families (not seeking help at the clinic) reported that clinic families were lower on cohesion, expressiveness, and organization, and higher on conflict, than "non-clinic" families, using the same scale.

Bernstein (1980) conducted a study with kibbutz families who had at least one member in psychiatric treatment and those who had no family member in treatment. In general, the findings showed that the families with a member in treatment were higher on conflict and control, and lower on cohesion and organization. Similar results are noted by White (1978) in a study of schizophrenic patients' (N = 20) perceptions of family relationships. These patients perceived their families to be low on cohesion, independence, achievement orientation, and moral-religious emphasis.

In examining the family environment of depressed clients, Billings and Moos (1983) again reported similar results. Families with depressed parents experienced more conflict and less cohesion, less

expressiveness, and less organization, and were less likely to emphasize independence, active-recreational and moral-religious orientations. These research studies certainly point to the emergence of a particular type of family environment as it relates to psychiatric symptomatology in family members.

The literature also demonstrates significant correlations between FES subscales and demographic variables such as family size, parents' age and education, type of family (nuclear family or family of origin), and stage of family development (Moos & Moos, 1981; Oliveri & Reiss, 1984).

A recent study was conducted on family environment and family members' mental health and quality of life. Rhoads, Ainlay, and Sensinig (1980) obtained information about family environments on a community sample of 189 individuals (one per family) and related it to indices of positive and negative mood, self-rated mental health, and quality of life. Once again, cohesion and expressiveness were considered most highly related to psychological well-being. In addition, cohesion and lack of conflict were most highly related to life satisfaction and perceived quality of life.

Therapy preferences of depressive population

There have been no studies currently in the literature that specifically address hospitalized depressed clients' preferences of support and therapy. There have been very few studies of psychiatric inpatients' attitudes toward their hospital treatment. Two relevant studies from the literature review are presented here.

Wesenberg (1984) explored psychiatric inpatients' attitudes toward the major forms of their treatment. Four Semantic Differential scales (Valuable-Not Valuable, Effective-Ineffective, Sincere-Insincere, and Dependable-Undependable) were used to assess attitudes of 100 psychiatric inpatients toward seven types of treatment providers (Psychiatrist, Psychologist, Social Worker, Nurses, Aides, Activity Therapist, Other Patients) and six types of treatment (Medication, Ward Environment, Conversations with Psychiatrist, Contacts with Psychologist, Contacts with Social Worker, Activities). An open-ended question asking for suggestions for improvement was included.

In general, patients rated psychologists, social workers, and activity therapists significantly more positively than they rated psychiatrists, nurses, aides, and other patients. Contacts with psychologists, contacts with social workers, and activities were rated significantly more positively than were conversations with psychiatrists, medication, and ward environment. Counseling was rated more positively than were other psychology contacts. There were no major differences on sex or length-of-stay. Taking qualitative data into account, Wesenberg (1984) notes that the results fit the following pattern: patients preferred non-medical treatment and one-to-one interactions of relatively longer duration; non-compassionate and restrictive treatment was not preferred.

In a study to ascertain why particular treatments achieve therapeutic relevance, Delaney (1984) explored psychiatric patients' perceptions of the significance of treatment on short-term psychiatric units. Specifically, psychiatric patients were asked to discuss their attitudes towards their illnesses, past efforts to cope with them, how they perceived specific therapies and professional relationships, and finally,

how they viewed discharge and discharge readiness.

Data for the study (Delaney, 1984) were collected on three short-term psychiatric units. Two methods of data collection were utilized: participant observation and unstructured interviews. Throughout the data collection, provisional hypotheses were postulated and then purposefully explored for building a descriptive model of patients' perceptions. Conclusions were based on 350 hours of participant observation and 48 patient interviews.

Findings indicated that patients view treatment experiences in relation to their need to restore a sense of control in their lives. Most respondents had recently experienced a disruption in their lives that challenged them to put their life (mood, thoughts, emotions, or mind) back into equilibrium. Consequently, patients formulated a definition of control and a route to regain control. Routes to regain control ranged from medication to life style changes. In discovering how patients planned to regain control, their responses to treatment were clarified. Essentially, the treatment program was viewed as beneficial if somewhere in it's offerings it included

an intervention which meshed with patients' plans for regaining control.

The diverse response of 48 patients to psychiatric treatment, in this study, is a demonstration of the heterogeneity of patient populations on short-term psychiatric units. The lack of a collective response to treatment holds implications both for those designing treatment programs and those planning nursing care.

Summary of relevant literature

The literature demonstrates a relationship between one's self-esteem and emotional health (Lorr & Wunderlich, 1988; Lynch, 1968; Vargas, 1968). Research on self-esteem reveals considerable data supporting such a contention. It was noted that persons with positive self-esteem exhibited healthy personalities and had a high frequency of positive experiencing and openness in interpersonal interactions. Conversely, persons with negative self-esteem reported having a high frequency of negative experiencing, demonstrated more closeness or defensiveness in interpersonal interactions, and felt

more dissatisfied and inadequate.

The literature denotes a relationship between self-esteem and depression. Earlier research indicates depressed individuals as exhibiting low self concept upon hospital admission, moving to a higher self concept at time of discharge (Laxer, 1964). It has also been proposed that dysfunctional self-esteem maintenance is critical to the development of depressive episodes (Becker, 1962; Alloy, 1982). More recently, a high correlation has been demonstrated between the depth of depression and level of self-esteem, reflecting differences in the role of self-esteem for mild compared to severe depression (Tennen, et al., 1987).

There appears to be an emergent trend in the family environment of persons with emotional problems. Family conflict, lack of cohesion within the family, and less emphasis on expressiveness by family members, have been highly related to physical symptoms, obesity, anxiety, depression, and behavior problems in family members. Furthermore, relapse of psychiatric symptomatology has been associated with a family environment consisting of less family cohesion,

less expressiveness within the family, and a high level of conflict and control in the family. Negative family interactions have also been implicated in the maintenance or exacerbation of depressive symptomatology.

The literature indicates diversity in the treatment preferences noted by psychiatric clients. However, in general, clients viewed treatment experiences in relation to their need to restore a sense of control in their lives and identified ways that they perceived would assist them in regaining this control. Psychiatric clients also preferred non-medical treatment and one-to-one interactions of relatively longer duration (non-compassionate and restrictive treatment was not preferred). There were no studies in the literature eliciting information on preferences of support and therapy in the depressive population alone.

The literature review conducted has implications for the present study. First, since the literature suggests a high correlation between low self-esteem and depressive symptomatology, it

is valuable to explore whether any changes in self-esteem are related to changes in depressive symptomatology during hospital stay and following discharge.

Secondly, the literature implicates critical family environment to be conducive to the recurrence of depressive symptomatology, and negative family interactions as maintaining or exacerbating depressive symptomatology. The literature further suggests that family conflict, lack of cohesion and less emphasis on expressiveness within the family as being highly related to depression. It is therefore relevant in the present study to examine the relationship between the dimensions of conflict, cohesion, and expressiveness in families, and depressive symptomatology in family members.

Finally, the literature indicates psychiatric clients' preference for treatment that helps to restore a sense of control in their lives, and preference for non-medical treatment and one-to-one interactions of longer duration. It is important to elicit information with regard to support and

therapy preferences of individuals in this study, in order to know what depressed adults perceive as critical in assisting them to alleviate their symptomatology and regain a sense of control in their lives. In addition, this information is valuable in providing implications for improving mental health services and providing treatment based on the client's preferences.

Definition of Terms

The following terms were used throughout the investigation.

1. Affective disorder: Psychopathology characterized by a primary and preponderant disturbance in mood, as reflected in the criteria established by the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980).
2. Mood: A pervasive and sustained emotion that, in the extreme, markedly colors one's perception of the world (Stone, 1988).

3. Depressive Symptomatology: The presence of self-reported symptoms on the Beck Depression Inventory (BDI, long form, Beck, et al., 1961) (see Appendix A), as evidenced by a score of 15 or above.

4. Self-Esteem: The overall level of self-esteem as reflected in the Total Positive Score (Total P Score) on the Tennessee Self Concept Scale (TSCS), Counseling Form (Form C) (Fitts, 1965) (see Appendix B).

5. Family: A primary group whose members may be related by blood, marriage, adoption, or mutual consent, who may interact through certain familial roles, and may create and maintain a common subculture (Stevenson, 1977).

6. Family System: A group of interrelated people or "parts" which interact and form a family; the family system contains subsystems and is also a subsystem of the community (Norris, Kunes-Connell, Stockard, Ehrhart, & Newton, 1987).

7. Cohesion: The degree of commitment, help, and support family members provide for one another as measured by specific questions on the Family

Environment Scale (FES), Real family (Form R, Moos, 1974) (see Appendix M).

8. Expressiveness: The extent to which family members are encouraged to act openly and to express their feelings directly as measured by specific questions on the FES, Form R (Moos, 1974) (see Appendix M).

9. Conflict: The amount of openly expressed anger, agression, and conflict among family members as measured by specific questions on the FES, Form R (Moos, 1974) (see Appendix M).

Theoretical Framework

This study was guided by a theoretical framework consisting of: (a) self theory, and (b) general systems theory. A conceptual model derived from these theories provided the basis for this study.

Explanation of the Study's Model

The conceptual model for this study (Figure 1) incorporates the two theoretical frameworks: (a) self theory, and (b) general systems theory, and combines them to develop a comprehensive theoretical

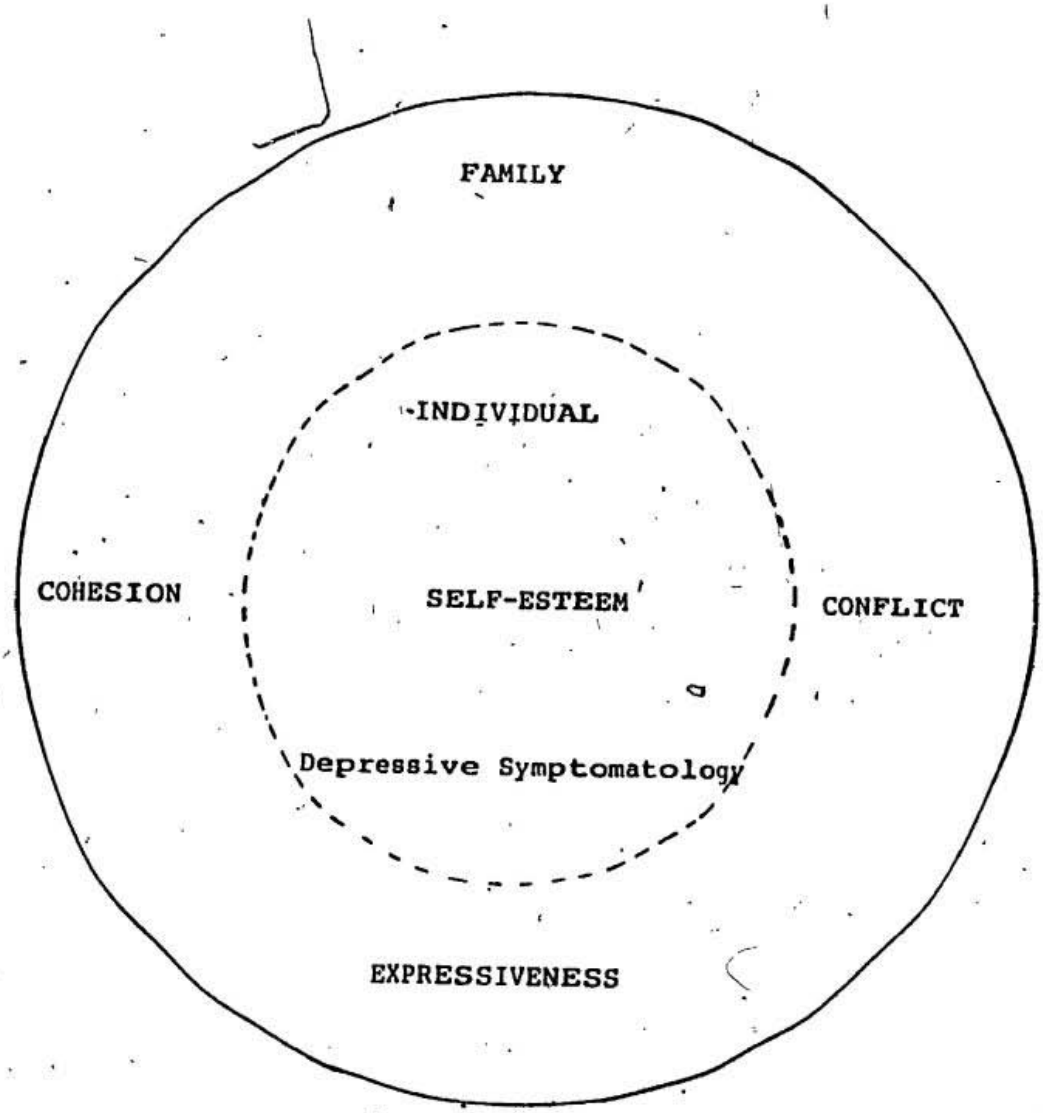

Figure 1: Conceptual model depicting the relationship between self-esteem, the individual and depressive symptomatology, and the family environment denoting the dimensions of cohesion, expressiveness and conflict.

perspective that was used as the basis for this study.

Self concept has a powerful influence on human behavior and interactions, and hence is both a central and significant variable in the individual's health and well-being. Of particular interest for this study is the role of self-esteem in depressive symptomatology. Therefore, for the purpose of this study, the individual's overall level of self-esteem was used in this model.

In this model, all components mutually interact and influence each other. The individual is viewed as an integrated open system (depicted as the smaller circle made up of broken lines) in a state of constant exchange with the environment, in this instance, within the family system. The concepts of interdependence, interrelatedness, and complexity of interaction patterns between the individual and the family allow changes in the relationship dimensions, particularly the extent of cohesion within the family, the amount of expressiveness among members, and the level of conflict between family members.

The theoretical perspective adopted for this study provides a more comprehensive view of the individual

and the role of self-esteem and the family relationships dimensions (cohesion, expressiveness, and conflict) in depressive symptomatology.

Self Theory

Self theory evolved as a theoretical school from the works of Lecky (1945), Rogers (1951), Combs and Snygg (1959), Wylie (1961), and others. Self theory is strongly phenomenological in nature and is based on the general principle that a person reacts to his/her phenomenal world in terms of the way he/she perceives this world (Combs & Snygg, 1959). According to this theoretical approach, probably the most salient feature of each person's phenomenal world is his/her own self - the self as seen, perceived, and experienced by oneself. This is known as the "perceived self" or the individual's self concept (Combs & Snygg, 1959).

The term 'self concept' is more commonly used than the term 'self', since one is not always aware of the absolute, true or actual self but only of the concepts and perceptions one has about himself/herself. Self theory holds that human behavior is always meaningful and can be understood if one could only

perceive the person's phenomenal world as the person himself/herself does. Since perceiving any person's phenomenal world as the person himself/herself does, is impossible, a close approximation can be to measure the individual's "perceived self" or the person's 'self concept' (Fitts & Richard, 1971, p. 3). The importance of self concept is illustrated by the fact that not only is the self concept the most prominent aspect of the individual's phenomenal world, but it also tends to be the most stable feature (Fitts & Richard, 1971, p. 3). The person's environment is constantly shifting and changing but the self concept is relatively fixed and stable.

Self theory also holds that the self concept is the frame of reference through which the individual interacts with his/her external world (Combs & Snygg, 1959; Rogers, 1951). Therefore, the person's self concept becomes a powerful influence in human behavior and interactions. If self concept is a means toward better understanding of human behavior and interactions, it further implies that self concept is both a central and significant variable in the individual's health and well-being. Of particular

importance then is the role of self concept in influencing one's mental health and consequently psychiatric symptomatology.

Furthermore, as is purported by self theory, human behavior is always meaningful and can be understood if perceived through the person's phenomenal world. One's choice to seek treatment and the type of support and therapy preferences sought, is then, guided by the person's phenomenal world and based on how helpful the person perceives the therapy will be to him/her. Thus, self theory provides a useful theoretical framework when attempting to identify and understand an individual's preferences for therapy and support with reference to mental health care.

General Systems Theory

General systems theory has been applied with increasing frequency to the study of individuals and families. This proliferation of systems information is also evident within the nursing literature. General systems theory was developed by Bertalanffy (1967, 1972, 1974), who defined it as "a discipline concerned with the general properties and laws of 'systems'" (1967,

p. 69).

General systems theory proposes the concept of open system (Bertalanffy, 1967). An individual is viewed as an open system in a state of constant exchange with other systems as well as the environment. The family can also be viewed as an open social system composed of a structural complex of elements among which there are patterned relationships.

Furthermore, the theory advocates three important characteristic properties as they apply to systems. These characteristic properties include: (a) wholeness, (b) nonsummativity, and (c) equifinality (Bertalanffy, 1967).

Wholeness: The concept of wholeness denotes that a whole consists of more than its individual parts. It also includes the interaction of these parts with each other. Thus, a change in one part results in a change in other parts. Individuals are systems composed of various component parts (biopsychosocial and spiritual components) that depend on each other for functioning as a living system. Therefore, a change in a subsystem will consequently result in one or more changes in the remaining subsystems of the individual. Furthermore,

families are systems characterized by wholeness or unity, as reflected in the complexity of the interdependence of its members to form a whole. It is not possible to assess the needs and strengths of one family member without assessing how these needs and strengths relate to the total family unit.

Nonsummativity: The concept of nonsummativity denotes the interrelatedness among the system parts. Interrelatedness means that one cannot assess the various parts (subsystems) of a system individually and then add the obtained scores in order to obtain the degree of interrelatedness among the subsystems. This implies that the system in its totality cannot be understood or appreciated by a mere summation of its subsystems. To assess nonsummativity, assessments must be made of every possible interaction pattern exhibited within the system. The system's elements are in constant meaningful interaction with one another. Therefore, nonsummativity, or the degree of interrelatedness among the system parts, provide valuable information about the pattern(s) that emerge in relation to the system (individual or family), and consequently determine or predict how the system will

manifest itself.

Equifinality: The concept of equifinality denotes the progressive complexity of interaction patterns of the system that are similar and repetitious over time. The component parts of a system maintain or engage in mutual and meaningful interaction. Thus, the interactions between the components (subsystems) are not perceived as linear but rather cyclical in nature. The focus then must be on the function and relationship of subsytems within a cyclical (interdependent, rather than linear) manner. Maintenance of the system's functioning is therefore based upon a process of feedback; on a cyclical model. Interactions between family members are circular in the sense that there are few simple cause-effect relationships. The phenomenon of complex and repetitious interaction patterns of a system is known as equifinality. The characteristic of equifinality within a system provides valuable information about the interaction patterns of the system irrelevant of when and at what particular point the assessment of interactions is conducted.

Individuals and families experience stress and conflict as inevitable accompaniments to growth and

change. Any change in the individual family member will affect other members within the family and the family as a whole. Family members contribute to, and are an essential part of, the sequence of reciprocal interactions within the family. The concepts of interdependence, interrelatedness, and complexity of interaction patterns are essential in the understanding of health and illness in individuals and hence imperative in this study. The implications of using general systems theory to study individuals and families are profound. From this theoretical approach, changes in the well-being of individuals are perceived in the context of the family system.

Families from time to time experience changes which tax the system's resources, and threaten stability and integrity of the family and individual family members. It must be recalled that any change is not an isolated event, rather it occurs within the context of an already existing family system, and is managed according to the resources available. Since the family is an interdependent system, change in one family member is followed by change in other members. Change at any point in the system (family) may well

affect any or all of its components (family members) (Sager & Kaplan, 1972, p. 256). Familial relationships and the social climate of the family provide the necessary resources to its members to maintain stability and integrity of individual members and the family as a whole. Thus symptomatology of any kind in individual family members is perceived in relation to the family (and the family environment), and therefore understandable only within the context of the current family system.

Research Questions

The following research questions were addressed in this study.

1. Will depressed adults demonstrate a higher level of self-esteem upon discharge and at one month follow-up than upon admission to a psychiatric facility?
2. Will depressed adults perceive their family environment as more cohesive, more expressive, and less conflictual upon discharge and at one month follow-up than upon admission to a psychiatric facility?

3. What are the support and therapy preferences of depressed adults, when experiencing depressive episodes?

Purposes of the Study

The immediate purposes of the study were: (a) to describe in clinically depressed adults, the relationship between depressive symptomatology and two variables, self-esteem and perception of the nature of the family environment, specifically in relation to the dimensions of cohesion, expressiveness, and conflict within the family, at three different times - admission and discharge from a psychiatric facility, and one month post-discharge; and, (b) to identify depressed adults' preferences of support and therapy when experiencing depressive episodes.

The ultimate aims of the study were to: (a) aid mental health nurses in the assessment of and provision of therapy to depressed adults by increasing understanding of the variables that influence depressive symptomatology, and possible need for including families in the assessment, treatment, and follow-up care of these individuals; (b) generate

hypotheses and research questions that would lead to further research; and, (c) contribute to nursing theory and practice an understanding of self-esteem and the nature of the family environment as significant variables to consider in predicting and minimizing the risk for psychiatric rehospitalization, and planning nursing care toward health maintenance.

Summary

This chapter provided the background of the problem to be addressed by this research study. The study will investigate the relationship between self-esteem and family perception in depressed adults. The study will also attempt to identify depressed adults' preferences of support and therapy when experiencing depressive episodes. Pertinent literature review with regard to self-esteem, family environment, therapy preferences, and depression was presented. Relevant terms specific to the study were then defined. The theoretical framework including a conceptual model for the study based on self theory and general systems theory were described. Three research questions were introduced to be investigated in the study. Finally,

the immediate and ultimate purposes of the study were noted. The research methodology is presented in Chapter II.

CHAPTER II

METHODS AND PROCEDURES

Research Design

This exploratory study investigated the relationship between depressive symptoms in clinically depressed adults and two variables, self-esteem and family perception, specifically in relation to the dimensions of cohesion, expressiveness, and conflict, at three different times - admission and discharge from a psychiatric facility and one month post-discharge. In addition, the study elicited information with regard to support and therapy preferences of clinically depressed adults, when experiencing depressive episodes.

Setting

The research settings constituted two health care facilities located in two different provinces of Canada. One setting was a 30 bed psychiatric admission unit from a 452 bed general hospital, in the province of New Brunswick. The other setting was a 36 bed acute admission unit from a 466 bed

psychiatric hospital, in the province of Ontario. In addition, the subject's place of residence was also used as a research setting.

Data for the study was collected on three separate occasions. The first and second data collection times involved administration of research instruments to the subject on the unit. The third data collection time constituted administration of research instruments to the subject at his/her place of residence. The place of residence was located within a 50 mile radius of the city where the subject had been hospitalized. All data was collected by the investigator over a period of 12 months.

Sample

A convenience sample of 41 male and female adults, who fit the selection criteria for the study, were identified. Attrition due to refusal to participate in the study (n = 5), voluntary dropouts (n = 3), transfer to another health care facility (n = 2), drastic change in emotional health status (n = 1), and failure to complete the research instruments prior to discharge from the hospital with the subject not leaving a

forwarding address or telephone number with the investigator (n = 5), resulted in a final sample size of 25 subjects.

Subjects were all voluntary admissions to the psychiatric unit and met the following selection criteria:

1. Subjects were between the age of 20 to 64 inclusive;
2. Subjects had an admission medical diagnosis indicative of depression, specifically bipolar disorder - depressed, or major depression, or dysthymic disorder (DSM-III, American Psychiatric Association, 1980);
3. The subject was able to speak, read, write, and comprehend English;
4. The subject gave a freely informed consent to participate in the study;
5. The subject resided upon discharge within a 50 mile radius of the hospital where he/she had been admitted.

Exclusionary criteria included no psychotic features, no alcoholism, and no symptomatology due to

organic causes.

The study was limited to English-speaking subjects, since the investigator lacked fluency in any other language, and the instruments were also in English. In addition, a 50 mile radius of the hospital was considered to be a reasonable distance for the investigator to have easy access to the subjects after discharge from the hospital for purposes of data collection.

Procedures for Obtaining Informed Consent

The research study protocol was approved by the Research Committee at Memorial University of Newfoundland. Following this, consent to conduct the study in the two hospitals was obtained through the Director of Education (for the first hospital) and the Director of Research (for the second hospital). The Research Committees of both hospitals approved the study protocol and consented to its conduction on the specific psychiatric units. The investigator met with the Chief Psychiatrists, the Patient Care Coordinator, and Head Nurses of the units to discuss the study and procedures employed to obtain informed consent from the

subjects. A letter explaining the study, and seeking support and cooperation, was sent to the other psychiatrists on the units (see Appendix H).

The investigator required the assistance of the senior clinical nurse, primary nurses, and the ward clerks on the psychiatric units to screen potential subjects for the study. The investigator ensured that they understood the subject selection criteria, and left a copy of the criteria on the unit to facilitate the screening process. The investigator left her telephone number on the units for purposes of notification when a potential subject was identified. In addition, the investigator required the assistance of the primary nurses to inform the potential subject of the study, and to obtain permission for the release of the individual's name to the investigator. A standardized introduction was used by the primary nurses for this purpose (see Appendix K).

If an individual was willing to listen to an explanation of the study, the primary nurse proceeded to introduce the investigator to the person. The investigator then explained the nature and purpose of the study, the extent of subject's participation,

safeguards to preserve confidentiality, and the subject's right to withdraw from the study at any time and/or to refuse to answer any questions. A written copy of this explanation was given to the individual if he/she was willing to participate in the study (see Appendix E). The individual was then asked to sign a consent form to participate in the study (see Appendix F). The signed consent form was kept by the investigator for her records.

Data Collection

Data Collection Instruments

The data collection instruments utilized in this study were an operationalization of the five variables outlined in the study's model. Table 1 describes the variables, the instruments, and the location of the instruments.

In addition to the instruments noted in Table 1, the investigator gathered information about the subject, using a Subject Profile (SP) form (constructed by the investigator) (see Appendix D). The SP form provided data about personal characteristics of the

Table 1

The Study Variables, the Instruments and their Location

Variables	Instruments	Location
Depressive Symptomatology	Beck Depression Inventory (BDI)	Appendix A
Self Esteem	Tennessee Self Concept Scale (TSCS), Counseling Form (Form C)*	Appendix B
Cohesion	Questions 1, 11, 21, 31, 41, 51, 61, 71, and 81 of the Family Environment Scale (FES)**	Appendix C
Expressiveness	Questions 2, 12, 22, 32, 42, 52, 62, 72, and 82 of the FES**	Appendix C
Conflict	Questions 3, 13, 23, 33, 43, 53, 63, 73, and 83 of the FES**	Appendix C

*The total P Score of the TSCS, Form C was used for this study. Items 91 through 100 of this form were eliminated as these reflected Self Criticism Score and were not part of the Total P Score.

**The scoring for cohesion, expressiveness, and conflict variables used in the study was based on the questions identified in this table (see Appendix M).

subject related to sex, age, medical diagnosis, and number of psychiatric admissions (Items 1-4). These variables were identified due to their potential effect on the major variables under study, and to permit description of the population. The final question (Item 5) of the SP form was an open-ended question designed to elucidate the subject's identification of means of help and support that he/she felt was needed.

Sensitivity and Meaningfulness of the Data Collection Instruments

The instruments used in this study were felt to accurately assess the major variables of the study.

The Beck Depression Inventory (BDI, long form, Beck et al., 1961) is sensitive in assessing the depth of depression; although it cannot provide a diagnosis of clinical depression. Since the study was addressing depressive symptomatology as a variable, the BDI provided sensitivity by assessing the presence of 21 depressive symptoms (Coyne & Gotlib, 1983; Love, 1987; Turner & Romano, 1984).

The Tennessee Self Concept Scale (TSCS, Form C, Fitts, 1965) was felt to assess accurately the

self-esteem of individuals, since this scale is comprised of self-descriptive statements allowing the person to describe himself/herself in relation to the multidimensional structure of self concept. (Examples of areas assessed include identity, self-satisfaction, behavior, physical self, moral-ethical self, personal self, family self, and social self.)

The use of self-descriptive statements in the TSCS also minimizes the possibility of errors created by virtue of the interviewer/observer's clinical expertise and bias when an interview schedule or observation-rating scale is used. In addition, the TSCS is a widely used and well validated measure designed for use with psychiatric samples (Fitts, 1965; Gross & Alder, 1970; Schalon, 1968; Williams & Byar, 1970) and is considered one of the better measures of self concept (Suinn, 1972).

The possibility of skewed scores for the self-esteem measured by the TSCS, was considered by the investigator. Skewed scores can occur as a result of defensive distortion by the individual, notably paranoid schizophrenics (Fitts, 1965), or individuals with bipolar disorder who demonstrate self-evaluative

lability, alternating between periods of high self-esteem (manic phase) and intensely low self-esteem (depressed phase) (Swallow & Kuiper, 1988).

In order to determine whether the Total P Score (overall level of self-esteem) is artificially elevated by defensiveness on the part of the respondent, the TSCS, Form C includes 10 items comprising the Self Criticism (SC) Score that help identify the presence of such distortion. The investigator felt that the possibility of defensive distortion of self-esteem was minimized considerably, since the study sample did not include individuals with a medical diagnosis of paranoid schizophrenia or bipolar disorder - manic; thus, calculation of the SC Score was deemed unnecessary and not utilized for this study.

The sensitivity of the Family Environment Scale (FES, Moos, 1974) is reflected in, its multiple uses with clinical populations; careful selection of subscale items (using five psychometric criteria); documented temporal stability; its consistently demonstrated ability to discriminate between disturbed and normal family populations; and, its sensitivity to changes in family environments during therapy

(Anderson, 1984). It was thus felt that the FES items accurately assessed the dimensions of cohesion, expressiveness, and conflict in the study sample. The FES, Form R (Real Family) was used for this study since this form assesses the social climate of the family as it exists presently.

The Subject Profile (SP) form was considered sensitive in gathering data about personal characteristics of the subjects (Items 1-4), due to the closed-ended nature of the questions asked. Item 5 on the SP form was an open-ended question eliciting information about what the respondent perceived he/she needed with regard to help and support. The investigator felt that this question (Item 5) elicited the information sought with minimal bias, since the investigator did not introduce any facilitating comments or prompts when asking the question. If the respondent requested further clarification, Item 5 was simply repeated with no prompts.

For a more detailed explanation of the nature of the data collection instruments, including information with regard to reliability and validity of the instruments, see Appendix L.

The research instruments used in this study were all meaningful. The BDI (long form), the TSCS (Form C), and the FES (Form R), all related to the theoretical framework of the study and were directed at investigating the research questions. This examination may extend nursing's knowledge of the significance of assessing self-esteem and family environment of depressed individuals and suggest directions in nursing care.

The SP form was meaningful since: (a) it provided important information about other variables that may have a potential effect on the major study variables, and (b) it may enhance nurses' awareness of the client's perception and need for specific support and therapy, thus suggesting directions in nursing care.

Data Collection Procedures

The investigator was responsible for all data collection. Data was collected after approval to conduct the study had been granted by the Human Subject Review Committee of Memorial University of Newfoundland, and the Research Committees of the two hospitals where the study was conducted. Once the

subject had agreed to participate in the study by providing a written consent, the investigator and the subject agreed upon a mutually convenient time for the data collection.

The time limits used for the data collection were:

Time 1 - within ten days of admission to the psychiatric unit;

Time 2 - within three days prior to discharge from the hospital; and,

Time 3 - between fourth and fifth week post-discharge.

The first and second data collection times involved administration of research instruments to the subject on the unit. A quiet, private area was chosen to maintain confidentiality and comfort for the subject. The third data collection time constituted administration of the research instruments to the subject at his/her place of residence. The place of residence was located within a 50 mile radius of the hospital where the subject had been admitted. In some instances, upon request by the subject, data collection for Time 3 was conducted at the hospital in a quiet room specifically booked by the investigator for research purposes. The total time required to complete

the four research instruments was approximately one and one-half hours on each occasion.

The investigator was available to provide clarification on the instrument items as was necessary, on all three occasions. To minimize the introduction of investigator bias, no prompts were used to influence the subjects' responses. After the subject had completed responding both verbally, and by providing the written answers, he/she was thanked verbally by the investigator for participating in the study. The subject was reminded of the next data collection occasion if one was to follow.

The investigator then proceeded to access the subject's clinical records to verify data obtained on the Subject Profile (SP) form and added information to the SP form as indicated (for instance, medical diagnosis and number of psychiatric admissions).

A code number was assigned to each subject and was written on the upper right hand corner of each page of the research instruments, immediately following data collection. The code number maintained anonymity of the data collected, thus protecting subject confidentiality. The subject's name was not recorded

on any of the questionnaires. The code numbers facilitated easy retrieval of data per subject, and eliminated possible mix up of data should pages be accidentally separated from one another.

The key to the coding system to match Times 1, 2, and 3, was maintained securely and separately from the data. All data and consent forms for the study were stored in a locked metal box, and destroyed after conclusion of data analysis. This assured confidentiality for the participants.

If a subject had been rehospitalized prior to the 4-5 week post-discharge period assigned for data collection (Time 3), data would have been collected at the hospital. This would be noted appropriately in the data analysis. No subject was rehospitalized within the post-discharge period of the study.

Safeguards for the Subject

As far as can be determined, and to the investigator's knowledge, this study presented no risk to the health or safety of the subjects. The investigator employed the following safeguards to minimize the risk:

1. The subject was able to complete the research instruments without undue discomfort. (Discomfort was measured by the subject verbally indicating so, or the subject exhibiting signs of discomfort such as restlessness and inability to concentrate on the questions.) The administration of the research instruments was rescheduled if signs of discomfort were noted.
2. The administration of instruments was rescheduled if the subject verbalized feeling unwell and was unable to complete the instruments.
3. The investigator attempted to allay anxiety by providing a quiet, comfortable environment, and a relaxed non-critical demeanor.
4. Any change in emotional health of the subject, either communicated verbally to the investigator, or noted on the Beck Depression Inventory, and requiring intervention or referral, was discussed with the subject following completion of the instruments. The investigator also suggested to the subject that he/she contact the primary health care giver or health care facility as soon as possible, or appropriate referral was made by the

investigator to the primary nurse with the subject's consent.

5. In all instances, the investigator informed the psychiatrist of the subject's risk of suicide as noted on the Beck Depression Inventory, immediately following the subject's completion of the research instruments at each of the data collection times.

Pretest

A pretest of the research instruments was conducted with the first three subjects selected for the study, employing the design and data collection procedure outlined for the actual research study. Three subjects were considered an adequate number for the pretest as the sample availability was limited by virtue of specific selection criteria.

The pretest was conducted to determine: 1) whether the questions were clear and easily understood, 2) the length of time required for completion of instruments, and, 3) potential difficulties that may arise. Information derived from the pretest assisted in the refinement of

the data collection procedure.

The first respondent was unable to use the separate answer sheet for the Family Environment Scale (FES, Form R), and was thus instructed to mark "T" or "F" beside each item in the FES booklet. The responses were then transcribed by the investigator onto the FES answer sheet to facilitate scoring. This procedure was subsequently employed for the other two respondents and in the actual research study. No other difficulties were noted and the respondents were able to complete all four research instruments in approximately one and one-half hours.

There were no revisions required to the research instruments, thus, all three respondents from the pretest were included in the study population and data analysis.

Data Analysis

Initially, a description of data obtained on the Subject Profile (SP) form will be presented. In addition, statistical analyses carried out on the data obtained from the research instruments will be described. The analyses was conducted with the help

of a Stats Plus computer program available for the Apple IIc computer.

Statistical Analysis

Separate one-way analysis of variance (One-Way ANOVA) with repeated measures was carried out to assess change in depressive symptomatology, self-esteem and family perception over time (Polit & Hungler, 1978; Winer, 1971).

Multiple comparison test, Tukey's honestly significant difference (HSD) test was utilized in the event of significant ANOVA results (Kirk, 1968; Winer, 1971).

Simple *t* tests were used to evaluate the relationship between study sample means obtained on admission for TSCS (Total P Score) and FES subscales (cohesion, expressiveness, conflict), and means obtained from normative data for TSCS and FES subscales, respectively (Fitts, 1965; Moos & Moos, 1981).

Limitations of Study

1. The study design included a one month follow-up period. A six months or one year follow-up of subjects after discharge from the hospital, may be useful in examining the relationship of self-esteem, family perception, and recurrence of depressive symptomatology in adults.
2. The study design dictated data collection on three separate occasions (admission, discharge, and one month follow-up). It is possible that subjects may relocate to an area farther than the 50 mile radius specified in the study. This relocation during the post-discharge period would warrant elimination of these subjects from the study sample, since such relocation was not accounted for in the study design.
3. The study design dictated the first data collection to occur within ten days of hospital admission, followed by a second data collection within three days prior to discharge from the hospital. It is possible that data on a subject could be collected on Day 10 for Time 1 and on days 11 or 12 for Time

2 if the subject was ready for discharge from the hospital. The closeness of time duration between Time 1 and Time 2 could result in not providing an accurate reflection of the variables under investigation. A less than five days gap between Time 1 and Time 2 would warrant elimination of the subject from the study sample, since the closeness of time duration for Times 1 and 2 was not accounted for in the study design.

4. The time required to complete all questionnaires may have led to fatigue and/or carelessness in responses.
5. The study was conducted in two hospitals - one a general hospital and the other a psychiatric hospital, each located in different provinces of the country. By virtue of these differences, there may have been other factors not accounted for, which may have affected the findings of the study.
6. The small sample size precludes generalizations of the results beyond the sample population.
7. The study design dictated that inclusion of subjects require the completion of research

instruments for all three separate occasions (admission, discharge, and one month follow-up). A high percent of subjects (16 subjects or 39 percent of the original sample size of 41 individuals identified as fitting the selection criteria for the study) did not complete the study for various reasons (see p. 55-56). These reasons were not adequately accounted for in the study.

8. Limited control of extraneous variables requires that findings be viewed with caution.
9. In this study, no cause-and-effect relationships could be inferred.

Summary

This chapter comprised the methodology used for the study. A description of the research design, study settings, sample size, and selection criteria were provided. Procedures for obtaining informed consent from the subjects were clearly outlined. A brief description of each research instrument utilized in the study was presented next, followed by relevant information on the sensitivity and meaningfulness of

these instruments. Data collection procedures were outlined in detail. Safeguards for the subjects in this study were clearly specified. Information on a pretest prior to the conduction of the study including rationale for the pretesting was given. A brief description of the data analysis utilized in this study, including relevant statistical methods employed, were specified. Finally, limitations of the study were noted. The findings of the study are presented in Chapter III.

CHAPTER III

THE RESULTS

The results of the study are presented in five sections:

(a) Personal characteristics of the sample;

(b) Research instruments scores over time (admission, discharge, one month follow-up);

(c) Research questions; and,

(d) Additional analyses undertaken by the investigator.

Personal Characteristics of Sample

The potential size of the sample for this study was forty-one. As noted earlier (see p. 46), due to attrition, the study sample was reduced to twenty five. The sample (N = 25) consisted of 8 men (32%) and 17 women (68%).

Twenty four subjects completed all the research instruments used in this study (Beck Depression Inventory; Tennessee Self Concept Scale, Form C; Family Environment Scale, Form R; and the Subject Profile) on all three occasions - admission, discharge, and one

month follow-up. One subject completed three research instruments on all three occasions, however, refused to complete the Family Environment Scale. She provided the following rationale: "I don't feel like I have ever belonged to a family, therefore cannot relate to these questions." None of the subjects were rehospitalized within the one month post-discharge period of the study.

Table 2 presents the frequency distribution of age, sex, and number of psychiatric admissions for the study sample. All subjects were Caucasian. The ages in the sample ranged from 21 to 54 years with the mean age being 41.08 years. Although adults of both sexes were admitted to the psychiatric units from which the sample was drawn, the number of females admitted were typically greater. Considering that both major depression and dysthymic disorders are identified more commonly among females (DSM-III, American Psychiatric Association, 1980; Stuart & Sundeen, 1987), this observation is not surprising.

The sample presented an interesting picture when the number of psychiatric admissions were examined.

Table 2

Frequency Distribution related to Age, Sex, and Number of Psychiatric Admissions

Variable	Category	Frequency
Age	20 - 29	2
	30 - 39	12
	40 - 49	5
	50 - 59	6
Sex	Male	8
	Female	17
Number of Psychiatric Admissions	1 - 4	20
	5 - 8	1
	9 - 12	2
	13 - 16	2

Note. N = 25

Twenty (80%) subjects had less than four psychiatric admissions, indicating a relatively lower number of readmissions. One (4%) subject had eight psychiatric admissions; two (8%) subjects had nine psychiatric admissions each; and, two (8%) subjects had over thirteen psychiatric admissions.

The frequency distribution of admission medical diagnosis of the sample is presented in Table 3.

Table 3

Frequency Distribution of Admission Medical Diagnosis

	Sex	
Admission Medical Diagnosis	Male	Female
Major depression	8	10
Bipolar disorder, depressed		5
Bipolar disorder, mixed[a]		1
Agitated depression		1

Note. N = 25

[a]This subject was depressed upon admission.

Eighteen (72%) subjects were diagnosed as experiencing major depression on admission (M = 8, F = 10). Five (20%) subjects had an admission medical diagnosis of bipolar disorder, depressed; one (4%) subject had the medical diagnosis of bipolar disorder, mixed; and, one (4%) subject was admitted with agitated depression.

Research Instruments Scores

The data from the Beck Depression Inventory (BDI, long form), the Tennessee Self Concept Scale (TSCS, Form C, Total P Score), and the Family Environment Scale (FES, Form R) subscales (cohesion, expressiveness, conflict), are presented in this section. The scores for each research instrument are noted over time - admission (Time 1), discharge (Time 2), and one month follow-up (Time 3).

The BDI scores showed considerable range in this clinical sample, with scores from 5 to 50 (admission), 0 to 34 (discharge), and 3 to 32 (follow-up). The BDI and standard deviations for the sample are presented in Table 4.

One-Way analysis of variance (One-Way ANOVA) yielded a significant difference between subjects' mean

scores over time (F = 22.92, df = 2, 72, p < .001). A Tukey's honestly significant difference (HSD) test revealed that subjects' BDI scores were lower upon discharge and at one month follow-up than upon admission to a psychiatric facility. It was anticipated that subjects would leave the psychiatric facility feeling less depressed as compared to admission.

Table 4

Beck Depression Inventory (BDI) Means and Standard Deviations

	Time		
BDI	1	2	3
M	26.16	14.44	14.52
SD	13.62	10.36	8.72

Note. *N* = 25

In addition, One-Way ANOVA yielded no significant differences among the mean scores of subjects on the

TSCS Total P Score (overall level of self-esteem) over time (F = ,849, df = 2, 72). The mean scores for Total P did not vary significantly from admission (Time 1), to discharge (Time 2) and one month follow-up (Time 3) (see Table 5).

Table 5

Tennessee Self Concept Scale (TSCS) Means and Standard Deviations

	Time		
TSCS (Total P)[a]	1	2	3
M	297.0	312.92	303.4
SD	46.22	41.27	68.08

Note. N = 25

[a]Total P = Overall level of self-esteem.

The mean scores of each of the Family Environment Scale (FES) subscales (cohesion, expressiveness, conflict) did not change significantly over time

(see Table 6).

Research Questions

Three research questions were investigated in this study. First, would depressed adults demonstrate a higher level of self-esteem upon discharge and at one month follow-up than upon admission to a psychiatric facility? The results indicated no significant difference between the self-esteem of the sample from admission (M = 297.0, SD = 46.22), discharge (M = 312.92, SD = 41.27), and one month follow-up (M = 303.4, SD = 68.08). Therefore, depressed adults demonstrated no significant change in self-esteem from admission to discharge, and at one month follow-up.

Secondly, would depressed adults perceive their family environment as more cohesive, more expressive, and less conflictual upon discharge and at one month follow-up than upon admission to a psychiatric facility? The results indicated no significant difference between the mean scores of the sample on any of the family relationship dimensions (cohesion, expressiveness, conflict) from admission

Table 6

Family Environment Scale (FES) Subscales' Means and Standard Deviations

	Time		
FES Subscales	1	2	3
1. Cohesion[a]			
M	5.96	5.54	5.71
SD	2.37	2.96	2.82
2. Expressiveness[b]			
M	3.96	4.00	4.17
SD	1.85	1.89	2.26
3. Conflict[c]			
M	3.46	3.29	3.25
SD	2.45	2.20	2.36

Note. n = 24

One-Way repeated measures ANOVA:

[a] $F = .785$, $df = 2, 69$. NS

[b] $F = .209$, $df = 2, 69$. NS

[c] $F = .157$, $df = 2, 69$. NS

discharge, and one month follow-up (see Table 6). Therefore, depressed adults' perceptions of their family environment remained relatively constant from admission to discharge, and at one month follow-up.

Thirdly, what are the support and therapy preferences of depressed adults, when experiencing depressive episodes? The Subject Profile (SP) form elicited interesting information with regard to the type of support or therapy that the sample preferred or felt they needed. A variety of preferences were identified (see Table 7).

A high percentage (40%) requested the need to talk to a health care professional. Among the professionals identified were nurses, psychiatrists, psychologists, psychometrists, social workers, and the pastor. One subject verbalized the need for reassurance from his psychiatrist. In addition, it is important to note that many subjects emphasized the need to talk to empathetic and caring staff. A comment by one subject highlights the need to feel worthy and cared for: "When you are depressed, you need assurance that staff cares".

Table 7

Type of Support or Therapy Preferred

Category	Sex	
	Male	Female
HCP[a]	5	5
Friend	3	3
Family Member	3	4
Support group	1	4
Help Center/Crisis Line	1	2
Training[b]	2	2
Family Counselling	0	2
Structured therapy[c]	0	1
Group therapy	0	1
Day therapy/Follow-up	1	3
Not Sure	1	5

Note. N = 25

[a]HCP = Health care professional.

[b]Training = Stress management training; Assertiveness training; Life skills training.

[c]Scheduled activities and therapies everyday.

Six (24%) subjects indicated the need to talk to a friend, and seven (28%) subjects verbalized the need for support from a family member. Five (20%) subjects identified the need for a support group. One subject commented: "I need to have a feeling that I belong to a group. Right now I feel that I don't belong anywhere". Two of these five subjects, who had previously attended a group noted that the support groups had been very useful and helpful to them.

Another subject who felt the need for a support group noted the following: "It would help if more lay people would know what depression is. This would provide opportunities to ventilate feelings". One subject who did not identify the need for a support group, but who had previously attended a support group and verbal group offered at the Hospital, stated that these groups were not helpful.

Three (12%) subjects indicated the need for a Help Center or Crisis Line which they would have access to, when severely depressed. One subject poignantly described her desperation with this comment: "When you are that desperate and want to kill yourself, you need a phone line where someone

who is trained can talk you out of that feeling".

Four (16%) subjects identified the need for specific training; two of these four subjects requested stress management training, one subject requested assertiveness training, and one subject requested life skills training. One subject verbalized the need to have structured therapy, referring to having scheduled activities and therapies during the day. This subject also indicated the need for group therapy in the hospital, stating: "This is when you are the sickest and need it the most".

Four (16%) subjects verbalized the need for day therapy or follow-up from the hospital after discharge. One subject mentioned: "Its when you are in the community, that's where you need most help".

Finally, six (24%) subjects were unable to identify the type of support or therapy they needed or preferred. This finding is not surprising, since a high level of uncertainty, indecisiveness, pessimism, and loss of spontaneous motivation typify depressed individuals (Beck, 1967; Stuart & Sundeen, 1987).

Additional Analyses

Additional analyses were undertaken to assess the extent to which the clinical sample compared to the normative sample, on self-esteem (from the Tennessee Self Concept Scale Manual, Fitts, 1965) and family perception (from the Family Environment Scale: Manual, Moos & Moos, 1981). Simple *t* tests were employed for these analyses.

A significant difference was noted between the clinical sample mean score of self-esteem (M = 297.0, SD = 46.22) and the mean score for the normal sample (M = 345.57, SD = 30.7). The study sample demonstrated lower scores than those of the normative sample (t = - 5.255, $p < .001$), indicating lower levels of self-esteem in the clinical sample. This confirms recent research findings (Tennen & Herzberger, 1987; Tennen, et al., 1987), showing lower levels of self-esteem among depressed adults.

No significant difference was found between the study sample mean scores and that of the normative sample on family perception of cohesion and conflict among family members. Subjects in the clinical sample

indicated the extent of perceived family cohesion (M = 5.96, SD = 2.37) comparable to that reported by the normative sample (M = 6.61, SD = 1.36). In addition, the clinical sample reported the amount of perceived family conflict (M = 3.46, SD = 2.45) comparable to that of the normative sample (M = 3.31, SD = 1.85). Therefore, depressed adults are not showing any differences in family cohesion and conflict than the normal sample.

Interestingly, a significant difference was revealed between the mean scores of the study sample (M = 3.96, SD = 1.85) and that of the normative sample (M = 5.45, SD = 1.55) for family expressiveness. The study sample had lower scores than the normal sample (t = -3.944, p < .001), indicating that the clinical subjects perceived their families as lower in expressiveness among its members as compared to the normative sample (Moos & Moos, 1981).

Summary

This chapter reported the results of the study. Information with regard to the personal characteristics of the sample was presented. Results of the scores

obtained from the research instruments followed. The research questions were then addressed. The results were presented in both narrative and tabular form. The discussion of the findings of the study is presented in Chapter IV.

CHAPTER IV

THE DISCUSSION

The results of this study will be discussed in relation to the purposes and theoretical framework of the study. The study variables, namely self-esteem and family perception of depressed adults will be examined in relation to depressive symptomatology. In addition, information elicited with regard to preferences of support and therapy will also be discussed.

Brief summary of major findings

The findings of this study indicated that depressed adults, as expected, showed improvement in their depressive symptomatology upon discharge from the psychiatric facility. In addition, the improvement of depressive symptomatology was sustained over a period of one month post-discharge.

The results also suggested that the level of self-esteem and the family perception of depressed adults were maintained over time, remaining relatively constant from time of admission to one month post-discharge. Further analyses showed that depressed

adults have lower levels of self-esteem than the Tennessee Self Concept Scale (TSCS) normative sample (Fitts, 1965).

The additional data analyses also indicated that depressed adults perceived their families as comparable to the Family Environment Scale (FES, Form R) normative sample (Moos & Moos, 1981) on the dimensions of family cohesion and family conflict. Interestingly, depressed adults differed in the perception of family expressiveness from that of the normative sample, whereby they perceived their families as lower in expressiveness among members than the FES normative sample (Moos & Moos, 1981).

Finally, this study provided important information with regard to the type of support or therapy depressed adults preferred while experiencing a depressive episode. A high percentage (40%) of depressed adults preferred to talk to a health care professional, followed by support from a family member (28%) and need to talk to a friend (24%). An important observation was the insistence by these individuals for empathy from staff and others; this need was verbalized by almost all the subjects except those individuals who

were not sure of what they needed when experiencing a depressive episode. Six subjects (24%) were not sure of the type of support or therapy they needed; a phenomenon not uncommon among depressed persons who present much ambivalence and uncertainty when attempting to make decisions (Stuart & Sundeen, 1987). The small sample size precluded analyses with regard to demographic variables (age, sex, number of psychiatric admissions) and their relationship to depressive symptomatology and the study variables (self-esteem, family perception).

Relationship of self-esteem to depressive symptomatology

The findings of this study indicated that depressed adults did not demonstrate any significant change in their self-esteem upon discharge from a psychiatric facility and at one month follow-up. Thus, the level of self-esteem did not change among these individuals during their admission to the psychiatric facility even when the symptoms of depression were greatly alleviated.

Evidence of low self-esteem in depressed individuals has been previously documented, whereby a high correlation was noted between depth of depression and level of self-esteem (Tennen & Herzberger, 1987; Tennen, et al., 1987). The literature further suggests that depressed individuals often display high critical evaluations of their abilities and aptitudes, seeing themselves as worthless and inadequate, even in the face of contrary evidence (Swallow & Kuiper, 1988).

The literature thus corroborates the findings of this study with regard to low self-esteem among subjects on admission. However, the literature does not explain the persistence of low self-esteem at discharge and one month follow-up, when the depressive symptoms were alleviated, in the present study. It is possible that low self-esteem may constitute part of the personality of depressed individuals. Such a contention has, however, not been supported in earlier findings. Laxer (1964) indicated that depressed patients showed a low self concept on admission to a hospital and moved to a higher self concept at the time of discharge.

The differences between Laxer's (1964) study and the present investigation may help account for the varied results. Laxer (1964) used the semantic differential test to investigate changes in the self-concept of neurotic depressive patients, whereas the present study utilized a tool comprised of self-descriptive statements (Tennessee Self Concept Scale) to measure self-esteem of subjects. Furthermore, the differences arising from the clinical diagnosis of Laxer's (1964) sample of neurotic depressives and the present sample of individuals with affective disorder who were depressed (DSM-III, American Psychiatric Association, 1980), are significant and may help explain the differences in findings between the two studies.

The subjects' length of hospitalization was not noted in the present study and for Laxer's (1964) sample. Analysis of findings would have been more useful if the length of hospitalization was included for the subjects and compared with other studies. Despite the low score on the Beck Depression Inventory (Beck et al., 1961), there may not have been sufficient time to demonstrate significant changes in the subjects'

self-esteem. The data collection time frame in the present study did not provide opportunity to observe possible changes in self-esteem of individual subjects relative to days of hospital stay.

An additional factor that is relevant and may possibly explain the higher self concept upon discharge for the subjects in Laxer's (1964) study could be the treatment received during their hospital stay. Staff interventions aimed to enhance the self-esteem of despressed individuals were not measured by Laxer (1964), and were not measured in the present study.

It is difficult to make any conclusive statement whether low self-esteem was a contributory factor precipitating a depressive reaction in adults in this study. In addition, from this study, it is impossible to make any statement as to whether specific nursing interventions were aimed at enhancing the self-esteem of depressed individuals. It was not the intention of this study to examine the relationship between nursing interventions and level of self-esteem of depressed adults.

Relationship of family environment to depressive symptomatology

The findings of this study indicated that depressed adults did not demonstrate a change in their family perception upon discharge from a psychiatric facility and at one month follow-up. These findings suggest the family perception of depressed adults was maintained relatively constant even though marked improvement was noted in their depressive symptomatology.

The literature describes the thought patterns of depressed individuals concerning themselves, the environment, and the future as being negative in nature (Beck, 1967; Beck, et al., 1979). With this evidence, it was anticipated that upon admission to a psychiatric facility, depressed adults would perceive their family environment as negative, specifically less cohesive, less expressive, and more conflictual in nature than at discharge or one month follow-up. This contention was based on the notion that significant alleviation of depressive symptomatology may influence positively the individual's perception of the family environment;

a positive perception would mean viewing the family environment as more cohesive, more expressive, and less conflictual in nature. The present study however demonstrated no significant association between family perception and alleviation of depressive symptoms of the sample.

This study revealed important information with regard to the family relationship dimensions as perceived by depressed adults when compared to the Family Environment Scale (FES, Form R) normative sample (Moos & Moos, 1981). The family perception of both the depressed adults and the normal sample matched closely on family cohesion and conflict, suggesting little association between depressive symptomatology and the extent of cohesion or conflict within the family.

Family conflict, lack of cohesion within the family, and less expressiveness by family members have been previously related to depression amongst members (Billings & Moos, 1983; Moos & Billings, 1982).

Furthermore, recent evidence (Coyne, et al., 1987) suggests that negative family interactions may tend to maintain or exacerbate depressive symptomatology. Negative family interactions could be measured by the

conflict subscale of the FES, Form R (see Appendix M). The present study did not suggest a high level of conflict within families of depressed adults, thus not providing support for the findings by Coyne and associates (1987). It must be noted that the conflict subscale addresses only the amount of openly expressed anger, aggression, and conflict among family members and thus may provide a limited definition of negative family interactions.

Recent research (Wetzel & Redmond, 1980) suggests family support as a most important variable discriminating between depressed and nondepressed individuals; lack of family support was noted to be a significant variable antecedent to the onset of depression. It must be noted that family support is measured by the cohesion subscale of the FES, Form R (see Appendix M). The present study failed to discriminate the degree of family cohesion as a significant factor in depressive symptomatology.

In this study, depressed adults reported less expressiveness among family members than did the FES (Form R) normative sample (Moos & Moos, 1981). This finding certainly suggests a significant

relationship between depression and the extent of expressiveness within the family. The finding of this study is corroborated by recent research (Finney, Moos, Cronkite, & Gamble, 1981; Moos, Finney, & Gamble, 1982) where less expressiveness among family members was evidenced in families of alcoholic patients and matched normal controls whose spouses were depressed. The literature also reports distressed families as demonstrating lower levels of expressiveness than normal families (Moos & Moos, 1981).

As noted, the findings of this study indicated that depressed adults come from a family system where members do not demonstrate high levels of expressiveness towards one another. Important information is revealed when examining the specific items of the expressiveness subscale of the Family Environment Scale (FES), Form R (see Appendix M). It appears that the family system does not allow open expression of feelings among members (Questions 2, 12, 22, 52, 72), nor does the family foster discussion of personal and family problems amongst the members (Questions 32, 62). A common characteristic of

depressed adults is difficulty in openly expressing feelings and discussing their problems, which may stem from the modeling effect of the family system. Furthermore, families of depressed adults seem to demonstrate a lack of spontaneity (Questions 42, 82), which may also explain a similar attribute in these individuals again due to the family modeling effect.

Although this study provided important information with regard to the consistency of family perception of depressed adults over time, and the lack of expressiveness among families of these individuals, several questions remained unanswered. Specifically, due to the small sample size, no attempt was made to correlate the Family Environment Scale (FES, Form R) subscales of cohesion, expressiveness, and conflict, with variables that have been shown to be significantly related to these subscales in the literature. Information with regard to correlations between FES subscales and the demographic variables noted may be useful in determining their potential influence in depressive symptomatology.

Another important area that was untouched by this study was the extent to which other family dimensions

such as personal-growth and system maintenance (Moos & Moos, 1981) are related to depressive symptomatology. Such an assessment was beyond the scope of this study, thus was not undertaken by the investigator. Future investigations assessing the family environment more comprehensively using the FES may provide valuable information as to the relevance of specific family dimensions to depressive symptomatology among it's members.

An additional question with regard to the family environment of depressed adults, that remains unanswered is whether the perceived family environment was indeed the family environment in actuality. This study was limited to examining the family perception of depressed adults only, thus no information was sought to examine the family perception of other members. Furthermore, no attempt was made to independently assess the family environment and provide congruency with what was reported by the depressed adults. A perplexing question remains: Did the family environment remain constant, as was perceived by the depressed adults in this study? Or, is it possible that the negative cognitive set of

depressed individuals contribute to their perceiving the family environment in a certain manner, particularly perceiving low levels of expressiveness among family members, over the study period?

Support and therapy preferences of depressed adults

A variety of preferences for support and therapy were identified by depressed adults in this study. Several individuals expressed the need to talk to a health care professional (HCP). Among the professionals identified were nurses, psychiatrists, psychometrists, social workers and the pastor. The need to talk to a HCP could be speculated as related to many factors, for instance, the subjects' need to receive help from a trained person; the subjects' past experiences with HCPs; the subjects' need for reassurance; or since the subjects were admitted to a psychiatric facility they would have easy access to HCPs, therefore requested to speak to one or more HCP.

It is worthy to note that depressed adults in this study persistently verbalized the need to talk to empathetic and caring staff. It appears that although these individuals expressed the need to talk to a HCP,

their preference was specific to empathetic and caring HCPs. This is an important finding. It appears that empathy from HCPs is an ingredient that depressed adults perceive as necessary and helpful in assisting them towards recovery.

According to Rogers (1961), empathy is "to sense the client's private world as if it were your own, but without losing the 'as if' quality" (p. 284). Kalisch (1973) defines empathy as "the ability to enter into the life of another person, to accurately perceive his current feelings and their meanings" (p. 1548). The author further purports that empathy is an essential element in the interpersonal process, and when communicated, it (empathy) forms the basis for a helping relationship between nurse and patient (Kalisch, 1973). Empathy then is one of the most delicate and powerful elements that HCPs can utilize when caring for depressed individuals. It is not surprising then that depressed adults in this study wished to know that the HCP understood their internal frame of reference and was sensitive to their current feelings and meanings they attached to these feelings.

The subjects in this study also identified the need to talk to a friend and have support from a family member. It appears that depressed adults need someone (HCP, friend, family member) that they can talk to and who they perceive as caring. It can be safely concluded that empathic understanding or receptivity demonstrated by the friend or family member toward the depressed person is perceived as helpful by the depressed adult.

Some depressed adults in this study identified the need for a support group, specifically conveying the need for belonging that they felt might be achieved through being a member of a support group. Two subjects who had previously attended a support group commented positively about the group. However, one subject having previously attended a hospital-based support group and verbal group, did not perceive groups as helpful. It is difficult to make any statement with regard to the efficacy of support groups in the care of depressed adults, from this study. Support groups may prove to be helpful for some depressed adults but may not always be the choice of therapy for all depressed adults.

Three subjects in this study requested a Help Center or Crisis Line (telephone) independent of the psychiatric facility. According to these individuals, a Help Center or Crisis Line would serve well those depressed people undergoing an acute suicidal crisis. The subjects emphasized the need for the contact person at the Center or the person reached by telephone to be an individual trained in dealing with suicidal crisis.

It is a well known fact that depressed individuals are a high-risk group for suicide, and that severely depressed persons are always suicidal risks (Stuart & Sundeen, 1987). The desperation to take one's life was clearly communicated by depressed adults in this study who had more than once experienced severe depressive episodes. The striking comment about the need for trained personnel as contact persons to assist depressed people in dealing with a suicidal crisis is not surprising. The anxiety that is associated with a deliberate attempt at self-destruction is overwhelming (Stuart & Sundeen, 1987), therefore a skilled person is required to assist depressed individuals to deal with this anxiety and feel a sense of control over their

life and future.

Four subjects identified the need for specific training, namely stress management training, assertiveness training, and life skills training. It is commendable that these individuals were able to identify areas in their life that they perceived as needing change to help them cope with the depressive crisis.

Stress management training may involve more than one of the following: self-awareness with regard to the individual's feelings, responses, and behavior; identification of the individual's previous coping mechanisms and learning new ways of dealing with stressors; realistic goal-setting; organizing and priorizing immediate and future goals; learning relaxation methods; learning effective problem-solving; and so forth. Any of the areas noted can be useful for the depressed individual in varying degrees depending on the person's unique needs and receptivity to change.

Assertiveness training involves the identification of one's previous and present responses and behaviors and learning new, assertive ways of communicating with others. The description of the steps involved in

assertiveness training is beyond the scope of this chapter and will therefore not be discussed. The literature is abound on information related to assertiveness theory and training (see Alberti & Emmons, 1974; Bowman & Spadoni, 1981; Chenevert, 1978; Galassi & Galassi, 1977).

A recent research study (Pietromonaco, 1985) noted affective sensitivity to be an important characteristic of depressed individuals; depressed individuals were more responsive than nondepressed controls to both negative and positive feedback. It would appear, then, that one aspect of depression is the tendency to focus primarily on the affective implications of incoming evaluative information (Swallow & Kuiper, 1988).

Assertiveness training may be particularly useful for depressed adults since assertion involves acceptance of positive input from others. If depressed adults have an increased affective sensitivity, it is possible that they may benefit from receiving positive feedback from others. The positive feedback in others may in turn serve to enhance the depressed individual's self-esteem.

Life skills training may include training in one or more of the following areas: housekeeping, cooking, shopping, money management, human relations, conversational skills, problem-solving skills, goal setting, utilization of community resources, and so forth. Depressed adults could benefit from life skills training in any one of these areas, again depending on the individual's unique needs and receptivity to learning and change.

In this study, one subject identified the need for structured therapy, referring to having scheduled activities and therapies during the day. The same subject indicated the need for group therapy in the hospital. For severely depressed hospitalized clients a structured daily program of activities can be beneficial (Stuart & Sundeen, 1987). Structured activities may be useful to set the tone of the day, help motivate the client, and provide distraction from negative ruminating. A routine may also help provide a sense of control and predictability for the individual.

Inpatient group therapy may vary in aim, purpose, and intensity. Some of the more common inpatient group

therapies are personality reconstruction groups, insight without reconstruction groups, problem-solving groups, remotivation and re-education groups, and supportive groups (Marram, 1978). It was not the intention of this study to examine whether any one particular type of group therapy would be beneficial for depressed adults. However, providing group therapy to these individuals remains a viable alternative. Future investigations assessing the usefulness of group therapy in the treatment of depressed adults may provide valuable information with regard to the relevance and type of group therapy that may be useful in the care of these individuals.

Four subjects identified the need for day therapy or follow-up after discharge from the hospital. The importance of follow-up care after discharge from the hospital cannot be overemphasized for individuals with emotional problems. The various issues related to psychiatric discharge and follow-up care are beyond the scope of this chapter. However, it must be emphasized that reintegration of an individual in the home and community following a psychiatric hospitalization requires readjustments of roles both within the family

and the community, particularly if the hospitalization period constituted several weeks or months.

A depressed individual may be hospitalized for an average of 3-4 weeks, and may therefore encounter reorganization of family roles upon return home. The return of the hospitalized member thus requires readjustment on the part of all family members. In addition, the depressed individual may need increased support dealing with the unresolved problems and instituting new ways of coping.

Families have felt guilt and shame following hospitalization of a member (Anderson, 1977), and have described the burden of coping with the patient over a long period of time (Grad & Sainsbury, 1968; Hatfield, 1981; Robin, Copas, & Freeman-Browne, 1979). Leavitt (1975) upon interviewing families of 16 psychiatric patients who were being discharged from the hospital, found that in general the families were not prepared for the discharge of the hospitalized member. Therefore, follow-up care of psychiatric clients may also facilitate family preparation and adjustment of all members upon the client's return home.

Furthermore, the stigma attached to mental illness may affect depressed individuals when leaving the hospital. The problems encountered by those with mental illness because of its stigma are well documented (Armstrong, 1980; Rabkin, 1974). Adequate follow-up may provide the individual with the necessary support during the early phases of reintegration into the family and community.

Caplan (1964) discussed the importance of assessing the family's prejudices with regard to mental illness so that family members can be given assistance in recognizing and overcoming these prejudices. Otherwise, the client may return to a setting where he/she is seen as weak, is not trusted, is overprotected, or is rejected. Follow-up care may allow the family to discuss their fears and provide the nurse with the opportunity to educate the family and in turn expel myths in relation to mental illness.

Finally, as noted earlier, it was not surprising that some depressed adults in this study were unable to identify the type of support or therapy they needed. The high level of uncertainty, indecisiveness, pessimism and loss of spontaneous motivation associated

with depressive symptomatology may account for the inability of these individuals to express any preference with regard to the therapy or support needed.

Although this study's findings provide a picture of what depressed adults in this study perceived as the type of support or therapy they needed (with the exception of six subjects), it leaves one with several unanswered questions. Specifically, the study did not attempt to weight or rank the various types of support or therapy, for instance, one type of therapy may indeed be more necessary and critical than another. Of particular importance are nursing interventions in the care of the depressed adult during hospital stay. The study did not attempt to identify subjects' preferences of one set of nursing interventions from another, or whether certain nursing interventions were critical than others when caring for these individuals.

This study also made no attempts to elicit information with respect to depressed adults' previous experiences with any number of therapies. It is possible that current therapy may influence

one's outlook and cognitive accessibility to the expression of similar therapy preferences. Furthermore, past positive or negative experiences may influence current therapy choices. Information of this nature would be useful to clinicians when determining priorities regarding the care of depressed adults, and would be valuable to obtain in future studies.

Limitations to generalizability

The investigator recognizes some important limitations of this study. The small sample size precludes generalizations of the results beyond the study population. In addition, a longer follow-up period, for instance six months or one year would help to demonstrate whether indeed the self-esteem and the family perception of depressed adults remained constant or changed with recovery.

Limited control of other variables may have influenced the results of this study. These variables include, the lack of distinction between the nuclear family and the family of origin; lack of differentiation of the stage of family development;

and, the age of the subject in influencing the family circumstances. In addition, a sampling bias may have resulted by virtue of the investigator being affiliated with both the hospitals used as study settings, thus possibly affecting the subjects' responses.

In view of these limitations and influencing variables, the investigator emphasizes that the findings of this study be interpreted with caution.

Summary

This chapter discussed extensively the results of this study. The major findings of the study were briefly highlighted, followed by discussion of the study variables (self-esteem and family perception) in relation to depressive symptomatology. A discussion with regard to preferences of support and therapy of depressed adults followed. Limitations to generalizability of the study results were also noted. The summary of the study including nursing implications and recommendations for nursing practice, theory and research are presented in Chapter V.

CHAPTER 5

SUMMARY, IMPLICATIONS AND RECOMMENDATIONS

Summary of Study

A convenience sample of 25 adults with an admission medical diagnosis indicative of depression from two psychiatric facilities participated in an exploratory study. This study investigated the relationship between depressive symptomatology and two variables - self-esteem and family perception in relation to cohesion, expressiveness and conflict within the family. In addition, the study elicited the subjects' preferences of support and therapy when experiencing depressive episodes. Data was collected on three separate occasions: admission and discharge from a psychiatric facility, and at one month post-discharge.

The subjects completed four research instruments. The Beck Depression Inventory (BDI, long form) provided a measure of depressive symptomatology; the Tennessee Self Concept Scale (TSCS) provided a measure of self-esteem; the Family Environment Scale (FES) provided a measure of the relationship dimensions of

the family; and, the Subject Profile (SP) form provided information with regard to personal characteristics of the subjects and their preferences for types of support and therapy.

The sample, as expected, showed improvement in their depressive symptomatology upon discharge from the psychiatric facility. Furthermore, this improvement was maintained over a period of one month post-discharge. Depressed adults in this study demonstrated low levels of self-esteem as compared to a normative sample (Fitts, 1965), with the level of self-esteem remaining relatively constant from time of admission to one month post-discharge.

The study showed that the perceptions of depressed adults and the perceptions of the normative sample (Moos & Moos, 1981) were comparable on the dimensions of cohesion and conflict among family members. A unique finding of this study was that depressed adults perceived their families as lacking in expressiveness among members. The family perception of subjects in this study remained relatively constant over time.

In addition, subjects indicated several preferences for support or therapy when experiencing a

depressive episode. A noteworthy observation was the subjects' insistence of empathy from staff and others.

Implications

The findings of this study have implications for nursing practice, theory and research. Several study limitations, however, prohibit generalization of the results. The small sample size precludes generalization of the findings beyond the study population. A one month follow-up after the subjects' discharge from hospital, may not have been a good indicator of potential changes in self-esteem and family perception that could occur with recovery from depression.

Furthermore, the study did not control for variables such as distinction between the nuclear family and the family of origin, differentiation with regard to stage of family development, and the age of the subject in influencing family circumstances. A sampling bias may have resulted by virtue of the investigator being affiliated with both the hospitals utilized as research settings. In spite of these drawbacks, however, the findings have implications for

health care.

Nursing Practice

The etiology of many psychiatric disorders remains unclear and thus precludes the extensive use of primary prevention techniques. A solid understanding of factors associated with psychiatric relapse is of evident value for intervention. However, clearly what is needed is a better understanding of what specific strategies help reduce the number of psychiatric relapses, thus extending the periods of wellness in individuals experiencing psychiatric disorders.

The nursing interventions related to severe mood disturbances must be based on a holistic perspective and a multicausal model of affective disorders. This model proposes that affective disorders have many determinates and many dimensions that affect all aspects of a person's life. Thus a single approach to nursing care would be inadequate. Nursing interventions must instead reflect the complex nature of the model and address all the factors that may potentially influence one's vulnerability to and recovery from mood disturbances.

Two factors that have been highlighted as being associated with depressive symptomatology in this study are: (a) low self-esteem in depressed adults, and (b) lack of family expressiveness perceived by the depressed adults.

Schultz and Dark (1986) maintain that a person with adequate or high self-esteem may be better able to deal with emotional difficulties. Mental health nurses therefore need to recognize the effect of disturbance in self-esteem on the client's coping capacity. Therefore, an essential part of caring for depressed individuals would be to enhance the person's self-esteem. Clearly, a better understanding of nursing strategies that lead to improved self-esteem in these individuals is of critical value. Nursing strategies aimed at enhancing the client's self-esteem must be individualized so that they focus on the client's unique strengths and needs.

Individuals with low self-esteem may have difficulty incorporating positive feedback and accurately assessing their personal strengths and needs. Nurses must assist clients in identifying their needs and individual strengths in order that

clients may use this knowledge to effect change in their lives.

Additional strategies that nurses can utilize to enhance the depressed individual's self-esteem include assisting the person to clarify any misconceptions he/she has about himself/herself and that of the care he/she is receiving. It is essential that the nurse encourage the client to ask questions: about his/her health problem, the treatment, progress, prognosis, and facilitate decision-making about his/her care. Providing opportunities for independent decision-making and successes are necessary, if clients are to incorporate positive experiences and feedback to help them modify their self-esteem in a more positive direction.

Affective sensitivity appears to be an important characteristic of depressed individuals (Pietromonaco, 1985). This knowledge becomes very relevant to nurses when providing care to these individuals. It is possible that with the heightened affective sensitivity, the positive feedback and praise for accomplishments that the nurse provides, may be incorporated into the client's view about himself/herself, thus enhancing

the self-esteem even further.

Relating to the theoretical framework of this study, the nurse enhancing the hospitalized family member's self-esteem will in turn be affecting the family system, bringing the system into balance with a different form of equilibrium. It is anticipated that feedback processes would result in higher levels of self-esteem that reverberate throughout the family system, resulting in a wide range of positive outcomes for the family. For instance, positive outcomes could constitute higher levels of functioning among members, goal-directed behaviors, enhanced interpersonal relationships, and a realistic world view.

An important implication when caring for depressed clients is the involvement of the family in the assessment and treatment of these clients. It is essential that nurses begin to examine the possible reciprocal relationships between depressive mood and family environment. It would be extremely valuable for mental health nurses to elicit the client's as well as the individual family member's perception of the family environment so that appropriate strategies to include the family in the treatment process can be instituted.

A distressed family environment warrants nursing intervention both at the individual and family levels.

Depressed individuals in this study perceived a lack of expressiveness within their families. Nurses play an important role in assessing expressiveness within the family and in eliciting information with regard to family expressiveness from family members. Family assessment interviews when a member is admitted to the hospital, may prove to be invaluable in conducting an independent assessment of the family and in gathering data about individual family members' perceptions of the level of expressiveness within the family and the overall family environment.

It must be noted that the nurse's assessment of the family should incorporate the growing body of knowledge about family responses to mental illness and about family needs when a member is hospitalized. Knowledge of systems theory, cybernetics, including family dynamics and processes is essential to conducting a holistic assessment of the individual and his/her family.

A better understanding of nursing strategies that effect creation of a positive family environment, and

specifically those that focus on enhancing expressiveness within the family, is also necessary. Family interviews while the client is hospitalized and during follow-up can provide the nurse with the opportunity to build relationships with the other family members. These interviews can then be utilized to provide feedback on the levels of expressiveness of each member and assist the member in expressing his/her views, thoughts, and feelings.

The nurse can also assist the family members in gaining insight into the communication patterns of each member, and facilitate ways of modifying these patterns in a positive direction. The nurse must be aware of his/her own communication patterns with the family, and role model effective communication patterns as well as demonstrate appropriate levels of expressiveness during interactions with the client and his/her family members.

The emotional climate to which the client returns upon discharge from the hospital can have a significant effect on the client's adjustment. As noted earlier, reintegration into the family, after weeks of hospitalization, may require readjustment of roles.

This is in keeping with the theoretical framework of the study, whereby a change in one part of the system (hospitalization of family member) would result in change in other parts (reorganization of the family structure and role responsibilities).

Mental health nurses must be cognizant of the family reorganization that takes place while a client is hospitalized, particularly if it is a relatively lengthy hospital stay. If the member is away for a prolonged time, the family reorganization may assume an aspect of permanence; members become emotionally attached to the new structure and may be reluctant to return to the earlier organization (Stuart & Sundeen, 1987). Adequate discharge planning with the family including follow-up family visits by the nurse may be extremely valuable. The nurse will thus have an opportunity to assess the client's adjustment upon discharge, and also identify any potential problems that were not detected earlier. Appropriate follow-up care or referral may then be provided as necessary.

Of particular importance are community mental health nurses in the follow-up care of depressed adults. These nurses play an important role in

providing the vital link from the hospital to the community, with continued assessment and follow-up care of depressed adults upon discharge. In addition to facilitating the client's readjustment into the family, community mental health nurses can assist in the creation of a healthy family environment and provide availability to the family as needs arise. Strong follow-up care may help reduce the need for rehospitalization, thus in turn minimizing the familial disruption that ensues hospitalization of a family member.

It is necessary to point out that not all communities in Canada have community mental heath nurses; in many instances follow-up psychiatric care is provided by hospital-based nurses during discharge visits to the client's home, or by the outpatient psychiatric nurses who function within the hospital setting.

The following observations were made for subjects in the present study, during the subject's discharge from the hospital. Subjects from the psychiatric admission unit of the general hospital received either: (1) Follow-up visits with the attending psychiatrist

and/or family physician, or (2) Referral to the day hospital program offered by the psychiatric services of the hospital. No nursing referral was made; however, subjects were welcome to call the nurses on the psychiatric unit if they needed/or wished to do so.

Subjects from the acute admission unit of the psychiatric hospital, received one of the following: (1) Follow-up visits with the attending psychiatrist and contact with family physician; or (2) Referral to the outpatient department of the hospital where follow-up visits were scheduled with the attending psychiatrist and continued follow-up provided by an outpatient psychiatric nurse; or (3) Referral to the outpatient department of the hospital where follow-up visits were scheduled with a health care professional (outpatient psychiatric nurse, psychologist, or social worker) who the client had been seeing for psychotherapy/counselling while hospitalized. The health care professional would contact the client's attending psychiatrist as needed. In addition, all subjects were encouraged to call nurses on the inpatient unit, if they needed to do so after hours when the outpatient department was closed.

It is necessary to note that the follow-up of depressed adults in this study concentrated on the care of the individual, with little emphasis on the care of the family as a unit. A shift from the individual to caring for the whole family is critical, if nurses are to provide more effective and holistic nursing care to this population.

This study elicited relevant information with regard to support and therapy preferences of depressed individuals. The preferences were noted (see Table 7, p. 87), and discussed fairly extensively in Chapter IV. What appears necessary is nursing interventions designed to assist depressed clients to access the support or therapy of their choice, and assist them to use the currently available support systems.

An important observation in this study was the expressed need by depressed adults for empathy from staff and others. It is impossible to accurately perceive the client's needs or understand his/her plight when experiencing a depressive episode, without understanding the client's internal frame of reference. Understanding one's internal frame of reference involves the person sharing his/her private perceptual

world and views about himself/herself. Such sharing occurs when the nurse communicates empathic understanding to the person. Nurses, must therefore be cognizant of developing high levels of empathy when caring for their clients, so that they may be privy to the client's private world. Information of the client's internal world will assist the nurse in accurately identifying the client's needs and in making decisions with regard to nursing care of these clients.

The information provided by the subjects with regard to therapy preferences have other implications for the mental health nurse. First, it highlights the necessity of including the client in the choice of therapies. Secondly, it emphasizes the concept of receptivity. A client's receptiveness to therapy inevitably influences the effectiveness of the therapy. To maximize the efficacy of nursing interventions, the nurse should involve the client in the planning stage of the nursing process. Mutuality of decisions will encourage self-responsibility in clients, and will provide them with a sense of control thus counteracting the feelings of helplessness and powerlessness commonly experienced by depressed individuals.

Theory and Research

The theoretical framework which guided this study provided an appropriate and useful model for the study. The framework could be beneficial in nursing practice as well as in research; knowledge and application of self theory and general systems theory in nursing continues to hold much promise. It is also critical that nursing theories be utilized in future research when studying self-esteem and family environment of depressed adults.

This study limited itself to measuring only the overall level of self-esteem of depressed adults and did not attempt to understand the individuals' phenomenal world as wholly as purported by self theory. It is important to note however, that the study made attempts at understanding the subjects' perceptions with regard to the family environment. A phenomenological approach to individuals not only focuses on understanding the private worlds of people, but is also concerned with the perceptions and the perceptual field of the human being.

The precise role of self-esteem in depressive experiences remains elusive, even though this study confirmed the evidence in the literature that depressed adults exhibit low self-esteem. It is, however, difficult to make any definitive statements regarding implications for theory on the role of self-esteem in depressive symptomatology, from this study. Nurses must, however, continue to learn more about the significance of depressed individuals' self-esteem and the theoretical and practical implications thereof.

The use of a theoretical framework based on a nursing theory utilizing a phenomenological perspective such as Parsi's (1981) Man-Living-Health theory of nursing, may be extremely useful as nurses attempt to understand the person's phenomenal world and perceptions, including the person's sense of self and it's relationship to depressive symptomatology. In addition, incorporation of a nursing theory is useful in conceptualizing nursing practice and identifying nursing strategies for caring for depressed individuals and their families.

The utilization of the concepts purported by general systems theory are abound in nursing

literature. General systems theory continues to remain an important theory in psychiatric - mental health nursing practice. Knowledge of the interdependence (wholeness), interrelatedness (nonsummativity), and complexity of interactions between the depressed individual and other systems, particularly the family, has important implications for the mental health nurse. This knowledge will provide a more comprehensive assessment of the client and in turn assist the nurse in prescribing more definitive and accurate nursing interventions for the client.

Perceiving changes in the client's well-being in the context of the family system allows the nurse to create a more expansive understanding of the individual, thus avoiding a reductionistic view of the client. Understanding the gestalt of the family of the depressed individual may assist nurses with effective interventions for the individual and the family.

This study examined the family perception of depressed adults. A useful extension of the study would be to consider all family members' perception of the relationships among members, thus providing a more complete view of the nature of the family environment

as reflected by all members. In addition, an important consideration would be for the nurse to assess the family environment independent of the members' perceptions. This can be accomplished by observing family interactions during family interviews upon admission of the depressed member, at discharge, and on follow-up visits.

Future studies based on the Neuman Systems Model (1982), which stems from general systems theory, may be useful for nurses, when examining the interrelationship between family environment and depressive symptomatology in a family member.

The research instruments used in this study appeared sensitive and provided important information which adds to the existing nursing knowledge. A clear picture of the depressed individuals' perception of the family environment with regard to the relationship dimensions was evidenced from the results of the Family Environment Scale (FES) subscales.

In this study the FES appeared both sensitive and comprehensive. Further use of this tool in nursing research should be encouraged. This use would expand knowledge in relation to the instrument's sensitivity.

For example, a unique finding in this study, as previously mentioned, was the perceived lack of expressiveness among family members of the depressed adult. Was this finding unique to this sample or was it a reflection of the instrument's sensitivity? Furthermore, is the instrument sensitive in detecting differences in the family environments of individuals suffering from other emotional disorders? Questions such as these can only be answered by further application of the FES to clinical samples of depressed groups and other psychiatric groups. In addition, the FES, if used in its entirety would provide valuable information with regard to the personal-growth and system maintenance dimensions of families of depressed persons.

Finally, the results of this study suggest the need for expansion and modifications to the present study and further research.

Modifications to the present study

1. A larger sample size of depressed adults, to elicit whether the present findings would remain consistent.

2. Include the individual's age of first hospitalization with a depressive episode, as an additional study variable for correlational purposes.
3. Include the individual's length of hospital stay as a variable, in observing possible changes in self-esteem relative to various time frames, prior to discharge.
4. A longer follow-up period, for instance at six months and one year intervals assessing depressive symptomatology, self-esteem, and perception of family environment. This would assist in observing significant changes in these variables over a longer time period.
5. Include the family perception of all members of the depressed adult's family concomitantly while assessing the depressed adult's perceptions, to determine similarities and/or differences among family members' perceptions.
6. Differentiation of sample in relation to family type (nuclear versus family of origin), stage of family development, and age of subject as influencing family circumstances.

7. Use a person independent of the research settings to collect data thus minimizing sampling bias possibly present by virtue of the investigator being affiliated to the hospitals used as research settings.

Future Research

Areas identified for future research as a result of this investigation include:

1. A longitudinal study to measure the relationship of self-esteem, family perception, and recurrence of depressive symptomatology over time.
2. An experimental approach in which all family members report the perceptions of the family environment, and independent observers rate family interactions through a one-way mirror. Family members could be invited for interviews on admission, discharge, and home visits made following the hospitalized member's discharge.
3. A study focusing on the quality of family environment and its relationship to depressive symptomatology among members.

4. A study using the Family Environment Scale (FES) in its entirety, thus assessing not only the relationship dimensions, but also the personal-growth and system maintenance dimensions of the family of depressed individuals.
5. A study to investigate specific nursing strategies that lead to improved self-esteem in depressed adults and nursing strategies that effect creation of a positive family environment.
6. A descriptive study focusing on depressed individuals' and their families preferences for support and therapy, and the nurses' perceptions of what the client and family members need with regard to support and therapy.
7. A study focusing on depressed individuals' previous experiences with various treatment modalities/therapies and its relationship to current treatment choices.
8. A study to investigate the level of empathy communicated by nurses as perceived by depressed adults and its effect on the nurse-client relationship and subsequent ventilation of feelings by the client.

Conclusion

This exploratory study investigated the relationship between depressive symptomatology, self-esteem, and perception of family environment of depressed adults on three separate occasions. The three instances were, within ten days of admission to a psychiatric facility, approximately three days prior to discharge from the facility, and at one month post-discharge. In addition, the study identified the depressed adults' preferences of support and therapy when experiencing depressive episodes.

Findings revealed a persistently low self-esteem among subjects and a fairly constant perception of the family environment over time, even though the symptoms of depression were greatly alleviated at discharge and one month follow-up. Depressed adults in the study perceived their family environment as lacking expressiveness among members. Subjects also indicated several preferences for support and therapy.

Until further studies are done, no conclusions can be drawn about the extent of involvement of self-esteem and perception of family environment in depressive

symptomatology. Researchers must continually attempt to explore the various reciprocal relationships that exist within the phenomenon of depression so that multimodal approaches to caring for depressed individuals are instituted.

Clinically, however, the results of this study suggest that therapeutic attempts aimed only at the individual client are unlikely to succeed in reducing the rate of recidivism among previously depressed adults, unless the client's family or support person fulfilling the role of the family, also becomes an integral part of therapy. The results also highlight the necessity of including the client in the choice of therapies to maximize the therapeutic effectiveness of the interventions and to promote self-responsibility in clients. Mutuality of decisions in therapy will provide these clients with a sense of control, thus counteracting the feelings of helplessness and powerlessness commonly experienced by depressed individuals.

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APPENDIX A

BECK DEPRESSION INVENTORY

NAME _____ DATE _____

On this questionaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one.

Be sure to read all the statements in each group before making your choice.

Permission to use this scale was obtained from:
CENTER FOR COGNITIVE THERAPY, Philadelphia, PA.

1	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisifed or bored with everything.
5	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8	0	I don't feel I am worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.

9	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.
11	0	I am no more irritated now than I ever am.
	1	I get annoyed or irritated more easily than I used to.
	2	I feel irritated all the time now.
	3	I don't get irritated at all by the things that used to irritate me.
12	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.
13	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions than before.
	3	I can't make decisions at all anymore.
14	0	I don't feel I look any worse than I used to.
	1	I am worried that I am looking old or unnatractive.
	2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.
15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.

16 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes ___ No ____

20 0 I am more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

APPENDIX B

TENNESSEE SELF CONCEPT SCALE

INSTRUCTIONS

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item. Read each statement carefully, then select one of the five responses listed below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

You will find these response numbers repeated at the top of each page to help you remember them.

Permission to use this scale was obtained from:
WESTERN PSYCHOLOGICAL SERVICES, Los Angeles, CA.

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
1.	I have a healthy body	1
3.	I am an attractive person	3
5.	I consider myself a sloppy person	5
19.	I am a decent sort of person	19
21.	I am an honest person	21
23.	I am a bad person	23
37.	I am a cheerful person	37
39.	I am a calm and easygoing person	39
41.	I am a nobody	41
55.	I have a family that would always help me in any kind of trouble	55
57.	I am a member of a happy family	57
59.	My friends have no confidence in me	59
73.	I am a friendly person	73
75.	I am popular with men	75
77.	I am not interested in what other people do	77
91.	I do not always tell the truth	91
93.	I get angry sometimes	93

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
2.	I like to look nice and neat all the time..	2
4.	I am full of aches and pains.....	4
6.	I am a sick person.....	6
20.	I am a religious person.....	20
22.	I am a moral failure.....	22
24.	I am a morally weak person.....	24
38.	I have a lot of self-control.....	38
40.	I am a hateful person.....	40
42.	I am losing my mind.....	42
56.	I am an important person to my friends and family.....	56
58.	I am not loved by my family.....	58
60.	I feel that my family doesn't trust me.....	60
74.	I am popular with women.....	74
76.	I am mad at the whole world.....	76
78.	I am hard to be friendly with.....	78
92.	Once in a while I think of things too bad to talk about.....	92
94.	Sometimes, when I am not feeling well, I am cross.....	94

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

	Item No.
7. I am neither too fat nor too thin.....	7
9. I like my looks the way they are.....	9
11. I would like to change some parts of my body.....	11
25. I am satisfied with my moral behavior.....	25
27. I am satisfied with my relationship with God.....	27
29. I ought to go to church more.....	29
43. I am satisfied to be just what I am.....	43
45. I am just as nice as I should be.....	45
47. I despise myself.....	47
61. I am satisfied with my family relationships.....	61
63. I understand my family as well as I should.....	63
65. I should trust my family more.....	65
79. I am as sociable as I want to be.....	79
81. I try to please others, but don't overdo it.....	81
83. I am no good at all from a social standpoint.....	83
95. I do not like everyone I know.....	95
97. Once in a while, I laugh at a dirty joke.....	97

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

	Item No.
8. I am neither too tall nor too short.....	8
10. I don't feel as well as I should.....	10
12. I should have more sex appeal.....	12
26. I am as religious as I want to be.....	26
28. I wish I could be more trustworthy.....	28
30. I shouldn't tell so many lies.....	30
44. I am as smart as I want to be.....	44
46. I am not the person I would like to be.....	46
48. I wish I didn't give up as easily as I do.....	48
62. I treat my parents as well as I should (Use past tense if parents are not living).....	62
64. I am too sensitive to things my family says.....	64
66. I should love my family more.....	66
80. I am satisfied with the way I treat other people.....	80
82. I should be more polite to others.....	82
84. I ought to get along better with other people.....	84
96. I gossip a little at times.....	96
98. At times I feel like swearing.....	98

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

	Item No.
13. I take good care of myself physically.....	13
15. I try to be careful about my appearance....	15
17. I often act like I am "all thumbs".....	17
31. I am true to my religion in my everyday life.....	31
33. I try to change when I know I'm doing things that are wrong.....	33
35. I sometimes do very bad things.....	35
49. I can always take care of myself in any situation.....	49
51. I take the blame for things without getting mad.....	51
53. I do things without thinking about them first.....	53
67. I try to play fair with my friends and family.....	67
69. I take a real interest in my family.....	69
71. I give in to my parents (Use past tense if parents are not living).....	71
85. I try to understand the other fellow's point of view.....	85
87. I get along well with other people.....	87
89. I do not forgive others easily.....	89
99. I would rather win than lose in a game.....	99

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

Item No.

14. I feel good most of the time.....14____
16. I do poorly in sports and games.....16____
18. I am a poor sleeper.....18____
32. I do what is right most of the time.....32____
34. I sometimes use unfair means to get ahead..34____
36. I have trouble doing the things that are right.....36____
50. I solve my problems quite easily.....50____
52. I change my mind a lot.....52____
54. I try to run away from my problems.....54____
68. I do my share of work at home.....68____
70. I quarrel with my family.....70____
72. I do not act like my family thinks I should.....72____
86. I see good points in all the people I meet.....86____
88. I do not feel at ease with other people....88____
90. I find it hard to talk with strangers.....90____
100. Once in a while I put off until tomorrow what I ought to do today.....100____

APPENDIX C

FAMILY ENVIRONMENT SCALE

FORM R

The Family Environment Scale is a questionnaire that provides statements about families. You are to decide which statements are true of your family and which are false. If you think the statement is True or mostly True of your family, mark T beside the statement. If you think the statement is False or mostly False of your family, mark F beside the statement.

You may feel that some of the statements are true for some family members and false for others. Mark T if the statement is True for most members. Mark F if the statement is False for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, I would like to know what your family seems like to you. So do not try to figure out how other members see your family, but do give your general impression of your family for each statement. Please make sure you answer every item.

1. Family members really help and support one another.
2. Family members often keep their feelings to themselves.
3. We fight a lot in our family.
4. We don't do things on our own very often in our family.
5. We feel it is important to be the best at whatever you do.
6. We often talk about political and social problems.
7. We spend most weekends and evenings at home.
8. Family members attend church, synagogue, or Sunday School fairly often.
9. Activities in our family are pretty carefully planned.
10. Family members are rarely ordered around.
11. We often seem to be killing time at home.
12. We say anything we want to around home.
13. Family members rarely become openly angry.
14. In our family, we are strongly encouraged to be independent.
15. Getting ahead in life is very important in our family.
16. We rarely go to lectures, plays or concerts.
17. Friends often come over for dinner or to visit.
18. We don't say prayers in our family.
19. We are generally very neat and orderly.
20. There are very few rules to follow in our family.
21. We put a lot of energy into what we do at home.
22. It's hard to "blow off steam" at home without upsetting somebody.
23. Family members sometimes get so angry they throw things.
24. We think things out for ourselves in our family.
25. How much money a person makes is not very important to us.

26. Learning about new and different things is very important in our family.

27. Nobody in our family is active in sports, Little League, bowling, etc.

28. We often talk about the religious meaning of Christmas, Passover, or other holidays.

29. It's often hard to find things when you need them in our household.

30. There is one family member who makes most of the decisions.

31. There is a feeling of togetherness in our family.

32. We tell each other about our personal problems.

33. Family members hardly ever lose their tempers.

34. We come and go as we want in our family.

35. We believe in competition and "may the best man win."

36. We are not that interested in cultural activities.

37. We often go to movies, sports events, camping, etc.

38. We don't believe in heaven or hell.

39. Being on time is very important in our family.

40. There are set ways of doing things at home.

41. We rarely volunteer when something has to be done at home.

42. If we feel like doing something on the spur of the moment we often just pick up and go.

43. Family members often criticize each other.

44. There is very little privacy in our family.

45. We always strive to do things just a little better the next time.

46. We rarely have intellectual discussions.

47. Everyone in our family has a hobby or two.

48. Family members have strict ideas about what is right and wrong.

49. People change their minds often in our family.

50. There is a strong emphasis on following rules in our family.

51. Family members really back each other up.

52. Someone usually gets upset if you complain in our family.

53. Family members sometimes hit each other.

54. Family members almost always rely on themselves when a problem comes up.

55. Family members rarely worry about job promotions, school grades, etc.

56. Someone in our family plays a musical instrument.

57. Family members are not very involved in recreational activities outside work or school.

58. We believe there are some things you just have to take on faith.

59. Family members make sure their rooms are neat.

60. Everyone has an equal say in family decisions.

61. There is very little group spirit in our family.

62. Money and paying bills is openly talked about in our family.

63. If there's a disagreement in our family, we try hard to smooth things over and keep the peace.

64. Family members strongly enccurage each other to stand up for their rights.

65. In our family, we don't try that hard to succeed.

66. Family members often go to the library.

67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).

68. In our family each person has different ideas about what is right and wrong.

69. Each person's duties are clearly defined in our family.

70. We can do whatever we want to in our family.

71. We really get along well with each other.

72. We are usually careful about what we say to each other.

73. Family members often try to one-up or out-do each other.

74. It's hard to be by yourself without hurting someone's feelings in our household.

75. "Work before play" is the rule in our family.

76. Watching T.V. is more important than reading in our family.

77. Family members go out a lot.

78. The Bible is a very important book in our home.

79. Money is not handled very carefully in our family.

80. Rules are pretty inflexible in our household.

81. There is plenty of time and attention for everyone in our family.

82. There are a lot of spontaneous discussions in our family.

83. In our family, we believe you don't ever get anywhere by raising your voice.

84. We are not really encouraged to speak for ourselves in our family.

85. Family members are often compared with others as to how well they are doing at work or school.

86. Family members really like music, art and literature.

87. Our main form of entertainment is watching T.V. or listening to the radio.

88. Family members believe that if you sin you will be punished.

89. Dishes are usually done immediately after eating.

90. You can't get away with much in our family.

APPENDIX D

SUBJECT PROFILE

CODE # _____

1. Sex Male _____

   Female _____

2. Age _____ Date of Birth _____

3. Medical Diagnosis: Primary _____

   Secondary _____

4. Number of Psychiatric Admissions: _____

5. What do you feel could be helpful to you or that you would prefer in terms of support and therapy right now?

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX E

EXPLANATION TO SUBJECT

My name is Gulrose Jiwani and I am a nurse completing a master's degree in nursing at Memorial University of Newfoundland. As part of my program, I am carrying out a research study. The purpose of this study is to gather information about how adults with emotional concerns such as yours, view themselves, their family, and their emotional health. This information will assist nurses and other health care givers in identifying times when these people require support and therapy so that necessary assistance may be provided sooner, to avoid possible rehospitalization.

Your participation in this study will consist of providing written answers on three separate questionnaires. In addition, you are expected to respond verbally to some questions that I may ask you after you have completed the written questionnaires. Together, the written and verbal responses will take approximately one and one-half hours. You will be required to complete all three written questionnaires and respond verbally to some questions on three separate occasions; this includes two separate occasions while you are in the hospital, and one time after you are discharged from the hospital. The third occasion will be in your home or if you are rehospitalized, it will take place in the hospital.

If you decide to participate in this study, you are free refuse to answer any questions and are free to withdraw from the study at any time. Whether or not you participate in this study will in no way affect the care you receive. The decision to participate in this study is entirely your own. If you do participate, you are assured that information that you provide, will be strictly confidential. Names will be substituted with numbers, and your name will not appear on any of the questionnaires. Nor will your name appear in any of the findings that may be published. You will receive information about your answers at the end of the third interview. In addition, your psychiatrist will receive information in relation to your health that may require attention immediately.

You personally may not benefit from this study. However, you will add to the understanding of when persons with emotional concerns such as yours require support and therapy, and thus reduce the number of readmissions into the hospital.

A report on the findings of this study will be sent to _____(name of hospital)_____. If you are interested in knowing about the findings of this study, you may contact the Director of Research or Director of Education at the hospital.

Do you have any questions? Are you willing to participate in this study? If you agree to participate, I would like you to read the Subject Consent Form and provide your written consent to participate in this study.

If you need to contact me for further information about this study, please do not hesitate to do so. My telephone number is _____. Thank you.

APPENDIX F

SUBJECT CONSENT FORM

I, _____, have been asked to participate in a study to gather information regarding my views about myself, my family, and my emotional health.

I understand that participation in this study involves completing three separate written questionnaires and responding verbally to some questions asked by Gulrose Jiwani, on three separate occasions. I understand that the three occasions will include two separate occasions in the hospital, and once after I have been discharged from the hospital. I understand that the third occasion will be in my home or if I am rehospitalized, it will take place in the hospital. I understand that together, the written and verbal responses will take approximately one and one-half hours on each occasion.

I understand that my answers will remain strictly confidential. I understand that my name will not appear on any of the questionnaires nor will it appear in any findings that may be published. I understand that I will receive information about my answers at the end of the third interview. I understand that my psychiatrist will receive information about my health which may require attention immediately.

I understand that I may refuse to answer any questions and that I am free to withdraw from the study at any time without any effects on the care I am currently receiving.

I understand that I may not directly benefit from participation in the study. However, the information may be useful in adding to the understanding of and in providing therapy to persons in similar circumstances in the future.

I hereby give my consent to participate in this study, the nature of which has been explained to me.

_____ _____

Date Signature of Subject

APPENDIX G

LETTER SEEKING HOSPITAL APPROVAL

Dear _____:

This letter is to request permission to conduct a nursing research study in your hospital. I am a graduate student currently registered in the graduate program in the School of Nursing, Memorial University of Newfoundland. This study is a partial requirement for the master's degree in Nursing and is under the supervision of Dr. Mary Jo Bulbrook.

The purpose of my investigation is to describe the relationship of the self-esteem and the perception of the family environment of individuals with affective disorders, on admission and discharge from psychiatric facility and at one month post-discharge. In addition, this study will elicit information with regard to support and therapy preferences of depressed adults, when experiencing depressive episodes.

Enclosed are the following:

1. The research proposal.
2. A copy of the research instruments: (a) Tennessee Self Concept Scale (TSCS), (b) Family Environment Scale (FES), (c) Beck Depression Inventory (BDI), and (d) Subject Profile (SP).
3. A copy of the consent form and explanation to the individual to participate in the research study.
4. A copy of approval of research proposal by the Thesis Committee, Memorial University of Newfoundland (MUN).
5. A copy of approval of research proposal by the Research Committee, MUN.

I will require the assistance of your hospital for the identification and initial contact with clients.

.../2

This would necessitate that I have your permission to meet with the Patient Care Coordinator/Head Nurse of the psychiatric admission unit at your hospital, for explanation of my research study. In addition, I will require the assistance of the senior clinical nurse and primary nurses on the psychiatric unit to:
(1) help me identify potential subjects, and
(2) approach the individual to inform him/her of the study and to obtain verbal consent from the individual to release his/her name to me, for purposes of explaining the research study and obtaining written consent for participation in the study.

If the individual is willing to release his/her name to me, I will contact the person to explain the research study and obtain a written informed consent to participate in the study. I will be responsible for the administration of the research instruments and data collection on three separate occasions as outlined in the research proposal, of which two occasions will be on the psychiatric unit at your hospital. I will also require permission from your hospital to have access to records of clients who have consented to participate in the study, during the study period to verify information that is required on one of the research instruments, the Subject Profile (SP) form. I anticipate my data collection on the psychiatric unit will take approximately six months.

I hope you will look upon this request favorably. I shall be pleased to provide any further information you may require and meet with you to discuss the study. I can be reached at_____.

Thank you for your interest and consideration of my request. I look forward to a reply at your earliest convenience.

Sincerely,

Gulrosebegum N. Jiwani, B.Sc.N., R.N.

APPENDIX H

LETTER TO PSYCHIATRIST

Dear Dr._____

I have received permission from your hospital to conduct the following nursing research study, "Self-esteem, family perception, and therapy preferences of depressed individuals: An exploratory study," on your unit.

Please note the following details:

1. All subjects will provide a written consent prior to participation in the study.
2. You will be notified of patients who are included in the study.
3. The interviews for data collection will be conducted at a time that does not interfere with patient programs, groups, physician appointments, or other therapies.
4. You and the primary nurse will be notified immediately if your patient expresses suicidal ideations during the interview.

Thank you for your support and co-operation.

Sincerely,

Gulrosebegum N. Jiwani, B.Sc.N., R.N.

APPENDIX I

LETTER TO THE PATIENT CARE COORDINATOR/HEAD NURSE OF PSYCHIATRIC UNIT

Dear_____:

I have received permission from your hospital to conduct a nursing research study on the psychiatric unit. I am currently registered in the graduate program in the School of Nursing, Memorial University of Newfoundland. This study is a partial requirement for the master's degree in Nursing.

The purpose of my investigation is to describe the relationship of the self-esteem and the perceptions of the nature of the family environment of individuals with affective disorders, on admission and discharge from psychiatric facility and at one month post-discharge. In addition, information with regard to support and therapy preferences of depressed adults, will be sought.

This letter is to request the assistance of the senior clinical nurse and primary nurses on your unit, to:

(1) help me identify potential subjects, and
(2) approach the patient to inform him/her of the study and to obtain verbal consent from the patient to release his/her name to me, for purposes of explaining the research study and obtaining written consent for participation in the study.

If the patient is willing to release his/her name to me, I will contact the person to explain the research study and obtain a written informed consent to participate in the study. I will be responsible for the administration of the research instruments and data collection on two separate occasions on the unit. I will also be accessing records of individuals who have consented to participate in the study, during the

.../2

study period to verify information that is required on the Subject Profile (SP) form developed by me. The SP form is enclosed herewith for your perusal. I anticipate my data collection on the unit will take approximately six months.

I hope you will look upon this request favorably. I shall be pleased to provide any further information you may require and meet with you to discuss the study. I can be reached at _____.

Thank you for your interest and consideration of my request. I look forwrad to a reply at your earliest convenience.

Sincerely,

Gulroseb[redacted]um N. Jiwani, B.Sc.N., R.N.

APPENDIX J

LETTER TO THE SENIOR CLINICAL NURSE AND PRIMARY NURSES OF THE PSYCHIATRIC UNIT

Dear _____:

I am conducting a nursing research study to explore the relationship of the self-esteem and perceptions of the nature of the family environment of individuals with affective disorders, on admission and discharge from psychiatric facility and at one month post-discharge. In addition, information with regard to support and therapy preferences of depressed adults, will be sought. It is anticipated that the findings will be useful in identifying individuals with affective disorders who may be a high risk for rehospitalization and planning care for such individuals so as to reduce the number of potential readmissions.

I have received approval for the study from the Ethics Committee at the School of Nursing, Memorial University of Newfoundland and the Ethics/Research Committee at the hospital. The Patient Care Coordinator/ Head Nurse has also been informed.

This letter is to request your assistance with this study. I would like you to help me to identify potential subjects which meet the following criteria:

1. The subject is between the age of 20 and 64 years.
2. The subject has a medical diagnosis indicative of depression upon admission to the psychiatric unit.
3. The subject is able to speak, read, write and comprehend English.
4. The subject will reside upon discharge within a 50 mile radius of the hospital.
5. The subject is competent and able to give a freely informed, written consent to participate in the study.

.../2

I would like to approach the potential subject using the attached standardized introduction to inform the individual of the study and to obtain his/her verbal consent that he/she would be willing to release his/her name to me and listen to an explanation of the study. If an individual is willing to release his/her name to me, I will then visit him/her at the hospital to explain the study and obtain an informed, written consent to participate in the study.

I will be responsible for the administration of the research instruments and data collection for the study. The subject will be asked to complete three written questionnaires and provide verbal responses asked by me from the Subject Profile form that I have developed for the study. Data collection will occur on three separate occasions for each subject; this includes two separate occasions while the subject is in the hospital, and once at the subject's home after he/she is discharged from the hospital. The written and verbal responses would take approximately one and one-half hours of the subject's time on each occasion. I will also be accessing records of individuals who have consented to participate in the study, during the study period to verify information that is required on the Subject Profile form.

Thank you for your interest and cooperation with this study. I look forward to meeting with as many nurses as possible in the near future to discuss this study. I can be reached at _____.

Sincerely yours,

Gulrosebegum N. Jiwani, B.Sc.N., R.N.

APPENDIX K

STANDARDIZED INTRODUCTION BY THE SENIOR CLINICAL NURSE OR PRIMARY NURSE TO THE INDIVIDUAL

Hello / Mr./Mrs./Ms. _____.

Gulrose Jiwani, a registered nurse, who has worked with persons having emotional problems, is conducting a study concerning individuals who have emotional concerns such as yours. She would like to have the opportunity to explain the study to you and to ask for your participation. The fact that you agree to listen to her explanation in no way commits you to participate in the study.

May I have permission to give her your name?

_____

APPENDIX L

EXPLANATION OF THE NATURE OF THE RESEARCH INSTRUMENTS

A. Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI) was developed by Beck (Beck et al., 1961). The BDI (long form) is an instrument designed to measure dimensions of depression (Appendix A). The BDI provides an estimate of the current degree of severity of depressed mood. While the BDI serves as a predictor of depression, it should not replace diagnosis in the sense of clinical judgement. It must be noted that the subjective experiences tapped by the BDI and the signs of depression assessed by the DSM-III (1980) "are two separate and relatively independent phenomena" (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982, p. 119).

Structurally, the BDI (long form) consists of 21 items, each item containing four self-descriptive statements, labeled from 0 to 3, to which the subject responds by encircling the statement that best describes how he/she is feeling at that point in time. The 21 items included in the BDI are: A. Sadness,

B. Pessimism, C. Sense of failure, D. Dissatisfaction,
E. Guilt, F. Sense of punishment, G. Self-dislike,
H. Self-accusations, I. Self-harm, J. Crying Spells,
K. Irritability, L. Social withdrawal,
M. Indecisiveness, N. Self-image change,
O. Work difficulty, P. Sleep disturbance,
Q. Fatigability, R. Anorexia, S. Weight loss,
T. Somatic preoccupation, and, U. Loss of libido.

The BDI is a self-administered paper-pencil test, and can be used with adults. Scoring of the BDI consists of adding up the encircled numeral values. The total score provides an estimate of the degree of severity of depressed mood. The mean scores can be interpreted as follows:

	Mean	Standard Deviation
Not depressed	10.9	8.1
Mildly depressed	18.7	10.2
Moderately depressed	25.4	9.6
Severely depressed	30.0	10.6

For the purpose of this study, the total score on the BDI was used as a reflection of the extent of

current depressive symptomatology exhibited by the subject. The higher one's score on the BDI, the more pervasive is one's depression, since a higher score requires that different symptoms be endorsed.

Reliability and Validity of the BDI. The reliability and validity data for the BDI have been reported by several researchers, with both psychiatric (e.g., Beck, 1967; Beck, et al., 1961) and normal samples (Bumberry, Oliver, & McClure, 1978). The BDI has been widely used both as a self-rating scale and in clinical settings.

Several research studies utilizing the BDI have been reported in the literature, purporting that the BDI is a reliable and valid instrument. High internal consistency (Peterson, Schwartz, & Seligman, 1981; Tennen & Herzberger, 1987) and test-retest reliability (Golin, Sweeney, & Shaeffer, 1981; Rehm, 1976; Tennen & Herzberger, 1987) have been reported in college student samples.

The BDI has reasonable predictive and concurrent validity (Beck, 1967). Furthermore, Coyne and Gotlib (1983) reviewed investigations of the psychometric properties of the BDI. The BDI has also been validated

to yield very good sensitivity and specificity ratios (Love, 1987; Turner & Romano, 1984).

B. Tennessee Self Concept Scale (TSCS)

The Tennessee Self Concept Scale (TSCS) was developed by Fitts (1965). The TSCS is an instrument designed to measure the multidimensional structure of self concept (Appendix B). Structurally, the TSCS consists of 100 self-descriptive statements to which the subject responds on a five-point response scale ranging from "completely true" to "completely false." The TSCS is a self-administered paper-pencil test, and can be used with persons 12 years or older who have at least a sixth-grade reading level.

Ninety of the items, equally divided as positive and negative statements, make up the eight subscales of the test which define Self-esteem. The subscales include: Identity, Self Satisfaction, Behavior, Physical Self, Moral-Ethical Self, Personal Self, Family Self, and Social Self. The remaining ten of the 100 items came from the Minnesota Multiphasic Personality Inventory (MMPI) L-Scale and comprise the Self Criticism Scale (a measure of overt

defensiveness).

The TSCS has two forms. Both forms use the same 100 items, however utilize different answer-profile sheets. The Counseling Form (Form C) provides information on a number of measures, including response defensiveness, a total score, and self concept scales that reflect "What I am," "How I Feel," and "What I Do". The Clinical and Research Form (Form C & R) yields additional measures, including the six empirical scales: Defensive Position, General Maladjustment, Psychosis, Personality Disorder, Neurosis, and Personality Integration. Special scoring keys are required. For the purpose of this study, the Counseling Form (Form C) of the TSCS was utilized, and scores were obtained for the 90 items that provide the Self-esteem Score (Total P Score).

Reliability and Validity of the TSCS. The reliability and validity data for the TSCS have been reported in the Manual (Fitts, 1965). The test-retest reliability coefficients of all major scores on the TSCS (Form C) are reported (see Fitts, 1965, p. 14).

The test-retest reliability coefficient of .92 has been reported for the total positive self-esteem

score in a sample of college students, noted over a two-week period (Fitts, 1965). Other researchers note the test-retest reliabilities for the self-esteem score as ranging from .75 to .92 (Gross & Alder, 1970). In addition, the TSCS has been used in over 1,350 research studies, as reported in the Tennessee Self Concept Scale: Bibliography of research studies (Reed, Fitts, & Boehm, 1981).

The validity of the TSCS has also been previously established and reported in the Manual (Fitts, 1965, pp. 17-30). Four kinds of validation procedures have been reported: (1) content validity, (2) discrimination between groups, (3) correlation with other personality measures, and (4) personality changes under particular conditions. In addition, several of the measurement studies of the TSCS, reported subsequent to the Manual's (Fitts, 1965) publication, have been directed toward an elucidation of its validity, particularly construct validity (e.g., Culbertson, 1975; Shapiro & Swensen, 1977), or toward a description of the influence of situational variables (e.g., social desirability, response set), on TSCS scores (Fitts, et al., 1971, pp. 45-61).

C. Family Environment Scale (FES)

The Family Environment Scale (FES) was developed by Moos (1974). The FES is an instrument designed to assess the social climate of the family (Appendix C). Specifically, the FES measures the interpersonal relationships among family members, the directions of personal growth which the family emphasizes, and the basic structural organization of the family. The FES is a self-administered paper-pencil test, and can be used with persons 12 years or older.

Structurally, the FES consists of 90 true-false items which form 10 subscales. These subscales create tripartite-dimensional conceptualization of the family environment: Relationship dimensions, Personal Growth dimensions, and System Maintenance dimensions. The statements are worded such that a "true" response indicates the presence or encouragement of a specific behavior within the family unit. "False" responses indicate that the respondent perceives the family as lacking a certain characteristic.

Each subscale constitutes nine items scattered throughout the questionnaire. The subject responds on a separate FES answer sheet. Scoring of each of the

FES subscales is a simple clerical task using the template provided. Separate scores, ranging from zero to nine, are reported for each of the subscales. Higher subscale scores reflect a greater degree of emphasis on that characteristic of the family environment. The FES also yields Family Incongruence Scores, both for any given pair of family members, or for the entire family.

The FES has been adapted into several major forms. The most frequently used form the Real Family Form (Form R), is used to characterize the family environment as it exists presently. Other forms include the Ideal Family Form (Form I), designed to measure the family as the members would ideally like it to be, an Expectation Form (Form E), which measures the family member's expectations about family settings, and a Short Form (Form S) composed of 40 items of the regular 90-item form (Form R). For the purpose of this study, the Real Family Form (Form R) of the FES was utilized.

Reliability and Validity of the FES.

The reliability data for the FES includes test-retest reliabilities for 8-week, 4-month and

12-month intervals. The average correlations reported by Moos and Moos (1981) for the 10 subscales of the FES for each time period are .78, .74, and .73, respectively. Internal consistency reliabilities for the subscales using both the Kuder-Richardson Formula 20 (Moos, 1974) and Cronbach Alpha (Moos & Moos, 1981) methods of calculation have shown coefficients in the .61 to .78 range. However, these statistics were derived from relatively large samples (N = 814 and 1,067, respectively). Internal reliabilities (alpha) with smaller samples have been lower (e.g., Anderson, 1983; Pribyl, 1984). Anderson (1984) posits that the 2-point, true-false response format of the FES may be responsible for artificially inflating internal reliability with larger samples.

The validity data on the FES has not been systematically reported in the literature (Forman & Hagan, 1983). Instead, the Manual (Moos & Moos, 1981) describes the relevant information in terms of areas of application, making reference to empirical relationships betweeh FES and other measures.

According to Anderson (1984), given the attention to the psychometric criteria in the selection of the

final items of the FES, the content validity of the subscales appear relatively well established. Evidence for the predictive validity of some of the FES subscales have been noted (Finney, Moos, & Newborn, 1980; Wetzel & Redmond, 1980).

Evidence for the concurrent validity of the FES is mixed. For instance, Russell (1980) found that the Cohesion subscale did not correlate well with other self-report and observational measures of family cohesion. In addition, Oliveri and Reiss (1984) found no relationships between the FES and their direct observational measures of similar dimensions. In contrast, Moos and Moos (1981) report a number of studies which suggest strong concurrent validity both with psychiatric and normal populations. The mixed findings regarding the concurrent validity of the FES may be due to the use of small samples in many of the studies and the problems, discussed earlier, as with internal reliability in such samples (Anderson, 1984).

Construct validity has been demonstrated by the ability of FES subscales to consistently discriminate between normal and disturbed groups of families (Moos & Moos, 1981, 1983; Scoresby & Christensen, 1976) and

to be sensitive to changes in clinic families' environments during treatment (e.g. Bromet & Moos, 1977; Moos & Moos, 1983). In addition, strong empirical support has been found for the proposed theoretical relationship between family stresses and family social environments as measured by the FES (Boss, 1977; Maynard, Maynard, McCubbin, & Shao, 1980; McCubbin, Patterson, & Wilson, 1982). While these empirical findings offer strong support for the theoretical foundations of the FES, it is important to note that factor analyses of the FES items, as far as can be determined by the investigator, have not been reported in the literature to statistically confirm the construct validity of the subscales.

D. Subject Profile (SP)

The Subject Profile (SP) form was developed by the investigator for the purpose of this study. The SP consists of five items (Appendix D) and was used to elicit data about personal characteristics of the subject (Items 1-4). In addition, the last item on the SP form (Item 5) was an open-ended question, eliciting information from the subject about the type of help

and/or support the subject perceived he/she required.

Data for the SP form was collected via subjects responding verbally to questions asked by the investigator (following the SP format of items), and the information verified from the subjects' clinical records in the hospital.

APPENDIX M

FAMILY ENVIRONMENT SCALE

SCORING KEY

COHESION

Real family (Form R) Item Number	Scoring Direction	
1	T	Family members really help and support one another.
11	F	We often seem to be killing time at home.
21	T	We put a lot of energy into what we do at home.
31	T	There is a feeling of togetherness in our family.
41	F	We rarely volunteer when something has to be done at home.
51	T	Family members really back each other up.
61	F	There is very little group spirit in our family.
71	T	We really get along well with each other.
81	T	There is plenty of time and attention for everyone in our family.

EXPRESSIVENESS

Real family (Form R) Item Number	Scoring Direction	
2	F	Family members often keep their feelings to themselves.
12	T	We say anything we want to around home.
22	F	It's hard to "blow off steam" at home without upsetting somebody.
32	T	We tell each other about our personal problems.
42	T	If we feel like doing something on the spur of the moment we often just pick up and go.
52	F	Someone ususally gets upset if you complain in our family.
62	T	Money and paying bills is openly talked about in our family.
72	F	We are usually careful about what we say to each other.
82	T	There are a lot of spontaneous discussions in our family.

CONFLICT

Real family (Form R) Item Number	Scoring Direction	
3	T	We fight a lot in our family.
13	F	Family members rarely become openly angry.
23	T	Family members sometimes get so angry they throw things.
33	F	Family members hardly ever lose their tempers.
43	T	Family members often criticize each other.
53	T	Family members sometimes hit each other.
63	F	If there's a disagreement in our family, we try hard to smooth things over and keep the peace.
73	T	Family members often try to one-up or outdo each other.
83	F	In our family, we believe you don't ever get anywhere by raising your voice.

(From Moos, 1974)